

BUILDING EQUITABLE PARTNERSHIPS

TOOLS AND LESSONS LEARNED

A RESOURCE FOR INDIVIDUALS
AND ORGANIZATIONS

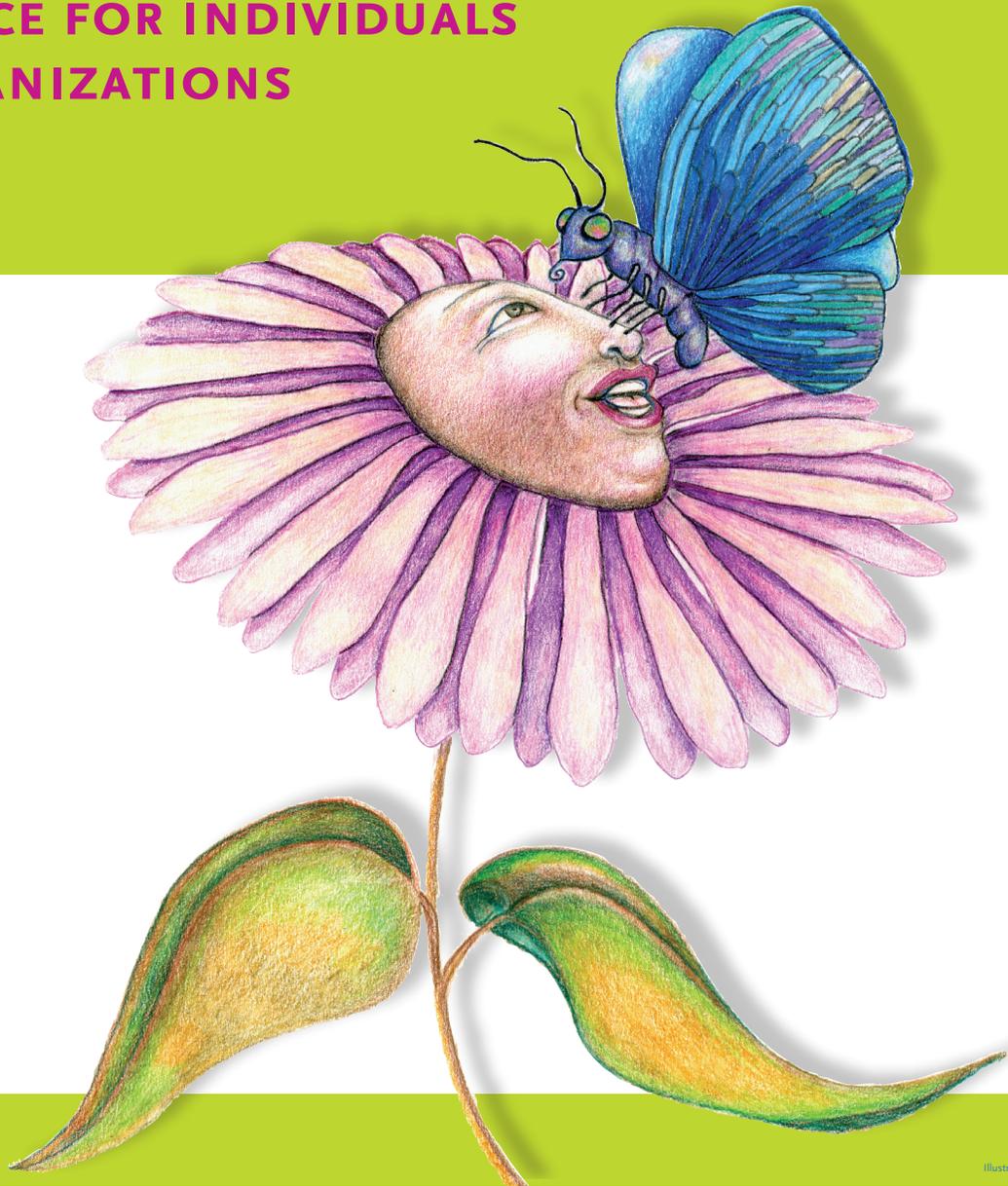


Illustration: Claudette Nevins



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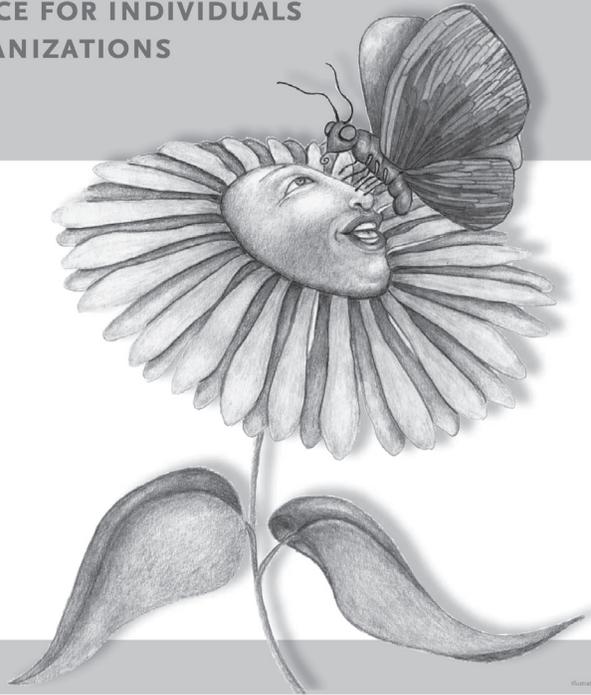


Illustration: Claudette Noyens

Acknowledgments

This resource is an evolution of the Building Equitable Partnerships Project that has, over the years, involved a number of partner organizations and groups: most recently, the Canadian Mental Health Association (CMHA)–Toronto Branch, the Centre for Addiction and Mental Health (CAMH), the Committee for Accessible AIDS Treatment (CAAT), the Multicultural InterAgency Group of Peel (MIAG), Sistering, community participants and mental health advocates.

A huge thank you to all who shared their stories of building, sustaining and evaluating equitable partnerships for this publication. Their willingness, openness and generosity greatly added to the richness of this resource.

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Building
Equitable
Partnerships



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About this resource

Angela Martella

Project background

In 2001, the Centre for Addiction and Mental Health (CAMH) initiated the Building Equitable Partnerships (BEP) project out of a desire to partner and engage effectively and equitably with diverse communities, groups and organizations. Over the course of several years, the project evolved and grew from an initial staff development course to an in-depth course on equitable partnerships with diverse and marginalized groups, open to CAMH staff and the community. The course was developed and delivered with community partner agencies serving people with disabilities, and the LGBTTTIQ (lesbian, gay, bisexual, transsexual, transgender, two-spirit, intersex and queer), East Asian and South East Asian communities.

In 2008, a symposium was held to reach a broader audience and to showcase a variety of voices speaking on the topic of equitable partnerships. The planning and organizing of the BEP Symposium 2008 included collaboration among community partner agencies, the Canadian Mental Health Association (CMHA)–Toronto Branch, CAMH, the Committee for Accessible AIDS Treatment (CAAT), the Multicultural Inter Agency Group of Peel (MIAG), Sistering and service users from the partner organizations. The planning of the symposium was itself a process of building an equitable partnership.

Through keynote addresses, workshops, panels, artistic performances and displays, the BEP symposium provided a forum for dialogue among groups and individuals with a stake in delivering culturally competent mental health and addiction services, and related health care. Speakers from each of the more than 30 workshops at the symposium reserved time

to collaboratively develop one or two recommendations to build and strengthen equitable partnerships with diverse and marginalized communities and groups. (See Appendix B for a list of these recommendations.)

The latest evolution of the BEP project includes the development of this BEP resource, designed as a synthesis of practical examples and resources featured at the symposium. Participants and presenters were surveyed about the usefulness of such a resource and identified three key areas:

- initiating equitable partnerships
- maintaining equitable partnerships
- evaluation and critical reflection.

Symposium presenters were invited to contribute a profile of their equitable partnership work based on their presentation and workshops. Their contributions, contained here, are intended to provide readers with information about their partnerships pertaining to the theme area, along with contact information for further discussion. Efforts have been made to include a range of examples and to provide opportunities to groups who would not otherwise be published but have valuable information to share.

Both in organizing the symposium and in this resource, efforts were made to reflect a diversity of communities and partnerships; however, we acknowledge that examples contained here are not exhaustive or representative of all communities. They are intended as a sample that highlights the best efforts of groups at forming, maintaining and evaluating equitable partnerships.

A context for partnership

Partnership, as defined in the Victoria Youth Mentoring Alliance’s Partnership Self-Assessment Toolkit (www.youthmentoringvic.org.au/file/file/Community%20Partnerships/Anna%20Frearson%20Partnership%20Self%20Assessment%20Tool.pdf), can simply be two or more organizations, groups or individuals working together toward a common goal. For the purposes of this resource, partnership also includes the relationship between service provider and service user.

Much has been written about partnering between organizations but little emphasis has been given to equitable partnerships between organizations or between service users and service providers. The BEP partners define equitable partnerships as those formed on the basis of equity and respect, which recognize the power imbalance between large institutions and organizations entering into partnerships with smaller community-based agencies. Equitable partnerships also recognize that there are different and varying types of oppression manifested in large health institutions as well as in community-based agencies and organizations.

Oppression can be defined as, or may include:

- discriminatory practices
- imbalances of power affecting decision making
- the inequitable distribution of resources to marginalized individuals, populations or smaller organizations.

Partnerships should be initiated, sustained and evaluated with the aim of ensuring equitable participation for everyone—including the most marginalized—and for the creation of programs and services that strive to reduce health disparities. Research clearly shows that barriers such as language, sexual orientation and lack of treatment options persist (Ontario Federation of Community Mental Health and Addiction Programs, 2009, p. 8). Poor health outcomes and prevalence of disease can be associ-

ated with social inequities related to socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or often the intersection of these inequities (Brennan Ramirez et al., 2008).

As part of our work together, the BEP partners agreed to build an equitable partnership among ourselves by committing to modelling the very best of inclusiveness, respect and equity in all of our activities. We have been and continue to be committed to challenging oppression and inequity in all of our institutions and to use our experiences for mutual learning and growth.

How to use this publication

The partnership examples that follow provide strategies, tips and lessons learned from practical experiences of working together to form equitable partnerships. They are organized in three key theme areas:

- initiating equitable partnerships
- maintaining equitable partnerships
- evaluation and critical reflection.

Each of these three sections opens with a summary of key principles and lessons learned from the partnership examples.

Each partnership’s example is organized in a format similar to that in *Promoting Health Equity* (Brennan Ramirez et al. 2008). Each example contains the following sections:

- Who we are
- Our goals
- What we do
- How we initiated our partnership (initiating equitable partnership) / How we overcame challenges (maintaining equitable partnerships) / How we reflect critically and evaluate our partnership (evaluation and critical reflection)

- How our work/partnership/initiative reflects principles of equity
- What we have learned
- Key documents
- How to reach us.

It is our hope that the partnerships and their accompanying resources will be useful to a broad audience, including mainstream mental health and addiction agencies, hospital services, community agencies, service providers, service users, policy-makers and funders.

References

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- Victoria Youth Mentoring Alliance. *Partnership Self Assessment Toolkit: A Practical Guide to Creating and Maintaining Successful Partnerships*. Available: www.youthmentoringvic.org.au/file/file/Community%20Partnerships/Anna%20Frearson%20Partnership%20Self%20Assessment%20Tool.pdf.

Introduction

Pat Capponi*

The following introduction summarizes an interview with Pat Capponi, author and facilitator with Voices from the Street. She has direct experience with poverty and is a psychiatric survivor. Voices from the Street is a 12-week program offered to people who have experienced homelessness, mental illness, addictions or extreme poverty.

Pat Capponi provided a keynote address at the Building Equitable Partnerships Symposium 2008 and was invited to provide an introduction for this publication, commenting on why equitable partnerships are important and discussing some of the key principles to keep in mind in initiating, maintaining and evaluating equitable partnerships. Pat's experience relates to partnerships between service providers and service users as well as partnerships between organizations. She passionately describes the importance of being genuine and being in tune with power dynamics while embarking on and sustaining equitable partnerships.

* as told to Diana Ballon

The best advice I can give to people embarking on partnerships is to be real. Be real. Be real. Be real. Learn. Be excited. There are so many remarkable people out there who have a lot to say. If we lose the top-down attitude, which never works, and develop partnerships based on equality, then we can go far.

Sharing power

Equity is about sharing power. It's about getting people who are disempowered to feel they have power. And it involves understanding the lives of people with less power.

Any time you're working with people, it becomes critically important to pay attention to the dynamics that are going on. The more hierarchical an agency or institution, the more difficult it may be for staff to feel empowered or heard. If people are really unhappy at their jobs and feel disrespected and powerless, or are afraid of their supervisors or of losing their job, this fear can prevent them from fighting for themselves and others. If you feel you don't have power, are you going to be willing to share power with your clients? How can you work with clients in an empowering way?

It's very important to work toward a healthier work environment. Many staff are in a union and can ask for help to meet with supervisors or other bosses to correct what may be a toxic work environment.

*The best advice I can give to people embarking on partnerships is to be real. Be real.
Be real. Be real. Learn. Be excited.*

Speak to your peers, see if others feel the way you do; if so, encourage speaking out.

People with serious mental health and addiction problems often also live in poverty, have no personal power, are precariously housed, and depend on supportive housing for their shelter. Getting people who are so severely marginalized to feel and accept that they have power is challenging.

Mental illness and addictions are just two of the pathways into poverty. There are many ways in and very few ways out. Valuable partnerships involve learning from each other. They involve putting the voices and experiences of people first to ensure the grass“roots” can work with the grass“tops,” terms I am borrowing from the Metcalfe Foundation’s Colette Murphy.

Learning from clients

To me, equity involves taking time to understand all the factors affecting your client’s life, rather than simply seeing the person through the lens of mental illness. We’ve learned respect for multiculturalism—for wanting to understand where other people come from, what they think, what they want out of life. But we don’t feel as compelled to learn and be educated by the client. If someone is schizophrenic, I would want to know what kind of neighbourhood that person lives in, what food she can afford, what her aspirations are and what things she needs.

When initiating equitable partnerships with clients, we need to shut up and listen. Don’t go in as the expert. Realize that clients have a lot to teach you, and go in humble. Hang out in the doughnut shop, hang out in the mall, go check out where they have to do their shopping. And ask community leaders from that population why our focus is so damn narrow. We have to open up our eyes.

Equity will happen when a client feels he can challenge a worker respectfully without fearing retaliation—without worrying about sounding ungrateful. Clients don’t have to be silent. Psychiatric survivors and the “simply poor” (poor without a psychiatric diagnosis) have been talking directly to people who have power, such as ministers, policy advisers and

their staff, about what is happening to them and to their friends. They are having these conversations without workers interpreting what they are saying. This experience has been empowering for the survivors, and really informative for the policy experts working on poverty and mental health issues. It shows how aware, articulate and able our population is to speak for themselves.

We need to accept that we have much to learn from our clients, and begin integrating them as staff to show that we value experiential knowledge as much as academic credentials.

Once a partnership has been established, it needs to be maintained. When people are taking their first steps to being empowered, don’t be too quick to say “no,” or “you can’t do that.” For instance, if people don’t have a meeting place, provide that space for them.

Being honest, critical and reflective

Partnerships break down for two main reasons: they fall apart when clients become so radicalized and—justifiably or not—so angry that they can’t negotiate, and they fall apart when staff want to maintain their power, without sharing it, which we call reverting to a “power over” stance.

To evaluate and critically reflect on a partnership, you need to bring in outsiders. Bring in strangers, but strangers that have lived the same way. For instance, if you’re evaluating a client program, bring in clients of other programs to do the evaluations.

INITIATING EQUITABLE PARTNERSHIPS

SUMMARY OF KEY PRINCIPLES AND LESSONS LEARNED

Key principles

- Commitment to working from an anti-oppression framework and building the anti-oppression framework into the project
- Commitment to reducing the risks or harms to the client that stem from an activity
- Striving to be accessible and inclusive to all those using the services
- Supporting women in making self-directed, informed choices about sex and sexuality
- Establishing a culture of reflexivity and feedback from all team members early on in the partnership
- Enabling skill building and professional development through educational courses, workshops and conferences for those interested, including research personnel and case managers
- Recognizing the diversity of skill and expertise each collaborator brings; for example, in community engagement, research methodology, project management, case management and peer mentorship
- Making learning from each other and building each others' capacity and knowledge an integral component of the partnership
- Ensuring that reflexivity, frequent communication and feedback from all team members is established early on

Lessons learned

- Community consultation and leadership are invaluable and necessary to maintain principles of equity and conduct high quality community-based research.
- Frequent and open communication and transparency about the roles, agendas and responsibilities of all team members is pivotal to ensure effective project management.
- It is important to recognize the time required to conduct high quality community-based research and to build strong relationships between members of a research team.
- Respect and honesty for the community partnering, and openness and flexibility in dealing with unforeseen circumstances, are very important.
- Partners need to approach challenges by revisiting the philosophical underpinnings or core values that have brought the team together in the first place, as well as the roles and responsibilities outlined in the terms of reference.

Initiating equitable partnerships: An introduction

Winston Husbands and Wangari Tharao

Stakeholder partnerships are a beneficial way to address many of the issues and challenges related to health, well-being and social justice affecting our communities. First, partnerships recognize and acknowledge the diverse interests that are at stake in responding to social issues. Community issues are complex, which usually puts them beyond the scope of individual organizations or groups acting alone. Second, partnerships benefit from the various strengths and resources that the different partners bring to any project or program. And third, by harnessing the interests, strengths and resources of different stakeholders, partnerships may be an efficient mechanism for responding to community issues.

Some partnerships develop organically over an extended period, while others may emerge more or less spontaneously to respond to a pressing issue demanding a fairly urgent response. The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) (www.accho.ca) is an example of the former.

In the mid-1990s, community-based HIV/AIDS organizations serving Toronto's African, Caribbean and Black communities were experiencing increasing demand for their services. Fearing they would be overwhelmed, and anxious about the implications of the growing epidemic for their communities, those organizations started a dialogue amongst themselves, and the AIDS Bureau of the provincial Ministry of Health and Long-Term Care, to strategize a more proactive and collaborative response to dealing with this pressing need.

ACCHO was eventually established in 2004 as a provincial body of service-providing organizations, community members, researchers and policy-makers co-ordinating the response to HIV among African, Caribbean and Black communities in Ontario. However, even in the eight intervening years before the coalition was officially established, the organizations and policy-makers (municipal, provincial and federal) undertook many important initiatives, in addition to extending the number and diversity of participating stakeholders. One of those initiatives involved developing the Strategy to Address Issues Related to HIV/AIDS Faced by People in Ontario from Countries where HIV Is Endemic (www.accho.ca/pdf/ACCHO_strategy_ENGLISH_Dec2003.pdf).

The different stakeholders have been able to develop a strong allegiance to the partnership and its work by collaborating on numerous initiatives over an extended period. They took time to grow the partnership. Still, ACCHO has experienced challenges and changes common among all types of partnerships. For example, although the partners were able to collaborate with consultants to develop the strategy, once it was in place as part of Ontario's response to HIV, ACCHO had to institutionalize its operations to ensure a high level of commitment to co-ordinating the implementation of the strategy. That meant developing robust terms of reference, setting up an office and hiring staff, rather than relying on volunteers, as it had initially. This demonstrates that—though stakeholders should be enthusiastic about

their partnership—enthusiasm alone is insufficient to sustain a partnership. Partnerships often require an infrastructure and institutional support.

The longevity and productivity of ACCHO, from its inception in the mid-1990s as the HIV Endemic Working Group and later as the HIV Endemic Task Force, highlight some additional observations. Partnerships should be guided by a commitment to certain core principles or values. In ACCHO's case, a commitment to transparency, accountability, anti-oppression and social justice helped to strengthen collaboration and guide the day-to-day content of the partnership.

Partnerships also provide opportunities for stakeholders to develop their potential and to deploy their resources equitably. Not all partners will or can contribute to the same degree all the time. Some partners may have more resources at their disposal than others. Therefore, while partners come to the table as equals, partners must understand that their individual contributions may depend on the varying capacity of individual members to contribute resources at any time.

Partnerships also require leaders. Someone or some group of members must take overall responsibility for seeing that the partnership's activities are

implemented according to the principles, budgets, tasks and timelines that the partners have agreed on. However, leadership should reflect the interests of the partnership rather than simply that of the leaders. Similarly, while all partners will contribute to making decisions collectively, decisions are made on behalf of the partnership, its constituents and stakeholders rather than merely through self-interest.

The following section will highlight a number of examples of how partnerships have started organically, spontaneously or as a formal response to an identified need. Each of the partnerships offers practical examples and wisdom about the process of equitable partnership-building.

Winston Husbands is Director of Research at the AIDS Committee of Toronto and a member of the Executive Committee of the African and Caribbean Council on HIV/AIDS in Ontario. He may be reached at whusbands@actoronto.org.

Wangari Tharao is the Program and Research Manager at Women's Health in Women's Hands Community Health Centre and Co-Chair of the African and Caribbean Council on HIV/AIDS in Ontario. She may be reached at wangari@whiwh.com.

*Partnerships often require an infrastructure
and institutional support.*

Frontline Partners with Youth Network

Jenny Katz

Who we are

Frontline Partners with Youth Network (FPYN) (<http://fpyn.ca>) is a unique network comprised of people working directly with youth across sectors and across the Greater Toronto Area. The growth of this network is an expression of the heartfelt need among front-line youth workers to connect with each other.

FPYN has a listserv of more than 1,200 people and a core group of two part-time staff, two full-time staff as well as students and a volunteer stewardship group. Our broader network of volunteers, advisors, members and participants is difficult to measure; however, we know that it is well over 200 people.

Our goals

Our network strives to continuously recognize the link between systemic oppression and the violence that initially brought us together in all that we do. FPYN's goals are:

- to break down isolation among people working directly with youth
- to provide systems of support and training for people working directly with youth
- to create a safe space to think, research, develop and advocate for people working directly with youth.

What we do

SYSTEMS OF SUPPORT AND TRAINING

Many front-line workers work in isolation and deal with complicated situations without always having the training and/or support to deal with the issues they're coming up against.

We support each other through regular get-togethers across the city where we discuss our successes, challenges and ideas. We also talk about the kinds of changes that we hope to make in the city. Out of these get-togethers has emerged a support network that helps us deal with situations that stretch beyond the mandates of our jobs and our formal employment support systems. We have decreased isolation among people working with youth, increased their hopefulness and created opportunities for innovative collaborations.

We continue to provide free and almost-free trainings and safe spaces for front-line workers. Recent trainings have included:

- Endings: How do we say goodbye to youth?
- Narrative therapy
- Supporting Indigenous struggles in Canada: Starting the journey
- An inside look at Canada's Tamil community (in partnership with the Canadian Tamil Congress)

We are a safe place to discuss the impact that racism, white privilege, violence and despair have on ourselves and the youth and families we work with. We are a safe place to make mistakes and develop self-awareness.

SPACE TO THINK, RESEARCH, DEVELOP AND ADVOCATE

Several think tanks have evolved from providing safe places for people connected to the youth-serving community to come together for reflection and advocacy. We host open, honest discussions about how policy, funding and organizational structures, and systemic discrimination affect programming, workers and ultimately youth, families and communities.

We continue to provide a safe place, empowering people to do advocacy without putting their jobs at risk. We anticipate that these think tanks will eventually produce position papers and policy recommendations examining factors that affect working with youth.

By talking about what affects people's ability to feel hopeful and what sabotages communities' abilities to heal, we are changing the terms of the dialogue. The sector's focus on mental health and other individualizing and western-based framings has started to shift. Front-line workers are now more empowered to talk about the social determinants of health, including racism, the unequal distribution of wealth, safety and other policy-related issues. Front-line workers are beginning to become more comfortable talking about the ways they are affected by how the sector is organized. The mental, spiritual and physical health of people "delivering services" is now being considered among front-line workers themselves as well as among policy circles where FPYN has made inroads.

Some of our "think tanks" and discussions have included:

- Race and culture—A think tank for workers of colour
- De-constructing counselling youth
- Youth workers' Bill of Rights
- What is "professionalism" and who benefits from it?

In 2009, FPYN completed a report examining grief and trauma among front-line workers, supported by the Provincial Centre of Excellence for Child and Youth Mental Health (<http://fpyn.ca/content/fpyn-stuff/frontline-worker-grief-and-trauma-fpyns-f-sos-report>). We are now working with the data

we gathered to further examine the issues and develop recommendations based on our findings.

INFORMATION SHARING: THE "MISH MASH" NEWSLETTER AND THE FPYN WEBSITE

We have become an essential resource for over 1,200 people working directly with youth across the city to receive and distribute information they may not have accessed otherwise. Through our collective connections and expertise, we help youth learn about and take advantage of non-traditional opportunities.

Our ability to freely share information and resources directly translates into increased city-wide youth participation in forums, apprenticeships, trainings, grassroots program development, volunteer opportunities and paid employment.

Our ability to freely share information has also resulted in increased professional development, employment, empowerment, advocacy, educational, networking and engagement opportunities for front-line workers.

HOW WE INITIATED OUR PARTNERSHIP

We came together in December 2005 to support each other in dealing with the effects of gun violence. Jenny Katz, an employee at a children's mental health centre, called an initial meeting to find out what others were doing in Toronto to address the impact of this violence in their programs and its effect on participants.

What emerged was the realization that many front-line workers were themselves largely unsupported, marginalized, silenced and struggling. Many of the front-line workers felt betrayed by organizations that continually ignored the evidence of the systemic root causes of violence and were instead resolutely addressing issues primarily at the individual level.

This meeting marked the beginning of lasting relationships based on mutual support and a deep commitment to systemic change. We established our network on a foundation that privileged relationships over money.

It soon became clear that in order for FPYN to be able to create safe spaces to have the kinds of conversations and to carry out action that front-line

workers required, the network needed to be housed outside of the social service sector.

FPYN's first real home was the Centre for Social Innovation (CSI) as an incubated project. CSI helped us develop our governance structure, grant proposals and relationships with funders and eventually became our trustee. CSI continues to provide us with space to work and meet in, a broad network of relevant resources and connections to draw on, Internet access, voice mail, a locker, moral support and practical advice. They have also promoted our work throughout their networks. In a nutshell, they believe in us.

FPYN has recently joined with Tides Canada Initiatives, which provides administrative infrastructure support, allowing us to retain our unique governance structure and remain flexible (<http://tidescanada.org/projects>).

How our work/partnership/initiative reflects principles of equity

FPYN strives to work from an anti-oppression approach and is filled with people committed to challenging themselves and each other to look deeply at the choices we are making and whether they reflect our values. This culture of challenging each other, of reflection, and of developing self-awareness, safety and respect is written into our governance structure, our guiding principles and our evolving policies and procedures. (See our website fpyn.ca)

We consciously do not differentiate between “youth” and “adults” at FPYN. Many ages and levels of work/life experience are represented and different mentoring relationships occur naturally as a result.

Our governance structure outlines our position: we strive to partner with people and not organizations or institutions with the exception of institutions where we have developed a trusting relationship with its current leadership. We operate in a culture of reflection and learning and therefore continually evaluate our experiences as they relate to the partnerships we are engaging in. We strive to keep bureaucracy at a minimum and to work with organizations that do the same. As a result, we often end up

working more closely with smaller organizations that tend to be more fluid, responsive to, and inclusive of community and generally less concerned about ownership and liability.

What we have learned

We have learned that it is important to be patient, to be honest about our mistakes, to feed people, to examine the ways in which we are privileged and/or oppressed, to be upfront about our personal and professional agendas, to be generous, to call it like we see it, to be courageous, to think outside the box and to believe that the right partnerships will emerge if we stay true to our values.

How to reach us

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The wHEALTH Community-Based Research Project

Allyson Ion and Dr. Adriana Carvalhal

Who we are

Women's HIV Empowerment Through Life Tools for Health (wHEALTH) is a community-based research project that aims to assess the impact of a particular case management approach on the quality of life of women living with HIV in the Greater Toronto and Hamilton areas. The multi-stakeholder wHEALTH team was established as a partnership between community leaders, academic researchers and front-line service providers.

The team's co-principal investigators represented the Department of Psychiatry and Behavioural Neurosciences in the Faculty of Health Sciences at McMaster University and Voices of Positive Women, a provincial, women-focused AIDS service organization.

Co-investigators included representatives from Voices of Positive Women, the Ontario HIV Treatment Network, the McMaster University School of Social Work, Women's Health in Women's Hands Community Health Centre and the Centre for Research on Inner City Health—St. Michael's Hospital. Project staff included peer case managers and research personnel from Voices of Positive Women and McMaster University.

Our goals

The wHEALTH is guided by the community-based research principles of equitable collaboration, capacity building and policy relevance. Our objectives are to:

- determine whether six months of a proactive, peer-delivered strengths-based case management intervention is more effective in increasing the physical and mental health-related quality of life of women

living with HIV/AIDS who access the services of community-based AIDS service organizations, compared to the general health program most currently receive

- evaluate whether the strengths-based case management intervention decreases depression levels, improves coping skills and increases social support among women living with HIV/AIDS.

What we do

- *Developed manual to guide peer-delivered, strengths-based case management*

The manual was originally developed to train and guide wHEALTH case managers in their work; however, the information it contains is relevant to HIV-positive women working as support workers, peer mentors or case managers in other contexts. The goal is to make this manual available to community-based organizations across Ontario who provide support services to HIV-positive women.

- *Trained wHEALTH peer case managers*

We conducted a seven-day training with the wHEALTH case managers prior to commencement of the study to familiarize them with the wHEALTH intervention.

- *Conducted community outreach and study recruitment*

The wHEALTH team reached out to organizations and service providers in the Greater Toronto and Hamilton areas (including Brant, Haldimand-Norfolk and Niagara regions) that offered services to HIV-positive women; for example, HIV clinics, AIDS service organizations, women's centres and community health centres. Enrolment began June 2008 and is expected to continue until June 2011.

- **Promote knowledge translation and exchange**
wHEALTH team members attended community forums (e.g., AIDS Committee of Toronto Research Day, Voices of Positive Women special events) and provincial and national research conferences (e.g., Ontario HIV Treatment Network, Canadian Association for HIV Research) to promote the study and present preliminary findings. Study results will be submitted for publication in peer-reviewed journals once available.
- **Communicate as a team**
The research and case manager teams continue to meet frequently to discuss and make decisions on project management and implementation issues. They also debrief and strategize about delivery of the support interventions.
- **Engage the HIV-positive women's community**
HIV-positive women, the target population of this project, were involved at all stages of the project other than as users of the support services under investigation. HIV-positive women were involved in:
 1. development of the study protocol
 2. finalization of the study implementation plan and partnership with community-based organizations
 3. planning and executing the wHEALTH case manager training
 4. development and finalization of the wHEALTH manual Strengths-Based Case Management: A Manual for HIV-Positive Women Working as Peer Case Managers
 5. providing input throughout the project on recruitment, methodological and ethical issues that were raised.

HIV-positive women also represented wHEALTH and the research team at provincial, national and international conferences, presenting study findings and networking with relevant stakeholders.

How our work/partnership/initiative reflects principles of equity

- Equity in philosophies guiding the project.
The wHEALTH intervention and community-based research study as a whole are based on the following core values:
 1. **Anti-oppression framework:** We recognize that women's experiences with HIV are shaped by other realities in their lives such as race, class, gender identity, sexual orientation, ability and immigration status. We strive to address and challenge oppression in ourselves and our activities, designed to reflect the diverse realities and communities of women living with HIV across Ontario. For example, HIV-positive women with multiple experiences and identities were invited and encouraged to participate in wHEALTH. No women were excluded based on socio-demographic characteristics. No assumptions were made about a woman's ability to participate in study interviews; women were asked if they required any accommodations to complete the study interviews and/or support sessions. Flexibility and responsiveness to participants' needs was important to plan study visits. Women were consulted prior to each study visit about the location, day and time that worked, whether they required transportation assistance, interpretation or translation, etc., to ensure that they could participate fully in the research project on their terms.
 2. **Harm/risk reduction:** We are committed to reducing the risks or harms to the client that stem from an activity, rather than attempting to stop that activity. We recognize that women engage in high-risk sexual activities and drug use patterns for a variety of reasons. We want to minimize the adverse health, social and economic consequences associated with these activities.
 3. **Women-focused and inclusive:** We strive to be accessible and inclusive to all women living with HIV.

4. **Sex positive:** We support women in making self-directed, informed choices about sex and sexuality. We affirm the rights of women living with HIV in how they choose to define their sexuality, how to express it, and with whom.

- ***Equity in opportunities for development and capacity building***

All research team members shared the task of orienting the case managers to the project (e.g., developing the training schedule and content, facilitating a component of the training). Throughout the project, resources have been allocated to enable skill-building and professional development. Educational courses, workshops and conferences have been available for anyone interested, including research personnel and case managers. For example, the wHEALTH case managers attended the Ontario HIV Treatment Network Research Conference in November 2009 to strengthen their research skills in developing and presenting an abstract.

As a multidisciplinary team, we recognize the diverse skills and expertise each collaborator brings; for example, in community engagement, research methodology, project management, case management and peer mentorship. The opportunity to learn from each other, and build each others' capacity and knowledge, has been an integral component of this study and partnership.

- ***Equity in the research methodology***

The core values listed above have also influenced our research methodology. Research team members have implemented and co-ordinated the study to ensure that the processes reflect emancipatory and anti-oppressive principles; not only is the case management intervention based on a model of empowerment, so too is the research process itself. For example, to strengthen rapport with participants and further engage the broader HIV-positive women's community, the study protocol was amended to include a form of participatory respondent-driven sampling. Respondent-driven sampling is a form of snowball or chain-referral sampling whereby participants refer people they know, these individuals refer people they know,

and so on. This form of sampling has enabled the HIV-positive women's community to refer their peers to peer-based support and introduce them to the formal and informal support networks that exist through Voices of Positive Women. Respondent-driven sampling has also enabled the study team to reach women who were perhaps not as connected to the HIV-positive women's community, thereby potentially increasing and strengthening their social support network. The need for incorporating a particular kind of recruitment and sampling strategy was discovered in consultation with the wHEALTH case managers.

How we initiated our partnership

- The wHEALTH study was established when the HIV-positive women's community identified that there was insufficient information available about how to best support HIV-positive women throughout Ontario. A partnership between Voices of Positive Women, the Ontario HIV Treatment Network and academic researchers at McMaster University was formed to investigate the optimal approach to providing support services to women living with HIV that would improve their mental health and quality of life. Stakeholders representing these organizations worked collaboratively to refine a study proposal and apply for operational study funding. Once funding was received, other community-based and academic stakeholders joined the research team in an advisory capacity. All team members have worked together to establish guiding principles (e.g., terms of reference), solve logistical and feasibility issues, and guide co-ordination and execution of this community-based study. At the same time, they have continually acted in an advisory capacity and provided support to research personnel.
- A culture of reflexivity and feedback from all team members was established early on. Frequent communication among team members and partner organizations has enabled us to manage challenges and maintain principles of equity. Monthly debriefing sessions between research personnel and case

managers (that is, staff working on the “front lines”), have been invaluable; these meetings have provided an open forum for transparent dialogue, problem-solving and critical appraisal of processes. As a whole, team members have committed to solving challenges and reaching the objectives of this project, even when discussing difficult issues or making difficult decisions.

What we have learned

- **Importance of community consultation and leadership**
Community consultation and leadership is invaluable and necessary to maintain principles of equity and conduct high quality community-based research. For example, feedback from the community led to important changes in the research methodology, which resulted in increased accessibility of the project and increased capacity to offer support services to HIV-positive women. Frequent consultation with the HIV-positive women’s community has led to a greater understanding of how and why community-based services must be grounded in the everyday realities of HIV-positive women’s lives.
- **Importance of communication and transparency**
Frequent and open communication and transparency about the roles, agendas and responsibilities of all team members are pivotal to ensure effective project management.
- **Importance of flexibility and adaptability**
Recognizing the time required to conduct high quality community-based research and to build strong relationships between members of a research team is essential. Academic researchers need to be respectful and open to the pulse and pace of the community they are partnering with, and vice versa; all parties should be honest about their desired timelines, while maintaining flexibility in the event of unforeseen circumstances. If challenges arise, it is always beneficial to revisit the philosophical underpinnings or core values that have brought the team together in the first place, as well as the roles and responsibilities outlined

in terms of reference. These foundational tools can help to simplify and efficiently resolve challenges.

Key documents

The following are some key documents related to this partnership work:

Carvalho, A., Binder, L., Gillies, K., Ndlovu, U., Tharao, W., Ion, A. et al. (2008, November 13–14). The wHEALTH intervention project for women living with HIV/AIDS. Poster session presented at the Ontario HIV Treatment Network (OHTN) Research Conference, Toronto.

Caswell, J., Mwalwanda, M., Ion, A. & Carvalho, A. (2009, November 16–17). 50+ years as women living With HIV: Case Managers provide a ‘wHEALTH’ of Experience. Poster session presented at the Ontario HIV Treatment Network (OHTN) Research Conference.

Ndlovu, U., Ion, A., & Carvalho, A. (2010). “My children and my home”: The most recent and challenging stressors of HIV positive women. *Archives of Women’s Mental Health*, 13, 215–222.
wHEALTH Terms of Reference

To obtain a copy of these documents, please contact Dr. Adriana Carvalho.

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Mental health services for newcomer youth: Exploring needs and enhancing access

Dr. Nazilla Khanlou, Dr. Yogendra Shakya and Tahira Gonsalves

Who we are

This newcomer youth project was a community-academic partnership. The academic partner was Dr. Nazilla Khanlou at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, and the community partner was Dr. Yogendra Shakya, Access Alliance Multicultural Health and Community Services.

The funding was channelled through the Faculty of Nursing, where the co-principal investigator, Dr. Nazilla Khanlou, was an associate professor at the time of the study. The project was funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (www.onthepoint.ca/index_e.htm).

The three investigators were:

Dr. Nazilla Khanlou (Co-Principal Investigator; Chair in Women's Mental Health Research, Faculty of Health, York University, & Adjunct Professor, University of Toronto)

Dr. Yogendra Shakya (Co-Principal Investigator; Director of Research and Evaluation, Access Alliance)

Dr. Carles Muntaner (Co-Investigator; University of Toronto)

Our goals

On average, 35,000 immigrant and refugee youth between the ages of 15 and 24 settle in Canada every year (Citizenship and Immigration Canada, 2009). A large percentage of immigrant youth settle in Toronto, Montreal and Vancouver; immigrant youth thus comprise a significant segment of youth population in these cities. In the City of Toronto, for example, immigrant youth between the ages of 15 to 24 constitute

39.5 per cent of all youth in that age group.

In 2006, the Canadian Mental Health Association estimated that about 10 to 20 per cent of youth were affected by a mental illness. Mental health issues can be compounded by settlement-related challenges. Despite the significant number of immigrant youth in Canada, limited literature existed about their needs when this project was developed. It was with a view to addressing this gap that this project was created. The project was influenced by a mental health promotion approach with the aim of understanding the social determinants of newcomer youth's mental well-being and identifying both their challenges and resiliencies. Specific objectives of this project included:

- to explore how newcomer youth from diverse cultural backgrounds understand and conceptualize mental health and mental illness
- to explore the mental health needs and help-seeking behaviours of newcomer youth
- to explore access and barriers to community-based mental health services
- to propose integrated policies and recommend proactive practices that improve access and reduce barriers for mental health services for newcomer youth in Ontario
- to actively engage newcomer youth in the research process.

What we did

We conducted seven focus groups and 16 in-depth interviews with youth, aged 14 to 18; their parents, who had come to Canada within the last five years from Afghan, Colombian, Sudanese and Tamil

communities; and service providers. We also administered 56 questionnaires to youth.

As well, we hired peer researchers (PRs) who helped with recruitment. As the PRs were the ones recruiting youth and parents, they also provided them with information about the project objectives and purpose in their own languages. As well, PRs administered a number of the questionnaires, providing some on-the-spot translations for youth participants in the process.

This project was framed within a community-based participatory research (CBPR) framework, where a youth advisory committee (YAC) and the PRs were hired to advise us in how to make the study youth-friendly and culturally sensitive, assist with recruitment, contribute in data validation, and assist with knowledge exchange activities

A unique aspect of this project was a youth-led conference organized with the YAC and PRs, with the aims of raising awareness and combating the stigma around mental health, within a settlement framework. The conference was targeted primarily at newcomer and immigrant youth and some service providers.

How we initiated our partnership

Prior to the formal start of the project, discussions were held between the two partners, Dr. Khanlou and Dr. Shakya, as both shared an interest in the mental health and well-being of youth from diverse backgrounds. Dr. Khanlou was doing ongoing research in youth mental health promotion and Access Alliance was developing its youth program. The community partner, Dr. Shakya at Access Alliance, identified the communities of interest for the study, given their program, planning and research foci.

At the beginning of the project, we formulated a memorandum of understanding between the community and academic partners, which addressed various responsibilities of each partner, and set out

joint responsibilities such as obtaining ethics approval, ensuring rigour of research, and creating a transparent and collaborative decision-making process. With the YAC, we also created a terms of reference document, which outlined their responsibilities in the project, and sought to incorporate their input at various points during the research process.

These documents formed a guide and a reference for processes and practices between the project partners and the research team as a whole. We kept detailed minutes at meetings and approved previous minutes in the first half of every meeting. In this way, we ensured that all research team members agreed on the progress of the project and next steps. When any potential misunderstanding arose, we addressed it immediately, going back to the minutes for clarification as necessary. As well, the research co-coordinator (RC) kept in regular contact with both PIs throughout the project, conveying relevant information and seeking approval or feedback for various aspects of the project as needed.

How our work/partnership/initiative reflected principles of equity

All aspects of this research project were shared between the community and academic partners, keeping in mind their particular strengths and resources.

A computer, printer, photocopier and fax machine were available to the RC at the academic institute, as were rooms for project meetings, which could be easily booked, at no cost.

Access Alliance was able to provide access to the communities of focus in the project and to settlement and other staff who at times provided entry into different community groups. YAC members and PRs were also provided with training workshops on a range of topics, such as community-based research and the social determinants of mental health, through the community partner.

We formulated a memorandum of understanding between the community and academic partners, which addressed various responsibilities of each partner, and set out joint responsibilities

Using a CBPR framework, we ensured that research was accountable, meaningful and reflective of the community. We thus sought feedback from our YAC based on preliminary findings we presented to them. Feedback from our YAC and PRs in their formal post-project evaluations indicated that they found both the training workshops as well as the youth conference at the end of the project to be highlights of their involvement in the project.

What we have learned

Given that universities are usually better resourced to conduct research, we made attempts to equalize the power hierarchies that tend to be associated with university-based research. We did this by incorporating equally the expertise of both PIs (at the university and at the community health centre).

We also worked to equalize the power imbalance traditionally associated with academic institutes in such partnerships by, wherever possible, drawing on the community and contextual-cultural knowledge of staff (e.g., social workers, settlement workers and research personnel) at Access Alliance while making sure that this did not pose an excessive work burden or costs on Access Alliance. This included using Access Alliance to gain access to the target communities, to keep us informed of some of the potentially sensitive issues that may arise with communities when doing research around mental health.

Initially, our academic–community partnership model included hiring two researcher co-ordinators, one based in the university setting and one in the community; however, we ended up with one research co-coordinator, who moved between the two settings, both physically, in terms of office space, as well by maintaining regular contact with the PIs and addressing administrative requirements of both institutional

settings. This had some challenges in terms of the financial structure. The community partner had to provide financial advances for larger expenses to the RC, as the university rules only allowed for claims to be submitted after expenses had been incurred.

Despite having just one RC, with the help of the research assistant we were able to maintain a connection between the two settings, because it was a small research team and because all members of the team worked to respond quickly to e-mails and phone calls and met regularly face-to-face.

Working within a CBPR framework takes time and much self-reflection, as well as the flexibility to reformulate goals. When conducting a research project with youth, it is essential to bring in the youth's perspective throughout various stages of the research process. Youth engagement is often sought at the beginning of projects but may diminish toward the end. Through the youth conference, the YAC and PRs in this project were able to participate in the dissemination of the research as well as being involved in the earlier stages of the project.

Key documents

Preliminary project results and information can be found on the Access Alliance website. Please check the Access Alliance website for future dissemination of project results at <http://accessalliance.ca/research>.

How to reach us

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References

- Citizenship and Immigration Canada (2009). Facts and figures 2008: Immigration overview. Available: www.cic.gc.ca/english/resources/statistics/menu-fact.asp.
- Statistics Canada. (2004). Canada's ethnocultural portrait: A changing mosaic. Available: www12.statscan.ca/english/census01/products/highlights/Immigration.

Partnering to address the problem gambling prevention and treatment needs of ethnocultural communities

Who we are

This initiative reflects a partnership between CAMH's Problem Gambling Institute of Ontario and the Problem Gambling Service at COSTI Immigrant Services.

The Problem Gambling Institute of Ontario (PGIO) brings treatment professionals and leading researchers together with experts in communicating and sharing knowledge. Its focus is on collaboratively developing, modelling and sharing evidence-based solutions to gambling-related problems, within Ontario and around the world.

COSTI's Problem Gambling Service provides culturally and linguistically appropriate awareness, education and treatment for gamblers and family members in the Italian, Portuguese and Spanish-speaking communities, as well as outreach and public education activities directed to various ethnocultural communities in the Greater Toronto Area (GTA).

The community development component of COSTI's Problem Gambling Service currently targets the Hindi, Korean, Polish, Portuguese, Punjabi, Spanish, Sinhalese, Tagalog, Tamil and Vietnamese-speaking communities.

Our goals

The goal of this partnership is to increase availability of culturally and linguistically appropriate problem gambling services to members of ethnocultural communities underserved by the current system. PGIO provides the gambling expertise, while COSTI provides expertise on working with immigrant populations—both with the goal of improving access for underserved populations.

What we do

In order to support the goals of this partnership, both partners have undertaken a number of activities both together and separately since the partnership was initiated in 2001.

- COSTI has established culturally appropriate treatment programs for Italian, Portuguese and Spanish-speaking clients that include psychosocial assessments; individual, marital and family counselling; and telephone counselling.
- The PGIO Education and Community Resources developed materials as part of its Promoting Community Awareness of Problem Gambling Resource Package for the provincial treatment system, which includes sections on cultural issues, and on outreach to ethnocultural groups.
- Clinical and outreach materials have been translated into 20 languages, disseminated to community partners in the GTA and made freely available outside the GTA. Much of this material is available on the PGIO's website, www.problemgambling.ca. One instrument, the Behaviour and Symptom Identification Scale (BA SIS-32), which measures mental health symptoms and daily functioning, has been translated into 22 languages. These and 11 existing translations have been made available to the Ontario addiction treatment system. The Education and Community Resources (*Problem Gambling: The Issues*, *The Options* and *Problem Gambling: A Guide for Families*) have been translated into 10 languages and are available on their website.

- COSTI and PGIO, both in partnership and separately, have done extensive development work with ethnic community groups and agencies on problem gambling.
- Building on new relationships with ethno-specific treatment providers, the PGIO, COSTI and the ethnocultural specialist in the PGIO Clinical Service have trained professionals in providing problem gambling treatment and outreach.
- PGIO and COSTI furthered their work with ethno-specific community agencies by creating the Multilingual Problem Gambling Services (MPGS). The MPGS is a network of trained professionals available to provide culturally competent problem gambling support and treatment services to individuals and their families within their own communities, in their own languages. Funds for this work are drawn from the budgets of the PGIO Clinical Services and COSTI. The PGIO and COSTI work collaboratively to support their partner agencies' work, and to develop an expanded network of providers. MPGS agencies are included in the trainings provided by the PGIO Education and Community Resources to the problem gambling treatment system. These services are available in many languages and can be reached throughout the province through toll-free numbers. Services are free and confidential.
- Since 2003, these trained professionals have offered culturally appropriate problem gambling treatment and outreach within their own communities, in their own languages.
- The Ontario Resource Group on Gambling, Ethnicity and Culture was established in 2001. In 2004, it began hosting a one-day conference on problem gambling and ethnicity issues. COSTI now offers this conference annually in partnership with the Resource Group. The group also wrote a clinical manual for mainstream problem gambling treatment agencies on working with ethnoculturally diverse populations.

How we initiated our partnership

PGIO approached COSTI to work together to better address the problem gambling and treatment needs of ethnocultural communities. Both agencies acknowledged the gaps in appropriate problem gambling services for the clients they were seeing in their respective services.

The PGIO and COSTI partnership was then formally initiated in 2001 when a three-year pilot project was funded by the Ministry of Health and Long-Term Care. For this initial pilot, COSTI was to engage ethnocultural communities to carry out research and awareness-raising activities and establish a problem gambling treatment service for the Italian-Canadian community. PGIO's role in the pilot project was to lend its expertise in problem gambling and research to the process. Thus each partner would bring to the table what they did best.

As a first step, COSTI approached leaders and organizations of some of the largest language groups in the GTA, as reported in the 1996 census, to be involved as partners in the research process and in the development and delivery of problem gambling awareness-raising activities. COSTI's long history of working with many of these community partners facilitated their engagement in this new project. Ethnospecific community agencies became involved from the onset of the pilot project. In recognition of the resources required to participate in program activities and the agencies' expertise, they were paid a consultation fee to complete activities.

The initial pilot project led to a fully-funded problem gambling program at COSTI. Recognizing the benefits of partnership, the PGIO and COSTI have continued to work together. They include ethnospecific community agency partners in their collaborative work to ensure culturally appropriate and responsive treatment and awareness for problem gambling.

How our work/partnership/initiative reflects principles of equity

From their collective experience in research and program development, COSTI and the PGIO have developed an innovative community development model of working with ethnocultural communities to help build capacity, infrastructure and deliver services. Their goal has been to increase accessibility to services, information and participation of all members of immigrant and ethnocultural communities, while maintaining and respecting accountabilities.

The partnerships that PGIO and COSTI have with community agencies are based on equality, and on the premise that the community has the authority and expertise to communicate, and to develop strategies and methods of engagement, to deliver services and programs where none exist.

These partnerships recognize that individuals have the right to services appropriate to their culture and language. Although COSTI and PGIO provide leadership, resources, training and support, the partners have full autonomy to adapt and develop the material for their own communities' needs. Our partners are included in our trainings (free of charge), and they have been invited to train our mainstream service providers; in this way, we draw on each other's expertise. The focus is on working collaboratively with ethnospecific agencies and communities, embracing and respecting cultural values, differences and unique qualities that exist in all communities.

PGIO and COSTI have used a community development approach to their problem gambling work with ethnic communities. They recognize the importance of involving community members in all aspects of the work. The prevention and treatment work have both involved outreach. There has been training, consultation and support. Of particular interest has been the success of the MPGS initiative, in which ethnocultural agencies offering outreach or prevention activities and counselling sessions are reimbursed for their services.

What we have learned

We have learned:

- the value of a community development approach
- the importance of building community capacity
- the need for cultural and linguistic appropriateness
- the importance of working with partners
- the importance of building networks
- the need for planning, co-ordination and integration
- the cost-effectiveness of capacity building through community partnerships.

The most effective services for ethnocultural groups are developed with the input and expertise of these communities and when they feel a sense of control and ownership of the services.

As agencies with credibility, substantial history, size, experience and expertise, COSTI and PGIO together are in a position to provide support and leadership in developing services.

The community has the authority and expertise to communicate, and to develop strategies and methods of engagement, to deliver services and programs where none exist.

Key documents

For more copies of the translated resources please visit www.ProblemGambling.ca.

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MAINTAINING EQUITABLE PARTNERSHIPS

SUMMARY OF KEY PRINCIPLES AND LESSONS LEARNED

Key principles

- Commitment to meaningful and progressive engagement of affected communities, empowerment, social change and anti-oppression values
- Responsiveness to communities' needs
- Supporting and fostering leadership among all partners
- Ensuring high level of target group involvement, and open and inclusive processes, at all stages
- Respecting and honouring diversity
- Openness and inclusiveness
- Treating target community group members (e.g., youth) as equal partners
- Accountability to all stakeholders: equitable partnership includes showing respect and accountability in reporting results/findings of the work to the affected communities
- Respecting mutual/reciprocal learning
- Commitment to open dialogue and effective communication
- Recognizing and valuing lived experiences of affected communities, and the different skills each partner or stakeholder brings to the table

Lessons learned

- Facilitating target group participation involves flexible meeting schedules and ways of participation, and innovative use of technology (via e-mail and listserv).
- Consistent meeting time and space can facilitate easier community participation.
- Be prepared for turnover when working with youth; accept and respect youth forms of expression; provide flexible opportunities for participation; focus on short-term goals with tangible end points.
- Being outcome- and result-focused is helpful to community engagement, especially with youth.
- Structured rotation of responsibilities can help facilitate members' participation, but flexibility is key; paid staff support is important to prevent overburdening of volunteers.
- Peer/community members' employment in project positions is important to facilitate meaningful engagement and community empowerment.
- Peer-facilitated consultation with diverse stakeholders' groups can help in developing an equitable governance model that involves the community.

- A commitment to effective community inclusion needs to be supported by proactive systemic processes and resources at all levels of activities, such as interpretation and child care, incentives (food) and ways to compensate people's time (e.g., honorarium, transportation assistance).
- It is important to build in anti-oppression policy training to sensitize all stakeholders to power relationships.
- Acknowledging diversity and actively promoting structured dialogue amongst diverse members with history of tensions is helpful to increase collaborative partnerships.
- Community empowerment is a long-term process requiring structured resource dedication and ongoing capacity building.
- Create capacity building opportunities for stakeholders; provide space for each member to reflect on emerging issues in their areas of concern.
- Training and processes need to address inequities in social determinants to ensure meaningful participation of marginalized members.
- Clear principle and values statements are critical in clarifying ownership, leadership and accountability amongst different stakeholders.
- Long-term community empowerment needs to be supported by proactive succession planning and mentorship.

Maintaining equitable partnerships and overcoming challenges: An introduction

Mary Quartarone

As Pat Capponi writes in her introduction, “equity involves taking time to understand all the factors affecting your client’s life, rather than simply seeing the person through the lens of mental illness.” Maintaining equitable partnerships with the people and organizations we serve requires that we expand on that principle—accepting that the building of equitable partnerships extends well beyond the first few meetings. In fact, it is a vital element in all activities related to a project or a service, from initial conception and design of an offer of partnership to stakeholder communities, through to evaluation.

This section offers several rich examples of how partnership groups have been able to maintain principles of equity in their work together and overcome the challenges that inevitably arise.

The Chester Le Coalition provides an example of how local community stakeholders can come together to address concerns that matter to them. This multi-partner and diverse coalition is beautifully woven together to be inclusive and empowering of the various segments of Chester Le. The coalition also shares its experiences and highlights the necessary elements to ongoing engagement.

The Downtown Eastside Women and Harm Reduction Research Group (WHRRG) includes, as partners, the women directly affected by the research generated to inform addiction policies and services. In finding opportunities and mechanisms that facilitate the participation of women who use drugs in Vancouver’s Downtown Eastside, the WHRRG has generated valuable research and resources.

Joanna Ochocka and Sarah Marsh describe the Community-University Research Alliance (CURA) project as embracing “equity as a guiding value.” They go on to describe how the framework they have developed for moving toward a more culturally effective mental health system is “at its heart the value of reciprocal collaboration”: this is one of the major learnings from their research across six CURA demonstration projects.

The work of the Committee for Accessible AIDS Treatment (CAAT) draws from its experiences in coalition partnership building to address social determinants affecting immigrants, refugees and non-status people with HIV/AIDS. Alan Li and Maureen Owino detail the core building blocks of creating lasting equitable partnerships by building the evidence, bridging the gaps, and moving from engagement to empowerment by “passing the torch to affected marginalized communities.”

The VALIDITY♀ project offers valuable insights around maintaining equitable partnerships with girls and young women who have experienced or are at risk for depression. The project’s signature poster, “Let’s talk—I’m more than what you see,” gives us a visual framework of the many factors that can affect girls and young women’s lives and points us toward the many entry points for engaging this group.

From offer to invitation to engagement to reciprocal capacity-building and, eventually, what we hope we can call an equitable partnership, service providers, researchers, clinicians and community advocates must continue to not only document our frameworks

but live them every time we embark on a new project or pursue the thread of a service. “Living” our frameworks means that every time a challenge arises, we pull back and consider how best to engage our partners, from their perspectives, life views and experiences. Those of you who work in this area know that, often, this is not an easy, quick step in the journey. It takes time, considerable effort and an active commitment to stated and emerging principles from the project—the flexibility to receive, reflect and realign our thinking and our actions in support of where our communities lead us.

Mary Quartarone, currently with the Organizational Development department at CAMH, co-ordinated the initial BEP staff and community courses and was a member of the organizing committee for the BEP conference. She has been involved in building community partnerships for over 25 years through her work in diversity education, health promotion program development and addictions and mental health systems integration. She can be reached at Mary_Quartarone@camh.net.

“Living” our frameworks means that every time a challenge arises, we pull back and consider how best to engage our partners, from their perspectives, life views and experiences.

Chester Le Community Coalition: Residents and partners work together to strengthen and support the community

Sheela Subramanian, Cynthia du Mont and Jamillah Managhaya

Who we are

The Chester Le Community Coalition is a coalition of community residents and partners in Chester Le, Scarborough, who have come together to strengthen and support their community.

The coalition is made up of more than 20 partners and a core group of community members. Partners include a child and family centre; several youth-related organizations; a local school board; police services; legal services; the Canadian Mental Health Association, Toronto; and several City of Toronto services.

Our goals

The Chester Le Community Coalition is working together to strengthen and support our beautiful community by sharing resources, listening to our diverse voices, and taking action for change. The partnership was initiated in 2003 in response to highly publicized incidents of violence, growing isolation and lack of services within the community.

It is guided by a vision of community members and partners working together in a safe, healthy and trusting community.

The overarching objectives of the coalition are to:

- engage the community in developing local solutions and initiatives
- strengthen community capacity
- reduce violence
- bring community services into Chester Le
- increase access to existing services

- develop links between the Toronto Community Housing Corporation (TCHC) community and the broader Chester Le neighbourhood.

What we do

Since September 2003, the coalition has worked with community members and partners to support residents of the Chester Le community. This work has included the following.

COMMUNITY CAPACITY BUILDING

Groups of residents with common interests started to meet, with support from Chester Le Coalition staff. These included a moms' group, volunteer-led ESL and conversation classes, a community garden, the Call to Action group dealing with issues of concern to residents, and youth initiatives. Community residents were hired for positions as community animators and Community Corner staff and were trained in various governance models. Workshops were offered to residents alongside staff and other partners. Community members also became active with the coalition as volunteers and many attended coalition governance meetings.

Community residents were actively engaged in the equitable governance process (2006–2008), when a new governance model for the coalition was being developed.

Residents are now involved in a committee responsible for planning the design and use of the future community space funded by the City of Toronto.

PROGRAM AND SERVICE DELIVERY

The Chester Le Community Corner (2005–ongoing) is a small TCHC-donated community space where numerous programs and services are offered. Residents have access to computers, information and referrals, and opportunities to participate in community initiatives, such as the community garden.

Children and youth gather after school for assistance with homework and to join various groups, such as the photography club. Community organizations provide staff for employment programs and the moms' group.

RESIDENT ENGAGEMENT AND COMMUNITY BUILDING

Each June, the coalition organizes an anniversary block party to celebrate the achievements of residents and groups in the community. A community showcase event also takes place in December. Residents have increased opportunities to work together, celebrate together and support each other in times of crisis. Residents organized a candlelight memorial for local residents affected by domestic violence in February 2009 and 2010.

The Call to Action was a community-driven initiative that brought together many residents to identify and take action on local community issues such as housing, policing and neighbourhood stigma. Community members connected with similar resident groups in other parts of the city and key partners and allies in the different issue areas.

Arts-based community-engagement initiatives have included two photography workshops for local children and youth, a mural project and other special projects.

BUILDING BRIDGES

The coalition builds bridges between the community and other institutions. Some residents, especially youth, were mistrustful of police due to local incidents and how youth were treated following these incidents. The Coalition developed a proposal for the Dialogue Makes a Difference project, which was funded by the Toronto Police Services Board. The goal of the

initiative was to improve relations between police and local youth and to promote dialogue on tough topics related to youth.

How we overcame challenges

Some of our strategies for responding to challenges include building trust and resources; finding space to suit growing needs; and taking on governance work.

BUILDING TRUST AND RESOURCES

Initial challenges included slowly rebuilding the trust that had been broken between community members and partners and a number of disengaged residents.

In 2003, staff at Chester Le Junior Public School accessed funds for a community worker. This worker and local school staff began the process of community outreach and needs assessment. Additional community service providers and residents were brought in and invited to form the Chester Le Community Coalition. Monthly meetings and grant proposals began with the goals of bringing services into the community and acquiring space. Once a small staff team was assembled, they assessed community needs by going door to door to speak with residents.

Over time, new groups of community members began to see their interests and needs reflected in the work of the coalition, especially with the introduction of children-focused programming, resident-led initiatives and those designed to meet the needs of specific community groups.

FINDING SPACE AS WE GROW

A significant challenge facing the coalition was lack of community space. Space was needed to hold community meetings, programs and special events, and to house staff to provide one-on-one support, information and referrals. In 2005, as the partnership became more established, TCHC donated a town home unit to be used as a community space, called the Community Corner. During this time, the coalition grew to include over 20 partners and a core group of community members.

This new space made it possible to engage disengaged community members through creative initiatives, and provide safe and confidential support for community members on a range of issues.

With hundreds of community members visiting the Corner monthly, the space challenge continues! Through the support of multiple partners, including the City of Toronto, a larger community centre is being built at the local public school. Community members are involved in the planning and design process.

TAKING ON GOVERNANCE WORK

As the partnership grew, the coalition's informal structure presented multiple challenges for effective decision making, governance and staff support. For support in addressing these challenges, the coalition applied for and received resources to undertake governance work through the City of Toronto's Social Development Investment Program (SDIP). A second organization, West Scarborough Neighbourhood Community Centre, took on the role of trustee for this stream of activity.

The SDIP project staff facilitated a community-based partnership development process with the goal of formalizing partnerships and moving toward a clear governance structure. The process involved interviews and focus groups with all coalition stakeholders—community residents, trustees, agency partners and staff. It also involved a literature review of equitable partnership building and interviews with Toronto-area community partnerships to identify promising practices.

Through this process, we developed a new vision and mission statement, increased staff support, and proposed three models for governance. Although each model featured different core strengths—equity, sustainability or flexibility—the equity-oriented partnership model was selected by all partners, including community members. The equity-oriented model featured partnership categories that reflect stakeholder interests and integrate a commitment to community-led decision making and stronger support for coalition staff.

A highlight of this process was peer-facilitated community focus groups in seven languages: English, French, Somali, Farsi, Tamil, Cantonese and Mandarin. At these peer-facilitated focus groups, community members discussed the coalition's governance processes, learned about the three models and their features, and voted for their preferred approach to governance.

Since 2008, partnerships with residents and other partners have continued to grow with the strengthening of existing partnerships and addition of new ones to better respond to community needs. Coalition partners have continued to provide or fund capacity building activities in Chester Le and provide network links that facilitate increased access to relevant services.

Existing formal agreements include:

- trustee agreements with funders
- space use agreements
- continuous development of partner agreements.

How our work/partnership/initiative reflects principles of equity

The CLCC seeks to reflect principles of equity in the following ways:

- Actively promoting community inclusion by:
 - participating in trainings and capacity building programs
 - providing various programs to respond to different community needs
 - providing language interpretation and child care support where possible
 - engaging community members in hiring processes and as staff where possible
 - providing a strong volunteer program
 - involving the coalition in governance matters.

- Developing a strong anti-oppression policy and checklist by:
 - consulting with community, staff, trustees and partners
 - providing additional training sessions to all stakeholders together, focusing on how power relationships shape everyday relationships in Chester Le and at the Corner.
- Designing and implementing creative initiatives such as Dialogue Makes a Difference that increase dialogue between groups with histories of tensions, such as police and youth
- Adopting hiring practices reflective of and responsive to community needs and dynamics, including hiring community members where appropriate
- Acknowledging diversity of stakeholder voices at the table and promoting dialogue to ensure that community member, partner, trustee and staff concerns are identified and addressed
- Providing staff support by:
 - developing clear reporting structures
 - providing training and bi-annual staff retreats to identify challenges and promote self-care.
- Promoting equitable space use within the Chester Le Corner
- Developing a formal equitable governance model through consultations and peer-facilitated community engagement including community focus

groups in seven languages (English, Somali, Cantonese, Mandarin, French, Farsi, Tamil).

What we have learned

Our experience has taught us much about the process of building equitable partnerships:

- Community engagement and partnership building take hard work, respect, trust building, patience and forgiveness.
- All partners—community members and other stakeholders—must be engaged according to their interest, mandates and/or levels of commitment.
- Good stakeholder relationships are built through open dialogue and clear communication, by identifying common goals, and by balancing different interests.
- A commitment to equity must be put into practice, not simply put down on paper.
- Difference must be acknowledged, respected and valued!
- Staff need support and clear reporting relationships in a complex partnership environment.
- Agencies acting as trustees have unique needs in managing partnership funds.
- Agreements should be simple and reflect the

*Community engagement and
partnership building take hard work,
respect, trust building,
patience and forgiveness*

partners' goals, role and responsibilities. For example, a partnership model that includes community members could be based on a co-operative model. Residents may join the partnership as members when they first participate in the community space, program or services. As members, they would then be entitled to participate in decision making and governance. In contrast, a trustee partner's agreement may include details about the management of funds and staff.

Key documents

- Three proposed governance models
- Anti-oppression policy
- Dialogue Makes Difference project fact sheet

Please contact Cynthia du Mont (see contact info below) for copies of these documents.

How to reach us

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The Downtown Eastside Women and Harm Reduction Research Group

Dr. Amy Salmon

Who we are

The Women and Harm Reduction Research Group (WHRRG) is a loose affiliation of approximately 30 members, functioning as a network. Our members include university- and hospital-based researchers, health care and social service providers, representatives of grassroots community-based organizations advocating with and for women who use criminalized street drugs in Vancouver's Downtown Eastside (DTES), and community members committed to reducing harms experienced by women who use drugs. We maintain an open membership structure, which invites participation at any time from all with an interest in women and harm reduction in the DTES.

Our goals

WHRRG's goals are two-fold:

- providing networking and information sharing opportunities among members
- engaging in participatory, action-oriented research, which means that women from the DTES are involved in research leadership, in research that shapes policies affecting their lives and in the dissemination of evidence-based research findings.

Persistent health and social inequities among women who use illicit drugs in the DTES are the result of a complex interplay of social, political and economic factors that influence health status and access to health care. DTES community leaders have repeatedly observed that women who use substances

have had their health concerns and their priorities for research either ignored or minimized.

While women who use drugs hold valuable insights and expertise that are critical to improving health research, policies and services, there have been few mechanisms for facilitating their inclusion and leadership in research. Given the increased reliance on "evidence-based" approaches to mental health and addiction policy and service delivery, it is essential to ensure that marginalized women who use drugs, and who will be on the receiving end of these policies and services, are meaningfully involved in processes through which this evidence is derived, and that efforts are made to communicate evidence to others in their community.

The 12-block radius of Vancouver's DTES community has been extensively studied over the past decade, with millions of dollars invested in harm reduction research. However, research efforts, uptake of findings on harm reduction initiatives for women in the DTES, and their incorporation into policy and practice have been fragmented. Communication gaps exist between researchers, health care and service providers, policy-makers and women who use drugs, and these gaps inhibit efforts to mobilize needed harm reduction and public health interventions.

Addressing these gaps in knowledge creation and uptake requires inclusive mechanisms for supporting research and knowledge exchange that are capable of responding to the priorities and concerns of women who use drugs, embedded in the shifting conditions of their community. The WHRRG is one effort to respond to these needs.

What we do

Members of WHRRG meet regularly to exchange information about:

- the needs, concerns and experiences of women who use drugs in the DTES
- research projects that are underway
- activities being undertaken by community organizations to reduce harms to women who use drugs
- findings from completed studies that could support community organizing or service provision
- new opportunities for collaborating and sharing limited resources more effectively.

Through this networking activity, WHRRG members have worked together to undertake a range of participatory, action-oriented research and knowledge exchange projects with a strong social justice focus. These include:

- The VANDU Women CARE study (funded by the Michael Smith Foundation for Health Research): a qualitative, policy-focused study examining the impact of local primary health care reforms on the health care experiences of marginalized women who use drugs
- The Ethics Project (funded by the CIHR Ethics Office): a study examining issues in ethical and respectful research practice with women who use drugs
- The Women's Health Information Project (funded by the CIHR Institute for Neuroscience, Mental Health, and Addiction and CIHR Knowledge Translation): a knowledge exchange project that synthesized findings from academic literature about the effects of methadone, crack and heroin on women's bone, dental, reproductive and gastrointestinal health and delivered a peer health advocate training program to women in the community
- The Peer Anti-Violence Education (PAVE) Project (funded by the Canadian Women's Foundation): a project to create a short film and accompanying toolkit to engage women affected by active substance use and violence in practical safety planning

- Healing Ourselves (funded by the Victoria Foundation): a two-year, community-based project to develop meaningful grief and loss supports for mothers with substance use problems who have lost a child.

Together, WHRRG members have:

- conducted community needs assessments to gather information about research priorities and opportunities
- reviewed proposals and provided letters of support for funding applications
- given presentations to academic, service provider, government and community audiences
- written reports of research findings and reflected on their experiences in research
- organized and participated in focus groups
- assisted with participant recruitment for studies
- served as peer interviewers to collect data for research projects
- participated in data analysis
- hosted community forums on issues related to harms from drug use, violence and barriers to accessing health services.

We have developed and compiled resources for training peer interviewers and peer health educators, and have produced a series of wallet cards for women who use drugs—one focused on patients rights, and one on rights of research participants. (These are available by contacting Dr. Amy Salmon at asalmon@cw.bc.ca.)

How we overcame challenges

Challenges have included:

- finding ways to reach out to members who may not have access to computers, who are often occupied in daily struggles simply to survive, and who are otherwise marginalized
- giving members equal opportunities (e.g., to training)
- operating on limited budgets, and maintaining paid staff positions when activities are funded by time-limited project grants.

We have addressed these challenges in many different ways. Whenever possible, capacity and partnership building opportunities are integrated into all aspects of the research process. We recognize that all of our members bring different skills, experiences and resources that are necessary and valuable for our work together. Our meetings provide an opportunity for members to strengthen group facilitation, problem-solving, leadership and research skills, and provide space for each member to reflect on emerging issues of importance to their work to address harms for marginalized women who use drugs in this community.

We try to ensure that these opportunities and responsibilities are shared among all members of the group, and that decisions are made by consensus. For example, because not all members of the WHRRG have regular access to computers or telephones, decisions about group processes, identifying our group's research priorities, and assigning tasks all happen during our regular face-to-face meetings, ensuring that all group members can participate.

WHRRG members connected to grassroots community groups contribute their knowledge of the neighbourhood and their networking skills by ensuring that notices about meetings, events and other opportunities for involvement are circulated throughout the community. These members also follow up with women not able to attend specific meetings to ensure they don't miss any important information.

Additional opportunities for women to become involved in research and knowledge exchange are shaped by the demands of specific projects and the skills and availability of individuals involved, grounded in principles of mutual respect and reciprocity. All

members (researchers, trainees, project staff and community representatives) receive necessary training, support and feedback from other members to undertake their work in their respective roles. For example, community organizers have, at times, given academic researchers guidance on such issues as effective and respectful participant recruitment strategies, knowledge strategies for communicating research findings to women with limited literacy, and ways to establish collaborative research processes that meaningfully engage street-involved women who use drugs. In turn, academic researchers have provided training to community members on such topics as qualitative interviewing skills, interpreting research results, and procedures to obtaining informed consent.

Since 2006, WHRRG infrastructure has been supported solely by two proposal development grants of \$3,500 each from the Women's Health Research Network and the BC Mental Health and Addictions Research Network. Most of the activities undertaken by the WHRRG and its members are funded through short-term project grants held by academic researchers. We thus try to find ways to effectively share resources to meet common needs. For example, WHRRG members holding research grants with funds allocated for "knowledge translation" have held community meetings with the WHRRG to share results of their research, and used these funds to provide snacks, stipends and meeting space. This provides an opportunity for WHRRG-related meetings to be supported. Whenever possible, we make sure that researchers present results of their work with community members, and we provide cash stipends to all volunteers who contribute. At times when we have operated without

We recognize that all of our members bring different skills, experiences and resources that are necessary and valuable for our work together.

funding, stipends have been provided by contributions from individual members, or by grassroots community organizations who provide a stipend to members elected to represent their organization at WHRRG meetings.

How our work/partnership/initiative reflects principles of equity

The WHRRG includes women who use drugs and live in Vancouver's Downtown Eastside, representatives from grassroots peer-driven community organizations, clinicians, service providers and academics. Having such a diverse and collaborative membership provides a means to effectively communicate and gather information from various constituencies who might not otherwise have many structured opportunities to engage with one another. Collaborating to develop research and knowledge exchange activities in this way ensures that research projects (and action that follows) are firmly rooted in community priorities and needs. The WHRRG also serves as a forum to involve and empower women in the Downtown Eastside who use or have used drugs, providing a space for them to be involved and to influence DTES research initiatives.

Our team consists of women who occupy very different sites of privilege and oppression. To redress this disparity, an ongoing priority has been to facilitate the participation of women who use drugs and live in poverty. Getting community residents and peer advocates to participate, given the many urgent priorities of these low-income women, requires compensating them for their time and expertise, providing food at meetings, and supplying transportation assistance when needed.

We recognize that it is not always possible for all members, regardless of their social location, to attend all meetings. We support everyone's ongoing inclusion through an open door policy at meetings: everyone is always welcome, at any time, whenever it is possible for them to attend.

We also ensure that results of research conducted by WHRRG members in the DTES are reported to members of the DTES community before being disseminated through academic conferences and journals, and WHRRG members work together with others in the community to identify methods for effective, respectful and timely communication of research findings.

What we have learned

In a collaborative, networking organization where members are frequently transient or homeless, experiencing crises, and often occupied with meeting basic survival needs or competing commitments, we have learned a number of lessons about how to best facilitate ongoing and active participation by all members:

- We make sure to hold all of our meetings at the same time and place, following a predictable schedule.
- Women make use of their neighbourhood networks and other group meetings to spread the word about upcoming meetings and community events.
- Providing small stipends in a transparent way, according to a process agreed on by WHRRG for its members, is critical for supporting the ongoing involvement of some members, as the time required to attend meetings, make presentations, or undertake other tasks can take away from other survival needs (such as opportunities to receive free food or other paid work).
- Rotating opportunities and responsibilities among group members according to a set schedule ensures that everyone gets a chance to participate in all areas of activity that are of interest to them. We recognize that not all members are always able to participate in all activities all of the time. Providing ways for members to drop in and out without penalty is key.

- Ongoing organizational support from paid staff is critical to ensuring that communication is frequent, accessible, effective and transparent, and that community organizations that primarily rely on volunteer labour are not over-burdened in their participation.

Key documents

“Your Rights in Research: A Guide for Women”:
www.bccewh.ca/publications-resources/documents/YourRightsinResearchAGuideforWomen.pdf

When Researchers Come Calling: A Guide for Organizations that Work with Women: www.whri.org/newsandevents/whri_publications.htm

Me, I’m Living It”: The Primary Care Experiences of Women who use Drugs in the Downtown Eastside:
www.whri.org/newsandevents/documents/VanduClinic-web.pdf

How to reach us

Downtown Eastside Women and Harm Reduction Research Group

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Our partners—Vancouver Area Network of Drug Users (VANDU), the VANDU Women’s Group, the BC Association of People on Methadone and the Western Aboriginal Harm Reduction Society at:
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www.vandu.org

Taking Culture Seriously in Community Mental Health: a CURA research initiative

Joanna Ochocka and Sarah Marsh

Who we are

Taking Culture Seriously in Community Mental Health was a five-year Community University Research Alliance (CURA) research program. This research initiative was based on a collaboration among 45 partners from the Waterloo and Toronto regions in Ontario, including interdisciplinary academics, ethnocultural community leaders and groups, and leading practitioners from mental health and settlement sectors.

From 2005 to 2010, the project was led by Joanna Ochocka of the Centre for Community Based Research and funded by the Social Sciences and Humanities Research Council of Canada (SSHRC) and the Ontario Trillium Foundation. (Full list of partners available at: www.communitybasedresearch.ca/takingcultureseriouslyCURA).

Our goal

This initiative was designed to explore, develop, pilot and evaluate how best to provide more effective community-based mental health services for Canada's culturally diverse population.

What we did

The project was carried out in three phases:

1. exploring diverse conceptualizations of mental health problems and practice through primary data collection
2. developing culturally effective practice through

collaborative proposal development with partners and community members

3. evaluating demonstration project development and implementation.

The study used a participatory action research (PAR) approach. This involved doing research “with” rather than “on” the various communities. We hired 10 community researchers who meaningfully involved the five participating cultural-linguistic communities (Somali, Sikh-Punjabi, Polish, Mandarin and Spanish-speaking Latin American in both Toronto and Waterloo Region) in each study phase.

Throughout the project, partners collaborated to share and discuss our findings with all stakeholder groups, including community members, academics, service providers and policy-makers. Our partnership structure included a partnership group that provided overall direction to the project, and two local steering committees that guided each step of project implementation in the Toronto and Waterloo sites. Several sub-committees provided leadership on the various study methods, on knowledge mobilization and on evaluating the partnership. A multidisciplinary research team included academics, students and 10 community researchers.

Partners clustered in smaller groups to develop 12 innovative demonstration project proposals, of which half were funded. These six demonstration projects put into practice many of the ideas generated by the research findings. They were evaluated in the last phase of the CURA project, and three of them will continue in future years. (See www.communitybasedresearch.ca/takingcultureseriouslyCURA for more details about each project.)

How our work/partnership/initiative reflected principles of equity

Our partnership reflected values of equity in both its process and outcomes. Through shared decision making power, strong internal and external communication, and a concerted effort to involve the cultural communities participating in the research, our work embraced equity as a guiding value. We structured our partnership so that all significant decisions (and most minor ones) were made collaboratively, and we maintained good communication among partners.

One of the outcomes of our study is a framework for how to move toward a more culturally effective mental health system. Based on our research findings, this framework has at its heart the value of reciprocal collaboration. It acknowledges the sharing of knowledge and power, and the need for cultural groups, service providers and policy-makers to work together to build a better, more equitable system of mental health supports. (See www.communitybasedresearch.ca/takingcultureseriouslyCURA/files/TakingCulture-SeriouslyFrameworkExplained.pdf for detailed framework.)

How we overcame challenges

As challenges arose, we addressed them by:

- reflecting on PAR values at each stage of the process
- working in teams rather than in isolation

- following our knowledge mobilization policy. (Principles of equity are the basis of our knowledge mobilization policy—its main purpose being to encourage full and fair participation of all partners in writing, presenting and participating in project activities.)

What we have learned

PAR is possible to do on a large scale. Communities were engaged at every phase of the research (participatory) and many products resulted from the work (action), including 12 demonstration project proposals, six active demonstration projects, 12 scholarly articles and more than 40 presentations.

Leadership from every stakeholder group is needed to make sustained change. Funders and policy-makers were not as actively engaged in our work from the beginning as they could have been. We held a Roundtable for Action with policy-makers and funders in our final year, but learned that it would have been better to involve them earlier in the process.

Reciprocal collaboration is essential to equitable partnerships. This learning was one of our main research findings, based in theory (as described above) and in practice, as we demonstrated in six CURA demonstration projects.

People build equitable partnerships more easily when relationships are built for the longer term beyond project timelines.

How to reach us

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*People build equitable partnerships more easily
when relationships are built for the longer term
beyond project timelines.*

The Committee for Accessible AIDS Treatment

Dr. Alan Li and Maureen Owino

Who we are

The Committee for Accessible AIDS Treatment (CAAT) is a network of more than 40 service organizations from the health, legal, settlement and HIV/AIDS service sectors and individual immigrant, refugee and non-status people living with HIV/AIDS (PHAs).

Our goals

CAAT was formed in 1999 in response to the barriers faced by newcomer and non-status people living with HIV/AIDS in accessing treatment and services. Since its inception, CAAT has been proactively involved in education, research, service co-ordination and advocacy with the goal of removing access barriers and promoting the health and well-being of people living with HIV/AIDS.

What we do

CAAT's key initiatives include various projects geared toward:

1. Developing programs and services to bridge barriers to access:
 - Setting up a program of compassionate medication programs for non-insured people with HIV/AIDS
 - Increasing service providers and PHAs' knowledge and skills in navigating the complex immigration policies and HIV and health service systems (through the HIV and Immigration Service Access training program)
2. Evidence-based advocacy through community-based participation research:
 - Research study to document challenges faced by non-insured people with HIV/AIDS and explore

- strategies to deal with these challenges
 - Comprehensive review of public policies affecting immigrants and refugees with HIV/AIDS
 - Research study to improve mental health service access for immigrant and refugee PHAs by identifying key best practice framework
 - Mobilizing ethnoracial community leaders in anti-stigma HIV prevention interventions.
3. Community capacity-building programs that foster progressive engagement and leadership of affected populations:
 - Peer treatment counsellor training programs to build treatment literacy and peer support skills
 - Research knowledge transfer exchange ambassadors program that engage, train and deploy PHAs to be key agents to disseminate research findings and advocate for systemic changes
 - Legacy project that builds structured mentorship support and organizes practicum opportunities for PHAs to further develop their career path.

How our work/partnership/initiative reflects principles of equity

CAAT's work reflects the principles of equity by:

- Being respectful and responsive to the needs of all stakeholders in the partnerships, starting from project developmental processes through to the outcome and evaluative steps
- Respecting and valuing lived experiences of people living with HIV/AIDS
- Building proactive and flexible mechanisms to facilitate diverse partners' participation, especially

people with HIV/AIDS

- Committing resources for capacity-building opportunities, to support “progressive engagement” for people with HIV/AIDS to assume decision-making and leadership roles
- Active community engagement strategies to ensure accountability and build broader partnerships to effect social change.

For our work in advancing service access, equity and civic participation, CAAT received the Access, Equity and Human Rights Award from the City of Toronto in 2009.

How we overcame challenges and maintained principles of equity

Some critical challenges we faced included:

- distrust and fear from newcomer PHAs in engaging with diverse partnership network due to stigma, discrimination and lack of status
- non-responsiveness of public service systems in addressing our target populations’ needs
- competing settlement, health and social priorities to ongoing participation
- language and technical skill/knowledge barriers facing newcomer PHAs in participating in academic/community partnerships.

We address these challenges by building in / developing:

- Systemic support and resources to ensure equitable partnerships—paid positions, mentorship and

training cost, language-specific tools and access, support to enable community (PHA) participation.

- Innovative methodology to involve diverse partners (use of “concept mapping” software in research recommendation development, organizing community feedback and planning sessions and multi-stakeholder think tanks to increase engagement; Knowledge Exchange Ambassador program to facilitate target communities taking on roles as agents for social change, etc.)
- negotiated guiding principles and practices through clear articulation and terms of reference in research and partnership that addresses ownership, control, access, possession of data, authorship, roles and responsibilities, common vision and values.

What we have learned

- In building and maintaining equitable partnerships, there must be committed resources and processes to address inequities in power and barriers in social determinants of health that affect partners’ ability to participate equitably and meaningfully.
- Demonstrating community responsiveness through accountability in project processes and outcomes has been the most effective galvanizing force in maintaining our partnerships through the years.
- Proactive and systemic plans for community succession that involve sharing power and passing the torch to the target affected communities are critical in ensuring true equitable partnerships in the long run.

Plans for community succession that involve sharing power and passing the torch to the target affected communities are critical in ensuring true equitable partnerships in the long run.

CAAT is especially proud that over the past 10 years, we have evolved from a service provider-driven network to community-driven partnerships with a majority of immigrant, refugee and racialized PHAs on our governing body.

Key documents

Our terms of reference, project highlights and publications are available on our website:
www.hivimmigration.ca.

How to reach us

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VALIDITY♀ (Vibrant Action Looking Into Depression in Today's Young Women)

Cathy Thompson

Who we are

The original project team consisted of young women, community partners and CAMH staff. Today, all of these groups continue to be involved with the VALIDITY♀ project. Community partners include Youth Net/Réseau Ado Ottawa and Halton, the Canadian Mental Health Association, public health departments and other organizations focused on young women's mental health.

Our goals

The goals of the VALIDITY♀ project include:

- exploring the factors that may contribute to depression in young women
- developing ways to help prevent and reduce the harm that depression may cause.

We strive to create resources that are timely and relevant for service providers working with young women across Ontario and Canada. Knowledge exchange initiatives are important to the VALIDITY♀ project. We continue to share our findings and resources at conferences, events and online. All of the project's resources are driven by the recommendations and voices of young women with lived experiences with depression.

What we do

Since 1999, a dynamic collective of young women aged 15 to 24 alongside service providers across Ontario have consciously used the lens of diverse young women's perspectives to focus on one of the key health issues of our time—the prevention of depression in young

women. This participatory action research project is aimed at gaining a better understanding of factors that lead to depression in young women, with the goal of developing strategies, materials and interventions to address these factors.

Young women have been actively involved in positions of leadership. This has included their leading focus groups in various provincial communities to gather information from peers and service providers about depression and young women. And it has meant planning a very successful provincial conference in 2001. The results of this participatory action research study have been published in the *Canadian Journal of Community Mental Health*. (See list of key documents at the end of this section.)

The overwhelming theme that emerged throughout the focus groups and provincial conference was the need for a safe place where the girls could go and just be themselves, without having to deal with the unrelenting pressures of adolescence and daily life. The feedback stressed the need to have a supportive environment to share their feelings with other girls without fear of negative comments or ridicule. They also described a need for strengthening self-esteem, understanding ways to develop meaningful relationships, understanding the influence of the media on young women, and educating parents, teachers and service providers about depression and how they can help.

GIRLS TALK

Based on the findings from the focus groups, the conference, and recommendations from the VALIDITY♀ Youth Action Team, the Girls Talk program was created by CAMH and piloted in the spring of 2004 at two high schools in the Halton Region and in Ottawa. In

keeping with our model of youth involvement, CAMH partnered with Youth Net/Réseau Ado in Ottawa and the Youth Net Program in Halton to conduct the focus groups and deliver these programs.

Girls Talk is an anti-stigma program for young women to promote understanding of and awareness about depression. The mission statement reads: “The Girls Talk program provides a safe space for young women to connect with each other and to learn about depression and its contributing factors. Young women will develop self-awareness, coping strategies and critical thinking skills through artistic and recreational activities.”

HEAR ME, UNDERSTAND ME, SUPPORT ME

Another key recommendation from the young women in the participatory action research study was to create a resource for service providers about depression from a young woman’s perspective. Under the leadership of CAMH and the incredible contributions from young women, the book *Hear Me, Understand Me, Support Me: What Young Women Want You to Know about Depression* was published in 2006. Young women gathered in 2005 for a writing weekend, led by an experienced youth facilitator, to share their personal stories about depression. This excellent resource has been disseminated throughout North America and has truly helped service providers who work with young women understand depression from a young woman’s perspective.

LET’S TALK POSTER

A subsequent recommendation from the young women was to educate family physicians about the many factors affecting young women’s health. The young women wanted a poster that clearly outlined the issues they are affected by and how these issues relate to depression. They also wanted to talk about their issues, and not simply be medicated. The Let’s Talk poster was launched in 2008 as a result of several focus groups with young women and service providers. It contains colours, words and photographs that resonate with young women as they told us in the design process. The objectives of the

poster are to:

- encourage young women and primary care providers to consider health from a more holistic standpoint
- raise service providers’ awareness of the various factors (including the social determinants of health) that affect young women’s well-being
- encourage young women to talk to their family physician about what’s going on in their lives
- encourage all service providers to ask about and listen to girls talk about various aspects of their lives that might be affecting their health.

Thousands of posters have been disseminated across Ontario and beyond in both the health and education sectors, with tremendous feedback about the usefulness of the poster in day-to-day conversations with young women.

All of the resources can be found at www.camh.net/validity; they are free of charge and available in both English and French.

How we overcame challenges

Youth involvement was maintained by ensuring the youth were working on aspects of the project that they were interested in. This was done by checking in with the youth, and keeping in touch by listserv and e-mail. We also periodically called on the core young women involved in the focus groups and the writing weekend to support initiatives and various aspects of the project.

One of the main challenges that needed to be addressed was the physical distance separating team members, posing a threat to everyone being able to participate meaningfully as a provincial initiative. This obstacle was overcome by holding meetings when youth were available (often evenings and weekends), using e-mail and telephone to meet and plan meetings as opposed to getting together face to face, and creating a listserv to keep in touch, share ideas and plan.

Continued interest in the project stems from

the young women's passion for the issue and their positive experience being involved in the project. One young woman who often speaks at conferences and events about VALIDITY♀ says, "When VALIDITY♀ calls, I'm there! I love this project and I think more people should know about it."

How our work reflects principles of equity

The main principles of the VALIDITY♀ project include:

- ensuring a high level of involvement from adolescent girls at all stages
- using an open and inclusive process of planning, research and evaluation
- focusing on practical outcomes that will contribute to preventing depression
- making a commitment to honour diversity—cultural, racial, sexual, socioeconomic, physical and mental ability—in designing and implementing the project.

- having a provincial focus.

The VALIDITY♀ project is an example of a youth-led initiative that developed out of a participatory model. From the initial planning stages, youth were conceptualized as having a lead role; however, their role expanded as they brought their own energy and ideas to the project. The young women in the VALIDITY♀ project have been instrumental in decision making and planning almost from day one.

The VALIDITY♀ project is unique in that the lived experiences of over 250 young women have influenced the development of the project's resources. It continues to evolve in response to the needs of young women and service providers working with them.

What we have learned

Over the past 10 years, the VALIDITY♀ team members have gained some insights into working with youth. Below is a list of some key points to consider when working with youth:

- Create a youth-friendly environment: keep it casual (both atmosphere and dress), accessible

Continued interest in the project stems from the young women's passion for the issue and their positive experience being involved in the project.

and fun. Accept youth forms of expression (painting, illustrating, poetry, creative writing, music or dance).

- Be realistic about expectations: Provide several ways for youth to participate in the project that allow for different levels of involvement and commitment. Be respectful of youth's time and be prepared for turnover. (We made sure we had enough volunteers at the outset to be able to manage this inevitable turnover.)
- Have the right attitude: make sure you want to work with youth, treat them as equal partners, use youth language when appropriate and cultivate mutual respect.
- Create and maintain open communication: keep things simple, be open and honest, discuss role expectations, and be clear about how the youth's input will be used.
- Youth empowerment and sharing control: recognize and validate youth expertise on the project, get youth involved from the beginning of an initiative, engage youth in initiatives that are relevant to them, and give youth credit for their contributions.
- Ensure a positive and supportive experience: create short-term goals with tangible end points so youth can see their impact immediately, support them in using and developing their skills, and check in with youth to continue an open dialogue.

Key documents

All information pertaining to this project can be found at: www.camh.net/validity

Ross, E., Ali, A. & Toner, B.B. (2003). Investigating issues surrounding depression in adolescent girls across Ontario: A participatory action research project. *Canadian Journal of Community Mental Health*, 22 (1), 55–68.

How to reach us

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EVALUATION AND CRITICAL REFLECTION

SUMMARY OF KEY PRINCIPLES AND LESSONS LEARNED

Key principles

- Involve stakeholders in the design of the evaluation.
- Encourage partners to engage in ongoing reflection rather than simply a one-time evaluation.
- Provide opportunities for partners to express the strengths and needs they bring to the process.
- Use an anti-oppression framework, which means paying attention to discrimination, systemic inequalities, history and social location.
- Offer a variety of mechanisms for participation.
- Assess the utility or appropriateness of an approach in the context in which it is being used rather than assuming a one-size-fits-all approach.
- Reflect critically to develop self-awareness of one's own social location and the impact this has on relations with partners both at the individual and organizational level.
- Be open to alternative ways of evaluating partnerships that acknowledge that people share information in different ways.

Lessons learned

- Continuous evaluation is essential to achieving wanted outcomes.
- Effective partnerships and partnership activity such as evaluation require organizational buy-in and commitment from senior levels.
- Time for critical reflection is essential in working through individual and group biases.
- Organizations need to prepare for an engagement process, as often a cultural shift is required (e.g., with youth).
- Effective equitable partnerships are needed for the future of multicultural Canada.
- Rather than imposing a model of care, we need to work toward culturally competent and safe care that incorporates traditional healing practices of diverse communities.
- Successful programming happens when partners have a consistent dialogue with one another on how the program is developing and running.

Evaluating and critically reflecting: An introduction

Dr. Kwame McKenzie

In a democracy, if you do not count, you do not count. In a world dominated by numbers, deciding whether something has worked or not is simply a matter of finding the right questionnaire or metric and getting people to fill it in. You do the questionnaire before you start. You mark the questionnaire and that gives you a score. When you finish, you do the same and again you get a score. You measure the difference between the starting score and the ending score and then apply a statistical test. If there is a significant change, then you show that your intervention has worked.

Right? Well, maybe not.

Unfortunately, life is not as simple as the mythical world of numbers. In a world of complex interventions and inter-relations, there may be no clear agreement about which approach should be used to evaluate something. Even if there were agreement, there may be no simple questionnaire that asks the questions that you want answered and no simple statistic that tells you whether something has worked or not. It may not be possible to capture the experience of a partnership, the trust that it has built or the fact that it has laid the foundations for work that will make a difference many years in the future.

This makes evaluating equitable partnerships challenging but very exciting. The aim is to do many different things. It is not simply to quantify what we feel about the way a partnership has turned out, but also to define what we wanted to feel and accurately describe what happened.

Evaluation is a cross-cultural journey. Done properly, it allows different parties to articulate their values and their culture and to express what a good outcome should look like.

Whatever form it takes, the process of evaluation needs to align with the concept of equitable

partnerships. It needs to give an equal voice to the parties by facilitating their balanced involvement in the process.

Both the evaluation process and the information that is captured by the evaluation can be important in increasing the partners' understanding of themselves, of each other and of the work they have set up a partnership to perform.

In this way, the evaluation is a form of participatory action research. It is a form of learning by doing. The person or people involved in the evaluation are part of the partnership and help build knowledge and understanding in the partnership. Using this approach, the evaluation can contribute both to the practical concerns of the partners while simultaneously capturing useful information and data. This takes some skill: those undertaking the evaluation need to be systematic, they need to understand the science of evaluation but also the art of social science. Participatory action research is not static. It is an ongoing cycle and is transformational: it turns partners into co-investigators and assumes that this type of participation helps people learn and increases the chances that they will apply what they have learned.

All the contributors to this section are grappling with evaluation in slightly different ways. You will see that some are more interested in getting agreement around the conceptual framework, others with the process of evaluation and others still with understanding what outcomes should be measured. They eloquently represent the range of lenses needed for an evaluation.

Dr. Kwame McKenzie is a professor of psychiatry at the University of Toronto and a senior scientist and deputy director of the Schizophrenia Program at CAMH.

The New Mentality: Toward more informed mental health services for children and youth

Nancy Pereira

Who we are

The New Mentality (TNM) is a program of Children's Mental Health Ontario (CMHO) that is aimed at making child and youth mental health services more relevant to youth by encouraging their equitable involvement.

Our goals

TNM engages youth and adult professionals to work together to reduce stigma and advocate for more effective mental health services. TNM defines youth engagement as “empowering all youth as valuable partners in addressing and making decisions about issues that affect them personally and/or that they believe to be important.”

Our three main objectives are to:

- increase the capacity of child and youth mental health agencies to engage youth
- increase public awareness around child and youth mental health issues
- improve mental health services for Ontario's children and youth.

What we do

We engage youth and professionals in working together to reduce stigma and create more effective mental health services for children and youth. The main activities of the TNM include:

- maintaining a network of youth across Ontario
- knowledge exchange: providing training and support to youth, adult allies and partnering organizations

- public education: seeking opportunities for youth to host awareness campaigns and speak out to other youth, government and the public at large.

How we reflect critically and evaluate our partnership

The Centre of Excellence for Youth Engagement (CEYE) did a formative and exploratory evaluation of the New Mentality pilot phase (February 2007–March 2009). This evaluation was intended to gather broad information on the program so that the findings could incorporate youth-identified solutions—serving as a resource for both the future of TNM and other youth engagement programs focusing on mental health.

In order to uphold youth engagement best practices, the evaluation incorporated youth participation, not just as respondents, but as evaluators who took part in the planning, analysis and reporting of findings. For further information, please find a copy of the report on our website: www.thenewmentality.ca/ye_resources.php.

How our work/partnership/initiative reflects principles of equity

Currently, the child and youth mental health field works *for* youth rather than *with* youth—providing services to young people who need treatment, but rarely asking for their feedback, help or ideas for improving services. TNM is working to shift this culture by actively engaging youth. We want youth to be seen not as problems that need fixing, but as invested partners

and active decision makers who can contribute to improving mental health services.

The New Mentality project has been conceived as a catalyst for encouraging and assisting agencies to adopt the practice of youth engagement. Our goal is to provide a practical and sustainable model for youth/professional/organizational partnerships, and for changing policy and practice to support meaningful youth engagement within the child and youth mental health system.

Through training and support, TNM can help agencies to understand, adopt and amend their internal practices to reflect the principles of youth engagement. By demonstrating their commitment to engaging youth, agencies will inevitably be more effective at meeting the needs of the populations they seek to serve.

Organizations who operate using a New Mentality model collaborate with youth in the community to develop a public awareness initiative. Projects should raise awareness and reduce stigma, as well as profile the partnering agency to community members.

Within the South East Region, a group of youth came together to create a mural that illustrates the experience of mental illness from a youth perspective. The initiative was led by Pathways for Children and Youth. The mural has travelled across the region, and has been presented at various conferences showcasing the great work that can be produced when adults and youth work together.

What we have learned

Initiating and sustaining youth engagement within an organization is a process that requires continuous evaluation to progress into an effective model of

practice. In order for youth engagement efforts to succeed, organizational buy-in must reflect commitment from the top, and support throughout all levels of the organization.

Both adults and youth need to take time to work through the stereotypes they hold of one another, as attitudes often create the biggest barrier to carrying out youth engagement. Similarly, agencies need to take the time to prepare themselves for youth engagement, as this way of doing work often requires a cultural shift within the organization and in how it does business.

Key documents

To identify strategies for engaging youth, and use tools for assessing organizational readiness, please visit www.thenewmentality.ca/index.php and download the *Ready Set Engage* manual and the TNM Evaluation Report.

How to reach us

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We want youth to be seen not as problems that need fixing, but as invested partners and active decision makers who can contribute to improving mental health services.

Health and Racism Working Group

Nicole Ghanie-Opondo and Kinsi Warsame

Who we are

This working group was set up in Peel region to better address the health issues of racialized people in the community. Our partnership is comprised of a coalition of community organizations including a women's shelter, a sexuality program with public health and an HIV/AIDS network.

Our goals

The objectives of the working group are:

- to stimulate action and educated awareness that recognizes and responds to the health experiences of racialized peoples in Peel region
- to emphasize self-care, self-development and participatory strategies.

What we do

The catalyst for the start of this group was frustration with diversity and cultural competency initiatives in Peel. Existing diversity and cultural competency work in Peel did not address systemic racism and other forms of systemic oppression. Without these issues being addressed, discussion of the impact of racism on racialized communities was completely ignored. We believed that creating a space for racialized communities to have discussions, to organize and to heal, was important to continue the momentum of change in Peel.

WORKSHOPS

We organize workshops, symposiums and consultations that speak to issues not being addressed by mainstream agencies and networks.

Examples include:

- Premiere Community Consultation on Health, Access, and Racism in Peel (January 2007)
- Open House: Addressing Gender and Race (April 2008)
- Colour of Poverty Workshops in Mississauga (March and April 2008)
- Presentation at Building Equitable Partnerships Symposium, CAMH (November 2008)
- International Day for Elimination of Racial Discrimination: Partnered with Interim Place and petitioned Peel Regional Council to declare this day in future years (March 2009)
- Symposium 2009 featuring Uzma Shakir, Dr. Erin Psota, True Daley and Anthony Templer that provided an opportunity to explore anger, racism and health (May 2009)
- Employment Equity 101 Workshop (October 2009)
- Ally or A Lie Symposium, The Truth about Being and Building Allies (May 2009).

TRAININGS AND WORKSHOPS

We believe that the internal capacity building of the group is important to stimulate resilience among racialized communities who do anti-racist work. We organize trainings and healing arts activities to create space for group members to grow and build relationships amongst each other.

Examples include:

- First generation of core members develop strategic plan and undergo anti-racism and anti-oppression training, to be conducted annually (April 2007)
- Two-day gender training workshop with Karen Craggs of Gender Equality Incorporated (June 2008)

- Body Mapping Expressive Arts group project on race, gender and health (March 2008)
- PhotoVoice Project: Invisible Reality...Anger Hurts (April 2009)
- Anti-racist LGBT Training (November 2009)
- Writing from Marginalized Voices Workshop with Farzana Doctor (December 2009)
- T-shirt Silk Screening and Identities Workshop with Kenji Tokawa (April 2010)

We value sharing information and gaining new knowledge. To help us do this, we maintain a blog that group members can contribute to that documents our work. We also maintain a Google Groups mailing list that is available to core and auxiliary members.

How we reflect critically and evaluate our partnership

To evaluate our partnership, we carry out electronic surveys of auxiliary and core members (using Survey Monkey) and discuss issues in person. We encourage “checking out” at every meeting, which involves each member sharing a thought before the meeting ends (often about how they are feeling after the meeting or what they plan to do with the information shared). We value input from our members and encourage conversation and participation by phone, e-mail, listserv and in person. We do training assessments to determine what training would build our group capacity and to take stock of new members’ skills. We integrate the feedback from evaluations shared by workshop and training participants in our annual strategic planning. The strategic planning is facilitated by the chair.

How our work/partnership/initiative reflects principles of equity

Our group recognizes that we need to continually be reflective of how we work with each other through principles of equity. Group dynamics are important in meetings and organizing workshops. We encour-

age and are mindful of the space each person takes up, and try to practise “stepping up and stepping back” in discussions and planning. It has been helpful to have critical discussions about how racism has affected us all differently and created varying experiences to contribute to our analyses. We are all at different points of power and privilege, depending on other aspects of our identities, such as sexual orientation, class and shade. Self-reflection—through journaling, discussion and the healing arts—helps us keep this awareness at the forefront of our work. Intersectionality is always a topic at our meetings, and the trust our chairs have nurtured has crafted a supportive environment.

We are flexible in responding to group members’ needs, whether this means adjusting meeting times, having lunch while we meet, participating differently, moving the location of meetings, or alternating evening events. Often members cannot be physically present at meetings, so we acknowledge contributions through e-mail, phone or listserv postings. If we haven’t seen a member for a while, we send individual e-mails or call to check on their status on the committee and give them the opportunity to give feedback on workload, meeting times, location, etc.

Co-chairing was introduced in 2009 as a way of building on a leadership goal set in strategic planning by the group. Group members randomly chose a month in the year that they would be responsible for chairing the meeting. Being chair includes sending the meeting reminder, assigning the minute taker, sending the agenda, soliciting agenda items, developing the meeting content, facilitating the check-out, and managing a follow-up to the meeting. Group members chairing for the first time were supported by the original chairs through mentoring and coaching.

We combine external activities on anti-racism issues with internal activities dealing with our own pain of experiencing racism daily. Our work is both about dismantling systemic racism through advocacy and education, and processing racism in our own lives so we don’t forget about our own mental health and wellness in this work. Our members’ lived experiences are valued; we encourage each other to give a voice to experiences that have been silenced. Opportunities

include expressive arts exercises and discussing issues at monthly meetings. Another way we continually self-reflect is by looking at our own privilege: we make it a priority to have anti-racism as an entry point into looking at other forms of oppression such as homophobia and sexism. We achieve this through training, by being mindful of facilitators we bring in, and by allying with other marginalized groups.

Decision making is a critical area for ensuring equity in our group practice. Our process of decision making is consultative, with most major decisions being made in person at our monthly meetings when possible. Chairs make an effort to consult with most members one-on-one for major decisions. We accept that this process takes longer, as added consultations means decisions are made more slowly. Decision making leadership is transformed as trust grows in the group, and new leaders emerge with mentoring from earlier generations of members.

What we have learned

- We learn from each others' strengths and weaknesses.
- We can be honest about our capacity.
- We accept that while we are working on changing systems, we must cope with the impact of racism today.
- We honour the complexity of people's lives.
- We continue to build trust among ourselves and our allies.
- We contribute to community development, but also make space for developing ourselves.

- We stay critical by keeping a mix of opinions and perspectives.

Key documents

Please visit our web site at www.eastmississaugachc.org/hrwgroup.php to read the Health, Access and Racism Post-Forum Report and to learn more about the Health and Racism Working Group.

How to reach us

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*Decision making leadership is transformed
as trust grows in the group, and new leaders
emerge with mentoring from
earlier generations of members.*

Practitioner and service user partnership

Hajera Rostam

Who we are

I am a counselling psychologist trainee pursuing my doctoral degree at the University of British Columbia, in a program that emphasizes practice and research. Currently a doctoral intern, my primary clients are students enrolled at the University of California at Berkeley whom I see for individual and group therapy. In addition, I partner with the campus community and departments to provide outreach (i.e., to international students) and consultation from a health promotion perspective. My former collaborations in the community have included working with culturally diverse clients entering residential treatment for alcohol and other drug-related problems. My role as researcher complements my practice: my doctoral dissertation focuses on how counsellors' understanding and incorporation of clients' ethnocultural diversity contributes to effective and culturally competent alcohol and drug treatment and services.

My goals

As a scientist-practitioner, my practice and research partnerships are aimed at:

- contributing to and raising awareness of mental health and addiction needs of diverse client populations (e.g., immigrants, refugees, international, LGBTQ groups)
- learning about and choosing appropriate interventions
- identifying access and barriers to culturally competent and safe services.

What I do

As a service provider, my priority in the partnership process is building and maintaining an empathic, safe and trusting therapeutic relationship with clients. My approach invites a collaborative and iterative process to counselling, where I value my clients' knowledge, competencies and resources. I try to establish a shared understanding of our goals for therapy, assessments, interventions and outreach. I consistently strive to understand and honour my clients' unique backgrounds (e.g., culturally and as part of a marginalized group), and to inquire how psychological concerns are understood, managed and expressed in my clients' unique communities. While I am familiar with formalized assessment and diagnostic instruments, I use these only when clinically or culturally appropriate to my clients' presenting needs. My practice is further informed by ethics and culturally competent and safe practices.

Since most counselling interventions and theories have their roots in Western thinking, I evaluate their effectiveness and application to multicultural and diverse groups. This evaluation process begins with an assessment of my own assumptions, values, biases, skills and limitations when working with clients that are different from me (e.g., with respect to gender, culture, ethnicity, sexual orientation, religious affiliation, socioeconomic status). I am critically aware of my own power as a service provider in my interpersonal relationships with clients and how I position myself in relation to clients from varied backgrounds. I work from a stance that empowers clients in making decisions for themselves. I also consider clients' comfort level in seeking help

from a mainstream mental health service provider or from their own communities. I gather information about factors from clients' sociocultural environment that may be affecting their overall functioning. This includes finding out about systemic barriers (i.e., oppressive factors such as racism and homophobia).

Together with clients, I explore the underlying cultural and group norms for particular behaviours and consider how expression and manifestation of affect, cognitions and behaviours may invariably differ across diverse groups. If my clients share their interest with me in traditional healing practices, I remain open and encourage them to help me incorporate these resources into our collaborative plan of care. I also examine the extent that my particular interventions are regarded as safe and culturally congruent by my clients and their families and I familiarize myself with the limited research available on the cultural appropriateness of particular therapeutic interventions.

In our therapeutic relationship or partnership, I remain open to discussing differences in cultural orientation and worldviews and demonstrate my commitment to a non-judgmental orientation and ethical practice. Since my work and training are influenced by a scientist-practitioner model, I engage with academics, scholars, students and communities to learn about, inform others and myself, and advocate for research aimed at exploring and examining the mental health needs of underserved and marginalized populations. I present at national and international conferences and public venues as well as serve on advisory boards to raise awareness about diversity and multicultural issues.

How I reflect critically and evaluate my partnerships

I embed my partnerships with service users and colleagues within a social justice perspective by attending to critical issues such as discrimination,

social oppression and systemic inequalities that marginalize various groups (Vera & Speight, 2003). A social justice stance calls for social responsibility and action on the part of the professional and his or her discipline to address "societal values, structures, policies and practices" (Goodman et al., 2004, p. 795) that give rise to and maintain power differentials and marginality, thus limiting access to equitable resources and quality care (Pieterse et al., 2009).

I position my partnerships within the framework of cultural safety, attending to issues of minority status, historical and political forces, power dynamics and dominant health discourses and structures that influence the lives of minorities and disregard their traditional and cultural health belief systems (Smye & Browne, 2002). From a practical sense, this framework privileges critical awareness and ensures the practice of safety aimed at honouring and respecting the unique cultural identities of different groups. It requires health practitioners or providers to be aware of the power differential that exists between them and the recipient of care. Thus, it goes beyond the professionals' awareness to clients' deciding what safe and competent services mean to them (Gray & McPherson, 2005).

This framework calls for actions aimed at eliminating cultural risk, defined as "actions that diminish, demean or disempower the cultural identity and well being of an individual" (Papps, 2005).

McEldowney, Puckey and Richardson (2005, p. 110) urge service providers to:

- act from a high level of personal and professional understanding of the self and the power positions of their own practice
- be accountable to the policies and legislation informing safe practice
- understand the socio-political and historical contexts affecting access and appropriateness within mental health care.

How my work/partnership/ initiative reflects principles of equity

In my partnership with diverse clients, I view diversity as multi-layered, encompassing interconnected dimensions such as age, race, ethnicity, culture, gender, sexual orientation, religion, and developmental and acquired disabilities. I introduce the principles of equity into my partnership with clients by incorporating a multicultural framework such as Sue and Sue's (2003) tripartite model of multicultural competency that focuses on three areas of counsellors' competencies.

These areas are:

1. awareness (i.e., being aware of and examining one's assumptions, values, biases and cultural frame of reference, and their impact on one's clinical practice)
2. knowledge (i.e., understanding and increasing knowledge about diverse groups, attending to contextual factors affecting clients' functioning; knowledge of socio-political and institutional systems that create barriers and marginalize groups; and increasing knowledge of approaches and interventions that are diversity and culturally-based)
3. skills (i.e., ability to engage in culturally-appropriate interventions and assessment tools with diverse clients, seeking relevant diversity and multicultural training, and examining the scope and limitations

of one's own helping styles) (Arredondo et al., 1996; Pieterse et al., 2009; Sue et al., 1992; Sue & Sue, 2008; Sue, 2001).

What I have learned

Equitable partnerships are needed for the future of multicultural Canada and its diverse communities. I have learned that building partnerships is a process that is iterative, emergent and works best when it is collaborative, participatory and focused on empowerment. As a practitioner working within the mainstream health services, I have learned that we need to move beyond imposing a Eurocentric model of care and work toward culturally competent and safe practices that promote access and incorporate the traditional healing practices of its diverse communities.

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*I view diversity as multi-layered,
 encompassing interconnected dimensions such as
 age, race, ethnicity, culture, gender,
 sexual orientation, religion, and
 developmental and acquired disabilities.*

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A Unique CMHA mental health program: Exploring partnerships with immigrant communities

Sharon Chakkalackal, Janet Priston, Terrie Wetle and Bobby Paikatt, MD

Who we are

Our partnership includes the Canadian Mental Health Association (CMHA), immigrant communities that attend the program, resettlement agencies and Sharon Chakkalackal, as an independent program evaluator. We formed this partnership to evaluate CMHA's mental health promotion program.

Our goals

The goal of this study was to conduct a program evaluation for CMHA's mental health promotion program. Although the partnership was not a main component of the evaluation, we collected and analyzed some data on the partnerships formed.

What we do

In 1998, the Canadian Mental Health Association, Toronto Branch (CMHA Toronto) began a mental health promotion program for immigrant women, called Let's Discuss It (LDI), conducted in English. In 2004, LDI expanded into more culturally and linguistically sensitive programming in the immigrant women's preferred language. Soon after, another program entitled Multicultural Women's Wellness Program (MMWP) was launched, modelled after the LDI framework. As of January 2009, both programs are referred to as the Women's Wellness Program (WWP).

CMHA has two staff members that act as technical assistant liaisons/supports for group leaders of the mental health promotion program. The group leaders of the Cultural Communities Initiative's Women's Wellness program are either volunteers from an immigrant community or personnel from a resettlement agency. The partnership formed between CMHA and the group leaders requires technical assistance and support from CMHA and cultural/linguistic creativity and leadership from their group leaders. As the evaluator, I looked at how these partnerships are critical to the success and effectiveness of the program.

How we reflect critically and evaluate our partnership

The partnerships were evaluated as one element in the program's effectiveness, through a mixed-methods process evaluation. Staff respondents from resettlement agencies and CMHA answered questions about the strengths and challenges of the partnerships and the program. The independent evaluator collected data and completed a qualitative analysis, resulting in a program evaluation report. The Question Guide used for the evaluation can be obtained by contacting Sharon Chakkalackal (Research and Program Evaluation Consultant for CMHA) at sharonc@alumni.brown.edu.

How our work/partnership/ initiative reflects principles of equity

As an evaluator, one way to measure equity is to observe the dialogue and conversation used between both parties. The interviewee transcripts revealed that both parties used such words as “fair” and “equal” when asked what they liked most about their partnerships. Another principle of equity, being client-directed, was noted in how immigrant communities frequently requested CMHA to help them start a group. Lastly, the cornerstone of the WWP involves allowing group participants to create what they want from the program: participants choose the topics they want to learn, they can become group leaders, and the programming is client-centred.

What we have learned

Successful community mental health programming occurs:

- when both partners see the partnerships as an opportunity to learn from each other (e.g., the program facilitators come from the community and the participants shape the program in the way they want)
- when both partners have a consistent dialogue with each other on how the program is developing or running: this requires such traits as honesty, trust and comfort.

Key documents

For a copy of the Staff Questionnaire Guide and/or the Participant Focus Group Guide, please contact Sharon Chakkalackal.

How to reach us

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Strengthening partnership resiliency through a “world café”

Who we are

We are a partnership of two: Tammy Decarie, formerly with Queen West Community Health Centre, is now with Parents for Better Beginnings at Regent Park Community Health Centre. Deborah Konecny, formerly with Families Are Important Resources project at Family Services Toronto, is now with the Catalyst Centre. We have come together on several occasions to implement a “world café.”

Our goals

Our purpose in using a world café is:

- to create a space and process that allows collective knowledge and decision making to be formed in the middle of the table rather than from the minds of individual participants.

What we do

There are a few important steps to take to create the right kind of environment for a world café. They are to:

1. Decide on the purpose of your conversation and create a series of questions that illicit more than “yes” or “no” responses and challenge conversation participants to think about the issue in new ways.
2. Invite people to participate in a fun way that allows them to know they are going to be experiencing something new.
3. Create an environment conducive to conversation and creativity by using small round tables covered with paper, with coloured crayons or markers on

hand, and quotes and other inspiring things posted around the room.

4. Explain the world café process to everyone, including the fact that people will be moving around to different questions throughout the time, that they will be meeting new people, and sharing and drawing their ideas and impressions.
5. Bring everyone back together in a plenary session that draws out new ideas from the discussion and creates something people can move forward with.

We have used world cafés to plan events so that everyone around the room has an opportunity to speak, share ideas in different ways (verbally or visually), meet new people and therefore be exposed to new ideas. This kind of approach encourages all participants to feel a sense of ownership and depth of participation. People’s roles organically came out of the things they were most passionate about.

We also used a world café to wrap up a three-year project and give the participants in the project a place to go. The partners who hosted the project also emerged with concrete learning and a number of next possible steps. This makes the world café a useful tool in reflecting critically on a project or perhaps a partnership.

We have also used the world café twice to challenge our own perceptions about community readiness. Often we think about community readiness in terms of “clients” being ready to participate in our programs or processes but rarely do we apply the same scrutiny to ourselves. By using a world café format at two conferences, one for family support workers and one for staff members from mental health organizations, we were able to hone our own praxis

about why our partnership works well and share that with others as a jumping off point for people to examine their personal, agency and community readiness to be fully engaged in partnerships. Best of all, we shared a tool, world café, with people so they could create a similar experience in their local partnerships.

For more information on this process, please refer to www.worldcafe.com.

How we reflect critically and evaluate our partnership

A world café is great as a critical reflection piece and evaluation tool. The café can be taught by experiencing it. By that I mean that an evaluation committee can learn about world café by using the process to:

- decide on the topic of evaluation
- create the questions for each round table
- design a plenary session that meets the evaluation needs of its partnership.

The process, when done well, is critical reflection at its best and most creative.

How our work/partnership/initiative reflects principles of equity

Using a world café reflects principles of equity by:

- acknowledging that people learn and share information differently by encouraging storytelling through words and pictures (by drawing on paper that covers each table)
- not having predetermined table hosts: each group decides which person will stay back and share the

group's thoughts with the next round of visitors to the table

- having a plenary process that is open to whatever comes up as wisdom in the room
- not predetermining what the outcome of the conversations will be but, rather, having an inclusive process that builds on collective knowledge and decisions.

What we have learned

We have learned that using the world café tool is a beautiful way to share knowledge and power. The potential for transformative learning kicks in from the very onset of planning a world café, and continues to provide learning opportunities for years later when we reflect back on conversations we have been a part of.

It is also a great tool for self-knowledge—whether that is the knowledge of the individual or the group.

How to reach us

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We were able to hone our own praxis about why our partnership works well and share that with others as a jumping off point for people to examine their personal, agency and community readiness.

Conclusion

Alan Li

Developing this resource has been an exciting journey. We appreciate our contributors' rich diversity of experiences and reflections and we hope we can all draw valuable lessons to inform and improve our work.

The more we recognize the complexity of the human condition and the many social factors that affect people's health, the more we realize that partnerships involving different stakeholders are essential in developing an effective response to the challenges faced by many marginalized communities. Effective and equitable partnerships are invaluable in facilitating the collective empowerment of affected communities to develop and implement solutions to advance positive social changes and improve individual and community health. However, deeply entrenched social power structures often create barriers for building equitable partnerships and can further marginalize and disenfranchise involved partners. For partnerships to work and reflect principles of equity, everyone needs to make a proactive and explicit effort to honour the core values and principles identified by contributors.

These core values and principles include:

- respecting diversity and honouring lived experiences of affected communities
- ensuring inclusiveness and access
- acknowledging power differences, challenging oppressions and sharing power
- being accountable to each other and to the group's collective vision
- being committed and open to learning from each other.

The experiences reflected in this resource represent a wide range of diverse community-building efforts of front-line service providers, affected communities, advocates, institutions and policy-makers.

APPENDIX A

Additional Partnership Resources

Afsana, K., Habte, D., Hatfield, J., Murphy, J. & Neufeld, V. (2009). *Partnership Assessment Toolkit*. Canadian Coalition for Global Health Research. Available: http://ccghr.ca/docs/PAT_Interactive_e.pdf.

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Frearson, A. *Partnership Self Assessment Toolkit*. East Leeds Primary Care Trust. Available: www.youthmentoringvic.org.au/file/file/Community%20Partnerships/Anna%20Frearson%20Partnership%20Self%20Assessment%20Tool.pdf. Accessed June 14, 2010.

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Roberts, J.M. (2004). *Alliances, Coalitions and Partnerships: Building Collaborative Organizations*. Gabriola Island, B.C.: New Society Publishers.

Williams Torres, G. & Margolin, F.S. (2003). *The Collaboration Primer: Proven Strategies, Considerations, and Tools to Get You Started*. Chicago, IL: Health Research and Educational Trust. Available: www.hret.org/upload/resources/collaboration-primer.pdf.

APPENDIX B

BEP symposium recommendations

Each of the over 30 workshops at the symposium reserved time to collaboratively develop one or two recommendations to build and strengthen equitable partnerships with diverse and marginalized communities and groups.

A brief summary of recommendations generated over the course of the symposium was presented to delegates and a panel of LHIN representatives for comment at closure of the event.

Below is a comprehensive report of recommendations collaboratively developed by BEP symposium delegates and workshop facilitators. In compiling these recommendations, the words of workshop participants were used as much as possible. A team of symposium organizers reviewed all the notes and recommendations recorded by volunteers acting as workshop hosts. The recommendations were grouped together based on similar themes that coincide with the issue areas of the workshops.

The four overarching areas are:

1. Principles for equitable partnerships/processes for successful partnerships (both organization and personal/professional)
2. Partnering with clients and diverse and marginalized communities
3. Partnering between agencies of all sizes, researchers, funders and policy-makers
4. Partnerships to address social determinants of health.

1. PRINCIPLES FOR EQUITABLE PARTNERSHIP/ PROCESSES FOR SUCCESSFUL PARTNERSHIPS

Organizational considerations

- Have clear and open communication with partners, operating from clear guidelines / terms of reference and fostering a transparent process throughout.
- Develop effective partnerships with agencies and clients through personal relationships that identify shared goals and populations.
- Create an environment of partnering: create time, space and trust to talk about our environment and any tensions; find ways to understand each other; share a common vision; develop outcomes; build consensus; and communicate openly and frequently.
- By working collaboratively within the organization, you can influence what happens in partnerships out in the community.
- Spend time doing “cross training” among partners (including job shadowing).
- Disseminate information about the powerful work accomplished by partnerships.
- Develop an understanding of cultural differences.
- Be physically where the partner is.
- Develop contractual agreements with partners to ensure that the terms of the partnerships are respected showcase what we have that is unique and highlight what we have in common.

Personal/Professional

- Integrate time and resources for critical self-reflective practice into the building of equitable partnerships.
- Recognize that partnerships are actually about relationships: we are responsible for creating opportunities for shared leadership.
- Respect and accept each other as partners.

2. PARTNERING WITH CLIENTS AND DIVERSE AND MARGINALIZED COMMUNITIES

Principles

- The true leadership of a partnership should be directed by the identified community. The partnership has to be for them and it has to be about them. The identified community must be the one to direct the allies regarding what their care will or should be. The allies and the community need to be cross-trained and must understand each other's language and perspectives. There must be a genuine interest and tangible commitment to address issues of power and oppression.
- Ask clients what their priorities are for services
- Nothing about us without us [service users]!
- The target communities most affected by the partnership must have a leadership role in the partnership.
- In order to create community engagement and equitable partnerships, it is imperative to get the buy-in from the potential partners and stakeholders.
- Knowledge production must lead to action with/for the community.
- Make a conscious effort to examine and challenge how language and literacy are issues of power, and think about what you can do to negotiate those power issues equitably.
- Building partnerships means going beyond tolerance to acceptance and truly valuing the individual, community, etc.

Considerations for working with specific populations/communities

- Identify bilingual capacity within an organization for better partnering within an organization to meet the needs of francophone communities.
- Partner with agencies providing French language services (e.g., OASIS Centre des Femmes) to enhance service capacity for francophone communities.
- Build youth engagement through equal adult-youth partnership and youth contribution to change.
- Work with young women: give them a position of power, work with them.

Resource and infrastructural considerations

- Disclosure agreements are an important part of partnerships with clients.
- Have resources or funds to provide child care, honoraria, etc., when involving the community.

3. PARTNERING BETWEEN AGENCIES OF ALL SIZES, RESEARCHERS, FUNDERS AND POLICY-MAKERS

Principles

- Ensure that the voices and needs of front-line workers are reflected [or heard] in the decision making process. Ensure both front-line workers and executive are involved when building partnerships.
- Involve community members in the development of partnership framework
- Everyone should have a role to play in moving the partnership forward: they can both contribute to the partnership and gain from it.
- Ensure that the partnership honours the diversity and skills of all partners and facilitate learning by and of all partners.
- Build in support mechanisms within the partnership to ensure ongoing, clear and honest communication and motivation to keep all partners engaged and committed.

- Communicate openly and clearly with partners and operate from clear guidelines / terms of reference and foster a transparent process throughout.
- Evaluate partnerships/integration.

Research/community-academic partnerships

- When researchers and communities come together, time must be allotted to develop strategies to build trust, and understand goals and roles, on an ongoing basis.
- Ensure community-academic partnerships have collaboration at all stages (i.e., project design, establishing operational processes, writing and applying for grants, applying for ethics review, hiring project staff, data collection, analysis, dissemination)
- Community-based research partnerships must be reciprocal, mutual partnerships where leadership role is shared and flexible.
- Peer researchers can be used as the bridge between academia and the community.

Resource and infrastructural considerations

- Funding for community-based research should provide more flexibility in delivering and using funds and in their timelines to conduct the research.
- Funding for community-based research and program development should provide for more flexibility in delivery and use of funds as well as timelines for funding.
- Funding models need to change. Stop basing funding on strategic partnerships or on a project basis.
- Funders need to be educated in ways to support the partnership process.
- Need for infrastructural support
- Operational budget money should be given to allow (smaller) agencies to build capacity.
- For certain partners (i.e., hospitals) making resources (i.e., research and evaluation resources and capabilities) available helps build equitable partnerships.

- Partners who have very different skill sets than you can increase opportunities for learning.
- Use of technology can help build relationships between agencies, particularly when participants are busy and there is little time to meet in person.

4. PARTNERSHIPS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

Principles

- Support partnerships that create synergies among social and health agencies to address the life needs of diverse and marginalized communities.
- Incorporate holistic approaches and bridges between cultural groups.
- More partnerships improve integration within the system and can be particularly empowering for smaller organizations.

Specific partnership recommendations

- Bridge gap between acute care sector and community-based sector.
- Develop partnerships between mental health, addictions, housing, police, shelters and other community organizations to get safe housing and other needed services for clients with HIV.
- Provide seed money for operational budgets for supportive and affordable housing.
- Build awareness among service providers about the impact literacy can have on mental health.
- Focus on reducing the stigma of mental health and addictions.

APPENDIX C

BEP symposium workshops

The list of workshop titles and presenter contact information that follows provides a complete reference of all partnerships presented at the symposium.

Body Mapping: Race and Gender Explored Through Art and Health

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Bringing the Stigma of Mental Illness Out of the Shadows: A Diverse Forum with a Diverse Audience but Shared Lessons

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Building and Maintaining Partnerships with Francophone Communities

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Building Partnerships to Address the Problem Gambling Prevention and Treatment Needs of Ethno-cultural Communities

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Building Reciprocal and Action-Oriented Research Collaborations: Challenges, Successes and Possibilities

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Building Research Partnerships to Explore Mental Health Issues for Newcomer Youth

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The Coalition on HIV and Mental Health: Lessons Learned from Nine Years in the Life of a Collaborative Service Delivery Project

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Concurrent Disorder Support Services: Building Capacity through Partnership

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Developing a Multi-disciplinary Outreach Team to Serve Homeless Individuals with Health/Mental Health Needs

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Engaging the Community and Moving Forward

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**Evaluating Equitable Partnerships:
CAMH's Partnership Evaluation Toolkit
Roslyn Shields**

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**Evaluation of a Unique Mental Health Program:
Exploring Partnerships with Immigrant
Communities**

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**Frontline Partners with Youth Network—
Reflections on Power, Organizations and
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How Do We Create an Environment of Partnering

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**Innovative Partnerships to Address Inequities
and Promote Community Empowerment**

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Intersections of Marginalization

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An Introduction to Critical Self Reflection

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**A Journey of Equitable Partnerships—the Vibrant
Action Looking Into Depression in Today's Young
Women (VALIDITY♀) Project**

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Journeying Together: A Case Study of How Two Very Different Agencies Joined Forces in aid of Victims of Violence

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Marginalized Populations? Reflections on a Community-Research Partnership to Address Evidence/Action Gaps

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Necessary Partnerships: A View of Mental Health and Substance Abuse Provider Networks in Rural and Urban Missouri

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The Ontario HIV and Substance Use Training Program (OHSUTP)

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The Ontario Works Addiction Services Initiative: A Collaboration

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Partnering for Change: Working Together to Create Tools for Advocacy, Equity and Community-Building

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**PHA ACCESS: Improving Access to HIV Mental
Health Services in the Community through
Community-Hospital Collaboration—Lessons
Learned and Key Ingredients for Success**

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**The Power to Participate: Exploring the
Relationships Between Mental Health,
Literacy, and Social Determinants of Health**

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**St. Clares' Housing Model for Affordable Housing
for People**

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**Stories from Both Sides: Marginalized Communities
and Mental Health and Addiction Service Providers**

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**Strengthening Partnership Resiliency through a
Critical Examination of Community Readiness**

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New Mentality—Ready...Set...Engage!

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**Understanding "Partnership" Across 3 Community-
Based Research Projects With and For Women Who
Use Drugs in Vancouver's Downtown Eastside**

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The Use of a Calendar to Share Research Results: An Innovative Participatory Research Project Focused on Occupational Engagement

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What Works and Why to Address Concurrent Disorders Among The wHEALTH Community-based Research Project—Women's HIV Empowerment Through Life Tools for Health

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