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REPORT | MAY 2011

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six Centres financed by the Public Health Agency of Canada. The six Centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics.

FOREWORD

This short document is part of a series which reports on the contribution of not-for-profit (NFP) organizations to public health. The series comes out of a two-pronged project undertaken in 2007 with several organizations in Canada. One focus of the project was a year-long process that supported the organizations in their policy-influencing practices through a series of thematic discussions designed to help them adopt a reflexive point of view on their activities. The second part of the project consists of documenting the organizations' practices and looking at them through lenses of different issues in public health and public policy. The organizations vary in their histories and domains of activity, but all are active in programs which can be viewed as contributing to the promotion of healthy public policies. Their approaches generally have different specific targets than the promotion of health, but each of them acknowledges the relationship between the situations they seek to address and the broader context of public health. Public health actors often seek, or are sought out, to work in partnership with not-for-profit or community organizations and our series of short descriptive analyses attempts to highlight some of the issues which are common in interactions between public health and community actors.

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1 INTRODUCTION

The following is a descriptive analysis of the policy frames used to interpret the central concerns of two organizations in their work to improve economic, social, and physical well being in some of the lowest-income neighbourhoods in Saskatoon, Saskatchewan. The central goal is to examine how different frames impact on the definition not only of the problems to be addressed, but on the solutions which are to be favoured. Awareness of these frames and how they colour approaches may be useful to those seeking to inform partnerships between public health actors and institutions and non-governmental groups. Choosing to concentrate on those areas where the frames are compatible may lead to more successful collaborations.

1.1 WHAT IS "FRAMING"?

The concept of framing is used here in ways similar to how it has been employed in the social sciences, particularly in policy studies. Thus, "framing is a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading and acting" (Rein & Schön, 1993, p. 146). More simply put, "a frame is a perspective from which an amorphous, ill-defined, problematic situation can be made sense of and acted upon" (Rein & Schön, 1993, p. 146). In some ways, frames can be seen as cognitive shortcuts which allow us to quickly understand complex issues and file them with other "knowns". In doing this, frames provide limits on our understanding. Just as a frame around a photograph defines what is inside and what does not belong, so too do discursive frames. Frames will affect how a problem is viewed and understood and also how it is to be solved. It is important to underline here that pointing out the dominant frames used in discussions about Saskatoon's low-income neighbourhoods and their residents is not to say that these frames are intentionally adopted and put forth by the organizations in question. In some cases, that may be so, but the use of the concept of framing here is meant to draw attention to underlying logic structures that 'overdetermine' (Althusser, 1969) the frames that dominate. As an example of framing viewed this way, we might think of how gambling might be differently conceived of depending on whether it is framed as criminal activity or as an addiction which affects some individuals (and these are only two of the many ways of framing this.). If the issue is framed primarily through the lens of gambling as criminal, the tendency might be to focus on individuals who engage (or might engage) in illegal activity and who ought to be punished and attempt to suppress further illegal activity. This was, in general, the dominant frame in North America before the state in many places began sanctioning and eventually largely controlling all access to gambling. This frame eventually gave way to one of the more current ones where gambling is viewed as legitimate entertainment and any problems associated with it are deemed to result from individual pathology (the image of the "problem" or "pathological" gambler). In short, both frames deal with seemingly the same objective phenomenon, gambling, but the way it is viewed and ultimately dealt with is strongly impacted by the way it is framed. Neither frame can be said to be right or wrong in absolute terms, although proponents of either might claim the moral high ground, but frames need not be completely incompatible either. Indeed in this example, while many different framings of gambling put the emphasis on different aspects, they can, and in many cases do, work well together. One might think of framing as a "gaze," a way that one is given to (or made to) look at something whether by formal training or through cultural disposition, for example. So the addiction counsellor views gambling primarily as self-

destructive behaviour and treats the individual; the policeman who specializes in organized crime may view gambling as leading to a whole host of crimes related to money lending; the public health official may primarily see the potential social ills of proliferating casinos on disadvantaged populations, etc. Some frames will be incompatible and much less amenable to partnering with those whose views are perceived as radically different, but in many cases, awareness of the frames one uses as well as those used by others around us can contribute to fruitful partnerships. It is hoped that this brief description provides an opportunity to think about how not-for-profit organizations and public health agencies might frame issues differently and how this might affect their respective abilities to work in partnerships with each other.

2 FRAMING THE CORE NEIGHBOURHOODS

The description which follows is based on a variety of written documents produced by the Saskatoon Health Region, media documents concerning health in Saskatoon's low-income neighbourhoods, documents produced and circulated by Quint Development Corporation, and interviews with key members of core neighbourhood organizations. Also taken into consideration are the reflective documents described above. Finally, a workshop prepared for and held at the Canadian Public Health Association's Annual Conference in Winnipeg in June 2009 involving the National Collaborating Centre for Healthy Public Policy (NCCHPP) and a number of public health actors helped focus and hone the descriptive analysis suggested here. The description is intended to be suggestive for public health actors and authorities involved in partnerships with NFP organizations and not as a definitive analysis of one particular health region and one particular NFP.

2.1 QUINT DEVELOPMENT CORPORATION: PROGRAMS AND ACTIVITIES IN COMMUNITY ECONOMIC DEVELOPMENT

Quint Development Corporation was founded in Saskatoon, Saskatchewan in 1995 in response to acute poverty-related housing and community crises in five of Saskatoon's oldest "core" neighbourhoods: Pleasant Hill, Westmount, King George, Riversdale, and Caswell Hill. These five neighbourhoods are home to a large portion of Saskatoon's most economically deprived residents and Quint's mission is to "strengthen the economic and social well being of (the) core neighbourhoods through a community-based economic development approach" (Quint Development Corporation, 2007a, p. 2). Quint's preoccupation with the residents of the core neighbourhoods and their living conditions is solidly grounded in what is called Community Economic Development (CED). CED has existed since approximately the mid-1980s as an alternative to "top-down" economic development programs, and in response to widespread changes in, and cuts to government funded social programs. Proponents of CED describe the approach as one which is holistic, responsive to community specificities and needs, devoted to local ownership and control, and which emphasizes the inclusion of all community members.

Quint Development Corporation employs between 25 and 30 workers, most full-time, in its programs. At any given time, there are between eight and twelve board members, 75% of whom are mandated to be residents of the core neighbourhoods. Quint offers programs in four broad areas: affordable housing, business development, employment development, and the now annual social celebration, *Our core communities shine*.

Currently, Quint's affordable housing programs have four main components: Pleasant Hill Place is a co-operative residence established in 2000 for up to five student mothers aged 16 to 21 and their children; the Male Youth Lodge has been in operation since 2003 and provides temporary shelter and support for 10 young men at risk of homelessness; two apartment complexes, which provide 40 affordable rental units; and the *Neighbourhood Home Ownership Program* (NHOP). In each of these programs, Quint offers a variety of support, integration, and mentoring mechanisms whereby the potential of the programs is maximized both for the residents of each of the programs, as well as for the organization.

The cornerstone of Quint's programs is the NHOP. Started in 1997, this innovative program aids low-income residents of the core neighbourhoods to become homeowners. Although soaring housing prices have effectively put an end to the ongoing purchase of houses, more than 100 families, through the establishment of several co-ops, have been housed through the NHOP and many of these continue to assume ownership of their homes after a period of five years.

In the area of business and community enterprise development, Quint is involved in two principal program initiatives: the provision and facilitation of small business loans to local residents for neighbourhood business initiatives; and the establishment, through co-operative effort, of community enterprises (principally, the establishment of a grocery store, aiding in establishing daycare services and centres, as well as acting in a supportive role for a number of other initiatives). Quint's most ambitious undertaking in this area is Station 20 West, planned as a co-operatively owned and managed community enterprise centre. Quint initiated the project along with the *Child Hunger and Education Program* (CHEP), another Saskatoon community organization. After significant funding changes and design modifications, this project is slated to begin construction in 2010. Station 20 West will consist of a combination of affordable housing units (already opened and operated by the Saskatchewan Housing Corporation), retail outlets for a co-operative grocery store, shared commercial kitchen space, as well as space for a library branch and the offices of several community organizations, including Quint and CHEP, as well as a number of spaces reserved for neighbourhood groups and activities.

In the area of employment development, Quint runs a *Trades Training and Employment* program on a project basis in the delivery of services through many of its other programs (notably those in the area of affordable housing). Another of Quint's key programs is *Core Neighbourhoods at Work* (CNAW). CNAW provides assistance to neighbourhood residents through the provision of training programs and the development of relationships with local employers and businesses in identifying employment opportunities and possibilities, as well as providing life skills training workshops for those in need.

Finally, Quint's programs emphasize social inclusion. This is evidenced through their use of a co-operative model in the NHOP program, but also in the now annual celebration of the core and its residents, *Our core communities shine,* which began as a small Quint-led gathering and which now includes several other organizations and attracts as many as 500 residents. Partnering with other community organizations has long been a priority for Quint Development Corporation.

Quint discusses the challenges faced in the core neighbourhoods primarily in terms of poverty with concomitant emphasis on poor-quality housing partly related to an ageing stock and what might be called absentee capitalism—that is, rental unit owners largely living outside of the core and the relative lack of locally-owned retail outlets and businesses. The often deep poverty of many of the core residents is thus further entrenched at the level of the neighbourhoods in the situation where what little money there is continuously flows out in the metaphor of the "rusty bucket" of underdevelopment: "Poverty is not just caused because money does not come into the core neighbourhoods of Saskatoon. It is created because money does not stay in the core neighbourhoods of Saskatoon" (Quint Development Corporation, 2007b).

A large part of the poverty-related problems facing the core neighbourhoods are thus presented by Quint in a sort of insider/outsider dichotomy where the outside has been the primary beneficiary of income outflows and has moreover been the primary source of attempted solutions. Although here we are talking of a different outsider (government largely), there is also a strong affirmation on the part of Quint, and this is characteristic of Community Economic Development projects generally, that the problems of the core neighbourhoods need to be solved from the inside, or, in the language of CED, from the bottom up.

This framing has consequences for how Quint seeks to influence decision and policy makers. The challenge is to convince funders and public administrators that the residents themselves are the key to improving the fate of the neighbourhoods: through homeownership, through the development of local small enterprises, through in-program trades training, etc.

As pointed out earlier, Quint Development Corporation was in fact born in part as a reaction to top-down policy solutions. A group of concerned residents from the five neighbourhoods held a series of meetings to discuss how they could improve the quality of the social and economic well-being in their area with local solutions. A workshop on Community Economic Development solidified this approach as the one they would privilege and go on to employ since the mid-1990s. Their understanding of the key problems in the core neighbourhoods, while not completely at odds with those of the Health Region, are nonetheless distinct from them.

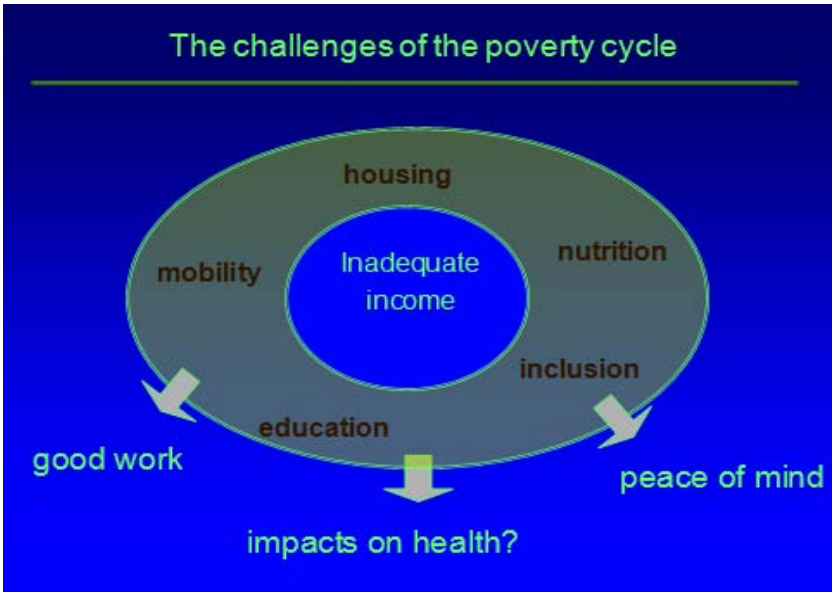

Figure 1 Quint's Framing of Poverty in the Core

Quint Development Corporation, 2007b.

Table 1 Saskatoon Health Region's Framing of Health Disparities

Disease category and ICD9 code range	2001 Age-standardized rate (95% confidence intervals)			Ratios (95% CI)	Ratios (95% CI)
	Low Income Neighbourhoods	Rest of Saskatoon	Affluent Neighbourhoods	Low: Rest	Low: Affluent
	N = 18,228	N = 184,284	N = 16,683		
Number of Hospital Separations*:					
Suicide Attempt (E950-959, E980-989)	242.88 (171.12-314.65)	64.82 (53.17-76.47)	15.59 (-2.05-33.22)	3.75 (2.65-5.30)	15.58 (4.84-50.16)
Mental Disorders (290-318)	885.42 (746.49-1024.37)	479.90 (448.30-511.50)	207.20 (129.05-285.36)	1.85 (1.56-2.19)	4.27 (2.84-6.43)
Injuries and Poisonings (E800-999)	2019.94 (1813.56-2226.32)	1307.59 (1256.13-1359.05)	819.79 (674.32-965.26)	1.54 (1.39-1.72)	2.46 (2.01-3.02)
Diabetes (250)	212.43 (143.03-281.82)	53.41 (42.99-63.82)	16.52 (3.30-29.74)	3.98 (2.72-5.82)	12.86 (5.42-30.51)
Chronic Obstructive Pulmonary Disorder (490-496)	251.05 (173.25-328.85)	181.54 (162.54-200.53)	163.80 (88.13-239.47)	1.38 (1.01-1.92)	1.53 (0.88-2.67)
Coronary Heart Disease (410-414)	533.27 (418.55-648.00)	399.04 (371.20-426.89)	313.54 (208.15-418.93)	1.34 (1.07-1.68)	1.70 (1.14-2.53)
Stroke (430-438)	204.29 (131.18-277.39)	154.18 (136.82-171.54)	112.29 (42.69-181.89)	1.33 (0.91-1.93)	1.82 (0.89-3.72)
Cancer (140-.0-239.9)	428.42 (323.46-533.38)	479.90 (448.30-511.50)	421.17 (302.02-540.31)	0.89 (0.69-1.15)	1.02 (0.70-1.48)

Lemstra & Neudorf, 2008, p. 131.

2.2 SASKATOON HEALTH REGION: MAKING HEALTH EQUITY A PRIORITY

Saskatoon Health Region has been one of the most prolific health authorities in terms of work on health inequalities in Canada. Starting with a groundbreaking report published in the *Canadian Journal of Public Health* (Lemstra, Neudorf, & Opondo, 2006), the Regional Health Authority has studied and documented how health status is distributed based on average neighbourhood income in their city. Their findings, in part presented in Table 1, show convincingly that neighbourhood income is related to health status. In virtually all areas, residents of Saskatoon's low-income neighbourhoods do less well than the city average; this gap is even greater when compared with residents of the city's affluent neighbourhoods. The publication of the 2006 article marked the beginning of a focus on these health disparities. From that, the *Building Health Equity Project*,[1] a vast report on disparities in 2008, as well as documentation in the Health Region's annual reports, has made highlighting the existing health

[1] This project includes partnerships between the Health Region and school boards, the Tribal Council, and several community based organizations (Saskatoon Health Region, 2006).

inequalities based on income and the attempt to redress the situation a priority for the organization. The particular concerns of the Health Region centre quite naturally on health and how it is related to income. The Health Region's role as part of the province's health apparatus is at least partly to recommend policy options that would optimize the role of the state in the health of its citizens. Table 2 below outlines how some of the frames that organize the way in which problems are viewed, as well as how their causes and solutions are portrayed, are distinct in the case of the two organizations discussed here.

Table 2 Key Frames Used by a Regional Health Authority and a Not-for-Profit Organization in Saskatoon

Key frames	Saskatoon Health Region	Quint Development Corporation
Population	• Residents of six lowest-income neighbourhoods • Aboriginal cultural status Comparison group: city average/affluent neighbourhoods	• Residents of 5 core neighbourhoods
Underlying Determinants	• Low income	• Roots of poverty: "rusty bucket of underdevelopment"
Outcomes (key problems)	• Health disparities o Higher rates of most illnesses	• High mobility • Poor housing • Poor nutrition • Social exclusion • Lower education
Key Goal	• Reduced Health Disparities	• Increased local control over social and economic development
Actions to be taken	• Policies to reduce o Poverty overall • Reduce disparities in o Income o Education o Housing o Employment o Health services o Cultural groups	• Community Economic Development o Affordable housing o Business renewal o Employment development o Social inclusion

The table above presents how Quint and the Health Region frame some of the issues they are concerned with. While not necessarily exhaustive, this table presents some of the key frames that emerge from public documents of each organization as well as interviews and conversations with Quint members. In the first row, we can compare how each approaches the "population" they are concerned with.

2.3 FIVE PRINCIPAL FRAMES USED

2.3.1 Population

For Quint Development Corporation, the key population is defined in terms of residence in the five "core" neighbourhoods (Pleasant Hill, Westmount, King George, Caswell Hill, and Riversdale) which originally formed the organization and which are among the city's lowest-income areas. The focus for Quint is thus on the neighbourhoods themselves (indeed, it requires that a high proportion of its board members be core residents). The Health Region, in its various reports, defines its population as the residents of the six lowest-income neighbourhoods (4 of these are part of Quint's mandate and the other two are immediately adjacent to them) in Saskatoon using income as the main measure of inclusion. This is of course, due in part to the way that income is tabulated in Canada by the official Census which divides the populations of Census Metropolitan Areas into tracts which are then compiled to correspond with existing neighbourhoods. In calculating income and hospital separations then, the measure of a patient's income level is "determined" by his or her neighbourhood of residence. This is not a perfect measure since we must rely on broad averages as well as forgo specific information on the relationship between income level and health, but it is the best measure available to us in Canada and in spite of its limitations does provide a constant affirmation that average neighbourhood income is a good predictor of health outcomes.[2] The Health Region then, defines its population by using a measure of neighbourhood residence while Quint uses a measure of lived neighbourhood residence/experience. The health region also includes Aboriginal cultural status in its analyses while Quint makes no distinction on the basis of ethnicity. Indeed, the lack of specific discussion of First Nations, Métis, or Inuit residents in the core neighbourhoods is somewhat noticeable given the very high proportion of residents that it represents. Quint has given itself a mandate that does not distinguish between Aboriginal and non-Aboriginal core residents.

2.3.2 Determinants

The second key frame used by the two organizations concerns what we might call determinants. That is, from their points of view, the main ingredient which leads to the problem with which each is concerned. In the case of the Health Region, this is low income. The Region's research regards how residents of the six low-income neighbourhoods fare in health terms when compared with the city overall and with residents in the affluent neighbourhoods. Once again, its frame is constrained by existing statistical measures which compare dependent variable hospital separations on a variety of illnesses/injuries and independent variable of neighbourhood of residence. The key determinant of poor health outcomes for the Region, then,

[2] It is worth considering the effects of increasingly called-for mixed-income neighbourhood development in light of how this might impact on the overall picture of the link between health outcomes and average neighbourhood income.

is the low income associated with neighbourhood of residence. Quint, on the other hand, appears to seek the roots of poverty in the core neighbourhoods by examining what it calls the "rusty bucket of underdevelopment" there. This is caused, according to Quint's frame, by the fact that income and revenue continually flow out of the neighbourhoods in the form of rent paid to absentee landlords, or goods purchased at chain (often box) stores who steer revenues out of their neighbourhoods. As we shall shortly see, the use of these different frames means viewing the problems of the communities differently as well as the actions which would improve them.

2.3.3 Outcomes

The third key frame which emerges from a reading of Quint and Saskatoon Health Region documents is that which guides the way that each sees the key problem(s) with which they grapple. For the Health Region, quite naturally, the key problem in Saskatoon's low-income neighbourhoods is worse health outcomes when compared with the city as a whole, and even more significant differences when compared with the affluent neighbourhoods. The specific problems then, from the perspective of this frame, concern the high rates of all types of injuries and illnesses listed in Table 1, in the lower-income neighbourhoods. Quint frames its key problem(s) quite differently. Here the problems associated with poverty are primarily identified as: poor quality housing related to absent landlords; high residential and school mobility affecting education as well as job stability, neighbourhood attachment, and social stability; poor nutrition related to an underdeveloped local economy and the implied lack of healthy food in the core; and social exclusion related to all of these factors. Interestingly, when the above graphic was used by Quint, the relationship of all of these factors to health is questioned, but not affirmed, as illustrated in Figure 1.[3] Although both of these organizations see poverty at the heart of the problems in Saskatoon's low-income neighbourhoods then, their respective frames lead them to view different issues as being the key problem(s).

2.3.4 Key goal

In terms of the key goal of each of the two organizations, while the community organization attempts primarily to increase local community control over the development of the core neighbourhoods, the Health Region's priority is the reduction of health disparities. Indeed, the scope of the Health Region's mandate in their recent reports is such that they are focused quite tightly on health as key to all of their frames.

2.3.5 Actions

That Saskatoon Health Region and Quint Development Corporation frame the key problems of the low-income neighbourhoods and the main goals they seek to achieve differently makes it unsurprising that the actions they view as key to overcoming these problems are also different. As described above, Quint favours neighbourhood development programs which are focused on promoting and sustaining economic and social well-being in the core. Quint does this through

[3] Note that since the publication of several documents by the Saskatoon Health Region on the robust correlation between poverty and poor health outcomes, Quint, particularly through its Station 20 West Project with CHEP Good Food, has incorporated information on health into its discourse on the underdevelopment of the core neighbourhoods.

direct community involvement and frames its key actions as being grounded in movements which are designed to be solutions "from the bottom up". Its programs focus on housing, employment, and local development. The policy-influencing activity Quint is involved in is concentrated in facilitating things like affordable housing.

By contrast, although again it is worth pointing out that the divergences are not overwhelming in this case, the Health Region's key actions are what some[4] have referred to as solutions "from the top down". That is, as part of its public health mandate, the Health Region recommends broad policy options.[5] In this case, its recommendations are vast and comprehensive, and cover a broad spectrum of the social determinants of health.

2.4 UNDERLYING PRAGMATIC CONCERNS

There is, in a sense, an underlying frame from which each of these organizations operates and that is constituted in large part by pragmatic concerns and their respective mandates and how they go about carrying these out. The Health Region is one part of a vast governmental institutional structure and is bound by a variety of institutional (and legal) constraints. Quint Development Corporation is similarly inscribed institutionally in the approach to community revitalization known as Community Economic Development (CED), and is similarly bound (with perhaps fewer legal and constitutional regulations) by the institutional approach contained therein. It is impossible to understand the key frames as described above without attention to these pragmatic boundaries. Indeed much of what are presented as key frames flow from the constraints and possibilities contained in their respective mandates and pragmatic concerns. For example, although it is not discussed in depth here, each underlying frame has implications for what constitutes "evidence" or proof of a problem. The institutional frame for community development organizations tends to take a heuristic view of the state of affairs, using the experience of living in neighbourhoods and witnessing the changes as proof, in this case, of both the deteriorating conditions and the need for local solutions. Also considered paramount are things like rates of homeownership, school mobility, car ownership, the distance to affordable grocery stores, etc. The institutional frame for many health authorities, on the other hand, is more likely to impose a set of methodological requirements gleaned from "evidence-based" medical science. These are differences of epistemology and contribute to producing a policy problem rather than a policy controversy. "Policy controversies cannot be settled by recourse to facts alone, or indeed by recourse to evidence of any kind. Because they derive from conflicting frames, the same body of evidence can be used to support quite different policy positions" (Rein & Schön, 1993, p. 148).

One positive outcome of this being more of a problem than a controversy is that the reports produced by the Health Region have indeed been incorporated into Quint's discussion of the core neighbourhoods. Where the difference lies is in the role given to these figures and tied in many ways to these overarching frames. Thus, the Health Region measures health outcomes using a variety of methods accepted as the gold standard within its fields (epidemiology, public health, etc.). The community development organization, on the other hand, sees their

[4] This was the case with many of the participants who attended the workshop in Winnipeg mentioned earlier, for example.

[5] It is worth noting here that the report prepared by the Health Region in 2008 included extensive community consultation in establishing the types of policies that would be supported by community members.

community as part of a large number of other neighbourhoods who have had similar experiences—and similar failures with solutions proposed or "imposed" by outside agencies—and applies a similarly tried and tested approach from their field (as witnessed by the well-established and growing meta-associations of this type of organization—in Canada, the CCEDnet, for example). What may compound this into a controversy is that each organization (or frame) sees its own conception of the problem and (particularly) its choice of indicators as THE key to solutions, at times to the detriment of other approaches. A step in reconciling these differences is to lay them out and see the disagreement as a product of the frames rather than one of fundamental disagreement.

3 CONCLUSION – PARTNERSHIPS BETWEEN REGIONAL HEALTH AUTHORITIES AND NOT-FOR-PROFIT ORGANIZATIONS

Although on the surface, and often in practice, the integration of different frames into common goals can be trying, it may well be a key to intervening in complex social contexts such as those beset by poverty and its attendant difficulties. Yet partnerships and intersectoral (both horizontal and vertical) coordination are seen as key ingredients to acting on a field as complex as public health and particularly health inequalities. Other work has referred to this as integrating two approaches, or two cultures of intervention. Clavier and Potvin, for example, suggest that a way forward for public health actors is to recognize the legitimacy of local knowledge as equal in importance to scientific inquiry (Clavier & Potvin, 2009) and looking at the two approaches as being ways of framing issues is a contribution to that discussion. Partnering successfully in working on policy-sensitive issues such as poverty and health inequalities might benefit from using the notion of frames and of framing as a discursive practice in seeking to find common ground from which all partners can move forward. In the case of the two organizations presented here, for example, housing strategies might be one area where a fruitful partnership could be made. Both see affordable housing as key actions to be taken in the core neighbourhood and while one (the regional health authority) sees policies on housing and housing allowance as priorities and the other (the community economic development organization) sees local ownership and control of both rental and owned housing, both agree that safe affordable housing is a key goal and the ways that each proposes to increase this are not incompatible and might well be an area where they could successfully collaborate. Choosing to focus on those areas where frames are compatible or at least more easily negotiable is more likely to lead to successful partnerships and problem resolution.

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