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Consumers’ Mental Health Recovery in a Psychiatric Outreach Program: A Process and Outcome Evaluation

Phillip Chan
Wilfrid Laurier University

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Canada

Consumers' Mental Health Recovery in a Psychiatric Outreach Program: A Process and Outcome Evaluation

by

Phillip Chan

B.Sc. Surveying Science, University of Toronto, 1985
M.Sc., Urban Planning, University of Hong Kong, 1990

THESIS

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for the Master of Arts degree
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ABSTRACT

This study was a process and outcome evaluation of a relatively innovative Canadian psychiatric outreach program that was multi-disciplinary, shared-care, community-based, consumer-directed, and self-determination oriented. Using structured interviews with participants (*n*=32), both quantitative and qualitative approaches were employed. The quantitative process measures included a demographic survey, a frequency of service utilization and satisfaction survey, and a shortened version of the Recovery Oriented System Indicator (ROSI) instrument. These measures revealed that the program was serving the target population; the consumers utilized the services frequently and they were satisfied with the program; and, in the eyes of consumers, the program conformed to the concept of mental health recovery. The qualitative evaluation of process revealed seven themes: the program process is consumer-friendly; the program is supportive; the program is seamless; the program is wellness-oriented; the program is strengths-based; the program is collaborative; and the staff goes above and beyond their regular duties in the process. The quantitative outcome survey completed by consumers and staff revealed predominantly positive ratings. Qualitative outcome themes included: realizing potentiality, healing and wellness, self-determination, managing symptoms, incorporating illness, thriving, becoming more responsible and committed citizens, social connectedness and relationships, more positive day-to-day functioning, and renewing hope and commitment. Correlations between the process and outcome measures indicated that the consumer-rated outcome total score was associated with the frequency of utilization, and that the ROSI total score was associated with consumer satisfaction. The overall results suggested that the psychiatric outreach program operationalized the principles of recovery and became an indispensable part of consumers' mental health recovery. However, the overall outlook for homeless Canadians who are affected by mental health issues remains bleak given existing housing policy.

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I would also like to thank the staff at the Psychiatric Outreach Program for their support, guidance, and participation in this project. You have taught me immensely about outreach interventions by allowing me to be the silent partner in your activities, which greatly expanded my horizons. I appreciate your enthusiasm, dedication, and as the participants commented, "*being-there,*" all of which made a huge difference in the community.

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more importantly, your smile. I could now say as the participants shared: "I could put a smile on my face throughout this research because you always smile at me."

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Introduction and Overview

The increasing number and diversity of backgrounds of Canadians who are homeless has become a major crisis in large and mid-size urban centres. In particular, homeless Canadians who are affected by mental health issues constitute one of the most vulnerable subgroups in the homeless population (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005). The needs of this subgroup have become too complex for traditional, medical-focused outreach services. Of particular interest are innovative psychiatric outreach models, which use flexible team-structures that employ medical as well as non-medical activities to address the needs of this subgroup, and which are based on the concept of mental health recovery. To date, there has been no Canadian community-based multidisciplinary psychiatric outreach model described in the psychiatric service literature, other than the hospital-based model reported by Farrell, Huff, MacDonald, Middlebro, and Walsh (2005). Also lacking in the literature is evaluation of such a model, and in particular, evaluation that is focused on the concept of consumer recovery in mental health.

This thesis is an evaluation of the Psychiatric Outreach Program of the Region of Waterloo. There are a few features of this thesis that will be of particular interest to psychiatric services researchers. First, the proposed evaluation is based upon a concept of mental health recovery. The concept of recovery for people who are affected by mental health issues in the context of this thesis extends beyond the mere reduction of symptoms to an emphasis on quality of life, self-esteem, empowerment, and the capacity to live a satisfying life within the constraints of one's mental health issues (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Self-determination has been identified as a critical element in recovery by mental health service advocates such as Mead and Copeland (2000). Second, the proposed research investigates the processes and outcomes of an intervention program that is currently implemented as a self-determination oriented, community-based, multi-disciplinary shared-care model (Chomik, 2005). In this model, health care providers work independently in their own scope of practice but collaborate through a formalized network to provide client-directed services to consumers of a local soup kitchen (Working Centre, 2005). The current model operates on a modest budget with minimal reliance on the availability of a psychiatrist, which is a challenge common to many mid-size Canadian communities. Furthermore, the team collaborates with other community partners to form a comprehensively networked "circle-of-care" that bridges existing gaps in the service system, particularly those between the corrections system and local health and social service providers. These program features are fairly innovative in psychiatric outreach operations, especially in the Canadian context.

The main purpose of the research is twofold. First, the research investigates the effectiveness of the outreach model by evaluating how successful the program is in meeting its outcome objectives. Second, the research investigates the factors that are critical for program effectiveness by evaluating the amount of consumer participation in the program components, consumer satisfaction with the program components, and the fidelity of the program components to a recovery model. This research will extend the scope of the only Canadian study of hospital-based multidisciplinary psychiatric outreach in Ottawa as recently reported by Farrell et al, (2005). The current research examines a smaller, community-based team and aims to collect and analyze empirical data concerning program processes and outcomes. The knowledge generated from the study should be useful to both the program and to other communities interested in establishing a similar program.

Personal Motivations for Undertaking This Research

The preparation of this thesis has been a rather intense process of self-reflection on my background, cultural legacy, and personal journey to this research. During the preparation of the proposal for this thesis, there was a peace protest in front of the Chinese Embassy in Toronto to join a worldwide marking of the 17th anniversary of the military suppression of pro-democracy movement in Peking, China. In 1989, a massive assembly of university students held a peace protest in the capital's public square to address the ubiquitous corruption in local governments. June 4 is the fateful date when the protest met with one of the most brutal suppressions of a civil demonstration in history. Shortly afterward, I made the same decision that my parents did when they were young and faced the coming of the communist regime. My parents fled from their farming village in southern mainland China to the then British colony of Hong Kong where I was born, raised, and educated. However, my journey into a new country in search of a better life has been filled with events I had neither expected nor prepared for.

Often during the writing of the proposal for this thesis, I felt like I was negotiating for an unfamiliar opportunity to participate as a researcher. I am in my mid-career as an urban planner, and topics of mental health issues or social justice are rarely discussed in my culture. Most of my cultural peers cope with unfortunate events through internalizing and moving on without looking-back. The journey into community psychology and this research has been a significant step in connecting with my past and the search of new perspectives to reposition myself in my career. Having noted this research as an "unfamiliar" opportunity, I must acknowledge that the meetings with the program staff and consumers in the St. John's Kitchen were amazingly encouraging and eye-opening experiences. I completely enjoyed doing this research with these people. I sincerely hope that the knowledge generated from this research will translate into: a) information products that are meaningful and helpful for individuals who are affected by mental health issues, and b) wisdom that can help me to come to terms with my close encounters with mental health issues that happened to people who are very important to me.

Literature Review

The prevalence of mental health issues and the increasingly diverse demographic composition of the homeless population have led to the development of innovative psychiatric outreach services in the U.S. These psychiatric outreach models, as described in the literature, typically use flexible and multi-disciplinary team structures to address the complex needs of persons who are homeless and affected by mental health issues. The description of a Canadian multi-disciplinary psychiatric outreach model did not appear in the psychiatric service literature until 2005. This model has been implemented as a hospital-based team that offers mobile psychiatric services in emergency shelters and drop-in centres in the city of Ottawa (Farrell et al., 2005). However, there is no study that evaluates a psychiatric outreach model in the Canadian context based upon the concept of recovery.

The challenges experienced by persons who are homeless and affected by mental health issues have received a considerable amount of attention in the research literature. The following review is organized into four major areas: a) homelessness in Canada, b) health problems and interventions to improve the health of homeless persons, c) social attitudes and social policies regarding homelessness, and d) mental health recovery and psychiatric outreach services. While Canadian literature is the primary focus of this review, international (mostly U.S.) sources are also included.

Homelessness in Canada

"National disaster" (*Toronto Star*, 1998), "heterogeneity" (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005), "grim reality" (Frankish, Hwang, & Quantz, 2005), and "critical issues" (Farrell et al., 2005) are a few examples of the descriptions used in the recent Canadian homelessness literature. To date, Canada still does not have a national figure of the homeless population that is agreed upon by researchers and advocates. Statistics Canada estimated, based upon the 2001 Census, that over 14,000 individuals are homeless in Canada. However, this number is highly debated and contested as an under-representation of the problem by most researchers and advocates (Frankish et al., 2005). Begin, Casavant, Chenier, and Dupuis (1999) commented that the lack of a commonly agreed upon working definition for homelessness, and the transient nature of this population are the major causes for the lack of a national figure. Local homelessness surveys in large Canadian urban areas (Calgary Homeless Foundation, 2001; 2002; 2003; 2004; City of Toronto, 1999; 2000; 2001; 2003; Social Services Planning Council, B.C., 2005) and in a number of smaller cities and regions, mostly prompted by the 1998 Big Cities Mayors Caucus of the Federation of Canadian Municipalities' declaration of homelessness as a national disaster (Burrett, 2002), however, revealed that homelessness has no doubt become an "obvious crisis" in large urban centres (Frankish et al., 2005). The Region of Waterloo (2006) indicated that: a) over 3,000 individuals used emergency shelters in the past year of 2005-2006; b) 35 to 40% of formal emergency shelter users are estimated to have experienced mental health issues and 25% of shelter users are estimated to have substance use issues; and c) 60% of church-run, Out of the Cold, emergency shelter users are estimated to have experienced mental health issues and 80% are estimated to have substance use issues.

The composition of the homeless population, once characterized as consisting predominantly of white, older, alcoholic males, now includes people from racially mixed backgrounds, casual workers, persons released from prison, aboriginals, and newly arrived immigrants. Vulnerable subgroups within the homeless population include women, children, teen-aged youths, refugees, women victims of spousal violence, and families, mostly headed by women, evicted from their homes for failure to pay the rent (Begin et al., 1999). Homelessness now affects Canadians mostly as a temporary or transient-episodic crisis, but persistently for a subgroup of individuals (Frankish et al., 2005).

In their survey of 360 homeless youth in Toronto, Gaetz and O'Grady (2002) provided a glimpse into the grim reality that young homeless Canadians are currently experiencing. Homeless youth, as a group, do not lack motivation, are not welfare dependent, and in fact do aspire to take jobs in the formal economy just like any members of our society. However, homeless youth experience social exclusion, severe competitive disadvantages in entering the economic mainstream, and marginalization. They operate on the economic margins of society typically competing for minimum wage jobs. Another survey in Ottawa-Carleton has revealed the two most common reasons for homelessness are being new to the city and being evicted from housing (Farrell, Aubry, Klodawsky, & Petty, 2000). This survey also reported that: a) families who are homeless have the lowest percentage of individuals born in Canada; b) the majority of individuals report low numbers of persons in their social networks; and c) a majority of persons report difficulties that are consistent with a diagnosable mental health issue.

Health Problems of Homeless Persons

Homeless persons are affected by a range of health problems at rates that are considerably higher than the general population. These health problems include: injuries from over-exposure to cold weather, tuberculosis, skin diseases, cardio-respiratory diseases, nutritional deficiencies, musculoskeletal problems, dental problems, HIV/AIDS, hypertension, sexually transmitted diseases, and depression, substance use and other mental health issues (Begin et al., 1999; Frankish et al., 2005). Being affected by these health problems, the homeless persons interviewed in the city of Ottawa (Aubry, Klodawsky, Hay, & Birnie, 2003) indicated that they are, however, less likely than the general population to have a health card and have had contact with health care providers. Some researchers attribute this phenomenon to the overwhelming needs of street survival. Other researchers also suggest the influence of mental health issues. Some researchers, such as Begin et al. (1999) and the City or Toronto (1999), estimated that 20 to 30% of the Canadian homeless population experience mental health issues. Other researchers have provided more specific estimates. Tolomiczenko (1997) found in the *Toronto Pathway into Homelessness* study that among individuals who are homeless, only 5.7% suffer from severe mental health concerns such as schizophrenia. This figure challenges the common stereotype of persons who experience homelessness as generally being delusional or mentally ill. However, other mental health concerns, including depression, anxiety, and substance use, were found in 67% of their sample (Goering et al., 2002; Tolomiczenko, 1997). It is worth noting that depression is the most commonly reported mental health concern by persons who experience homelessness and these numbers arguably more or less reflect the unfortunate circumstances in these people's lives. As well, studies increasingly reveal that mental illness is not a significant precipitating factor for homelessness, but rather a more macro-level failure of social policy to support people to achieve residential stability (Goering et al., 2002). Hardly any research has contested the fact that individuals who experience mental health issues constitute one of the most vulnerable subgroups in the homeless population.

Furthermore, some researchers have described this subgroup as "hard to serve". This notion is, however, completely different from the stereotyping that often suggests that the troublesome behaviours and challenges in the ability of persons who are affected by mental health issues to function cause them to be homeless. Another common misconception is that persons who are homeless and are affected by mental heath issues choose not to be housed because they cannot make rational decisions. Quite to the contrary, researchers revealed that persons who are homeless and affected by mental health issues often respond well to interventions (McBride, Calsyn, Morse, Klinkenberg, & Allen, 1998; Nelson, Aubry, & Lafrance, 2007). Persons who are homeless and affected by mental health issues manage to live steadily in independent housing units when provided with choices and consumer-directed supports (Shern et al., 2000; Tsemberis & Eisenberg, 2000; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). In addition, researchers have confirmed that the homeless status often found in persons affected by mental health issues is caused by the gaps and barriers within the health care delivery system (Bybee, Mowbray, & Cohen, 1995; Lipton, Nutt, & Sabatini, 1988). The "hard to serve" description refers to the fact that the traditional hospital or clinic-based system of health care delivery does not work for this population. Being of "no-fixed-address," many individuals are overwhelmed with challenges in street survival and simply lack the resources to arrange for appointments or access medication. As well, there is denial and stigma associated with seeking psychiatric help perceived by persons who are homeless and affected by mental health issues (Knowlton, 1997).

Interventions to Improve the Health of Homeless Persons

In recent years, innovative interventions have emerged in a few Canadian urban centres in response to the complex needs of persons who are homeless and affected by mental health issues. As mentioned briefly, one notable Canadian model has been implemented as a hospital-based (the Royal Ottawa Hospital) psychiatric outreach team that initially consisted of psychiatrists and psychiatric nurses who provided mobile psychiatric services in emergency shelters and drop-in centres (Farrell et al., 2005). The outreach team later expanded to include a range of additional professionals representing other disciplines including addiction workers, occupational therapists, psychologists, recreational therapists, and social workers. The psychiatric outreach team offers psychiatric care to homeless persons as well as training support to the partner agencies that provide services to homeless persons.

Frankish et al. (2005) developed a typology of four categories to describe current homelessness intervention strategies. These four categories are: a) biomedical and health strategies (such as health care, clinical services through outreach programs), b) educational and behavioural strategies (such as harm reduction counselling and referral services), c) environmental strategies (alteration of the social, economic or physical environment in a specific setting to create a supportive environment that facilitates behavior change), and d) policy and legislative strategies. The Psychiatric Outreach Program of the Region of Waterloo uses a combination of the biomedical, health, and environmental strategies. The latter strategy refers to altering the social environment in a community kitchen to facilitate behavioural change in persons who are homeless and affected by mental health issues so that they can comfortably engage with health care personnel.

Intention to Help Homeless People, Social Attitudes Towards Homeless Persons, and Social Policies Regarding Homelessness

Communications that are prosocial (i.e., those communications that generate solidarity with vulnerable groups or support positive social objectives) have been shown to be effective in promoting positive change in attitudes and intentions toward helping the homeless individuals (Hocking & Lawrence, 2000). When combined with education (including courses on poverty and homelessness), prosocial communication results in significant impacts on undergraduate students' attitudes, career choices, and long-term vocational or volunteer relationships with agencies that serve the homeless population (Roschelle, Turpin, & Elias, 2000). Buchanan, Rohr, Kehoe, Glick, and Jain (2004) reported similar effects of combining education and field experience in shelters on medical students' attitudes toward homeless people and their indication of long-term commitment to serving this population.

Empathy is one of the most common and natural reactions to homelessness. In fact, empathy is the factor most strongly associated with the intention to help the homeless, among other variables, including religiosity, household income, political orientation, gender, and race (Morgan, Goddard, & Givens, 1997). However, empathy fatigue, especially when the number of homeless people is increasing, often results in punitive measures toward homeless persons. Therefore, fostering a social attitude of empathy alone cannot solve the problem of homelessness; the solution must be addressed at the political level (Nelson & Prillenltensky, 2005).

After reviewing the homeless in U.S. history, Kusmer (2002) concluded that throughout U.S. history homeless persons have been viewed as outcast, deviants, or vagrants. In a similar vein, Golden (1992), after reviewing the literature on homeless women in British and U.S. history, concluded that U.S. policy "took its departure from the British system but developed a distinct character of its own. While importing 'all of the English features that stigmatized the stranger as criminals or dangerous,' (Crouse, 1986, p.16) the colonies made their own ... vagrancy laws even harsher" (p. 113). Moon (2005) remarked that American attitudes toward the homeless are ambivalent, and that they "tend to shift back and forth between compassion and compassion fatigue, between supporting policies to provide resources to the homeless and supporting punitive polices to exclude them from public space" (p. 157). A vivid illustration from recent history of the risk of leaving the problem of homelessness to the mercy of public empathy and the critical impacts of policies was reported by Morse in the December, 1999 issue of *Time* magazine. According to Morse (1999), people in the U.S. rated homelessness as an urgent priority in the1980s. In 1986, six million people locked hands to form a 4,152-mile human chain, Hands Across America, and raised 15 million U.S. dollars. Congress passed a landmark law to provide a variety of housing options for homeless persons. However, public concern has relaxed in recent years. When a homeless couple was alleged to have caused a warehouse fire that killed six fire fighters in Worcester, Massachusetts, local governments in various parts of the U.S. reacted very differently to the increasing homeless population. Thirty-five municipalities enacted punitive anti-vagrancy ordinances that include banning loitering on median strips, privatizing sidewalks in front of business, giving out bus tickets to move out of state for homeless people with families, and arresting nuns for serving hot meals without a proper permit. Addressing the root causes, the Clinton Administration reacted with a solution of $6 billion into a range of services including job training, mental health, and counselling. Morse (1999) reported that, as a result, a substantial percentage of homeless families exited homeless status.

It is therefore critical to frame the problem of homeless persons that are affected by mental health issues in a social and political context, and the problem to be addressed at political level. Feldman (2004) suggested conceptualizing homelessness as a political problem which should be solved by homeless persons' political participation. Homeless persons, however, often lack the resources for, and are thus excluded from, political participation. Community psychologists such as Seidman (2003) and Tsemberis et al. (2003) emphasized the provision of resources in social interventions, rather than focusing on the symptoms and personal weaknesses. Nelson, Lord, and Ochocka (2001) demonstrated the approach of providing resources and forming value-based partnerships (Nelson, Prilleltensky, & MacGillivary, 2001) with psychiatric consumer/survivors to collaboratively aim for the window of opportunity to make claims for social change.

The current problem of homelessness in Canada has its roots dated back to the policy made by the Mulroney government during the period of 1984 to1993 (Hulchanski, 2002). In 1949, the Canadian government amended the National Housing Act that first introduced a national public housing program. Being one of the last major western nations to introduce public housing, Canada managed to generate through the initial housing program a total of 12,000 units (Hulchanski, 2002) between 1949 and 1957 – an average of 850 units per year relative to a population of 13.4 million in 1957 (Statistics Canada, 2007). From 1964 to 1984, the subsequent Pearson, Trudeau, Clark, and Trudeau governments further developed a more inclusive public housing system. Together with the housing ownership-assisting program, the public housing system generated approximately 200,000 units or an average of 25,000 units per year from 1964 to 1984 (Hulchanski, 2002). The estimated population of Canada in 1984 was 25.6 million (Statistics Canada, 2007). In 1984, the Mulroney government, however, alleged the social housing program's threat to the private housing market and gradually replaced the housing program with a system of shelter allowances, claiming that the shelter allowance would restore free competition that was deemed as a necessity to a healthy housing market. The Mulroney government claimed that with the shelter allowance alone, the provision of affordable housing in Canada would be better addressed. Under the Mulroney government of 1984 to 1993, the national housing program was literally brought to a halt, with zero additional public housing units funded per year by the end of 1993. In 2001, the Chretien government finally allocated $136 million per year over five years, totaling $680 million, to restore the provision of pubic housing in Canada. This amount, however, was only sufficient to build about 5,400 units per year. Thus this current level of 5,400 units per year constitutes only 21% of the 25,000 annual units prior to the Mulroney government - relative to the current population of 31.3 million (Statistics Canada, 2007).

By 2001, Canada had the smallest social housing sector among Western nations; and Canada had the most private-sector-dominated, market-based housing system of any Western nations, except the US. Currently, Canada only spends about 1% of its budget on programs and subsidies for all the social housing units ever built. As suggested by Goering et al. (2002), mental illness is not a significant precipitating factor for homelessness; homelessness is the result of a macro-level failure of social policy to support people to achieve residential stability. The general outlook for homeless Canadians who experience mental health issues therefore remains bleak given the current social housing policy.

Mental Health Recovery and Psychiatric Outreach Services

The concept of recovery from severe and persistent mental illness has received increasing attention in the psychiatric research literature. In the U.S., the expanding recovery orientation of the system of care now currently serves as the fundamental goal for mental health care policy at a national level (New Freedom Commission on Mental Health, 2003). However, researchers such as Bullock (2004) commented that recovery remains an evolving paradigm in the treatment of persons with psychiatric disabilities. Also, lacking in the literature is empirical research on recovery, and particularly, in psychiatric outreach programs using recovery approaches.

The body of literature consisting of the writings of people with severe mental illness about their own recovery suggests, on the one hand, that recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles (Anthony, 1993; Anthony, Rogers, & Farkas, 2003). On the other hand, recovery is also considered as a product of dynamic interaction among characteristics of the individual, characteristics of the environment, and the characteristics of the exchange, such as hope, choice and empowerment (Dumont, Ridgway, Onken, Dornan, & Ralph, 2005). In the context of this research, the concepts of recovery and self-determination are both considered as multiple-level, dynamic interplay of many forces that are complex, synergistic and inter-related. At an individual level, self-determination has been identified as the critical element in mental health recovery by authors such as Mead et al. (2000), Copeland (2003), and Rogers and Rogers (2003). The concept of self-determination, its relevance to mental health recovery, and a proposed working model for the current research is elaborated in the following.

Self-Determination and Mental Health Interventions

Related to the discussion concerning health and political participation, and in particular to the context of the proposed research, is the concept of self-determination. The Psychiatric

Outreach Program at the Region of Waterloo has currently been implemented as a consumer-centred, self-determination oriented model. A brief literature review on self-determination is presented in this section, and the details of the program operations will be elaborated in the *Current Program Operations* section.

The Merriam-Webster Online Dictionary (2006) defines self-determination in two distinct ways, namely: "the free choice of one's own acts or states without external compulsion," and "the determination by the people of a territorial unit of their own political status." As indicated by Wehmeyer (2004), the primary difference between the two definitions lies in the meaning of the *"self,"* which refers to control over one's life in the first definition, and that of the national, political or collective right to self-governance in the second. These definitions evolved from the concept of self-determination dated back to the early debates of the religious doctrine of free-will versus determinism (Locke, 1683 cited in Wehmeyer, 2004), to the 20th century's notion that a people of certain geographic territory should have the right and opportunity to self-governance. Heater (1994, cited in Wehmeyer 2004) attributed the sense of self-determination, applied outside the arena of human action and pertaining to the rights of people(s) to self-governance, primarily to U.S. president Woodrow Wilson's "Fourteen Points" speech to a joint session of Congress on January 8, 1918. Six of Wilson's 14 points referred specifically to ensure that defeated nations in World War I have the opportunity for national self-determination.

Since the independent living and self-advocacy movements in the 1960s, the usage of the term self-determination has been extended beyond the field of political science and incorporated into services and supports for individuals with disabilities (Wehmeyer, 2004; West, Barcus, Brooke, & Rayfield, 1995) who demanded the right to exert greater control over their lives. In particular, since 1990, the promotion and enhancement of self-determination has been a primary focus in the development and provision of educational services for children and youth with disabilities, as well as enabling of adults with physical and developmental disabilities and their families to assert a greater level of control in the design and provision of their services and supports (Wehmeyer, 2004). However, the incorporation of self-determination into mental health services has not achieved the same level of success, as elaborated in the following.

Cook and Jonikas (2002) reported that people who are affected by psychiatric disabilities are often stereotyped and stigmatized as being violent, volatile, lacking the capabilities to make informed choices, considered as less deserving of self-determination than people who are affected by other disabilities. For these reasons, people affected by mental health issues have not experienced the same level of self-determination achieved by many other disability groups. This issue is further complicated by the lack of understanding of the meaning of self-determination by mental heath policy makers. Wehmeyer (2004) indicated that self-determination is often perceived by policy makers solely as self-decision making and consumers are left with self-decision making without the appropriate support. Self-determination is a process that needs to be facilitated and resources are needed to create the choices available to consumers (Wehmeyer, 2004), both of which are often neglected and thus result in minimal levels of self-determination for mental health services consumers in the U.S. (Cook, Terrell, & Jonikas, 2004).

This low level of self-determination experienced by mental health service consumers is also reflected in the lack of studies that investigate the perceived meanings of self-determination by mental health service consumers, and the lack of program evaluation studies that examine the effectiveness of enhancing self-determination in mental health services. Some researchers acknowledged that systematic efforts are only starting to explore this research area (Anthony, 2001; Leff, Conley, Phil, Campbell-Orde, & Bradley, 2003). Existing studies include the Finnish study (Välimäki & Leino-Kilpi, 1998) in which the researchers used a qualitative approach to investigate the perceived meanings of self-determination by psychiatric patients in the context of psychiatric care. Albeit preliminary and with limited representativeness, the result of this study revealed that the perceived meaning of self-determination in the context of psychiatric services consists of an intrapersonal aspect, an interpersonal aspect, some preconditions such as level of illness that affect the exercise of self-determination, and most importantly, a process of shared self-decision making in which patients require facilitation by people who support their exercise of self-determination. Another qualitative study by the Swedish researchers Nordgren and Fridlund (2001) similarly revealed that the majority of mental health patients in their survey expressed similar understandings of the concept of self-determination as in the Finnish study. As well, the patients in the Swedish study indicated a reliance on third party's provision of knowledge and information, especially concerning treatment strategies, in decision-making. In other words, these two preliminary qualitative studies revealed that individuals who are affected by mental health issues express similar perceived meanings and the necessary pre-conditions of self-determination compared to those revealed by individuals who are affected by other forms of disability.

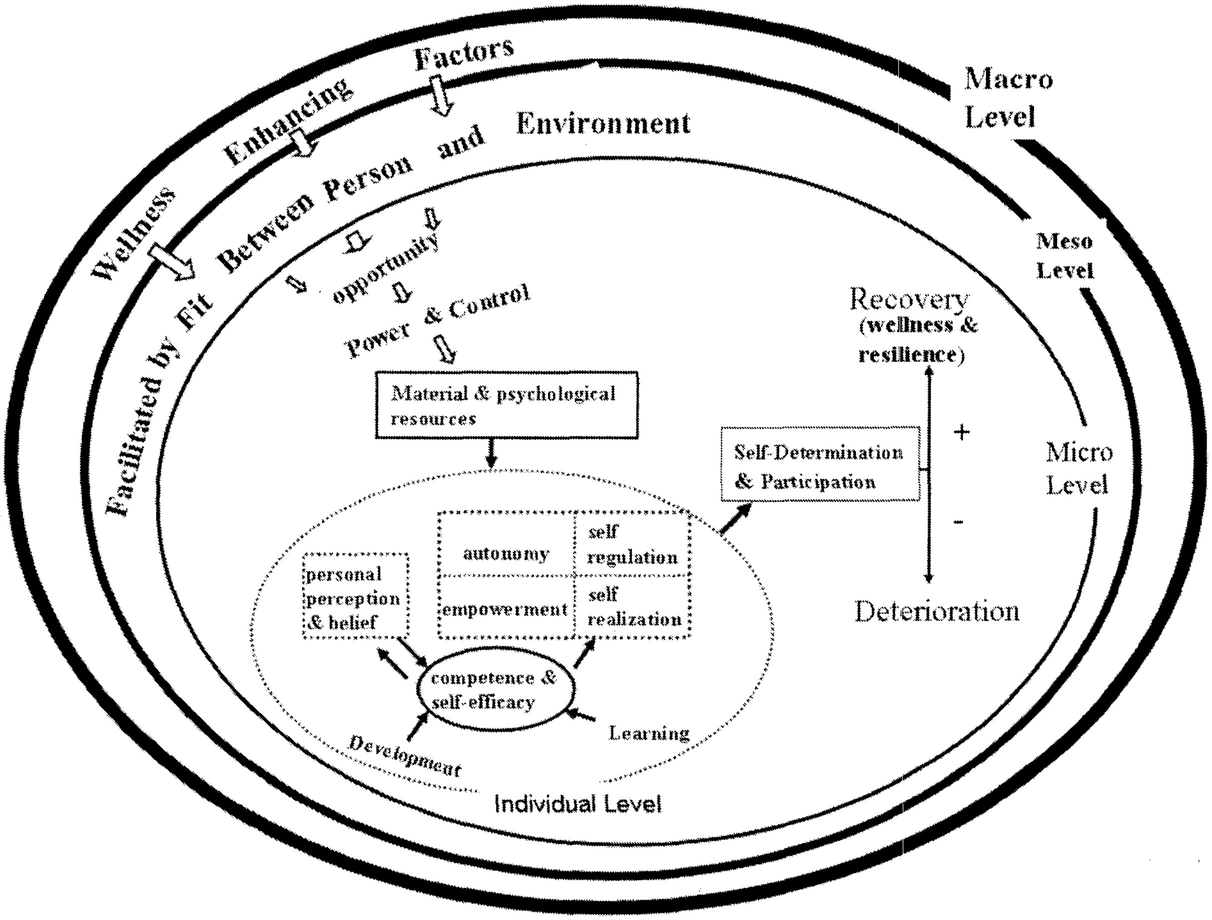
Furthermore, Standcliffe, Abery, and Smith (2000), Wehmeyer (2004), Wehmeyer and Bolding (1999), and Wehmeyer and Garner (2003) suggested that self-determination be conceptualized as a product of continuous interactions between individuals, who possess self-determination-related skills, knowledge, motivation, and the multiple-ecological levels of micro, meso, exo, and macro environments within which they function. Of particular interest, these researchers revealed that environmental factors, specifically living and working environments, among people who are affected by developmental disabilities, significantly affect their level of self-determination. This level of self-determination includes perceived autonomy, satisfaction, and opportunity for decision making when other factors such as gender, age, and intellectual capabilities are accounted for. There is, however, little research attention on the impacts of environmental influences on the self-determination of persons who experienced homelessness and mental health issues.

A Proposed Working Model for the Current Research

As briefly discussed above, the concept of self-determination has evolved from an intrapersonal construct to an interactive process of personal factors and multiple levels of the environment (Wehmeyer, 1998). Furthermore, Mithaug (1993, 1996) emphasized that a match between the individual's capacity and the environment is also critical. The concept of self-determination is, however, best further-defined by community psychologists. Fox and Prilleltensky (1997) advanced the concept to a notion of "reciprocal self-determination" whereby people promote their interests in consideration of other people's needs. Along a similar vein, Prilleltensky, Nelson, and Peirson (2001) and Prilleltensky and Nelson (2002) cautioned that self-determination is primarily a personal value, which needs to be harmonized with and pursued with collective values such as social justice. When made the main value of society, self-determination could lead to adverse effects such as victim blaming and become burdensome to society.

In their ecological analysis of pathways toward wellness and resilience for children, Prilleltensky et al. (2001) proposed a model that relates self-determination to power and control, which is the pathway to wellness and resilience. Wellness is promoted by offering power and control to individuals in terms of the opportunities to: a) access valued material and psychological resources that satisfy basic human needs, b) exercise participation and self-determination, and c) experience competence and self-efficacy. In this model, participation and self-determination refer to the opportunity to experience meaningful decision-making power in matters affecting well-being that defines a personal sense of agency, personal control, self-esteem, and self-efficacy, which in turn serve as protective factors in the face of adversity and promote wellness and resilience. With some additional features from Wehmeyer's (2003) model of self-determination, a working model based upon Prilleltensky et al.'s (2001) conceptual framework is proposed for studying mental health recovery in the current research. This working model is shown in Figure 1 below.

Figure 1. A proposed working model relating self-determination and pathways to wellness and resilience for current research



As illustrated in the above working model, self-determination in the context of this research is a multi-dimensional concept that consists of an individual-level component, interactions between personal factors and the program environment, with these two levels nested within a multi-level ecological system. At the individual level, self-determination is conceptualized as being affected by background, development, learning, and personal perception and belief. At the program level, self-determination is facilitated by the active provision of material and psychological resources, opportunities for exercising power and control, and participation in meaningful decision-making in matters critical to the well-being of consumers. Further nesting these personal factors and interactions with program operations within a multi-level ecological concept critically frames the final discussion of this thesis of program outcomes in relation to national policies. As will be seen in a later part of this thesis, while this evaluation revealed elements of remarkable success in the program operation that facilitated consumers' mental health recovery, I nonetheless argue that the overall wellness of the program population remains bleak given the current housing policy and the general lack of policies to support self-determination among mental health consumers. This will become clear later in the document.

Research Setting

History of the Region of Waterloo's Psychiatric Outreach Program

In July 2004, the Region of Waterloo implemented the Psychiatric Outreach Program in response to critical issues identified by local agencies during community consultations. Local agencies indicated that the existing hospital or clinic-based delivery of psychiatric treatments could not meet the needs of persons who are homeless and affected by mental health issues. With $30,000 in seed funding, the program recruited an on-site psychiatrist to engage persons who were homeless in local shelters and community kitchens, as inspired by the award-wining Project for Psychiatric Outreach to the Homeless (Knowlton, 1997). Outreach workers were also recruited to collaborate with the psychiatrist to engage persons who were homeless but did not access shelters or other facilities. The primary objective of the program is to encourage behavioural change in persons who are homeless and affected by mental health issues to comfortably engage with a psychiatrist and receive assessment on-site "without looking like treatment" (Falk, cited in Knowlton, 1997). The initial outreach program based its operations on the meal program that is run by the St. John's Kitchen, then hosted by the Church of St. John's the Evangelist in downtown Kitchener.

The program's initial outreach activities were implemented as collaborative efforts among local agencies, including: the Working Centre, Mary's Place, House of Friendship, Welcome Aboard in Cambridge, Region of Waterloo Employment and Income Support, and Reaching Our Outdoor Friends. Other agencies that were involved in an advisory manner included the Kitchener Downtown Community Health Centre, Grand River Hospital, Waterloo Regional Homes for Mental Health, and the local branch of the Canadian Mental Health Association. Partner agencies offered space for the program's outreach activities, which ran two days a week.

The current Psychiatric Outreach Program continues to base its operations primarily on the St. John's Kitchen meal program. In the spring of 2007, the meal program and the Psychiatric Outreach Program were relocated to an 1880's era two-story factory warehouse situated at the intersection of Victoria Street and Weber Street, near downtown Kitchener. Co-located with the St. John's Kitchen at the new location is the Worth a Second Look furniture and houseware recycling centre, which is on the main floor. The St. Vincent De Paul Thrift Store's processing centre is next door to the new program location. Having been in operation for 20 years, the community kitchen now has a team of 35 to 85 volunteers who prepare and redistribute a daily average of 700 pounds of food - serving as many as 350 consumers in the second floor of the refurbished building (Working Centre, 2007). The newly tiled, accessibility equipped, and brightly lit dinner hall occupies over half of the 7,000 square feet of floor space and hosts consumers who arrive as early as 9:30 AM to access breakfast as well as other facilities including shower, laundry machines, telephone, and newspapers. During the peak hours from 11 AM to 1 PM, the dinning area is usually packed with individuals who come to access the meal program. These are also the prime hours for the outreach personnel, social-work students, and the occasional visitors such as medical students to interact with the program population. When I first visited the Kitchen, I was very impressed by how well and seamlessly the Psychiatric Outreach Program was integrated with the meal program. Only a trained eye could decipher the operations of the outreach staff; the giving out of clothing or bus tickets, administration of medications, checking in with consumers, and casual counselling were done naturally and spontaneously to the appropriate consumers in the dinning area. Subtly but mindfully located in the stair hallway leading to the dinning area is a partitioned area where the Psychiatric Outreach Program and the counselling staff offer the services on a consumer-request basis on Thursday mornings.

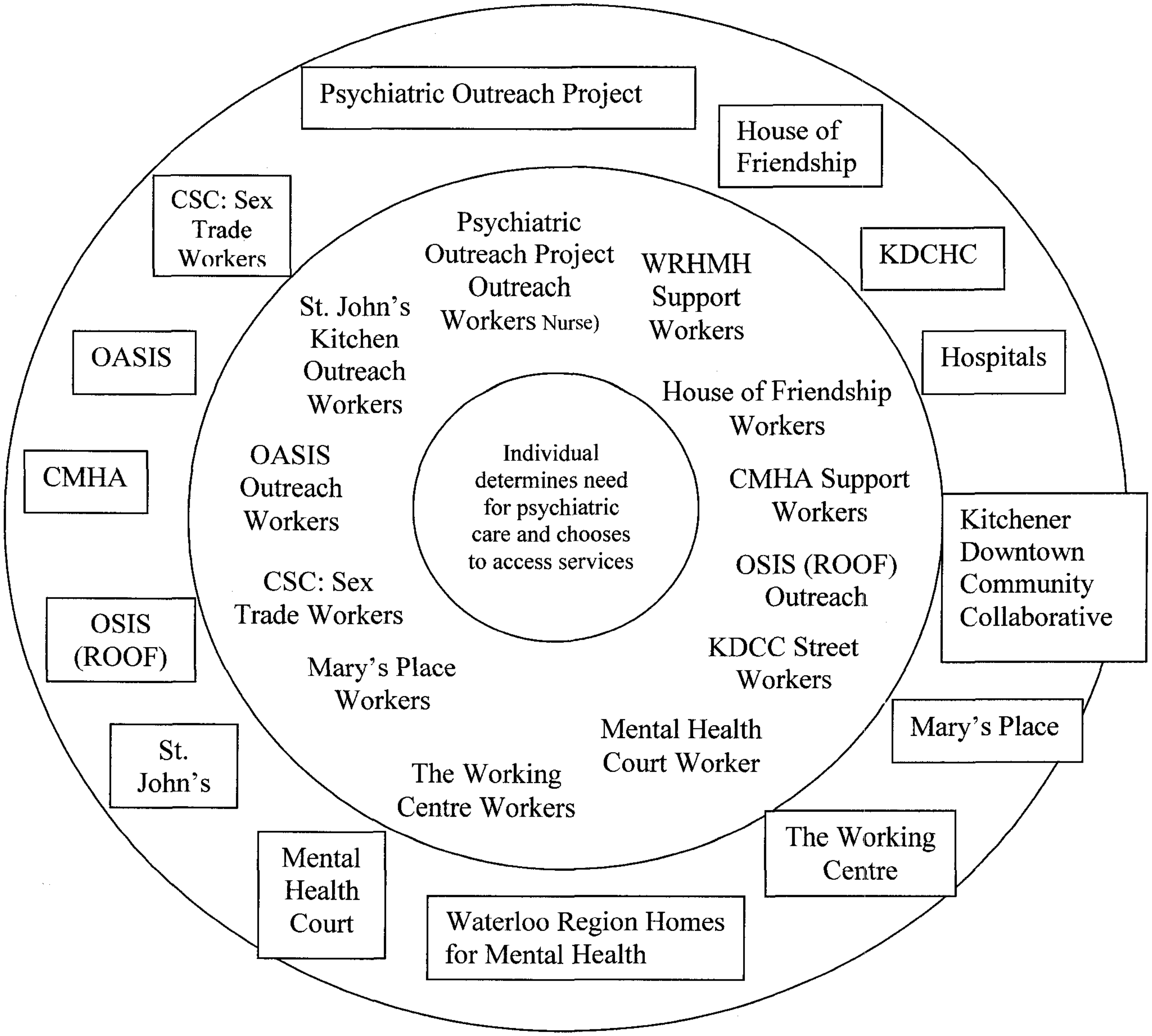
While the Working Centre has been outstandingly successful in running the meal program and the Psychiatric Outreach Program, there are many challenges that face the staff and consumers in this program. A key entry in my research journal recorded the first attempted suicide in the 20 year operation of the St. John's Kitchen. The incident happened the day after I received approval from the University's Research Ethics Board, when I anxiously wanted to proceed with the interview process. A distraught consumer went into the kitchen working area and self-mutilated with a knife taken from a cabinet. An unhappy scene of blood over the kitchen walls and the worry of not knowing when the interviews could proceed really unnerved me. The journal recorded the details of my frustration and self-doubt: a wrong research setting for my thesis. Fortunately, the doubt only lasted briefly. The collective resiliency demonstrated by the apprehensive yet undefeated staff and volunteers who quietly removed the blood stains, thoroughly sanitized the kitchen area, carefully re-established preventive protocols in securing the knife cabinets, and critically carried on the operations to make sure the consumers would receive a hot meal the following day proved that this was the perfect research setting for this thesis.

Current Program Operations

Dating back to January 2005, the initial program operation that primarily consisted of an on-site psychiatrist and outreach workers was suspended as a result of the psychiatrist's termination of service due to health reasons. The Region transferred the operation and management of the program to the Working Centre and St. John's Kitchen. In May 2005, the program restarted its service and operated as a client-centred, self-determination-oriented, and shared-model providing on-site services in the St. John's Kitchen as well as mobile services to consumers in the community at large.

This relatively innovative psychiatric outreach model was developed by the Working Centre. The client-centred, self-determination oriented approach aims to promote consumer choice and services. The shared-care operation is implemented based upon available resources and the protocols and policies required by the Personal Health Information Protection Act (Ontario Information and Privacy Commissioner, 2005). Running as shared-care, each program staff operates independently in her/his own scope of responsibilities or practice and collaborates through a formalized network of communication to provide comprehensive service to consumers at the point of care (Chomik, 2005; Working Centre, 2005). The current outreach team consists of a family physician, a consulting psychiatrist, a psychiatric nurse, a psychiatric social worker, outreach workers, and community coordinators. The team members collectively provide support to consumers based on shared information; and the program has also expanded the collaboration with a wider range of community partners including the police and probation services to bridge gaps in the service delivery system. The distinguishing characteristics of the program include the provision of services that are based upon and encourage consumers' self-determination, the provision of holistic on-site psychiatric care through a formalized communication network, and consumer connections with the larger network of support and social resources as a critical step in the treatment process. The current program is visually represented by a circle-of-care as developed by the Working Centre, shown in the following diagram.

Figure 2. Visual Representation of the Psychiatric Outreach Project's Circle-of-Care Model



With the new team structure, the current program offers sub-components that could be grouped as three main major categories, including:

1) *Outreach and Counselling.* Outreach is often done by program staff, nurses, physicians, social worker, visiting medical students, and volunteers who opportunistically engage with individuals that come to access the meal programs in the kitchen. In addition, the program staff and nurse also do specific outreach-visits in the community to connect with individuals who are referred to the program by other partner agencies or correctional services. Informal counselling is usually offered by program staff to consumers during casual contacts in the meal program area such as the dinning hall or other "hang-out" areas around the warehouse building. Once connected with the program, consumers are encouraged to engage with more formal and consistent counselling and psychotherapy appointments with social workers, nurses, and physicians that are done in a formal one-on-one setting inside the outreach clinic.

2) *Medical Assessment and Treatment.* Medical activities include assessment, treatment, and administration of medications. Assessment in turn includes triage by a psychiatric nurse, medical assessment by a physician or psychiatrist, Ontario Disability Support Program and or related housing support eligibility assessments. Treatment often includes prescriptions of medication in a formal clinic setting. However, upon consumer's request, treatment or consultation is sometimes conducted in a "walking appointment" during which the physician or nurse and consumer engage in an outside walk that may appear to be more relaxed and less formal. The administration of medication includes the on-site

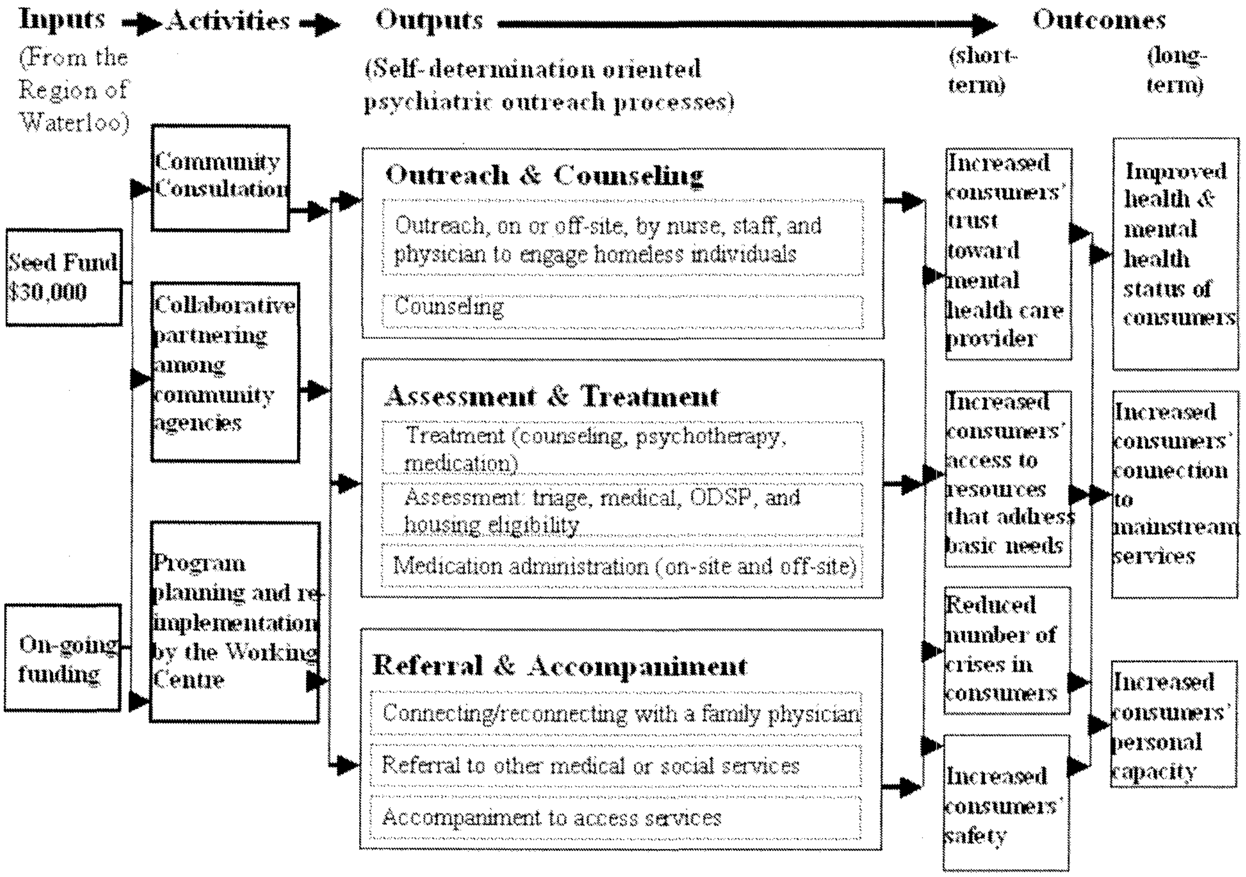
administration of medications when the consumers come to access the meal program, as well as off-site prescriptions of Pro Re Nata (PRN) medication by the psychiatric nurse in consultation with the physician for consumers who happen to be off-site and in need of medications.

3) *Referral and Accompaniment* to access other services. This component consists of activities that address consumers' health needs as well as access to resources that meet basic needs. On the one hand, the program physician often supports the consumers to connect or reconnect with a family physician who will become the consistent primary health care provider for the individuals. Also, the physician will connect the consumers with other medical specialists who can further address their specific health concerns. On the other hand, the program staff often networks the consumers with social services provided by partner agencies and in many cases, accompanies the consumers to access social services such as mental health court and hospital emergency for acute care that they may otherwise feel uncomfortable with and avoid involvement with.

Other program processes, including consultation to other partner agencies, research, and community development, remain in the planning stage.

This research was a process and outcome evaluation of the Psychiatric Outreach Program. The former is concerned with ascertaining how well the program has been implemented in terms of the utilization of program components, satisfaction with program components, and adherence of the program to a recovery model. The latter is concerned with assessing if the program produced the intended effects or beneficial changes to the target client population that it serves (Posavac & Carey, 1997; Rossi, Lipsey, & Freeman, 2004). The information the evaluation generates will be critical for refining and planning future program operations. The program components, processes, and desired outcomes of the current operations are summarized in the current program logic model as shown in the following figure.

Figure 3. Program Logic Model of the Current Self-Determination Oriented Psychiatric Outreach Program



Purpose and Objectives of Research

My interest in pursuing this topic extended from a personal desire to understand social interventions for persons who are confronted by mental health issues. Also, as discussed in the literature review, little research has focused on the empirical evaluation of this type of innovative psychiatric intervention. I was working as a planner in the Planning Information and Research Division, Planning, Housing and Community Services Department of the Region of Waterloo when the outreach program was in its design stage. Being a student in the Community Psychology program, I was pleasantly surprised to have developed a practicum opportunity under the mentoring of a colleague who worked as a Planning Associate in the Planning and Evaluation, Social Planning Department. This staff member is a graduate of the Laurier Community Psychology program who did the initial community consultations and program design of the outreach program using the values and principles of Community Psychology. Part of my practicum activities included a literature review on homelessness and mental health concerns for the design of the outreach program. When I was asked if I would be interested in doing an evaluation of the program as my thesis, I spontaneously and gladly accepted the offer. Since then, I helped out with the program in whatever ways I could on a personal basis and I developed a trusting relationship with the Working Centre, which operates the current program. When the initial outreach program was suspended due to the program psychiatrist's health concerns, I communicated this program news to my social network and helped to connect a family physician to the current phase of the outreach operation. I am pursuing this research entirely as my own personal undertaking in collaboration with the Working Centre. More explicitly, I am not working on the research project for the Region of Waterloo, which provides the major funding for this outreach program.

The overarching purpose of this research is to understand from the experiences of program consumers the implementation and effectiveness of the outreach program. The specific research objectives are:

a) to evaluate if the program is serving the intended target population of people who have experienced mental health or other health and psychosocial issues, homelessness and low-income, by examining the demographic profiles of the consumers;

b) to evaluate the program processes specified in the program logic model in terms of amount of utilization and consumer satisfaction;

c) to evaluate the fidelity of the program to a recovery model by examining the relationship between recovery-oriented systems indicators and utilization and satisfaction with the program components;

d) to evaluate the outcomes of the program to determine if the desired outcomes are being achieved; and

e) to examine the linkage between program processes and outcomes.

Methodology

Program Evaluation Using Mixed-Methods

There is a substantial amount of literature on program evaluation, such as the classic works by Guba and Lincoln (1982, 1989), Fettermen (2000), and Patton (2002). While I was attracted to the principles of empowerment evaluation suggested by these researchers, I could only implement these principles to a limited extent given the challenges and life concerns that are facing the program population. Furthermore, I decided to adopt a research methodology that is attuned to the current needs and directions as advocated by mental health researchers. Specifically, this emphasis refers to the adherence to the concept of mental health recovery that is grounded in consumer/survivor's lived experience with mental illness and journeys to wellness, and the application of consumer/survivor-derived instruments that measure recovery at the personal and program levels as elaborated by Campbell-Orde, Chamberlin, Carpenter, and Leff (2005). As such, I employed a pragmatic, mixed-method evaluation (McConney, Rudd, & Ayres, 2002) approach that included both quantitative and qualitative methods of data-gathering. Quantitative methods allowed me to statistically describe consumer outcomes and to investigate the relationships between program processes and outcomes. Qualitative methods allowed me to understand consumer's recovery, program experiences, and suggestions with information-rich data.

The principles of participatory action research that "maximizes the participation of stakeholders, those whose lives are affected by the problem under study, in the systemic collection and analysis of information for the purpose of taking action and making change" (Nelson, Ochocka, Griffin, & Lord, 1998, p. 888) were only implemented to the extent that program staff were involved as my steering committee in planning the research. The committee members included the psychiatric nurse, physician, psychiatric social worker, and program coordinator. Specifically, I began the foundation-laying stage by having the assumptions about the research, the selection of research participants clarified, and purposes of the evaluation developed with the steering committee. I also had the evaluation questions conceptualized and the data analysis methods developed in consultation with my steering committee, in addition to my supervisor. These steps were done as suggested by Taylor and Botschner (1998). The major barriers for including the program consumers in these stages included transience and communications issues among consumers.

Recruitment of Interviewees (Sampling)

A judgment sampling (Walonick, 2004) approach, an extension of convenience sampling, was used for selecting consumers to be interviewed. The program's psychiatric nurse, physician, and program staff selected the interviewees based upon their knowledge of consumer's background, history, communication skills, and capability of managing an approximately an hour to an hour and half long interview without detrimental effects. The objective of using this approach was to generate as meaningful and unbiased or heterogeneous a sample as possible from the active and willing consumers considering age, gender, psychosocial and health characteristics, and mental health history. Participants were selected by the staff members based on the criteria that they experienced major mental health issues and that they were homeless or deemed as at imminent risk of homeless. A total of 34 consumers out of a total of 95 active consumers volunteered as research participants, constituting about 30% of the program's consumer population.

Data Collection

The primary source of data for the current research was a structured interview. An interview instrument that was composed from a few selected sources specifically for measuring data relevant to several dimensions is elaborated below. Potential participants were provided with an information letter about the study (Appendix A) and asked to sign an informed consent (Appendix B) form if they wished to participate. Additional means of data collection for this research included document review, informal interviews, field observations, and staff reports of consumer changes. Documents such as the program design and monthly reports submitted by the Working Centre to the Region of Waterloo were reviewed and assimilated as background information. The information was useful for describing the research setting and discussion of research results. Supplementary to the background information were data from conversations with community partners and field notes taken by the researcher from being an observer, both active and passive, in the program site.

The data collected from structured interviews were primarily quantitative with open-ended questions that probed for in-depth information where appropriate. The six major dimensions of data that were collected included:

a) demographic and background information;
b) health, mental health, and psychosocial characteristics;
c) consumers' utilization of and satisfaction with program components, combined with participants' experiences of program processes;

d) participants' self-reported changes;

e) program staff's rated outcomes of consumers, as a means of triangulation to validate participant's outcome evaluation as elaborated immediately above in d); and

f) evaluation of the program's fidelity to a recovery model at a system level using a measure of recovery-oriented program practices.

In addition, I reviewed documents that were relevant to the program such as the monthly reports that the Working Centre submitted to the Region of Waterloo. The information was compiled as background information for describing the program as well as the discussion of research results. The types of data collected are summarized in Table 1 and elaborated in further detail in the next sections of this document. The time required for the consumer interviews ranged from half an hour to an hour and a half.

Table 1

Summary of Data Description for the Current Research

	Data	Rationale	Variables collected
a	Demographic and background information	For generating descriptive and summary statistics that are useful for evaluating if the target population is being served	Age, gender, race, if born in Canada, marital status, race, employment, source of income, years of schooling, and housing
b	Health, mental health and psychosocial issues	For documenting the types of issues faced by the target population and for evaluating if the target population is being served	History of chronic conditions, mental health, substance use, corrections system, and disability issues
c1	Process evaluation: Use of program components	For generating summary statistics on the utilization of program components	Yes-and-no check type of survey on use of program components and frequency of use using a scale of: never, once or twice so far, occasional (once a month) and frequently (once a week)
c2	Process evaluation: Satisfaction with and the experience of the program	For generating summary statistics regarding satisfaction with services and investigating consumers' program experience	One question using delighted-terrible-scaled responses on satisfaction with the program components, plus three open-ended questions per component, concerning experiences, importance to consumer, and suggestions for improvement, for the program components.

	components		
d	Outcome evaluation (rated by consumers)	For generating summary statistics on impacts of the program on recovery, as well as the qualitative data on outcomes	13 questions measuring outcomes using a seven-point Likert scale, plus two opened-ended questions concerning personal recovery.
e	Recovery-oriented system indicator evaluation	For generating descriptive statistics concerning recovery-orientation of the program	19 questions adapted from Dumont et al.'s, (2005) Recovery Oriented System Indicator instrument that measures recovery at a systems or program level
f	Outcome evaluation (rated by program staff)	For validating consumers' self-reported and self-rated outcomes	The same 13 questions asked of consumers, measuring outcomes using a seven-point Likert-like scale, plus two opened-ended questions similar to those used with consumers
g	Document review, informal interviews, and field observation	For developing background, history and supplementary program information	Conversations with community partners such as the Grand River Hospital Emergency education nurse, Downtown Kitchener Business Association, Canadian Mental Health Association (local)

Demographic and Background Information

There were 12 variables collected for demographic and background information. These included age, gender, race, if the consumer was born in Canada, marital status, employment status/condition, brief employment history, source of income, history of homelessness, years of schooling, and housing situation. These questions were adapted from previous surveys done by Bailey (2000) and Aubry et al. (2003). The data collected in this category were used for developing a profile of the characteristics of program consumers and evaluating if the program was serving the target population (see Appendix C, section A).

Health, Mental Health and Psychosocial Issues

The seven variables collected in this category included whether the participant had experienced a chronic health condition, mental health issue, alcohol use, drug use, the corrections system, a disability, and/or some other health or psychosocial issue. The majority of questions were adapted from Aubry et al. (2003). The answers to these questions were coded 0 or 1 so that a total score ranging from 0 to 7 could be generated (see Appendix C, section B).

Use of Program Components and Process Evaluation

There were nine sets of questions probing for data regarding utilization, frequency of utilization, satisfaction with services, consumer experiences, and consumer evaluations of each program component. The existing program components, described earlier, were grouped into three major categories: a) *Outreach and Counselling,* b) *Assessment and Treatment*, and c) *Referral and Accompaniment*. Depending on whether the consumer had used these program components, there were two questions that probed for scaled, quantitative responses regarding frequency of utilization and the level of satisfaction. The latter asked participants to rate their satisfaction about program components on a 7-point scaled response ranging from "terrible" to "delighted" similar to Lehman's (1988) subjective quality of life measure. In addition, there were three open-ended questions that probed for qualitative answers regarding consumer description of experiences with the program components, consumer descriptions of what they considered as the most important parts of the component, and suggestions for improvements. Also, the question on "networking with other social services" provided a list of agencies to be checked. The information collected was designed to tap program utilization and satisfaction (see Appendix C, section C).

Recovery Oriented Systems Indicators

As was discussed earlier, recovery is considered as a product of the interaction among characteristics of individuals and their environments. It was therefore necessary in this research to measure the recovery helping or hindering forces within a system. A shortened version of Dumont et al.'s (2005) Recovery Oriented Systems Indicators (ROSI) Measure that was designed for this purpose was used for the current research. This shortened measure was used as a means of evaluating the fidelity of the outreach program to the concept of recovery, and identifying recovery-enhancing practices in the program (Dumont et al., 2005). The instrument has a reported Cronbach's alpha of 0.95 based on a test of the full scale. One major drawback in recommending this instrument for the current research was that more detailed psychometric data on this instrument were not available at the time the instrument was designed. Nonetheless, this instrument is based upon a major national research project consisting primarily of consumer/survivors in the U.S. and thus a promising tool. 19 out of the original 42 questions from the measure were selected for part of the interview instrument (see Appendix C, section D). The questions that were not included were more concerned with outcomes, which I measured in a different way. The reason for using a shortened version of the instrument was to keep the proposed interview to a reasonable duration. Also, five of the selected questions that were originally worded in a negative sense were modified so that the responses could be positively rated. An example was question number 3 in which "program staff *do not care* about my physical health" was modified to "program staff *care* about my physical health." As such, the scores of the measure could be summed into a total score that indicated how strongly the consumer felt about the presence of recovery enhancing factors in the environment. Also, the word "staff" in the original questions is modified to "program staff" as this was considered more appropriate for the current research setting.

Outcome Evaluation

There were two identical versions of the outcome evaluation measure, one for the consumer (see Appendix C, section E) and one for program staff (see Appendix D). Each version contained 13 questions probing for Likert scaled 7-point responses ranging from "significantly worse" to "significantly improved" in various aspects of recovery at the individual level. The first eight questions asked for responses regarding outcomes as specified in the program logic model, including: access to resources that meet basic needs, trust of program staff and people around the consumer, connection to mainstream services, safety, health, mental health, and personal capacity. The additional four questions were concerned with other aspects of personal recovery including: a) emotional well-being, which is similar to that suggested by Campbell, Cook, Jonikas, and Einspahr's (2005) Peer Outcome Protocol; b) amount of fun, which is similar to that suggested by Giffort, Schmook, Woody, Vollendorf, and Gervain's (2005) Recovery Assessment Scale; c) amount of relaxation, which is similar to that suggested by Ridgeway's (2005) Recovery Enhancing Environment Measure; and d) the consumer's feeling about life as a whole, which is similar to that suggested by Bloom and Miller's (2005) Consumer Recovery Outcomes System, as well as Campbell et al.'s (2005) Peer Outcome Protocol. There was also an additional question that asked for consumer's perceived outcome concerning self-determination. Furthermore, there were two open-ended questions including "How have you changed?" and "How has your life changed?" as a result of participation in the program, that probed for detailed information of personal experiences of recovery. Meanwhile, the staff ratings of consumer outcomes by means of the same instrument were also completed with the consent of consumers.

Using a structured interview format, the above questions were read to participants, as previous research suggested that reading the questions to participants yields more reliable responses for people experiencing mental health issues (Corrigan et al., 1999). The scaled response options, including the delighted-terrible, Likert-type significantly-worse-to-significantly-improved, and those for the Recovery Oriented System Indicators were provided on cue cards to the participant. The participant's responses to the fixed responses were marked on the questionnaire and the responses to the open-ended questions were audio-taped. After the interview, the fixed responses to the quantitative questions as marked on the questionnaire were entered into a computer format as a Microsoft Excel spreadsheet. The taped responses to the open-ended questions were transcribed into computer format as a text file. During the interview, participants could take as many breaks as they wished. In the event that the research participant could not complete all the interview questions, the interviewee was invited to make another appointment to finish the remaining interview questions.

Data Analysis

Quantitative data collected from interviews were used for generating summary statistics, as well as correlation analysis. The former provided descriptive information including measures of central tendency and dispersion for the variables in the various data categories. The latter provided the measures of association between variables that helped to describe the relationships between program outcomes and recovery enhancing factors. Qualitative data were analyzed by open coding that reduce data and compare categories to develop common themes (Nelson, Hall, & Walsh-Bowers, 1995; Strauss & Corbin, 1990).

To examine the first research question of evaluating if the program was serving the target population, I developed the summary statistics that described the profile of the interview participants in terms of the means and standard deviations or percentage data for each of the items in the demographic and psychosocial survey. The levels to which the program had achieved in terms of serving the target population were evaluated based upon the percentage of consumers who experience homelessness, health and mental health issues, and poverty.

To examine the second research question of evaluating the program processes in terms of the frequency of utilization of the program components and consumer satisfaction, I reported the percentages of the sample that used the different components, and summary statistics on the frequency of utilization of each program component category, and participant satisfaction with each program component category in terms of percentages. The qualitative data pertaining to the three questions concerning consumer experiences, the most important part of the component to the consumer, and consumer suggestions for improvement were analyzed for common or overarching themes that emerged from the data. The program processes were then evaluated in terms of the percentage of the sample that used the services, the summary statistics of frequency of utilization and satisfaction, and participant descriptive and evaluative experiences.

To examine the third research question of evaluating if the program outcomes were achieved, I computed the summary statistics for the 13 quantitative questions that addressed recovery at the personal level. I also computed the coefficient alpha for the consumer and staff versions of these measures. The qualitative data from the two questions that asked how consumers perceived the general changes and how their lives had changed since participation in the program were analyzed for common themes emerging from the data. The program outcomes were evaluated in terms of the summary statistics of percentages of the quantitative recovery outcome questions pertaining to the outcomes specified in the program logic model as well as the additional outcome questions. The qualitative data provided more in-depth information regarding program outcomes.

To examine the fourth research question of evaluating the fidelity of the program to a recovery model, I computed descriptive statistics for the ROSI items as well as the correlations between the ROSI total score and the participant's utilization and satisfaction for each of the program component categories. Coefficient alpha was also computed for the ROSI measure.

To examine the fifth research question of evaluating the linkage between program processes and outcomes, I computed correlations between the outcome measures, with separate analysis for consumer and staff versions, and the following program process measures: the utilization scores for each program component category, the consumer satisfaction scores for each of the program component categories, and the total ROSI score.

Ethical Considerations

It was specified in my research proposal as imperative that my role as a researcher in the current evaluation be considered as an equal partner who was sensitive to opinions and interactions that might have negative impacts on the well-being of the participants. The evaluation was to be conducted with and for the program consumers.

Homelessness and mental health issues could be deemed as sensitive, humiliating, and stigmatizing experiences. A potential risk for the research participants was that they might suffer negative psychological or physical impacts by discussing painful and personal experiences. In order to minimize this risk, all interviews were pre-approved by the program's psychiatric nurse and physician, and were all arranged to be conducted on-site at the St. John's Kitchen during program hours according to terms and conditions specified by the participant. Prior to each interview, the participant was assured the immediate access to the program's health care personnel for debriefing or support if at anytime during the interview s/he felt the need to seek health care support. Nonetheless, almost all participants ended the interview with a pleasant smile and an appreciation for the opportunity of participating in the research. The longest interview took 4 hours, while the shortest took just under an hour. Most of the interviews were completed around an hour and 15 minutes.

In addition, all participants were assured that information shared during the interview would be kept confidential and would not be used in any research products without their approval. All participants were also assured that they reserved the right to refuse to discuss any issues and/or leave the interview at any time. These assurances were communicated both verbally and in writing. All participants provided their written consent to participate in this research.

All activities in this current program evaluation were continuously monitored and reviewed by staff of the Working Centre, the Program's psychiatric nurse, social worker, and physician. In addition, my academic advisor was informed on a regular basis and consulted when necessary. All research activities complied with Tri-Council Policy Statement (1998 with 2000, 2002, and 2005 amendments).

Research Results

Out of the over 95 currently active consumers of the Psychiatric Outreach Program, 34 individuals participated in the interviews for the current study. The data for two participants' interviews were not used in the final analysis. The first person was not included because the participant was later determined to have not fully met the inclusion criteria, while the second was due to data integrity concerns. Thus the final sample size was 32.

Research Objective One

The first objective of this research was to learn the extent to which the Psychiatric Outreach Program was serving the target population. A demographic profile of the participants was developed and the results are summarized in Table 2. As can be seen from Table 2, the majority of research participants were male, white, unattached, born in Canada, unemployed, had a low level of education, and had experienced homelessness, issues of health, mental health, drug and alcohol, and involvement with the corrections system. Specifically, the mean age of the interviewed consumers was 45, and the maximum age in the sample was almost 80. Many of the participants were unattached (88%), unemployed (81%), and receiving social assistance (40%) and disability income (40%). Close to 70% of the participants were currently homeless or had prior experience of homelessness. The mean income for the participants was $838, which is below the Statistics Canada's 2005 Low Income Cut Off or poverty line (Statistics Canada, 2006). Also, the average number of years of schooling that the interviewees reported was just below 12 years. Over 90% of the consumers interviewed identified themselves as having mental health issues, and 50% reported experience of involvement with the corrections system. From the information summarized in Table 2, it is clear that the Psychiatric Outreach Program served its intended target population.

Table 2

Demographics and Chronic Health, Mental Health, and Psychosocial Issues (n=32)

	Mean		Minimum		Maximum	
Age	45 (Male 44; Female 49)		20 (Male 20; Female 36)		79 (Male 69; Female 79)	
Gender			Male		Female	
			71.9% (*n*=23)		28.1% (*n*=9)	
Born In Canada			Yes		No	
			90.6% (*n*=29)		9.4% (*n*=3)	
Marital Status	Single	Separated	Divorced	Widowed	Married	Live with Romantic Partner
	40.6% (*n*=13)	18.8% (*n*=6)	18.8% (*n*=6)	9.4% (*n*=3)	3.1% (*n*=1)	9.4% (*n*=3)
Racial Background			Aboriginal	White	Black	Biracial
			3.1% (*n*=1)	75.0% (*n*=24)	3.1% (*n*=1)	18.8% (*n*=6)
Current Employment Status			Full-time	Part-time	Unemployed	Retired
			0% (*n*=0)	9.4% (*n*=3)	81.2% (*n*=26)	9.4% (*n*=3)
Current Source of Income		Social Assistance	Disability Income	Employment Earning	Retirement Income	Other
		40.6% (*n*=13)	40.6% (*n*=13)	3.1% (*n*=1)	9.4% (*n*=3)	6.3% (*n*=2)
Monthly Income			Mean	Median	Minimum	Maximum
			$838	$934	$206	$2000
Experience of Homelessness	No		Currently		More than 2 years Ago	
	31.3% (*n*=10)		43.8% (*n*=14)		25% (n=8)	
Years of Schooling			Minimum	Maximum	Mean	SD
			8	20	11.7	2.7
			Yes		No	
Chronic Health Condition			53.1% (*n*=17)		46.9% (*n*=15)	
Mental Health Issue			93.8% (*n*=30)		6.2% (*n*=2)	
Alcohol Use			28.1% (*n*=9)		71.9% (*n*=23)	
Drug Use			37.5% (*n*=12)		62.5% (*n*=20)	
Involvement with Corrections System			50% (*n*=16)		50% (*n*=16)	
Any Type of Disability			56.3% (*n*=18)		43.8% (*n*=14)	
Other Health or Psychosocial Problem			43.8% (*n*=14)		56.3% (*n*=18)	

Research Objective Two

The second objective of the research was to describe the frequency of consumer utilization and the consumer satisfaction with the following three program components: (a) Outreach and Counselling, (b) Assessment and Treatment, and (c) Referral and Accompaniment. Both quantitative and qualitative methods were used to achieve this objective. In the quantitative survey, participants were asked to indicate their frequency of utilization and rate their satisfaction with each of the program components. In the qualitative survey, the participants were first asked to describe their experiences with the program components. Second, they were asked to provide the evaluative descriptions of what they considered as the most important part to them of the program components. The results from both the quantitative and qualitative data analyses consistently showed that the program components were utilized frequently and that consumers were predominantly satisfied with, and more importantly, found the program components to be crucial in their recovery experiences.

Utilization and Satisfaction with Program Components: Quantitative Findings

The quantitative results of the study revealed that the participants utilized the three program components frequently and rated their experience as predominantly satisfactory. Outreach and Counselling was the most frequently used program component, followed by Assessment and Treatment, with Referral and Accompaniment the least utilized of the three. Specifically, 100% of the interview participants indicated that they had utilized the Outreach and Counselling, 97% utilized the Assessment and Treatment, and 88% utilized the Referral and Accompaniment component. Participants were most satisfied with the Outreach and Counselling. No one indicated any dissatisfaction with any of the program components. Descriptive statistics of participant utilization of the program components are presented in Table 3, while descriptive statistics of participant satisfaction with the program components are presented in Table 4.

Table 3

Participant Reported Utilization of Program Components (n=32)

	Never (1)	Once or Twice so far (2)	Occasionally (Roughly once or twice a month) (3)	Frequently (Roughly every week) (4)
Outreach and Counselling			40.6% (*n*=13)	59.4% (*n*=19)
Assessment and Treatment	3.1% (*n*=1)		62.5% (*n*=20)	34.4% (*n*=11)
Referral and Accompaniment	12.5% (*n*=4)	3.1% (*n*=1)	75.0% (*n*=24)	9.4% (*n*=3)

Table 4

Participant Reported Satisfaction with Program Components (n=32)

Program Components	Mixed (4)	Mostly Satisfied (5)	Pleased (6)	Delighted (7)	No Response (0)
Outreach and Counselling		15.6% (*n*=5)	31.3% (*n*=10)	53.1% (*n*=17)	
Assessment and Treatment		6.3% (*n*=2)	50.0% (*n*=16)	40.6% (*n*=13)	3.1% (*n*=1)
Referral and Accompaniment	6.3% (*n*=2)	6.3 % (*n*=2)	37.5% (*n*=12)	37.5% (*n*=12)	12.4% (*n*=4)

Utilization and Satisfaction with Program Components: Qualitative Findings

There were seven themes identified from the participant's descriptive and evaluative experiences of the program processes. These themes as elaborated below captured the distinctive qualities of the program process perceived and elaborated by participants.

The program process is consumer-friendly. One of the most prominent remarks made by participants was concerned with the program's friendliness toward consumers. The staff's consistently greeting consumers with a smile and by name and genuinely asking them how they were doing were greatly appreciated by participants. One participant shared, "I have to put it down to one thing …that they know your name and they care about how you are..." Another participant added, "Whenever they see me, they always smile at me saying: 'how are you'. That enlightens me." Most participants commented that, as a result, they felt welcomed, comforted, respected, uplifted, confident, and, as one participant said, "There are good people around me." Also, consumers felt that as if they were assured that staff would attend to them if they encountered problems, as one participant recounted, "I can't recall of a single occasion when I walk into this clinic without seeing a staff looking at me without a smile, and I honestly believe if they saw a problem on my face they wouldn't walk past me."

Another much cherished quality was staff's unconditional acceptance of consumers. One participant recalled, "I come in to see Jane and Pete [staff members]. I want to see if I could borrow some money… they are friendly… they don't judge me." Another participant added, "Most other people see us as bunch of low-lives-bums, these people see us and help us first, accepting - this is important to me, someone accepts me." The staff's unconditional acceptance and genuine willingness to help were in sharp contrast to the hostile discrimination that consumers often encountered. Participants indicated that, as a result, they were more willing to discuss their difficulties with staff as they felt that they could speak freely without having to worry how the staff might think of them. Also, consumers indicated that they were more likely to ally themselves with staff who were sympathetic, supportive, and resourceful problem-solvers. Another quality that was valued by consumers was staff's support in de-escalating stressful situations. Often, staff would intervene and explain or provide information to them in ways that they could understand. One interviewee commented, "If I am upset about a situation, they are very quick to reassure me and help me put my facts together where it is not so upsetting me." In general, consumers felt that they were assured and had a proper sense of direction in facing their difficulties.

Implicit across interviewees' narratives was the consumers' appreciation of the program's friendly and sympathetic environment. As one participant commented, "I much prefer to come here instead of the hospital… they know more about your body here than the hospital would, they are sympathetic." Apparently, the program process was also successful in minimizing stigma, the negative impacts of discrimination, and the psychological barriers that isolated consumers from accessing help. Furthermore, participants also reported feeling comfortable and encouraged to self-initiate engagement with staff, and considered the program as the hub and springboard to access other mainstream services.

The program process is supportive. Closely related with consumer-friendliness is the quality of supportiveness of the program. A common statement made by interviewees was the *haven* created by the program for consumers to unload burdens during stressful events. One participant described the following situation:

> When I first started coming into here it was really, really a place. I see people …same pain, the same shit … Women with their children…you know, prostitution stuff …It was around Christmas time, and my father died Christmas eve, and me and my daughter was talking …I kept crying and I couldn't stop the tears… was so tired…everything against me… Jane actually approached me…Amanda, Mary [staff members] they were there …trying to help…like a family, a town, all the people living in this town….

This experience typified the consumers' perception of being supported by staff, and the camaraderie of a supportive-community in the program. The notion of being supported and cared for as *in a family* was recurrently noted by research participants. Two interviewees shared: "They are 100% behind me, when I was in the hospital they came to see me… never had [anyone]… did that for me. The referral … they honestly care …they are like a family to me…the only family I have"; "They are like parents, not only did I get help but my family as well." The supportiveness of the program successfully conveyed a message of hope to consumers. As one participant said, "It is important to know that there is the friendship and they try to help me. Staff is helpful, helpful, non-judgmental. They are helping the ways they can, something that supports us, helps me to be hopeful of the future." The supportiveness of the program definitely became a significant source of psycho-social support for the program population.

The program process is seamless - internal and external programs are well-coordinated. As explained in the program model design, the program consists of three major components. Each member of the multi-disciplinary team works independently in the different components and collaborates through a formalized, shared-care network of communication to provide consumer-directed services. Furthermore, the program-team collaborates with a diverse range of partner agencies in the community to provide, and more importantly, to integrate consumers with comprehensively networked services. This designed feature of the circle-of-care, consisting of well-coordinated services both inside and outside programs, was manifested across the consumer's program experiences. Participants often cited fond memories of being smoothly connected with a primary health care provider, a pharmacist who waived service charges, the People in Motion program, K-W Counselling, the methadone clinic, and other educational opportunities. In particular, one participant recalled an experience – which happened during incarceration - that epitomized consumers' perceptions of a network of support coordinated by the program.

> I was in jail, I don't know what was in mind, I sort of punched the cop… They took me out of the jail to be medicated at the hospital. So, it's nice of the officers to do that …I see it all part of the program. They were all connected and they supported each other and that helped me to get the medication - the injection with Judy [program staff].

Other participants further commented, "They connect me with the right choices that I want to make"; "I trust them and I also trust the people they sent me to." The program's designed feature of a coordinated circle-of-care greatly facilitated the consumers' navigation in the local community-based mental health service system.

The program process is wellness-oriented. Another program feature that emerged from interviewees' experience was that the program's psychiatric intervention activities went beyond the mere reduction of symptoms and aimed to promote holistic health - physical, mental, emotional, and socio-economic well-being. According to the interviewees, the program actively engaged consumers with health care services, on the one hand, and the program also supported consumers with the emotional as well as tangible resources to take on a holistic approach that included exercise, balanced diet, relaxation, social integration, and active coping skills in caring for themselves, on the other hand. Thus, a notion of wellness enhancement often emanated from their experiences. One participant commented, "I have a feeling of well-being as a result of the treatment. I felt that my self-esteem was rising." Many participants reported having a balanced diet, exercise, social activities, and less use of alcohol and drugs as a result of a heightened awareness of a holistic approach to self-care. Furthermore, interviewees acknowledged the program efforts in addressing social justice that greatly facilitated consumers' access to valued resources including free medication dispensing, counselling, shelter, employment, education, recreation, ODSP, and welfare. In many ways, the program process attended to the various needs of consumers and had became an indispensable part of consumer's move toward wellness. One participant reflected:

> I only have the best experience with them, like I used to come here for ... to fight depression, to talk to the doctor about depression, try to, you know, stay out of the drugs. That was my main reason for coming here, detox and sane you know. He is excellent, but not just that, the process here, the process itself, getting up in the morning preparing to meet the doctor, I find that was the most helping already on its own....

The program process is strengths-based. The fifth theme that emerged from the data was that consumers were engaged as competent persons throughout the program process. Consumers reported that the program experiences helped them to focus on, and further develop, their strengths. Also, consumers acknowledged that this approach helped them to fight against the negative stereotypes that persons who experienced homelessness and mental health issues were delusional and incapable of making sensible decisions. One participant shared, "They are very kind people - open heart. They treat me like a human being… that makes me feel lots better and I can make decisions" A second participant added, "I appreciate their verbal ability to talk to me and that I understand…. increasing the capacity I could handle the situation." A third participant said, "I used to smoke and sell cocaine…and I'm considering going back to school and getting a job… They helped me a lot …makes me a social and helping person." Shifting the focus away from personal deficiency and weakness, the program emphasizes the provision of resources to consumers to develop their strengths. As a result, narratives about change were evident in the consumers' experiences. One woman described:

> They are there for me and that I am glad to see them. They actually put a smile on my face - helped me with my confidence. I feel a bit more confident in myself. I am a bit more hopeful of the future. I have been less hospitalized, last was 12 months ago. The staff visited me and I felt so much better. I felt connected with people - made me feel better about myself. I am just happy when I see the staff. I have a hard time with myself. I am taking one step at a time. I want to work and they are helping me with faxing my resumé…

Another code within this theme was that the program promoted interactions that enhanced social experiences of pleasure as a protective factor. One of my most memorable experiences was the Easter lunch. It was a fond memory hearing the consumers' talking among themselves how much they looked forward to the turkey on days prior to the event. The conversation lightened up the atmosphere in the program area and I could literally notice the frequent smiles on the faces of the interviewees during the days prior to Easter. Interestingly, the conversation continued days after the meals – consumers discussing how the gravy and cranberry sauce were missed. As shared by some participants, the Easter lunch was a comfort and necessity: "The food… the company…the warmth…", "I need it… I need to be around people… I need to be honoured."

Finally, the last code in the theme was that the program helped consumers to reconnect with their family members who became the psychological support that consumers could draw resources from to deal with problems and stressful events. This experience helped consumers to feel proud of their family and realize the potential that their family members could contribute to their recovery.

The program process is collaborative and involves power-sharing. The codes in this theme reveal that the program involves collaboration and power-sharing with consumers in activities including treatments and access to valued resources such as education and recreation. As a result of this participatory approach, consumers gained a sense of agency and an experience of assuming control in the program that helped to promote recovery. Some participants' comments included: "They didn't push any medication on me or anything like that. They just more let me talk about my issues what I am dealing with, very gentle, very professional"; "When I asked for changes with the dosage… Pete listened and prepared to try my suggestion… They were there to help me… pretty pleased"; and "The staff respects my opinion, they realize that I am adamant about medication and they respect my decision and they hooked me up with the walking program [People in Motion]. I am pleased… it is something positive." In particular, one participant, who stopped illicit drug-selling activities as a result of participation in the program recalled, "They did not tell me what to do … The fact that they let me do it on my own …helped me a lot." Similar to the results discussed in the last theme, participants felt more confident as well as an increased capacity in handling their own problems.

The staff goes above and beyond their regular duties in the program. The last theme concerned the perception that staff did what they were supposed to do, but performed these tasks so thoroughly that the consumers sensed that they received more time and attention than they expected based on past experiences. Some participants also felt that they were given special treatment by staff. One participant commented, "All the girls listened to me and talked to me and helped me figure out the solution to what ever it is." A second participant said, "I had several meetings with Pete [program staff], he is very helpful, he is very straight forward, and he is sympathetic, and he is very detailed". A third participant added, "I just saw Pete [program staff] … I feel like I am not just being looked at… he is looking for a solution… I feel I might be valuable." A fourth participant said, "She does wonderful things for me, see where I was …[she] made me talk!" Finally, a fifth participant shared, " Judy [program staff] knows so much about me she has helped me a lot that no one could help me before…" A significant acknowledgement by interviewees in this theme was that staff *was there* for the consumers and also that they made sure consumers' voices were heard during crises.

Research Objective Three

The third objective of the research was to evaluate the fidelity of the program to a recovery model by examining the ROSI indicators as well as the relationship between the ROSI total score and consumer utilization and satisfaction with the program components. Using an adapted version of Dumont et al.'s (2005) ROSI instrument consisting of 19 items (out of the original 41), data that tap the consumers' opinions on the recovery orientation of the program were collected. The result revealed that the participants rated the program's recovery orientation predominantly as positive on the five point scale for all 19 system indicators. This suggests the program's fidelity to the conceptual framework of recovery. In particular, the highest percentage of "strongly agree", which is at the top of the scale, being reported by participants is found in item 19. Specifically, this item pertains to the opinion that program staff provides consumer with information or guidance to get to the services and supports both inside and

Table 5

	Descriptive Statistics of ROSI (n=32)	Disagree	Mixed	Agree	Strongly Agree	Does not apply
1	Program staff understands my experience as a person with situational (such as anxiety) or other psychiatric needs		18.8% (*n*=6)	28% (*n*=9)	43.8% (*n*=14)	9.4% (*n*=3)
2	Program staff cares about my physical health.		9.4% (*n*=3)	37.5% (*n*=12)	53.1% (*n*=17)	
3	Program staff respects me as a whole person.		6.2% (*n*=2)	31.3% (*n*=10)	62.5% (*n*=20)	
		Some-times	Often	Almost Always	Always	Does not apply
4	Program staff sees me as an equal partner in my treatment	3.1% (*n*=1)	15.6% (*n*=5)	25.0% (*n*=8)	56.3% (*n*=18)	
5	I have a say in what happens to me when I am in crisis	6.3% (*n*=2)	12.5% (*n*=4)	12.5% (*n*=4)	56.2% (*n*=18)	12.5 % (*n*=4)
6	Program staff supports my self-care or wellness	3.1% (*n*=1)	6.3% (*n*=2)	15.6% (*n*=5)	75.0% (*n*=24)	
7	Program staff believes that I can grow, change and recover	3.1% (*n*=1)	3.1% (*n*=1)	18.8% (*n*=6)	71.9% (*n*=23)	3.1% (*n*=1)
8	Program staff does not use pressure, threats, or force in my treatment	3.1% (*n*=1)	6.3% (*n*=2)	12.5% (*n*=4)	78.1% (*n*=25)	
9	Program staff gives me complete information in words I understand before I consent to treatment or medication	3.1% (*n*=1)	6.3% (*n*=2)	21.9% (*n*=7)	65.6% (*n*=21)	3.1% (*n*=1)
10	Program staff encourages me to do things that are meaningful to me	3.1% (*n*=1)	3.1% (*n*=1)	40.6% (*n*=13)	53.2% (*n*=17)	
11	Program staff stands up for me to get the services and resources I needed		12.5% (*n*=4)	15.6% (*n*=5)	68.8% (*n*=22)	3.1% (*n*=1)
12	Program staff treats me with respect		9.4% (*n*=3)	15.6% (*n*=5)	75.0% (*n*=24)	
13	Program staff listens carefully to what I say	3.1% (*n*=1)	9.4% (*n*=3)	15.6% (*n*=5)	71.9% (*n*=23)	
14	Program staff has knowledge on the most effective treatments	3.1% (*n*=1)	18.8% (*n*=6)	21.9% (*n*=7)	53.1% (*n*=17)	3.1% (*n*=1)
15	Program staff does not interfere with my personal relationships	3.1% (*n*=1)	12.4% (*n*=4)	6.3% (*n*=2)	71.9% (*n*=23)	6.3% (*n*=2)
16	Program staff helps me build on my strengths	3.1% (*n*=1)	9.4% (*n*=3)	12.5% (*n*=4)	71.9% (*n*=23)	3.1% (*n*=1)
17	My right to refuse treatment is respected by program staff	6.3% (*n*=2)	9.3% (*n*=3)	9.3% (*n*=3)	68.8% (*n*=22)	6.3% (*n*=2)
18	I am treated as a person by program staff		6.2% (*n*=2)	21.9% (*n*=7)	71.9% (*n*=23)	
19	Program staff provides me with information or guidance to get to the services and supports I need, both inside and outside the program		6.3% (*n*=2)	12.5% (*n*=4)	81.2% (*n*=26)	

outside the program. Further details of the descriptive statistics of the 19-item ROSI survey are summarized in Table 5. Furthermore, the Cronbach's alpha for the adapted ROSI instrument was 0.90, indicating a very high level of internal consistency and reliability that was comparable to the published alpha value of 0.95 for the full measure. This, to a certain degree, supports the validity of the use of the shortened version of the ROSI instrument in this study.

In addition, a correlation analysis for exploring the relationship between the ROSI total score and the other measures of program process measures was done. The correlation between the ROSI total score and the participants' frequency of utilization of each program component, as well as the correlation between the ROSI total score and the participants' satisfaction with each program components, were computed. As can be seen in the results summarized in Table 6, the ROSI total score was found to be significantly correlated with the participant's satisfaction with the three program components. Furthermore, the participant's frequency of utilization of the program components also correlated, even though not statistically significant, with the total ROSI score. On the one hand, this suggests that consumers who utilized and felt satisfied with the program components would also likely agree with the ROSI items that positively reflected the program's fidelity to a recovery model. On the other hand, the results supported the consistency, and thus the validity, of both tools in the current study. Details of the correlation analysis are summarized in Table 6.

Table6

Correlations between Total ROSI and Participant Utilization Frequency of Program Components and Participant Satisfaction with Program Components (n=32)

		Correlation with Total ROSI	Significance
Outreach and Counseling	Participant Utilization Frequency of Outreach and Supportive Counseling	0.24	0.19
	Participant Satisfaction of Outreach and Supportive Counseling	0.62*	0.00
Medical Assessment and Treatment	Participant Utilization Frequency of Outreach and Supportive Counseling	0.19	0.31
	Participant Satisfaction of Outreach and Supportive Counseling	0.58*	0.00
Referral and Accompaniment	Participant Utilization Frequency of Outreach and Supportive Counseling	0.34	0.06
	Participant Satisfaction of Outreach and Supportive Counseling	0.50*	0.00

* Correlation is significant at the 0.01 level (2-tailed).

Research Objective Four

The fourth objective of the current research was to evaluate the extent to which the intended outcomes of the program were achieved. To examine the program outcomes, 13 quantitative questions and two qualitative questions were used. Also, the same instrument was used to collect staff input as a means of triangulation. The results to these outcome questions are presented in the following.

Quantitative Evaluation of Outcomes

The 13 quantitative questions concerning various aspects of outcomes were used to tap participants' quantitative outcome responses using a Likert scale, with the following anchor points: significantly worse (1), moderately worse (2), slightly worse (3), maintained (4), slightly improved (5), moderately improved (6), and significantly improved (7). As elaborated in the

Methodology, the first eight of the 13 items concerned the designed outcomes specified in the program logic model. The other additional five items, which were not specified in the program logic model, tap recovery from the different perspectives of emotional well-being, amount of fun, amount of relaxation, experience of self-determination, and consumer's perception of life as a whole. The descriptive statistics of the two sets of items – delineated by a bold horizontal line - are presented in Table 7. Items above the bold horizontal line are defined in the program logic model; whereas items below are additional items *not* defined in the program logic model. In order to facilitate visual comparison of the results, the weighted average scores based on the descriptive statistics were calculated as a means to reflect the rank among the items in terms of improvement. These scores are presented on the right hand side of the bold vertical line in Table 7. The weighted average was calculated by multiplying each score on the Likert-scaled response by the number of participants that reported the score. The multiplication products of each Likert-scaled score were summed and divided by the total number of participants, or 32.

The overall quantitative outcome measure revealed that all interviewees reported predominantly positive improvements for all 13 items - as compared to before they participated in the program. Close to half of the consumers perceived that the three items of access to resources that meet basic needs, the level of trust with people around them, and safety were "significantly improved." More than a quarter of the participants perceived that almost all outcome items were "moderately improved." There was only one instance of a consumer reporting a "slightly worse" in the measure of amount of relaxation. The Cronbach's alpha for this 13-item, participant self-rated outcome instrument was 0.90, indicating a very high level of internal consistency and reliability. The overall predominately positive ratings reported by consumers in this instrument suggested the satisfaction of consumers and the success of the program in delivering the intended outcomes, as shown in Table 7 in the following.

Table 7

Participant Self-Reported Outcomes (n=32)

Comparing to before you partcipated in the program,	Slightly Worse (3)	Maintained (4)	Slightly Improved (5)	Moderately Improved (6)	Significantly Improved (7)	Weighted Average
How do you feel about your access to resources that meet basic needs (such as housing, food, clothes) now?		6.3% (*n*=2)	21.9% (*n*=7)	31.3% (*n*=10)	40.5% (*n*=13)	6.0625 (Rank=1)
How do you feel about the level of trust you now have with people around you now?		18.8% (*n*=6)	12.4% (*n*=4)	25.0% (*n*=8)	43.8% (*n*=14)	5.93750 (Rank=2)
How do you feel about your connection to social services now?		12.5% (*n*=4)	31.3% (*n*=10)	18.7% (*n*=6)	37.5% (*n*=12)	5.81250 (Rank=8)
How would you describe the number of crises you experience now ?		28.1% (*n*=9)	37.5% (*n*=12)	12.5 % (*n*=4)	21.9% (*n*=7)	5.28125 (Rank=6)
How do you feel about how safe you are now ?		18.8% (*n*=6)	15.6% (*n*=5)	25.0% (*n*=8)	40.6% (*n*=13)	5.87500 (Rank=4)
How do you feel about your health in general now ?		18.8% (*n*=6)	15.5% (*n*=5)	31.3% (*n*=10)	34.4% (*n*=11)	5.81250 (Rank=7)
How do you feel about your mental health in general now ?		18.8% (*n*=6)	31.2% (*n*=10)	21.9% (*n*=8)	28.1% (*n*=9)	5.78125 (Rank=10)
How do you feel about your personal capacity to deal with problems now?		15.5% (*n*=5)	18.8% (*n*=6)	31.3% (*n*=10)	34.4% (*n*=11)	5.84375 (Rank=5)
How do you feel about your emotional well-being now ?		12.5% (*n*=4)	21.9% (*n*=7)	28.1% (*n*=9)	37.5% (*n*=12)	5.90625 (Rank=3)
How do you feel about the amount of fun you have now?		37.5% (*n*=12)	9.4% (*n*=3)	31.3% (*n*=10)	21.9% (*n*=7)	5.37500 (Rank=12)
How do you feel about the amount of relaxation in your life now ?	3.1% (*n*=1)	31.3% (*n*=10)	21.9% (*n*=7)	28.1% (*n*=9)	15.6% (*n*=5)	5.21875 (Rank=13)
How would you describe your experience of self-determination in your daily life now ?		25.0% (*n*=8)	15.6% (*n*=5)	28.1% (*n*=9)	31.3% (*n*=10)	5.65625 (Rank=11)
How do you feel about your life as a whole now?		18.8% (*n*=6)	12.5% (*n*=4)	37.5% (*n*=12)	31.2% (*n*=10)	5.81250 (Rank=9)

(Cronbach's alpha = 0.90)

A closer examination of the results in Table 7 reveals some interesting information. In particular, the participants – who had no knowledge of the program logic model - were more likely to report a higher score of improvement in the first eight items that were defined in the program logic model - as reflected by the weighted average score listed to the right hand side of the bold vertical line in Table 7. There are three plausible explanations for this observed pattern. First, the result seems to suggest the importance of specificity of intervention activities in the current program environment. In other words, those outcome items that were identified in the program logic model were clearly defined and associated with specific program components that were designed to deliver the intended outcomes. Therefore, it makes sense to see higher improvement scores reported in these specified outcome items. Second, the additional outcome items that were used in the instrument were meant to tap outcomes of "higher order needs," which might not come into focus when consumers are struggling with basic survival needs. Thus these items might be perceived as less-tangible to the consumers and not as readily measurable in the current research. Third, a more critical explanation is the lack of substantial support for consumers to access housing in the current intervention program. A good portion of the research participants relied on the local shelter programs to get by during the time of interview. Many of them were hopping from one church basement to the next on a day-to-day basis - while stopping by the kitchen to get a hot meal and catch up with the interview before they headed for a shelter for the evening. While the current program demonstrated remarkable success in addressing the provision of resources that meet basic needs, it lacked the financial means to provide more concrete support for consumers to access housing – which is a critical basic need. About one third of the participants reported that their amount of fun, amount of relaxation, self-determination, and number of crises were "maintained" – a mid-scale score that implied that the program had no impact on these areas of their life. The implications are further elaborated in the Discussion.

The same instrument was also used to gather the staff's ratings of consumer outcomes. Similar to the above, the descriptive statistics and weighted average of the staff rated outcome scores of consumer were summarized in Table 8. The Cronbach's alpha computed for the staff rated outcomes of consumers was 0.89, which is very comparable to the consumer rated outcomes and indicates a very high level of internal consistency and reliability. Furthermore, the staff rated outcome total score correlated significantly with the consumer-rated outcome total score (r= .43, $p < 0.05$, using a 2-tailed test of significance). The total score was calculated by summing the scores of the 13 items in the outcome survey – both consumer-reported and staff-rated outcomes. These various means of triangulation measures consistently support the validity of the consumer self-reported outcome scores.

In general, the overall improvement scores of consumers as rated by the staff were slightly lower than the consumer self-rated scores. On the one hand, this reflects that the consumers perceived that they had benefited more positively from the program services than the staff believed that they had. On the other hand, this also reflects that the staff was more conservative in their rating of consumer improvement and they may not have inflated their ratings to boast the benefits of the program. It is also interesting to see that the staff was similarly more likely to rate higher improvement scores in the outcome items that were identified in the program logic model than those items that were not in the program logic model. Another interesting observation is that while the consumers rated the most improvement in their access to resources that meet basic needs, the staff rated the most improvement in the number of crises among consumers. Meanwhile, the consumers rated the amount of relaxation as the item showing the least improvement, while the staff rated emotional well-being as the item that showed the least improvement.

Table 8

Staff Rated Outcomes of Participants (n=32)

Comparing to before the consumer partcipated in the program,	Maintained (4)	Slightly Improved (5)	Moderately Improved (6)	Significantly Improved (7)	Weighted Average (Rank)
How do you feel about her/his access to resources that meet basic needs (such as housing, food, clothes) now?	15.6% (*n*=5)	40.6% (*n*=13)	34.4% (*n*=11)	9.4% (*n*=3)	5.375000 (Rank=10)
How do you feel about the level of trust s/he now has with people around her/him now?	9.4% (*n*=3)	40.6% (*n*=13)	21.8% (*n*=7)	28.2% (*n*=9)	5.687500 (Rank=2)
How do you feel about her/his connection to social services now?	9.4% (*n*=3)	31.2% (*n*=10)	46.9% (*n*=15)	12.5% (*n=4*)	5.625000 (Rank=4)
How would you describe the number of crises s/he experience now ?	12.4% (*n*=4)	15.6% (*n*=5)	50.0 % (*n*=16)	22.0% (*n*=7)	5.812500 (Rank=1)
How do you feel about how safe s/he is now ?	12.5% (*n*=4)	37.5% (*n*=12)	40.6% (*n*=13)	9.4% (*n*=3)	5.468750 (Rank=8)
How do you feel about her/his health in general now ?	18.8% (*n*=6)	37.5% (*n*=12)	40.6% (*n*=13)	3.1% (*n*=1)	5.281250 (Rank=11)
How do you feel about her/his mental health in general now ?	6.3% (*n*=2)	46.9% (*n*=15)	31.2% (*n*=10)	15.6% (*n*=5)	5.562500 (Rank=5)
How do you feel about her/his personal capacity to deal with problems now?	3.1% (*n*=1)	50.0% (*n*=16)	37.5% (*n*=12)	9.4% (*n*=3)	5.531250 (Rank=6)
How do you feel about her/his emotional well-being now ?	50.0% (*n*=16)	28.1% (*n*=9)	15.6% (*n*=5)	6.3% (*n*=2)	4.781250 (Rank=13)
How do you feel about the amount of fun s/he have now?	31.4% (*n*=10)	34.4% (*n*=11)	34.4% (*n*=11)		5.031250 (Rank=12)
How do you feel about the amount of relaxation in her/his life now ?	3.1% (*n*=1)	53.1% (*n*=17)	31.3% (*n*=10)	12.5% (*n*=4)	5.531250 (Rank=7)
How would you describe her/his experience of self-determination in her/his daily life now ?	25.0% (*n*=8)	25.0% (*n*=8)	34.4% (*n*=11)	15.6% (*n*=5)	5.406250 (Rank=9)
How do you feel about her/his life as a whole now?		53.1% (*n*=17)	25.0% (*n*=8)	22.0% (*n*=7)	5.687500 (Rank=3)

(Cronbach's alpha = 0.89)

Also, the staff rated lower outcome improvement scores in the "higher order need" items - which was consistent with the rating reported by consumers for these items. In particular, the staff considered that half of the consumers had not benefited from the program in the areas of emotional well-being; and that the program had no positive impacts on one-third of consumers in the areas of amount of fun and self-determination. Nonetheless, the staff considered that between one-third to half of the consumers experienced moderate improvements in most of the outcome items. The staff also perceived that no consumers were negatively impacted as a result of their participation in the program; the lowest rating was that consumers *"maintained,"* which is the mid-anchor point of the scale for the outcome measure.

Qualitative Evaluation of Outcomes

In addition to the quantitative outcome questions, the participants were further asked two open-ended questions concerning changes. The first question asked the participants how they had changed since participating in the program. The second question asked the participants how their lives had changed since participating in the program. The data collected were analyzed using the same open coding approach as in the qualitative evaluation of program processes for themes. Ten overarching themes were identified:

Realizing potentiality. A prominent set of codes in the participants' elaboration of outcome experiences was centered on a heightened awareness that changes and a better future than the current circumstance were possible. One participant recounted, "I was worried about having no education… not able to concentrate…I could now pay attention to eating well …feeling much less depressed…a lot less anger… go for regular walks… I could be more expressing myself, carry on with goals …" A second participant shared, "I am starting to feel I like myself, … feeling not so bad about myself…There are times when I am actually me and I function at the full capacity - that never happened - and it's so wonderful, it's great …" A third participant added, "Rising up, waking up earlier, the best part of the day is in the morning - the outcome of the whole day is much better. I am more hopeful…not using anymore hard street drugs…refrained from crack cocaine…" A fourth participant said, "I see my future… see a nice home, a job…I just got to get out there and do that… It's there I know I am gonna have a good future and I just gotta do it." Furthermore, embedded in the other experiences of realizing potentiality was a sense of increased personal capability and the desire and ability among consumers to seek out opportunities to change. One participant shared, "Things changed dramatically with my son because a lot of things happened as a result of my participation in the program, other areas of my family have changed as well. The staff really made me feel good about myself that I was turning around and doing things quite differently…" A second participant added, "I feel more stability in my life. I am staying out of the corrections. I could focus on taking care of my kid. I see structure in life where I used to eat and drink a lot in my life…" A third participant further revealed, "I feel much less reduced in my number of crises; the staff definitely helped me with my personal capacity to deal with problems… and motivate myself." Also significant among the experiences was realizing that external resources such as the program's supportive network and other valued resources were available to support consumer to put on a positive attitude and take on the steps toward changes. One participant elaborated on this theme:

> When you are unemployed it is very difficult to have fun. I have seen people killing themselves, two instances near where I slept. I was sleeping underneath the bridge … one guy put himself on fire. I had gone through a long time seeing [the image] again and again before I could release myself from it. I was unstable…The staff and doctor here helped me to release the tension. Once that tension is released, I feel so much different. They can help me to have a positive approach on anything. I don't get angry anymore. I now will study the situation and meditate before I approach anything. I have seen some of the terrible stuff that the people had out there. They can give immediate advice and that is very important. They don't judge. Always positive, positive attitude is very important and it can make a lot of changes…

Meanwhile, personal stories that consisted of details of change that included preparation, contemplation, taking small steps, doing something different or having a change of activity, taking rests, looking forward, and being reflexive were also reported by participants. This observation revealed that many consumers were undergoing the change process toward a different and better future. One participant shared the following,

> [I] try to take steps daily, keep a journal, go for walks … work out, get out there … go for a walk and I am much better when I come back. I don't want to go down the road when I went before… so I am taking little steps. I am 38 and I don't have a job… I am going through a rough time and I am trying to get my life back together … I am depressed but I just want to move forward instead of going back ... I have a plan for myself. I want to go into the right path. I never see myself drunk but I see other people drunk. I am glad that I am not in that situation, just everything goes up and I just want my life to go to *normal*…

Healing and wellness. Closely related with the previous theme are the notions of healing and wellness in the consumers' experiences of outcomes. Embedded throughout the consumer discussions of outcomes, the meanings of healing included adjustment, personal growth, and a reclaimed positive image after the devastating effects of psychiatric illness. One participant shared, "The fact that somebody cares, that changes my personality and my outlook, my lookup to myself, and my lookup to others… I am more hopeful of my ADHD and bipolar things… I know this is up to me." A second participant added, "Hell of a downer … My dad was hard to deal with… People judge me and put a heavy burden on me…The probation officer never trusted me … I could now deal with anger …everything will be working out…" Besides, participants also reported active use of coping skills to move beyond psychiatric challenges and toward a more positive outlook on life – as shared by one participant. "I have a better outlook…and am confident of the future. My son is 17 and … I could be proud of the ways I raised him…I am very optimistic… knowing where he can turn to… and where I can turn to…." More importantly, many participants reported positive elements of wellness, these included: "I feel like they are like my family members, they bring out all the good parts about me"; "Not being afraid, I don't cry as much any more - I used to sit up at night and cried - I stop crying, I don't feel as horrible, I feel that there is a way out there. My housekeeping is getting better…"; "I am dealing with my illness lots better!"; "Seeing them smile makes everybody smile. I am not afraid anymore. I am more relaxed. I have more trust with people… and less stress in my life. When I see other people smile and I can smile back."; and "Better habits, less worrying, better shape, more exercise, better attitude, better outlook, not having to worry about, hopeful of a better future."

Self-determination. Prominent in the consumers' discussion of outcome were stories of self-determination that resulted in critical life changes. Also significant in these stories were the freedom and ability in making basic decisions or identifying a life goal, as well as the resources to honour and support them in taking the steps toward achieving the goals. Associated with the elaboration of these experiences was the appreciation for staff's active and persistent facilitation of resources, which further supported the discussion in the literature review that active facilitation was extremely important for consumers in their self-determination process. Matt, who had a long history of incarcerations, due primarily to mental health reasons, shared his experience of being supported in his self-determination to return to school, to be properly medicated, and to live independently in the community - as a means to aim for a new start and stay out of the corrections system - while acknowledging the staff's persistent support:

> I am already in school and I am properly medicated… I'm getting much closer to getting my diploma. I have my own place, finally getting on the ball, getting out there, being involved with programs, moving on from being on the streets… I want to get working, getting out of shelters, stay away from the corrections system… I don't want to have problems - like I am starting all over again… I'm excited and I'm properly medicated… I remember I had been wanting to go back to school and the staff assisted me…positive change, my days have been stable and more hopeful!

Another participant, Rob, who had a similar experience, accentuated the comment about the importance of the staff's pertinacious support in his self-determination experience:

> I've put myself into a lot of situations and Jane [program staff] was able to help me out. She got me involved back into school again - like she came and spoke and went to the meetings and stuff that we had. I liked it, it is a comfort. Somebody is still there regardless of whatever you've done - still there trying to help even though whatever you have screwed up, but still going to be there.

These stories of changes reflected the impacts of recovery that the program had on consumers as a results of supporting consumers in their self-determination experience.

Managing symptoms. Taking on a more active role in addressing symptoms was the fourth outcome theme. The codes in this theme included: gaining an awareness of when symptoms were negatively affecting them, discerning and avoiding situations or environments that might not be beneficial to symptoms, and becoming more insightful of symptom signals. Some participants also reported active use of coping skills and taking the initiative to do regular check-ins with staff as a means of managing symptoms. Some participants acknowledged the importance of having staff's support in getting proper and consistent medication, which greatly helped with managing symptoms. One the other hand, some participants noted the importance of non-medical alternatives, such as taking on a more active life style, exercise, a more creative routine, and healthy eating as the preferred means of managing symptoms. These participants also explained that the non-medical alternatives were preferred because they felt being in-charge and self-responsible in managing symptoms. A few participants also reported that having information about their symptoms explained to them in ways they could comprehend also helped greatly with managing symptoms. Also embedded in these experiences was the notion of a sense of control on minimizing the impacts of symptoms and carrying on daily activities with a sense of self-resilience. Last, but importantly, interviewees realized the importance of self-initiation to seek help during crises. Alexia – who experienced developmental challenges, mental health issues, and years of single-parenting her daughter by means of working in the sex trade – shared the following:

> I would like to talk about suicide level… There are times I would feel like I am half-stuck in this world you know, how much more pain I have to endure, how much more a person takes. If she [daughter] is ever to come to fruition… I realize that I do love her, I am here for her but I have to get my needs… first… I am not being selfish. Stuff like that, you know, like the pain is so raw and there are times that… but I can't do that. I can't hurt myself… You know I let myself go a day or two, but I can't kill myself, you know, I am just too scared to do something like that. The pain is so devastating… I remember I was pregnant when I was fifteen, my mother: "don't you girls ever get pregnant like something I did"… how can she said something like that - she's pregnant when she's fifteen, that bastard couldn't tell his name… I couldn't tell her, how can you ever do anything like that …I could never hurt myself like injure myself. I would grind my teeth little things like this nothing drastic but I couldn't… I *now verbally cry out for help* - you know, just seeing my needs are topping out…

Incorporating illness. Closely related with managing symptoms was the realization that illness was only part of a multi-dimensional life. In particular, interviewees reported that they had gained insights of limitations associated with their illness and the motivation to take steps to move beyond illness toward a better future. According to participants, the factors that facilitated incorporating illness included: rapport with staff and camaraderie within the program, support to focus on strengths, the belief that things will get better, social connectedness, pride in previous achievements, and the courage to move on. One participant shared, "My illness - I am dealing with it lots better. My compulsive thoughts and behaviour completely decimated. I am not as one-sided. I am more open to suggestions. The staff helped me to have a good outlook on life…" John, who had been frequently incarcerated and hospitalized because of indecent exposure in public as a result of psychiatric issues, but who currently was under proper medication and living independently in the community, shared, "My social encounters are more positive now. I have more people and friends who are looking out for me… They explained to me that they noticed the difference on days that I take and days that I don't take the medication…It helps me to maintain an optimistic outlook…. and the belief that I could become a health instructor…"

Thriving. Another encouraging theme concerned doing better than previously as a result of participation in the program. As mentioned in the above themes, participants reported abstinence from drugs and alcohol use, stable housing, volunteering, active exercise, active participation in treatment, success in job searching, progress in the pursuit of education, and drastically reduced involvement with corrections system. In particular, some participants mentioned reciprocity – about giving back to support others. Participants also reported the ambition to do well, looking forward to getting a job, being able to focus on things they need to do, having a positive attitude, being more open to suggestions, and doing better self-care. Amidst the discussions, participants crucially acknowledged the staff's efforts in providing the supports for them in surviving difficulties and weathering crises, which improved their resilience and helped them move on with life.

Becoming more responsible and committed citizens. The seventh theme in the outcome evaluation was that the program consumers were determined and actively searching for means to stay away from corrections system and other illicit activities. Furthermore, many reported active involvement in meaningful and fruitful activities including working, volunteering, studying, and advocacy. Meanwhile, some participants shared that they were more committed to their family members or to intimate relationships. Many participants further acknowledged that these experiences were due to the program's impacts on their sense of agency, sense of control over life, improved access to valued resources, and increased participation in the community. George was under a murder charge, again, at the time of the interview. The last time it happened, as George shared with me, he lost control of his temper and ended up hitting his wife's forehead with a hammer. As a result of the program's intervention, George's family members were connected with psychiatric support. George described the ways his life had changed since participating in the program:

> My anger has almost stopped - I used to be bad … I got help, I could speak openly with my wife, being able to stay calm, more hopeful of future, manage finance better, better decisions making. Son's performance in school improves. Son offers help to his peers. He

> is helping teachers to help other students, which makes us feel good. He deals with anger better - now he has a video that helps other people to deal with anger. He also reminds us of how to deal with anger - this helps a lot with family life.

Social connectedness and relationships. Having a bigger, stronger, more diverse, and more supportive social network was another theme. According to the data, consumers benefited from a much higher level of community integration in terms of having new friends, utilization of community services such as the local Canadian Mental Health Association and K-W Counselling, participation in employment or education opportunities, volunteering, advocacy activities, and accessing valued resources in the community. Also embedded in the consumers' experiences was the acknowledgement of staff's advocacy through their accompaniment in accessing valued resources. Their support made a drastic difference in the consumers' social circumstances and opportunities. Kim was a mental health consumer/survivor who needed services from the methadone clinics. Unfortunately, Kim was banned from accessing the clinic due to behavioural issues prior to participating in the program. As a result of the program's intervention, Kim was reconnected with the services of the methadone clinic. Kim shared her experience,

> I got kicked out... She [program staff] helped me and offered to accompany me to the doctor at the [methadone] program ... If it wasn't for this place, I would be blasted - seriously. I have more faith in places that they send me to. My compulsive thoughts and behaviours are completely decimated - like gone. That's phenomenal ... My anxiety level has gone down considerably... In retrospect I have a good outlook on life and [program] has helped with that ...My stubbornness...like I am not [as] one-sided. I am [more] open to suggestion... because of my culture I could not get treatment but ...they could [help] me to [access other services].

Lily was one of the consumers who was connected with ODSP as a result of participating in the program. Lily shared the difference that the program made on her social circumstances:

> Before I came into the program I didn't feel anybody was helping me ... In here, they helped me and they put me in touch with people and places that I could reach to and get help. Knowing what was available, getting real help, and the hope that somebody is here

> to help… getting to know the new people, and knowing the available resources, that changes my outlook.

More positive day-to-day functioning. Another significant set of positive outcome experiences reported by the research participants was about having a more structured or creative routine and the spirit of not giving up despite the devastating effects of psychiatric issues. Kent was a musician who volunteered to be the spokesperson for a special TV interview about the Out of the Cold program, which he indicated that he felt very proud of and which was a critical experience for his recovery. He further shared how he had benefited from participating in the program:

> I have a more creative routine, I went to cigarette because I used to compose music in the morning, then I … started to come to see the doctor and he motivated me to do things … rising up waking up earlier. The best part of the day is in the morning…I have been progressing… This program here helps considerably.

Ann was another participant who was connected with ODSP as a result of the program's intervention. She was further connected with an educational opportunity offered at the St. Louis Centre. Ann shared her experiences of refusing to give up:

> I have a …disorder. I am getting mixed-signals …[I] feel very quirky. It …tears you apart and makes you very sad… I feel now a little calmer…I certainly feel better. I am coming out of the crying stuff…I am eating. My hygiene is there. I go out more. I call people more, and my concentration is very slowly but very surely improving. And there again it's coming, and something to look forward to - something to do with life. Somebody told me once "you love life" and I do when I am around the right people. I really do love life… like having people like me and support me you know bring things out of me … Just like sitting in a bath with warm water. Just relax… You know little tiny things happen and the trick is it does have to happen…. I do have a long way to go but it's something … that is going to happen … to keep… healthy you know the body and the mind… I don't feel as horrible, I feel that there is a way out there. My housekeeping is getting better…

June was a program consumer who came from the Canadian Maritimes. She had to give up custody of her children due to mental health issues. She came to settle and looked for a new start in Kitchener. June experienced considerable involvement with the corrections system prior to her participation in the program. As a result of participating in the program, June is currently living independently in the community with a romantic partner. June's experiences reflected glimmers of more positive daily functioning:

> I have a better ability to handle things emotionally if I have their support, everything, going to court, medical appointments, food, clothes, [and] connections with services... When I go home now I have a proper sense of direction [because staff explained things to me that I could understand]. I am able to get it, figure it out and get out the old penance. Before, it was confusing and upsetting. Now I know the direction I am going...

Renewing hope and commitment. Lastly, but perhaps most importantly, the majority of participants indicated that they had a better outlook for the future, a desire and motivation to change, and a belief that things were going to change positively as result of participating in the program. Sam was a system engineer who used to work in the computer-numerical-controlled prototype design industry. As a result of his mental health issues, he lost three right hand fingers while working with the computer-controlled saw; his career in the industry ended abruptly after the accident. Sam shared his experience of gaining hope as a result of participating in the program:

> Having a microscopic amount of hope is like having a microscopic amount of faith. It is incredibly powerful... When you have no hope you can come here and you can actually hang onto their hope...I was hanging on their hope. They're saying "You are going to improve. There is no real necessity for you to kill yourself..." I sometimes wonder if there is a reason for me to maintain a pulse... but that hope has been so absolute to me... Looking back on things I give myself the respect looking at things differently because of them - I am grateful to have the people [staff members] in my life. I am confident like I can just go and talk to them and say you know, this is my problem and I know they are going to help me out, and I know that they will be there and they are happy to see me...

Another major code in this theme was the participants' determination and commitment to taking good care of themselves - despite being affected by mental health issues. One participant shared, "I ...want to take care of myself ... I might be frugal ...[but] determined that I am going to have a better life ... and I am determined to hang on to take care of myself better." Similarly, Diane, who experienced mental health challenges, developmental challenges and single-parenting a son, shared the following. “I look at things as half-full instead of half-empty. I look at things [as] better. I take things one day at a time - I would jump in - where now I will say ‘wait.’ I am looking at things differently and I am happier this way; and I am more confident of the future…”

Furthermore, participants reported that they were able to commit to and maintain a stable relationship, have a better budget and more commitment to their family members, and have aspirations and motivations to do more and move on toward a better future.

Research Objective Five

The fifth objective of the research was to investigate the linkages among program processes and outcomes. To achieve this objective, correlations among the outcome measures and process measures were computed and the results are summarized in Table 9 in the following. As can be seen, the correlations of participants’ frequency of utilization of two of the components (Outreach and Counselling, Medical Assessment and Treatment) and the consumer-rated outcome score were statistically significant. None of the other correlations were significant. One plausible reason for the insignificant correlation between the participant’s total outcome score and the participant’s frequency of utilization of the third program component was that the frequency of utilization of the Referral and Accompaniment only partially reflect the actual frequency of utilization of the services that the participants were referred to. This is further elaborated in the Discussion.

Table 9

Correlations Among Process Measures and Outcomes

			Consumer Outcome Total Score	Staff Rated Outcome of Consumers
Outreach and Counseling	Utilization Frequency	Pearson Correlation	**0.47***	0.13
	Satisfaction	Pearson Correlation	0.13	-0.06
Medical Assessment and Treatment	Utilization Frequency	Pearson Correlation	**0.44****	0.24
	Satisfaction	Pearson Correlation	0.35	0.11
Referral and Accompaniment	Utilization Frequency	Pearson Correlation	0.18	0.07
	Satisfaction	Pearson Correlation	0.31	0.12
ROSI Total Score			0.23	0.02

* Correlation is significant at the 0.01 level (2-tailed).

**Correlation is significant at the 0.05 level (2-tailed).

Discussion

Research Objective One

The first research objective was concerned with whether the program was serving the intended target population. The demographic profile of program consumers revealed that the program was clearly serving the target population. Also, the results provided more detailed and specific characteristics of the program population than the Region of Waterloo estimates that were discussed in the literature review. Specifically, the program population had a lower percentage of substance use issues but a higher percentage of mental health issues than the estimates. Furthermore, the results indicated that the program population had an average of less than 12 years of education, almost 90% unemployment rate, and substantial issues with disability, health, and involvement with the corrections system. Also, given the fact that the interviewees were consumers of a psychiatric outreach program, the percentage of mental health issues such as anxiety and depression was substantially higher than those in the Toronto studies (Goering et al., 2002; Tolomiczenko, 1997). The current study results support previous studies such as that by Farrell et al. (2002) who found that anxiety and depression are the predominant mental health concerns for individuals who experience homelessness.

Meanwhile, it is interesting to note that there were more male consumers and that many were of a younger age than their female counterparts. To a certain degree, this suggests that the program succeeded in minimizing the barriers among the male portion of the target program population in accessing services. As well, the results suggest that with younger male consumers accessing the services, gender-specific intervention activities could be delivered at an early stage of consumers' mental health experience.

Another observation from the demographic profile was the lower percentage of consumer self-reported alcohol and drug use relative to issues of health, mental health, and involvement with the corrections system among the program population. In other words, the consumers were apparently accessing the program services more likely because of their concerns about mental health, health, and psycho-social issues than their concerns with alcohol and drug use issues. Given the high percentage of health and mental health issues and involvement with corrections system reported by the consumer, it is nonetheless encouraging to see from the qualitative data that the consumers were determined to take on a holistic approach to wellness and to find active means to stay out of the corrections system as a result of participation in the program. This observation is consistent with the results reported by Gaetz et al. (2002) that young homeless Canadians are not welfare dependent and do aspire to take jobs in the formal economy just like any members of our society.

A potential challenge to the results of the current research was that the demographic profile might be distorted by the sampling approach. In other words, the ways staff members identified the interviewees from the relatively more active consumers whom they deemed to be capable of handling a one hour interview might, in a way, preferentially selected the "better-recovering" research participants. However, the majority of consumers who were sampled reported health, mental health, and psychosocial problems, as well as significant periods of homelessness. Neither the consumer self-reported outcome total score nor the staff-rated outcome total score were correlated significantly with the consumer self-reported health-mental-health-psychosocial total score. Thus, the consumers' health, mental health, and psychosocial characteristics did not have any significant impacts on the outcomes – either consumer self-rated or staff-rated.

Research Objective Two

The second research objective focused on participants' utilization of and satisfaction with each of the three components of the program. The quantitative results revealed that the program population utilized the program components frequently and were predominantly satisfied with the services. Specifically, 100% of the interviewees reported that they had utilized the Outreach and Counselling component, 97% utilized the Medical Assessment and Treatment component, and 88% utilized the Referral and Accompaniment component. All participants who had utilized the Outreach and Counselling as well as the Medical Assessment and Treatment services reported positive levels of satisfaction with these services, to varying degrees, on the Likert-scaled response. Only 6%, or two, of all interviewees who utilized the Referral and Accompaniment component reported a response of "mixed" – the mid-point in the 7-point Likert-scaled response. These data show that this outreach program successfully engages a hard-to-serve population who might otherwise not get connected with services.

The qualitative analysis of the subjective meanings of consumer experiences reflected the characteristics of program components that were deemed important to the consumer. The overarching themes from the consumers' descriptive and evaluative experiences revealed that the qualities of being user-friendly, supportive, well-coordinated, wellness-oriented, strengths-based, collaborative and power-sharing, and dedicated staff were highly valued by consumers.

Relevant to a program planning perspective, it is worth noting that the consumers used most frequently and felt most satisfied with the Outreach and Counselling component. This indicates the relative importance of, and the demand for, more informal supportive services that deliver both tangible and social-emotional support to consumers, given the challenges that the target population is facing day-to-day. As well, it is important for future program planners to be aware of the benefits generated from the consumer-centred approach and the associated qualities of being user-friendly, supportive, well-coordinated, wellness-oriented, strengths-based, collaborative and power-sharing, and dedicated to serving consumers.

Another important observation from the qualitative analysis of the consumer experiences of the program process is that the program operationalized the principles of self-determination as suggested by researchers mentioned in the literature review. First, the program created the necessary precondition, or the "match" (Mithaug, 1993, 1996), for consumers to exercise self-determination. Specifically, the qualities of the program process noted above provided the environmental conditions necessary for consumers to seek out the available opportunities given their capabilities. Second, the program played a critical role in facilitating the consumers' self-determination process through the active provision of the needed resources and information, and the creation of choices that are consistent with the principles suggested by Wehmeyer (2004), Wehmeyer et al. (1999), and Wehmeyer et al. (2003). In addition, the consumers' narratives concerning the program process being collaborative and involving power-sharing revealed some details about the intrapersonal and interpersonal aspects of self-determination that are consistent with the results of the qualitative studies reported by Välimäki et al. (1998) and Nordgren et al. (2001). Specifically, the participants of this current study revealed that their experiences of self-determination is a process of shared self-decision making in which they required, and to some degree relied on, the facilitation by staff in the provision of knowledge and information in the decision-making process.

Research Objective Three

The third objective of the research study was to evaluate the fidelity of the program to a recovery model. First, the results of the ROSI survey were examined in the data analysis. Second, the correlations among the process measures were also computed. The process measures in the correlational analysis included the ROSI total score and consumer utilization and satisfaction with each of the program components.

The descriptive statistics of the ROSI survey indicated that the consumers rated positively all 19 items of the ROSI survey and thus the results supported the program fidelity to a recovery model. The results of the correlational analysis of process measures revealed positive correlations among all measures. Specifically, the correlation between the consumer's satisfaction with the program components and the ROSI total score is statistically significant. At the same time, consumer utilization also positively correlated, even though not statistically significant, with the ROSI total score. The small sample size was a limiting factor in not being able to detect significant associations between the ROSI and the participation measures, although one correlation was significant at the .06 level. Taken together, these results suggest that satisfaction with the program components is associated with the dimensions of a recovery model. Furthermore, the results from the analyses of the consumer-rated process measures are consistent with the discussion about recovery as discussed earlier in the literature review. The results support the notion that recovery, while being a deeply personal process of changing one's attitude, values, feelings, goals, skills and or roles as suggested by Anthony et al. (2003), is also a product of dynamic interaction between the individual and a recovery facilitating environment as suggested by Dumont et al. (2005). Therefore, it makes sense that the more the consumers interacted with and were satisfied with the program components, the higher were their ratings of the program's recovery orientation.

Another interesting observation was the correspondence between the quantitative ROSI process measure and the qualitative themes of program process. The top seven of the 19 items of the ROSI, in terms of the percentage of consumers rating an item as "strongly agree," aligned with four of the seven qualitative process themes. This correspondence, in descending order of the percentage of consumer-rated "strongly agree" in the ROSI, is summarized in Table 10. To some degree, this observation supported the validity of the themes identified from the qualitative analysis of consumer narratives of program processes. Furthermore, this correspondence may also, in a way, reflect a hierarchy or level of importance of these themes in the eyes of consumers. Overall, this correspondence between quantitative and qualitative results served as the means of validation - for the choice of tools, the methods of analysis, and the results – that is currently lacking in the research.

Table 10

Correspondence Between ROSI Indicators and Qualitative Themes

Item	ROSI Indicator	Process Themes
19	Program staff provided information or guidance to get to the services and supports I need, both inside and outside the program.	Program process is seamless – internal and external services are well-coordinated
6	Program staff supports my self-care or wellness.	Program process is wellness-oriented
12 13 15 18	Program staff treats me with respect. Program staff listens carefully to what I say. Program staff does not interfere with my personal relationships. I am treated as a person by program staff.	Program process is consumer-friendly
16	Program staff helps me build on my strengths.	Program process is strengths-based

Research Objective Four

The fourth research objective was concerned with the investigation of the degrees to which the program was successful in achieving its intended outcomes. First, I would like to highlight the observation from the results that - while interviewees reported predominantly positive ratings on all 13 quantitative measures of outcomes - the three items of mental health, amount of relaxation, and amount of fun showed lowest scores of improvement. This observation is consistent with a comment often made by consumers during the interviews that it was difficult to have fun, relaxation, or better mental health when they faced homelessness and unemployment. It must be emphasized that while this program was extremely efficient and successful in facilitating the intended impacts on the program consumers, the existing housing policies and scarcity of employment support for the program population grimly challenge individuals who experience homelessness and mental health issues. Concerted policies and active social interventions that are outside the scope of the current intervention are desperately needed to address the challenges that face the target population.

Another important note that I would also like to highlight is about the outcome measure item that assesses consumer's perception of self-determination. In the quantitative Likert-scaled responses, 75% of the participants indicated positive improvement with their self-determination. Specifically, 15% rated "slightly improved", about one-third "moderately improved", and another one-third "significantly improved". However, a quarter of the participants rated their self-determination as "*maintained,*" which is at the mid-point of the scale, indicating neither deterioration nor improvement - despite the program's distinct emphasis on self-determination. Other items that exhibited comparable high percentages of "maintained" included items that tap the amount of fun and the amount of relaxation – items on which consumers reported difficulties with in their experience due to their homeless and unemployed status. This ties back to a research result revealed by Standcliffe et al. (2000), Wehmeyer (2004), Wehmeyer et al. (1999) and Wehmeyer et al. (2003) that environmental factors, specifically, living and working conditions have a significant negative impact on the self-determination of people who experience developmental issues. It is probable that a substantial portion of the program population, who are living in the streets and the margins of the society's job market, might experience similar impacts that negatively affect their self-determination experience and render them less-responsive to the program's self-determination oriented feature.

Also, the narratives recounted by consumers who reported positive improvements with self-determination confirmed that self-decision-making, while being a deeply personal process, required a highly facilitated and supportive environment that is needed for the consumer's journey toward recovery. Similar to the discussion of program process, interviewees who reported positive self-determination experience acknowledged the importance of the program process being collaborative and involving power-sharing. According to the interviewee's acknowledgements, the staff's persevering support and active mobilization of resources were critical to their self-decision-making, which had significant and positive impacts on their independent living in the community. Again, their experiences further supported the discussions as revealed by Wehmeyer (2004), Wehmeyer et al. (1999), and Wehmeyer et al. (2003) that self-determination is a highly facilitated process.

Also, the consumers' positive experiences of self-determination, and the overall context of the ten outcome themes, support the notions elaborated by Prilleltensky et al. (2001). As discussed in the proposed working model for the current research, Prilleltensky et al. (2001) elaborated that participation and the opportunity to experience meaningful decision-making power in matters affecting well-being define a personal sense of agency, personal control, self-esteem, and self-efficacy, which promotes wellness and resilience. Therefore, it can be inferred by following the proposed working model in Figure 1 that the opportunities, power and control, and material and psychological resources that are facilitated and provided to the program consumers by the psychiatric outreach program greatly enhanced the consumers' personal perceptions and beliefs, competence and self-efficacy, autonomy, empowerment, self-regulation, self-realization, self-determination and participation. Moreover, these qualities promoted wellness and resiliency that are critical to the consumers' journey to recovery as shared by participants in the ten themes concerning program outcomes.

In addition, it is encouraging to see that part of the consumer experiences links to the notion of reciprocal self-determination as suggested by Fox and Prilleltensky (1997) in which the consumers pursued their personal interests in consideration of other people's needs. In particular, one consumer recounted the experience of the determination to refrain from drug selling, pursue educational opportunities, and aim for a new start toward being a more socially responsible person as an outcome experience.

Overall, the majority of interviewees who reported positive ratings in the various outcome items suggested the program's success in delivering the planned outcome to the target population. This program satisfactorily delivered outcomes that supported the results found in previous studies that persons who are homeless and affected by mental health issues often responded well to interventions as reported by Nelson et al. (2007) and McBride et al. (1998). Furthermore, the current program also confirmed the research results revealed by Shern et al. (2003), Tsemberis et al. (2002), and Tsemberis et al. (2003) that a focus on providing services that are consumer-directed and with choices is a critical success factor in delivering interventions to persons who experience homelessness and mental health issues. More importantly, the program highlighted that homelessness and mental health issues in our population can be improved by services that bridge the gaps and barriers between the health care system and other service delivery systems – a program outcome that is consistent with those reported by Bybee et al. (1995) and Lipton et al. (1988). Last but importantly, the program is exemplary in demonstrating an awareness in its operations that self-determination is a personal value that needs to be harmonized with collective values such as social justice, as elaborated by Prilleltensky and Nelson (2002).

Research Objective Five

The fifth objective concerned the linkages between program process measures and outcome measures. One interesting observation is that the consumer-rated outcome total score correlated with the frequency of utilization of the first two program components, but not with the third. A plausible reason for this finding is that the frequency of utilization of the third component of Referral and Accompaniment did not report the actual utilization of the services that the consumers were referred to. In many instances, the consumers were successfully connected with employment, education, housing, or other community activities such as the People in Motion program as a result of their utilization of the Referral and Accompaniment component. The consumers benefited positively from these services at frequencies that were much higher than the utilization frequency of the program component that they indicated in the survey. This observation indicates a potential limitation of the current survey instrument.

The fact that the frequency of utilization of the other two program components was related to consumer-rated outcomes suggests a "dose-response" relationship between the frequency of utilization of program services and outcomes. There are two points that I'd like to make regarding this "dose-response" relationship. First, this finding is consistent with that of previous studies by Rife, First, Green, Miller, and Feichter (1991), and Morse, Calsyn, Allen, and Kenny (1994). Rife et al. (1991) studied case management services for persons who experience homelessness and severe mental health issues and the researchers found that more frequent contacts with consumers was associated positively with consumer outcomes. Similarly, Morse et al. (1994) found that service intensity was a significant mediator of client satisfaction. Second, this apparent "dose-response" relationship links with Dumont et al.'s (2005) and Onken, Craig, Ridgeway, Ralph, and Cook's (2007) conceptual framework that suggests that recovery is a dynamic interaction between the individuals and the environment. Given the recovery-facilitating characteristics of the program environment, a higher outcome total score would be deemed as the natural consequence of a more active participation in the program intervention activities.

Following from such analysis, a limitation in the current research resides in the ambiguity in the Outreach and Counseling component: that the casual and formal counseling was aggregated together in a single component. As this is the most frequently utilized component and relatively critical to the consumers given their daily challenges, it would have been helpful to have the casual and formal counseling differentiated and their dose impacts on outcomes identified.

Lastly, an interesting observation in the process and outcome measure analyses is that the staff-rated outcomes of consumer solely correlated with the consumer-rated outcomes. One may expect the staff-rated outcomes of consumers to be correlated with the consumer frequency of utilization of program components, as did the consumer rated-outcomes. It may require a larger sample size to further determine the correlation relationship between the staff-rated outcomes of consumer and the consumer-reported frequency of utilization of the program components. Nonetheless, the statistically significant correlation between the staff-rated outcomes of consumer and the consumer-rated outcomes at least confirmed the validity of the consumer-rated outcomes reported in the current study.

Suggested Program Improvements by Research Participants

The predominant code in the interviewees' suggestions for improvement regarding the three program components was to have more financial resources that can further support the current program operations. Specifically, most consumers would like to see more consolidated support for consumers to access housing, and education and employment opportunities. Consumers deemed these three types of support as the critical means to exit homelessness and avoid further involvement with the corrections system – confirming the observation reported in the Research Results that most program consumers do aspire to find employment in the job market and be responsible citizens in the society. As well, they would also like to see the hours of service extended and that the service be extended to provide at least brief hours of services on weekends or holidays, which are "edgy" days for people who are living with homelessness.

Another code in the consumers' suggestions for program improvement was related specifically to the Medical Assessment and Treatment component. Many consumers acknowledged the vulnerability to substance and alcohol use during weekends and that they would like to request the clinic operation be extended to provide at least some hours of brief services on weekend or holidays when they could use some medical support. Another request is to have culture-specific treatments such as the circle treatment for consumers who come from aboriginal communities.

Implications

Policy

The results of the current research clearly confirmed that homeless Canadians who experienced mental health issues responded well to a client-centred, resource-and-strengths-based, and target-specific intervention. By the same token, this thesis also revealed the dire lack of affordable housing that is challenging one of the most marginalized groups of society. At the policy level, there are therefore two major implications. First, under the current shortage of mental health housing and general affordable housing, a substantial number of psychiatric consumer/survivors are hopelessly out-competed by the general public in the rental housing market. The inadequate shelter allowance in the current housing market seriously fails to address the financial barrier faced by members of a most vulnerable subgroup of the homeless population in accessing affordable housing of a decent quality - thus leading to chronic housing instability. Researchers such as Hurlburt, Wood, and Hough (1996), Nelson et al. (2007), Rosenheck, Kasprow, Frisman, and Liu-Mares (2003), and Tsemberies, Gulcur, and Nakae (2004) suggested that housing and rent supplements, such as the Section 8 certificate in the US that was designed to assist very low-income households by paying the landlord the difference between 30 percent of the household's adjusted income and the market rent value of the housing unit, is effective in helping people with severe mental illness, and even a chronic history of homelessness, to successfully achieve housing stability. Furthermore, Nelson et al. (2007), Tsemberis et al. (2000), and Tsemberis et al. (2004) also identified that the "Housing First Strategy" (Pathway to Housing, Inc., 2005) - which targets individuals who experience severe mental health issues, drug use, and chronic homelessness by immediately offering them their own housing facilitated through rent supplements, in addition to psychiatric and financial support, succeeds in helping these individuals' to achieve independent living in the community without a priori requirement of a course of rehabilitation. Therefore, a target-specific housing supplement is desperately needed to address the current problem of homelessness under the deinstitutionalized mental health care system in Canada. Second, the current federal housing program and subsidies for all social housing constitutes merely 1% of the federal budget (Hulchanski, 2002), and as elaborated in the literature review, the supply of social housing falls grossly short of meeting the current demand for affordable housing. As suggested by Hulchanski (2002), another 1% of the federal budget is required to increase the supply of social housing and supportive and emergency relief housing, and to refurbish the existing public housing units in order to meet the housing demand among lower income households.

Practice

The results of the current research confirm the importance of the specificity of psychiatric interventions in facilitating mental health recovery among the homeless population. The success of the Psychiatric Outreach Program in reaching the target population and delivering the intended outcomes clearly related to the efforts invested in preliminary community consultation, program planning and design that established a comprehensive program logic model with a clearly defined underpinning philosophy that guides the values and principles of program operations. A critical success factor of the current program is the collaboration with community partners and the implementation of program operations on an existing community network that included the St. John's Kitchen which has a history of 20 years of outreach work in the community that cultivated trust, respect for diversity, and community inclusion and formed the foundation for the current program. Furthermore, the Psychiatric Outreach Program continues to expand collaboration to crucial new partners that include the emergency services of local hospitals, the corrections system, and the local mental health court and has thus formed a growing coordinated network that greatly facilitates consumers' navigation of the local mental health and social service systems. Also, "the approach of using a multi-disciplinary team that gradually evolved allowed different talents to develop according to the complex needs of a population; and that the team operations differentiated under a shared-care model avoided the danger of people working in silos" (N. Arya, personal communication, May 17, 2007) was crucial to the current program's success.

While the current program has succeeded in achieving the intended outcomes, it is seriously lacking the resources to provide sufficient support for consumers to access decent quality housing in the community. A substantial number of consumers interviewed are still relying on shelter programs such as the Out of the Cold to get by. Housing should be one of the major basic needs that are to be provided as the starting-point, rather than the end-point in the process of recovery (Anthony, 1993; Deegan, 1988; Nelson, et al. 2007; Ochocka, Nelson, & Janzen, 2005). Resources are desperately needed to provide support to access housing of a decent quality – as the first step in the intervention - for individuals who experience severe mental heath issues in psychiatric outreach interventions throughout Canadian communities.

Research

There are several implications for future research. First, future research should pay attention to the effectiveness of different types of intervention for different subgroups of the homeless population who experience mental health issues (Nelson et al., 2007), such as those who have issues of substance use. Second, it would be valuable to have comparative studies of different types of interventions (such as the current meal-program-based and self-oriented model, assertive community treatment, or intensive case management) that are combined with various housing supports within a Canadian context. Third, it will be valuable to see the dose-response relationship of different intervention activities compared in future studies. Fourth, it would also be valuable to have more in-depth fidelity assessment to determine if the key components of the intervention program were adequately implemented as well as the ways in which fidelity to the program model relates to outcomes. Finally, it is recommended that longitudinal design be incorporated in future studies to investigate the long-term effectiveness of similar intervention programs.

Theory

The proposed working model – that relates the intrapersonal construct as well as the transactional perspective of self-determination to mental health recovery and that both are nested within a multi-level ecological system – seemed to have worked well in helping me to understand and interpret the data in the current research. However, the proposed model could not clearly account for the notion of reciprocal self-determination and the ways in which it relates to mental health recovery. It would be valuable to see the proposed model used in future studies and to see the ways reciprocal self-determination in relation to mental health recovery could be further developed in the future.

Conclusions

I conducted a process and outcome evaluation of a psychiatric intervention program by means of an interview instrument that enabled me to gather quantitative and qualitative data on program processes and outcomes. The overall results revealed that the consumers were utilizing the program frequently and they were satisfied with the program components. The consumers' descriptive and evaluative experiences showed that the program was perceived as consumer-friendly, supportive, seamlessly-coordinated, wellness-oriented, strengths-based, collaborative and involved power-sharing, and that the staff went above and beyond their regular duties. The results from the ROSI survey indicated that the consumers confirmed that the system was recovery-oriented. The overall results confirmed that the current program had operationalized the principles of recovery in the current program intervention activities.

The quantitative outcome results revealed that the consumers and staff rated positive improvement in the 13 areas of outcome, and the qualitative outcome data gathered from consumers identified several important themes, including: realizing potentiality, healing and wellness, self-determination, managing symptoms, incorporating illness, thriving, becoming more responsible and committed citizens, social connectedness and relationships, more positive day-to-day functioning, and renewing hope and commitment. As further elaborated below, these outcome themes were considered indicative of consumer recovery.

I would like to conclude by first discussing the strengths and limitations of the study. The results of the current study were noteworthy considering the novelty, depth and breadth of the information product that was generated within the context of mental health recovery in a community-based psychiatric outreach intervention. The information will be valuable for program planning activities – especially given the scarcity of research in a comparable context. In particular, the study was able to empirically identify consumer utilization and satisfaction, and explore the various process and outcome factors and qualities that contributed to the program success and that facilitated consumer recovery. In addition, the study was able to establish the context for interpretation of the quantitative data and specify, at least to a certain degree, the comprehensive set of subjective meanings in understanding the experiences of recovery as reported by consumers. However, given the scope of the study, the data collected from the study were primarily retrospective. It is recommended that a longitudinal design coupled with a comparison group be incorporated in future studies to confirm the replicability of the results. As well, the judgment sampling approach used in the current research might have introduced bias that was unnoticed. Staff members may have selected those members most likely to report positive outcomes. The use of a primarily correlational approach in the current study also did not completely reveal the causal relationships that might exist in the various process and outcome analyses. Furthermore, the current study involved a relatively small and perhaps non-representative sample (*n*=32), thus limiting the generalizability of the findings. Finally, the current study aimed at investigating the effectiveness of the program and yet lacked a component of cost-effectiveness analysis to validate the financial sustainability of the program model.

Also, I would also like to conclude with an attempt to frame the overall results of the current study according to the ecological framework of recovery recently proposed by Dumont et al. (2005) and Onken et al. (2007). According to these researchers, recovery is viewed - rather than as process or outcome - as the characteristics of the individuals, the characteristics of the environment, and the characteristics of the interactions between the individuals and the environment. Thus, given the demographic and psychosocial characteristics of the consumers and the characteristics of a recovery-facilitating program process, the current psychiatric outreach intervention program generated the outcomes that are consistent with the characteristics of recovery as revealed in the mental health recovery literature. In many ways, the psychiatric outreach program serves as an exemplary model which has operationalized the principles of recovery and successfully become an indispensable part of the consumers' mental health recovery.

Finally, I would like to conclude by highlighting that while the program that was evaluated is exemplary in reaching out to a hard-to-serve population, utilizing a self-determination and recovery-oriented approach, and achieving positive outcomes, it is important to keep in mind that this program and this evaluation do not address the root causes of homelessness. Following the ecological perspective which was used as the working model for this research, it becomes obvious that the results in this study merely pertain to one of the "micro-systems" within a much larger, macro-level picture of a national housing policy. While the current research did not address the challenges that resulted from the current housing policy, it did provide the empirical evaluation for a modestly funded, community-based psychiatric outreach model that succeeded in creating the environment and resources that greatly facilitated recovery among consumers experiencing homelessness.

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Appendix B - Consent Form

I agree to participate in an interview being conducted by Phillip Chan for the evaluation of the Working Centre's Psychiatric Outreach Program. I have made this decision based on the information provided in the Information Letter. I have the right to request any additional details I want to know about the study. As a participant in this study, I realize that I will be asked to take part in an interview of about an hour to an hour and a half; and I may decline answering any of the questions, if I so choose. I also understand that the interview will be audio-taped in order to facilitate an accurate description of our interview discussion. All information that I provide will be confidential and I will not be identified by name in Phillip Chan's thesis, the Working Centre's psychiatric outreach program evaluation report or any other publications. I understand that I may withdraw this consent at any time by asking that the interview be stopped, and any audio-taped and written information including notes taken by Phillip Chan will be destroyed according to my request. I also understand that this project has been reviewed by and received ethics clearance through the University Research Ethics Board at Wilfrid Laurier University and that I may contact this office if I have any questions or concerns about my participation in this study. I also understand that I may contact Jennifer Main (the Working centre), Dr. Bill Marr (Wilfrid Laurier University), and Dr. Geoffrey Nelson (Wilfrid Laurier University) if any issues arise before or after the interview that I wish to discuss. I consent to have Phillip Chan approach and speak with me at the St. John's Kitchen and to share my experience and opinions about the Psychiatric Outreach Program in an interview to be held in the St. John's Kitchen or the Working Centre.

Participant's name: ________________________________

Participant's signature: _______________________ (Date signed: ______________)

Participant's telephone number: _________________

Date that Phillip Chan can have an interview with me: ________ Time: __________

I agree that Phillip Chan can ask the program staff, nurse, or physician how they feel about the outcomes as they see in me using the same outcome questions that is used in my interview. Yes ___ No ___

I agree to that direct quotes from the audio-tapes or the notes Phillip Chan jotted down during my interview may be used in reports or publications resulting from this research. Any direct quote will be used in a context that I will not be identified by name, characteristics or any other identification information. Yes ___ No ___

I have received $20 from Phillip Chan on _______________ as an honorarium for the interview. ____________________

Appendix C: Interview Guide for Program Consumers

ID# ____Date ______ Location __________________ Time from: ____ Time to ____Name ______________

Preamble

I would like to thank you for your participation in this interview. As you know, this interview is an evaluation of the Working Centre's Psychiatric Outreach Program. First, I will ask you questions about your background so that I can get an understanding of the range of people who are using the program services. I will then ask you questions about your experience with the program. Please feel free to tell me to pass on any questions that you do not wish to answer.

A. Demographic & Background Information

1. What is your age?	**2. Gender**				**3. Were you born in Canada?**					
	M		F		Other		Yes		No	

4. What is your marital status?								
Single		Living with romantic partner		Married		Divorced	Widowed	

5. How would you describe your racial background?									
Aboriginal		White		Black		Asian		Bi-racial	

6. How would you describe your current employment status?						
Part-time		Full-time		Unemployed		Anything about your employment you would like to mention?

If currently not working, what jobs did you have in the past 3 years?	

7. **What are your current sources of income?**									
Social assistance		Disability income		Employment earnings		Contribution from family/friends		Other	

8. How much is your current monthly income?

9. Have you experienced homelessness (for even a day or two) in the past two years?	
Anything in particular about your homeless experience you would like to mention?	

10. How many years of schooling do you have?

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
Primary									Secondary						Post secondary					

11. How would you describe your current housing situation? (e.g. with friends or anything about your housing situation that you would like to let us know)

B. Health, Mental Health and Psychosocial Issues

I am going to read you a list of health and psychosocial problems. For each one, please indicate which, if any, has been a problem for you.

1. ***Any chronic health conditions (e.g. asthma, diabetes, back problems)?*** *Yes___ No ___*

2. ***Mental health issues?*** *Yes___ No ___*

3. ***Alcohol issue?*** *Yes___ No ___*

4. ***Drug use problem?*** *Yes___ No ___*

5. ***Involvement with correction system?*** *Yes___ No ___*

6. ***Any types of disability?*** *Yes___ No ___*

7. ***Other health or psychosocial problems I haven't mentioned?*** *Yes ___ No ___*

(Specify:____)

C. Use of program component categories and your experience with program component categories

1. OUTREACH AND COUNSELING

(initial engagement with a program staff, psychiatric nurse, or the physician, and subsequent counseling sessions by program staff, nurse, social worker, or physician)

a. How often have you used the program's outreach and counseling service components?

Never (0)	**Once or twice so far** (1)	**Occasionally (Roughly once or twice per month)** (2)	**Frequently (Roughly every week)** (3)

If never, proceed to next component category.

b. How satisfied do you feel overall about the outreach service?

Terrible **(1)**	**Unhappy** **(2)**	**Mostly dissatisfied** **(3)**	**Mixed** **(4)**	**Mostly satisfied** **(5)**	**Pleased** **(6)**	**Delighted** **(7)**	**No Response** **(0)**

c. Tell me about your experience with outreach and counseling services.

---

d. What do you think is the most important part of outreach and counseling services for you?

---

e. What suggestions do you have for improving the outreach and counseling services?

C. Use of program components and your experience with program components

2. ASSESSMENT AND TREATMENT

(Assessment by nurse, physician, psychiatrist, or by staff for applications such as ODSP or social housing. Also included are consultation appointments with physician, nurse, medication services etc.)

a. How often have you used the program's assessment and treatment service components?

Never (0)	**Once or twice so far** (1)	**Occasionally (Roughly once or twice per month)** (2)	**Frequently (Roughly every week)** (3)

If never, proceed to next question,

b. How satisfied do you feel overall about the assessment and treatment service?

Terrible **(1)**	**Unhappy** **(2)**	**Mostly dissatisfied** **(3)**	**Mixed** **(4)**	**Mostly satisfied** **(5)**	**Pleased** **(6)**	**Delighted** **(7)**	**No Response** **(0)**

c. Tell me about your experience with assessment and treatment services.

---

d. What do you think is the most important part of assessment and treatment service for you?

---

e. What suggestions do you have for improving the assessment and treatment service?

C. Use of program components and your experience with program components

3. REFERRAL AND ACCOMPANIMENT

(Referral to other social service, connecting or reconnecting with a family physician, and accompaniment to access other social services)

Which services were you connected with?	**Referral**	**Accompaniment**
Other Medical specialists	________	________
family physician	________	________
Mary's Place	________	________
OASIS	________	________
House of Friendship	________	________
The Working Centre	________	________
CSC: Sex Trade Workers	________	________
Mental Health Court	________	________
OSIS (ROOF)	________	________
Canadian Mental Health Association	________	________
Kitchener Downtown Community Health Centre	________	________
Kitchener Downtown Collaborative Outreach Worker	________	________
Waterloo Regional Homes for Mental Health	________	________
Waterloo Region Assertive Community Treatment Team	________	________
Grand River Hospital	________	________

Other, specify: ____

a. How often have you used the program's referral and accompaniment service components?

Never (0)	**Once or twice so far** (1)	**Occasionally (Roughly once or twice per month)** (2)	**Frequently (Roughly every week)** (3)

b. How satisfied do you feel overall about the referral and accompaniment service?

Terrible (1)	**Unhappy (2)**	**Mostly dissatisfied (3)**	**Mixed (4)**	**Mostly satisfied (5)**	**Pleased (6)**	**Delighted (7)**	**No Response (0)**

c. Tell me about your experience with referral and accompaniment service.

d. What do you think is the most important part of referral and accompaniment service for you?

e. What suggestions do you have for improving the referral and accompaniment service?

D. Recovery Oriented System Indicators Survey

		Strongly disagree (1)	**Disagree (2)**	**Mixed (3)**	**Agree (4)**	**Strongly agree (5)**	**Does not apply**
1	Program staff understands my experience as a person with situational (such as anxiety) or other psychiatric needs						
2	Program staff cares about my physical health.						
3	Program staff respects me as a whole person.						
		Never/ Rarely (1)	**Sometimes (2)**	**Often (3)**	**Almost always (4)**	**Always (5)**	**Does not apply**
4	Program staff sees me as an equal partner in my treatment						
5	I have a say in what happens to me when I am in crisis						
6	Program staff supports my self-care or wellness						
7	Program staff believes that I can grow, change and recover						
8	Program staff **does not** use pressure, threats, or force in my treatment						
9	Program staff gives me complete information in words I understand before I consent to treatment or medication						
10	Program staff encourages me to do things that are meaningful to me						
11	Program staff stands up for me to get the services and resources I needed						
12	Program staff treats me with respect						
13	Program staff listens carefully to what I say						
14	Program staff has knowledge on the most effective treatments						
15	Program staff **does not** interfere with my personal relationships						
16	Program staff helps me build on my strengths						
17	My right to refuse treatment is respected by program staff						
18	I am treated as a person by program staff						
19	Program staff provides me with information or guidance to get to the services and supports I need, both inside and outside the program						

E. Outcome evaluation

	Comparing to how you felt before using the program service	**Significantly worse (1)**	**Moderately worse (2)**	**Slightly worse (3)**	**Unchanged (4)**	**Slightly improved (5)**	**Moderately improved (6)**	**Significantly improved (7)**
1	How do you feel about your access to resources that meet basic needs (such as housing, food, clothes) now?							
2	How do you feel about the level of trust you now have with people around you?							
3	How do you feel about your connection to social services now?							
4	How would you describe the number of crises you experience now?							
5	How do you feel about how safe you are now?							
6	How do you feel about your health in general now?							
7	How do you feel about your mental health in general now?							
8	How do you feel about your personal capacity to deal with problems now?							
9	How do you feel about your emotional well-being now?							
10	How do you feel about the amount of fun you have now?							
11	How do you feel about the amount of relaxation in your life now compared to before?							
12	How would you describe your experience of self-determination in your daily life now?							
13	How do you feel about your life as a whole?							
14	How have you changed since you started participating in the program?							
15	How has your life changed since you started participating in the program?							

Appendix D – Consumer Recovery Evaluation - by Program Staff

This evaluation is about ____________________________ who has completed an interview. Please indicate your opinions according to the questions regarding his/her recovery below.

Comparing to *before* using the program services,

		Significantly worse (1)	**Moderately worse (2)**	**Slightly worse (3)**	**Unchanged (4)**	**Slightly improved (5)**	**Moderately improved (6)**	**Significantly improved (7)**
1	How would you describe the consumer's access to resources that meet basic needs (such as housing, food, clothes) now?							
2	How would you describe the consumer's level of trust with people around her/him now?							
3	How would describe the consumer's connection to mainstream services now?							
4	How would you describe the consumer's number of crises s/he experiences now?							
5	How would you describe the consumer's feeling of safety now?							
6	How would you describe the consumer's health in general now?							
7	How would you describe the consumer's mental health in general now?							
8	How would you describe the consumer's emotional well-being now?							
9	How would you describe the amount of fun the consumer has now?							
10	How would you describe amount of relaxation the consumer has now?							
11	How would you describe the consumer's personal capacity to deal with problems now?							
12	How would you describe the consumer's experience of self-determination in her/his daily life now?							
13	How would you describe the consumer's life as a whole?							
14	How would you describe how has the consumer changed since s/he started participating in the program?							
15	How would you describe how has the consumer's life changed since s/he started participating in the program?							