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Bringing politics and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada

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ABSTRACT

An interesting question concerns how large-scale (mental) health services policy initiatives come into being, and the role of evidence within the decision-making process behind their origins. This paper illustrates the process by which motivation to address homelessness, in the context of the upcoming 2010 Vancouver Olympics, was leveraged into a pan-Canadian project including sites in Vancouver, Winnipeg, Toronto, Montreal and Moncton, New Brunswick. The aim of the initiative was to implement and evaluate an intervention, Housing First, to provide housing and support to previously homeless people with mental illness. This qualitative case study was conducted between December 2009 and December 2010, employing grounded theory, and drawing on archival documents and interviews with 19 key informants involved in the conception of the project. Overall, the findings affirm that policy-making does not follow a rational, linear process of knowledge translation/exchange (KTE) and implementation, whereby evidence-based "products" are brought forward to address objectively determined needs and then "placed into decision-making events" (Lomas, 2007, p. 130). Instead, evidence-based policy making should be understood within the much more complex context of "policy entrepreneurship" (Kingdon, 2003; Mintrom & Norman, 2009) which entails taking advantage of windows of opportunity, and helping to bring together the "streams" of problems, politics, and policy ideas (Kingdon, 2003).

Introduction

The At Home/Chez Soi project is the largest mental health services trial ever mounted in Canada. Funded by Health Canada and carried out by the Mental Health Commission of Canada (MHCC), the project uses a randomized controlled trial (RCT) design, following more than 2200 previously homeless people with mental illness in five cities for two years to examine outcomes (Goering et al., 2011). The focus of the current paper is on a qualitative study of the process of the conception of the At Home/Chez Soi, which the project team believed would provide useful lessons for other jurisdictions regarding the diffusion of innovative ideas for addressing complex health and social problems, like mental illness and homelessness.

As the research proceeded, it became evident that moving the ideas behind this initiative into policy entailed effectively positioning the outlines of a potential solution within a complex political climate, a process that can be understood as "policy entrepreneurship" (Kingdon, 2003; Mintrom & Norman, 2009), which brings the three "streams" of "politics", "problems" and "policies" together. Given the current focus on "evidence-based" policy making, and growing attention to the complex intersections between evidence and the political and social aspects of decision-making and "agenda setting" (Battams & Baum, 2010; Fischer, 2003; Kingdon, 2003; Russell, Greenhalgh, Byrne, & McDonnell, 2008; Tiernan & Burke, 2002), this investigation thus offered a valuable chance to broaden understandings on innovative policy-making in the mental health field. Finally, the present research, with its qualitative, case-study approach, also offers a chance to build our understanding of what is increasingly recognized as the "complex, dynamic, and social" nature of evidence-based policy-making approaches, such as knowledge exchange (Ward, Smith, House, & Hamer, 2012).

The focus of the paper is on the political phase of the At Home/Chez Soi initiatives' conception; hence, the perspective taken looks outward from Kingdon's "political stream" towards the "policy" and

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"problem" spheres, and focuses on how policy entrepreneurship helped link these spheres during this initial phase and resulted in the initiatives' funding. This paper is abstracted from a larger study (Macnaughton, Nelson, Piat, Eckerle Curwood, & Egalité, 2010) that also looks more closely at how the initiatives' policy specifics were adapted in response to local communities' perspectives on the problem. Factors related to cross-site implementation of the initiative (e.g., the coherence of the policy idea) or the longer-term sustainability of this (still in progress) demonstration project, will thus not be closely examined in this paper.

Some may argue whether demonstration projects could be considered "policy", given questions about continuation of funding; this risk, however, was weighed carefully against the tremendous opportunity to create a long-term policy legacy. At the time of writing, there has been formal commitment to continue funding the Housing First model at all sites beyond the end of the demonstration period, either indefinitely or for a transitional period, while the possible options for permanent funding are negotiated. In the event that plans are not fully realized in a local site, the project will transition those participants to other housing and support services. There are also many examples of the ways in which the project has already achieved shifts in program and system policy, both nationally (Goering & Tsemberis, in press), and internationally, including the launching of similar demonstration initiatives in France (Goering et al., 2012), Australia, and Portugal.

Literature review

Community mental health and homelessness

Despite the reforms of the community mental health movement, there is a general consensus that a large "quality chasm" exists between what the research suggests people with serious mental illness should receive and the proportion of individuals actually receiving those services (Lehman, 2010). The inadequacies of mental health services are reflected by the over-representation of people with mental illness among the justice system and among the ranks of the impoverished and homeless (Rochefort, 1997). Indeed, a study of two North American cities showed that people with serious mental illness accounted for approximately 50% of total bed days within homeless shelters, which have become a de facto parallel system of care for homeless people with mental illness (Culhane & Metraux, 2008).

As Battams and Baum (2010) described, inadequate housing for people with mental illness has been compounded by issues such as affordability, loss of housing stock, divided accountability, and lack of a "common view" about solutions that could facilitate action across the various policy and service delivery partners involved in housing people with mental illness. Moreover, in Canada specifically, as in other Western nations, a political climate of neoliberalism has contributed to the withdrawal of government from the social housing sphere, both in terms of funding and policy attention (Gaetz, 2010); the result is that what were previously federal and provincial responsibilities for social housing have now been increasingly placed on municipal governments, which lack funding to fill the policy void (Carroll & Jones, 2000).

In regards to homelessness and mental illness, there has been slow progress in implementing appropriate interventions, which the Nelson, Aubry, and Lafrance (2007) review shows, should combine Assertive Community Treatment (ACT) or Intensive Case Management (ICM), with supported housing, as does the Pathways/Housing First approach. Unlike traditional purpose-built mental health housing, the Pathways approach provides the individual with independent housing, and provides support on a mobile basis (Tsemberis, Gulcur, & Nakae, 2004).

Mental health policy responses

In response to the policy failure of community mental health in North America, and due to the growing public concern that accompanied it, Canada and the United States have recently undergone large-scale federal policy review processes. In the United States, a major consultation known as the President's New Freedom Commission was conducted. In Canada, a cross-country Senate consultation, spearheaded by then-Senator Michael Kirby, led to the report *Out of the Shadows* (Kirby & Keon, 2006). In both cases, these reviews resulted in a series of recommendations oriented towards developing evidence-based, recovery-oriented supports for people with serious mental illness. In Canada, supported housing was a central plank of the overall recommendations, and the report lead to the formation of the MHCC, funded for 10 years to spearhead reform. The MHCC has a formal organizational structure, and a board and committee structure that includes people with mental illness, family members, and mental health professionals. Through its committee structure the MHCC is also closely linked to an informal mental health policy network throughout Canada, and in the various provinces. For instance, the Chair of the MHCC's Services Committee, Steve Lurie, is well connected to an Ontario policy network that has contributed to previous reform in the province (Wiktorowicz, 2005).

The rationalist, evidence-based approach to mental health policy-making

In both countries, mental health policy reform coincided with efforts within the health services and policy fields to develop systematic and sustained strategies for translating evidence about what works into concrete policies and practices, a process often referred to in Canada as "knowledge exchange", "knowledge translation" or knowledge translation and exchange (KTE). For instance, the "Knowledge to Action" model, which has been adopted by the Canadian Institutes of Health Research (CIHR), involves a series of steps for developing, synthesizing, tailoring and applying knowledge to a given problem within a specific local context (Graham et al., 2006). The CIHR model in fact does encompass non-linear events such as interaction and mutual learning between researchers and policy-makers, and evidence is acknowledged to encompass experience and expertise. However, the emphasis of the model is arguably on employing systematic techniques for moving research evidence into policy and practice to address evidence/practice gaps.

In the United States, Damschroder et al. (2009) review a number of similar approaches that have arisen within the burgeoning field of "implementation science." Internationally, a number of authors have contributed to a special issue of *Health Research Policy and Systems* on "evidence-informed policy-making", which describes systematic procedures for using evidence during three stages – problem clarification, options formulation, implementation planning – of the policy-making process (Oxman, Lavis, Lewin, & Fretheim, 2009).

Underlying all of these approaches is the apparently reasonable assumption that effective policy reform hinges on the ability to develop and apply systematic techniques – or "technicist" approaches (Ward et al., 2012) – for addressing these evidence/practice gaps. Another underlying assumption here is that objective solutions exist to clearly manifested problems that potential knowledge users (e.g., policy-makers or clinicians) can be persuaded and helped to implement.

Critique of the rationalist, evidence-based approach

In an alternative constructionist view, such problems are by nature not objectively apparent, but are usually multi-faceted in