

**Program Evaluation of
Crisis Management Service**

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ABSTRACT

Throughout the last three decades there has been a shift in the provision of crisis services from the hospital to the community (Joy, Adams, & Rice, 2007). Further, the needs of individuals experiencing crises differ, making it essential that these community organizations are able to adapt to each client that they serve (Krupa, Stuart, Mathany, Smart, & Chen, 2010). Program evaluations are one way to determine if, and how, best services are being provided.

Using a utilization-focused (Patton, 1997) process evaluation (Stufflebeam & Shinkfield, 2007) framework, the purpose of this study was to explore client perspectives on the services that they are receiving from Crisis Management Service (CMS). Semi-structured interviews were conducted with 14 participants based on questions generated with CMS staff support. Using the general inductive approach (Thomas, 2006), transcripts were analyzed and eight dimensions emerged.

The results illustrate client experiences with CMS, client perspectives on the care that they are receiving from CMS, and the benefits they are receiving from being involved with CMS. However, the findings also indicate, that participants would like to change some elements of the program (e.g., having more constant support and having more finances).

This study provides valuable insight on clients' perspectives, particularly that of vulnerable clients in crisis situations, an area that is not extensively researched. This research may also benefit individuals in helping professions as it highlights the effects of working from a strength-based model with at-risk individuals, and the need to engage clients in their move to a healthier lifestyle.

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CHAPTER ONE

INTRODUCTION

Significance

Experiencing crises are a normal part of our existence; everyone feels distressed and troubled at some point in their life (France, 2002). Unfortunately, the experience of social, psychological, and health concerns have increased drastically in recent times (Roberts, 2005) and all of these stressors can create feelings of affliction. Further, although two individuals may experience many of these same pressures, this does guarantee that they will both experience a state of crisis (Roberts, 2005).

Crisis theory postulates that how an individual perceives a situation, and his/her ability to use his/her coping skills to resolve the concern, determines if the situation will develop into a crisis or not (France, 2002; Roberts, 2005). The perception of a situation being a crisis is influenced by, both, an individual's personality characteristics and the features of the situation (France, 2002); therefore, it is a unique experience. When a person's coping skills are inadequate to handle the situation, they experience emotional anguish. Depending on how the crisis response progresses, a person can either grow and change or they can become more vulnerable than they were previous to the crisis (France, 2002). In order to most effectively help individuals experiencing a crisis, support should occur immediately after the person starts to experience the crisis state (France, 2002; Rapoport, 1962). This tenant of crisis theory speaks to the need for effective crisis intervention techniques so that individuals can grow from their experiences rather than become more vulnerable.

The purpose of crisis intervention is to assist the person experiencing a crisis to strengthen their existing coping mechanisms and to develop an action plan, which often involves learning new coping skills. Additionally, crisis interventions exist to promote individual strengths, protective factors, and resilience (Roberts, 2005). The philosophy of crisis intervention proposes that, in order for individuals to resolve their crises, five components must be met. These components affirm that: (1) the individual experiencing the crisis should re-balance at their previous state or at an improved state of coping, (2) the intervention should be initiated immediately, (3) the client is capable, (4) the intervention focuses on the problem in its primary phases, and (5) the client is involved in the problem-solving process (France, 2002). In order to accomplish an effective crisis intervention, these philosophical components can be applied

through Roberts' (2005) seven fluid stages of crisis intervention: plan and conduct a crisis assessment, establish rapport, identify major problems, deal with feelings and emotions, generate and explore alternatives, develop an action plan, and establish a follow-up plan. After these stages are worked through, the feelings associated with being in a crisis should be alleviated and the person who experienced the state of crisis should be able to proceed more independently.

Over the past 30 years mental health care for crisis intervention has changed from being performed in the hospital to being implemented in the community (Joy, Adams, & Rice, 2007). This shift in focus highlights a basic need of organizations dealing with crisis situations to be able to change and adapt to the experiences of their vulnerable clientele (Krupa, Stuart, Mathany, Smart, & Chen, 2010). It is through program evaluations that programs can be improved (Fitzpatrick, Sanders, & Worthen, 2011) and can remain accountable, not only to their direct clientele, but also to society in general. Evaluations that ask clients for their input on the strengths and weakness of a program is one way to determine the various activities that are being, or that could be, implemented. A process evaluation (Stufflebeam & Shinkfield, 2007) framework meets these criteria.

Crisis Management Service (CMS) is a program that deals with individuals who experience different crises every day. Many of the clientele that CMS serves have mental illnesses, which are often misdiagnosed or undiagnosed. Furthermore, they may have some other hardships that affect them in their daily lives, in their ability to function in society, and in their ability to lead productive lives. Unfortunately, diagnosed mental illnesses affect one in five individuals (Conway, 2003) and according to the World Health Organization (WHO; 2010), "persistent socio-economic pressures are recognized risks to mental health for individuals and communities" (Determinants of mental health, para. 1). These pressures can include poverty, cognitive or intellectual disabilities, being stigmatized by one's community, and alcohol or drug addictions, to name a few. The clients that are seen by CMS are individuals that have been described by these very characteristics (Saskatoon Crisis Intervention Service, 2012).

Even in today's society, mental illness is stigmatized. Barney, Griffiths, Jorm, and Christensen (2006) state that the stigma associated with mental illness is one of the main reasons why people do not seek treatment. Individuals who suffer with mental illness often rely on organizations such as CMS to help them navigate the community in which they live. Given that CMS is an organization that seeks to help many people who suffer with mental illnesses, or other

factors that stigmatize them in society, CMS is a needed program. According to CMS, it is therefore essential that the services it provides are effective in attaining their goal of helping each client live at his/her optimal level of independence while utilizing community supports appropriately. It is with this in mind that a program evaluation of CMS was conducted to ensure the best care of its clientele was being achieved.

The Saskatoon Crisis Intervention Service (SCIS) contracted the Community-University Institute for Social Research (CUISR) to conduct a program evaluation of its CMS department. Based on CUISR's mandate, partnering with them will help to bridge the gap between scholarly research and its applicability and utility to society.

Purpose

CMS is a part of the SCIS along with Mobile Crisis. CMS deals with clientele who are "hard to serve, and difficult to engage" (SCIS, 2012, Crisis Management Service, para. 1). Many of the CMS clientele have mental illnesses, legal issues, addictions, Fetal Alcohol Spectrum Disorder, and Acquired Brain Injury, among other obstacles. The activities that CMS workers (CMWs) are engaged in include helping in the coordination of services for their clients as well as managing the cases of their clients (SCIS, 2012). Through this client involvement and management, the CMWs work from a strength-based approach. Although the strength-based approach focuses on a person's positive potential, it does not overlook his/her vulnerabilities. This approach asserts that recognizing a client's strengths and working with those strengths to reduce the client's vulnerabilities will help the client live a healthier lifestyle (Maton et al., 2004). Therefore, when CMWs assess their clients on the 10 'work areas' of: family, mental health, medical status, substance use, legal, housing, financial, self-care skills, education/employment, and social/recreational, they are looking for the individual's strengths and vulnerabilities. It is through this assessment that CMWs help their clients determine main areas to focus on while in programming, while always working toward the final goal of helping CMS clients live at their optimal level of independence while utilizing community supports appropriately. As CMS hopes to improve the lives of its clients, the organization that CMS contracted to perform their program evaluation, CUISR, also hopes to ameliorate the circumstances of individuals in the community through research.

CUISR is a partnership between community organizations in Saskatoon, Saskatchewan and students and faculty members at the University of Saskatchewan. CUISR seeks to bridge the

gap between university research and utility in the community to improve the quality of life of the individuals within that community. CUISR has been involved in a number of research initiatives throughout the city of Saskatoon in an attempt to build “healthy and sustainable communities” (CUISR, n.d., Building healthy, sustainable communities, para. 1).

Given the role that each of these organizations play, the purpose of the current research is fourfold. First, it helps to bridge the gap between university research and community benefits. Second, it can aid in the improvement of the accountability of the services that CMS provides to its clientele. Third, it gives the clients of CMS a voice in the improvement of the services they receive. Finally, it adds to the research literature regarding the strengths and weakness of crisis management programs.

Target Audience

CMS programming targets individuals who are “hard to serve and difficult to engage” (SCIS, 2012, Crisis Management Service, para. 1). These clients have a history of being underdiagnosed or misdiagnosed in terms of mental illness. Furthermore, lack of proper diagnosis is often coupled with a history of addictions, cognitive and behavioural impairments, legal involvement, poverty, physical illness, and social isolation. The clients can be referred to CMS by a number of avenues. Some refer themselves, while others are referred through their families, a mental health worker, medical practitioners, legal professionals, or through a crisis worker. Based on these referrals, CMWs collaboratively assess, with their clients, 10 ‘work areas’. It is through this assessment that CMWs determine where to focus their resources. Although there is the need to support these individuals, there is an attempt to teach clients how to care for themselves by using their strengths. CMS and the CMWs always strive to have their clients live at their optimal level of independence using community resources appropriately.

Evaluation Framework

Through meetings held between CMS and CUISR, a research agreement and work plan was negotiated. Concerning this program evaluation, it was through the work plan that the needs and wants of the CMS staff were made known. It was made clear that the focus of the evaluation would be on the strengths and weakness of CMS as per the point of view of the CMS clientele. Based on these meetings, the goals for the program evaluation, and the fit between the direction of the program evaluation and the desires of the CMS staff, a process evaluation (Stufflebeam & Shinkfield, 2007) using a utilization focused model (Patton, 1997) was chosen as the framework.

The intent of a process evaluation is to gain participants' perspectives of a program's weaknesses and strengths (Patton, 1997). It is through these perspectives that program improvements can be made (Patton, 1997; Stufflebeam, 2000b). Furthermore, employing the process evaluation model within a utilization framework provides greater assurance that the results of the research will be applied since various stakeholders will be engaged in many steps of the evaluation process.

Research Questions

Based on a meeting held between the researcher and the CMS staff, three research questions were developed:

1. What are the clients' experiences with CMS?
2. To what extent are the outcomes of CMS consistent with the services that its clients receive?
3. To what extent is the process of client engagement with CMS contributing to the desired outputs of CMS?

The above research questions were developed based on the current literature on crisis intervention programs (e.g., Joy, Adams, & Rice, 2007; Vingilis et al., 2007), crisis management programs (e.g., Simpson & House, 2002; Tierney & Kane, 2011), and the strength-based approach (e.g., Maton et al., 2004; Smith, 2006) which is central to CMS programming. Further, the principles of the process model for evaluation were a guiding factor in forming these research questions. Process evaluations are focused on client engagement and how the execution of activities contribute to outcomes rather than if outcomes are actually achieved (Stufflebeam, 2013). The above research questions mirror those characteristics.

Methods

A process evaluation (Stufflebeam & Shinkfield, 2007) within a utilization-focused framework (Patton, 1997) was used to conduct the current study. The CMS staff supplied their active and assessment clients with letters of potential involvement outlining that they may be contacted to be part of a program evaluation of CMS. CMS then supplied the researcher with a list of active and assessment clients to be potential participants. Although convenience sampling was used to select the participants, special attention was given to selecting an equal number of female and male clients of diverse ages. This was done to ensure that varied experiences and perspectives were acquired. Participant recruitment continued until no new raw data themes emerged after the 14 CMS clients were interviewed. One meeting time was set up with each

participant, individually, to meet the researcher and to participate in the semi-structured interview. Due to the nature of the participants, many of whom have no permanent address or telephone, a second interview was not scheduled with the participants. All interviews were conducted at the Canadian Mental Health Association in Saskatoon, SK, and each took approximately 45 minutes to complete. Prior to the commencement of the interviews, clients were explained the concept of consent and signed a form to document the same. At the end of the interview, participants were given an honorarium and were asked if they wanted to meet at a later date to review their transcript. All semi-structured interviews were conducted using questions generated through a meeting involving the CMS staff and the researchers, as well as through a literature review. Participant interviews were recorded for ease of transcription. The transcripts from the interviews were analyzed using a general inductive approach (Thomas, 2006) to determine program strengths, weakness, possible avenues for growth, and client satisfaction.

Role of the Researcher

In order for the reader to gain a clear understanding of how the researcher became involved in conducting a program evaluation of CMS, a summary of the researcher's involvement with CUISR will be explored.

In the summer of 2011 the researcher was contacted by the Strategic Research Coordinator of CUISR and was asked to conduct a program evaluation of CMS. Based on meetings with the researcher and her thesis supervisor, it was decided that this program evaluation would also form the basis for the researcher's thesis. A second student researcher was also added to the research team. The role of this second researcher was to help with the formation of the interview guide, to be present at all client interviews, and to help to control for the subjectivity of the primary researcher. This was done by ensuring that both researchers agreed on the dimensions formed and the quotes which show the essence of each dimension. The role of the primary researcher was to form the research questions and the interview guide, to be present for each interview with participants, to transcribe and analyze the data, and to form conclusions based on the results. Prior to this program evaluation neither of the researchers had any affiliation with CUISR or with CMS.

Definitions

Active clients: CMS defines active clients as those who are experiencing the most direct services from the CMS staff and organization. This is the fourth stage in the possible five stages of a CMS client. Before becoming an active client the client is an assessment client.

Assessment clients: CMS defines assessment clients as those who have just left the 'alert status' and whom have been determined to need further care. These clients are assessed based on 10 'work areas' and recommendations may be made to move the client to active status. The assessment stage is designed to fill in the gaps in the picture of the client's life and develop a working relationship between CMS staff and the client.

Circle of care: Circle of care in this research is defined as individuals who are part of the treatment and care of a person and the various activities they engage in. Therefore, it covers professionals and health care providers (Government of Canada, 2013) as well as informal supports such as a client's family.

Crisis: Crisis in this research can be defined as a state of instability due to one's perception of an event or situation. A crisis develops when the event or situation cannot be resolved by the individual through the coping mechanisms that he/she has. A crisis is often a defining moment for the person experiencing the crisis (Roberts, 2005).

Program evaluation: Program evaluation in this research can be defined as the exploration and investigation of a program's characteristics, worth, and merit (Fink, 2005; Stufflebeam, 2001). In this research, the participants' views of CMS' strengths and weaknesses will form the basis of the program evaluation.

Stakeholders: Stakeholders include any individual or agency that has an investment in the program that is being evaluated or in the results of the program evaluation (Fitzpatrick, Sanders, Worthen, 2011). In this study, this includes other agencies that provide services to CMS clients, agencies who deal with crisis management work, individuals in the community, CMS, SCIS, and the CMS clients themselves.

CHAPTER TWO

LITERATURE REVIEW

This chapter begins with a review of the literature on crisis theory and crisis interventions. Additionally, the strength-based approach to helping clients will be considered as it relates to crisis intervention. A review of the current research on crisis intervention and management programs will be undertaken. Finally, the role of Crisis Management Service (CMS) will be reviewed as well as how the program aligns with the available literature on crisis intervention and management.

Crisis Theory

The origins of crisis theory have a relatively short history, with a foundation that can be traced back to the 1940's and 1950's. The creation of crisis theory is credited to a research study that gathered information from psychiatric patients who were grieving the loss of a close relative (France, 2002; Roberts, 2005). Through this research, Lindemann (1944) explored grief and created an intervention plan for people who were going through the grieving process. Caplan (1951, as cited in France, 2002), who in the 1950's did work with immigrant families from Israel after World War II, is also recognized for the theoretical underpinnings of crisis theory (France, 2002; Roberts, 2005). Caplan's work is often seen as an extension of Lindemann's; however, Caplan was the first to outline the states of crisis (Roberts, 2005).

Crisis theory proposes that events perceived as crises can occur throughout a person's life, are a result of a threat to one's goals, can disrupt the homeostatic balance of a person's life, and, if not resolved, can cause instability. Moreover, this disruption in balance results from an individual's usual coping mechanisms not being appropriate or sufficient to resolve the crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). If the crisis is resolved in a timely manner, the individual can grow and become stronger, however, if it is not resolved, increased vulnerability may be the outcome (France, 2002). France (2002) also postulates that everyone can experience crises and that they are personal. That is, the experience of a crisis not only depends on that individual's coping mechanisms (France, 2002; Roberts, 2005), but also his/her personality traits (France, 2002), and his/her perception of the situation (Roberts, 2005). Essentially, even though two people may experience the same or similar circumstances and situations, it may only result in the experience of a crisis for one of those individuals (Roberts, 2005).

Caplan (1964, as cited in Roberts, 2005) describes four stages that a person enters after experiencing a crisis. First, the individual feels increased emotional strain because of the situation. Second, due to the individual's inability to solve the crisis, the distress rises and routine activities become disrupted. At the third stage, the person may feel so strained that they become depressed. Finally, the person may experience a breakdown or they may partly overcome the crisis through new coping techniques. Many of Caplan's crisis reaction components can also be found in France's (2002) stages of crisis. Unlike Caplan (1964, as cited in Roberts, 2005), however, France (2002) states there are three stages of crisis: (1) impact, (2) coping, and (3) withdrawal. At the impact stage, the individual reacts to the perceived problem that cannot be dealt with. The second stage, coping, is when the individual attempts to dissipate the apparent crisis through different coping techniques that the individual may have used in the past (e.g., ignoring the situation, self-medicating). If the crisis is not dealt with within these first two stages, the individual enters stage three, withdrawal. At this stage, the individual essentially shuts down and stops attempting to deal with the crisis he/she is facing (France, 2002).

In order to avert a state of withdrawal or increased vulnerability, there often needs to be some sort of involvement from other individuals (i.e., an intervention). One way to support those experiencing a crisis is to employ effective crisis intervention techniques. Below is a description of some of these interventions.

Crisis Interventions

The term *crisis* can be traced back to the Greek word *krisis* which means a 'decision making point' (France, 2002); further, the Chinese translation for the word *crisis* results in two symbols, one meaning *danger*, and the other meaning *opportunity* (Greene, Lee, Trask, & Rheinscheld, 2005). Knowing this, one can extrapolate that a crisis can be seen as a time to make a choice that could result in greater vulnerability or greater strength. It is often through crisis interventions that individuals can grow from their experiences rather than surrender to the state of crisis. Like crisis theory's short history, crisis interventions are still in their infancy. In fact, there was no shift to help people who were experiencing crises until 1906 when a New York prevention center was opened entitled the National Save-a-Life League (Roberts, 2005). The Save-a-Life League was essentially the first large scale crisis intervention center of its kind.

Despite the fact that crisis theory originated from two pieces of research which focused on people experiencing loss (Caplan, 1964, as cited in Roberts, 2005; Lindemann, 1944), crises

can be caused by many factors. Unfortunately, violent crimes, stressors, mental illness, natural disasters, and transitional stressors have increased in recent years, and all of these factors can induce a crisis situation (Roberts, 2005), which may require intervention.

The goal of effective crisis intervention is to stabilize the disequilibrium that was created from the perception of being in the crisis state and to ensure that the individual does not become stabilized at a more vulnerable state than they were prior to the crisis situation (Greene, 2005). This can be done by strengthening the coping skills the individual already possesses, by increasing the amount of coping skills the individual has access to, and by making an action plan to overcome the individual's distressing feelings and thoughts toward the situation (Roberts, 2005). By allowing individuals agency in developing their own coping skills that are meaningful to them, the individuals will be more able to resolve crises on his/her own in the future (Greene, 2005; Roberts, 2005).

In order to meet the goals of crisis intervention, France (2002) outlines five components of the philosophy of crisis intervention: restoration or improvement of coping, immediacy, client competency, secondary prevention, and problem solving. Restoration or improvement of coping is the term given to the act of helping the client deal with the crisis situation. The hope here is that, through this experience, they learn the coping skills necessary for future crises and, at a minimum, will be no worse off than they were prior to the crisis. The second component, immediacy, speaks to the notion that people are more open to receiving help when they are still in a crisis situation or when they are still experiencing anxiety (France, 2002; Rapoport, 1962). Within this context, crisis intervention should be provided while the person is still trying to cope with the crisis situation to ensure maximum benefit and to ensure that maladaptive coping skills (e.g., substance use, withdrawal) are not being employed. According to France (2002), the third component is client competency. Client competency involves advocating for and allowing the client to help him/herself as much as possible. Helping clients to be a main actor in their crisis resolution serves to empower the client and helps them realize that he/she has strengths. The fourth component is secondary prevention (France, 2002). Secondary prevention involves working with a client through his/her current crisis or problem in hopes that the crisis is shorter or less severe in its effects. This stage differs from preventative crisis aversion (primary prevention) and helping with the enduring effects of a crisis (tertiary prevention) because it is employed while the individual is still attempting to cope with the crisis his/herself. Finally, the

fifth component is problem solving. By having the client actively engaged in the problem solving process and the generation of possible solutions, it gives the client a sense of agency and helps the client feel empowered.

France's (2002) philosophy of crisis intervention can be interwoven into Roberts' (1991) seven stages of crisis intervention. Roberts' (1991) seven components include: plan and conduct a crisis assessment, establish rapport, identify major problems, deal with feelings and emotions, generate and explore alternatives, develop an action plan, and establish a follow-up plan. The first component, plan and conduct a crisis assessment, helps to determine if the individual seeking assistance is in any danger, either from external forces (e.g., another individual) or from themselves (e.g., at risk for death by suicide). If there is impending danger, emergency medical personnel or the police must be contacted. Throughout this stage, the crisis intervention worker is also collecting information (e.g., if there are any children present and in danger, if they need medical attention, and if the individual is under the influence of any substance(s)). Although the second component, establishing rapport, commences during the initial assessment, this stage is concerned with displaying respect, acceptance, and support to the individual. Third, during the identifying the major problems stage, the crisis intervention worker explores what directly preceded the individual seeking help and the coping techniques already used. The fourth component, dealing with feelings and emotions, allows the person to explore their crisis while being listened to in an empathetic way. Through this stage, the individual can feel more heard and understood, and in turn, supported. Fifth, the generate and explore alternatives stage, allows for a deeper exploration of the coping techniques that the individual attempts to use when in a crisis. This exploration includes both maladaptive and adaptive coping methods. According to Roberts (1991), it is at this stage where the client's strengths should be explored, new coping methods should be introduced, and alternative courses of action should be investigated. The sixth component involves creating an action plan not only to resolve the current crisis situation, but also to avert similar crisis situations in the future. Finally, through the seventh stage, establishing a follow-up plan, the crisis intervention worker ensures that the client knows that they will be present to support the client in the future should the need arise to come back for additional help (Roberts, 1991).

It is important to note that these seven components are not worked through in one session with a client. Further, some clients may work through some of the stages and then decide to

terminate the crisis intervention work (Roberts, 2005) and, in doing so, prevent effective crisis resolution. However, if all seven components are explored with a client experiencing a crisis, that individual should experience a state of greater equilibrium with more skills and support than he/she previously had.

Crisis Management Models

Although crisis intervention is applicable to crisis management programs, they differ in that the latter are generally more long-term (Roberts, 2005) and are for individuals who are vulnerable to experiencing many pervasive crises. While components of crisis intervention can be found in crisis management programs, the literature describes six different crisis management models (Bond, Drake, Mueser, & Latimer, 2001; Mueser, Bond, Drake, & Resnic, 1998).

The first crisis management model is the broker or expanded broker model (Bond et al., 2001; Mueser et al., 1998). Within this model, the function of the case manager is to assess the client and then connect that client with the services that they deem necessary, while monitoring those same services. This model was one of the first attempts to help individuals navigate their way in the community after the deinstitutionalization movement occurred. Even though the case managers are assessing their clients, unfortunately, they do not provide any clinical services to clients. Their role is primarily to be a liaison between various services and the client.

A second type of crisis management is the clinical case management model (Mueser et al., 1998). This model was developed in response to the broker model as case workers were often working as their clients' clinicians. According to Kanter (1989, as cited in Mueser et al., 1998), there are four areas in which clinical case managers are involved: assessment, environmental interventions (e.g., connections to community organizations), client interventions (e.g., teaching living skills), and client-environment interventions (e.g., crisis intervention). The main difference between the clinical case management model and the broker model is that, in the former, the case managers are able and encouraged to provide the client with psychotherapy and psycho-education.

The third model is the assertive community treatment (ACT) model (Bond et al., 2001; Mueser et al., 1998). The ACT model is a team effort and was originally developed for high-service users and those with severe psychiatric illnesses (Mueser et al., 1998). There are often many professionals involved in treatment including a psychiatrist, a nurse, and case managers. Six characteristics set the ACT model apart from the models described above: there is a low

staff-client ratio, the majority of the services are implemented within the client's community, caseloads are shared with different case managers, there is 24 hour coverage, most the services are provided by the ACT team, and support is not restrained by any time limits (Bond et al., 2001; Mueser et al., 1998). Further, it is reported that ACT programs help to increase client choice (Bond et al., 2001). These characteristics are in place to help the client learn daily living skills to use in the community, while still being actively supported by their case manager (Mueser et al., 1998).

The fourth model is the intensive case management (ICM) model, which was originally established for high service users (Bond et al., 2001; Mueser et al., 1998). As with the ACT model, there is a low staff-client ratio, there is outreach for the clients in their environment, and there are chances for clients to learn about daily life-skills. The main difference between the ACT model and the ICM model is that there is not usually caseload sharing in the ICM model.

The fifth model is the strengths model (Mueser et al., 1998). This model was developed because of the tendency of other models to focus on a client's limitations and vulnerabilities rather than their strengths. In this model the interventions are based on the client's own aspirations and there is a drive to utilize the resources in the community to help the client learn and make changes.

The sixth and final model is the rehabilitation model (Mueser et al., 1998). As in the strengths model, the rehabilitation model's goal is to help the client strive to reach their own endeavours rather than goals that are set out by society. A distinctive element of this model is the importance placed on helping clients with the skills necessary for them to be integrated and connected to their community.

With these six models in mind, Bond et al. (2001) and Mueser et al. (1998) report that there is some evidence that clients who are engaged with crisis management services that follow the ACT or ICM models tend to have higher client satisfaction. Although different programs modify the ACT model to fit their clients' needs, it is further reported that there are generally better outcomes (e.g., lower hospital admissions, increased quality of life, and increased social adjustment) for the clients in programs that generally follow the ACT model (Bond et al., 2001; Mueser et al., 1998; Simpson & House, 2002).

As evident in the models above, crisis intervention and management models have the potential to bolster and enhance a client's strengths, resilience, and coping skills (Greene et al.,

2005; Roberts, 2005). Further, Greene et al. (2005) reported that, in order for crisis intervention and management programs to be successful, a client's strengths must be emphasized as well as developed to a further extent. The strength-based approach to working with clients is particularly suited to meet these requirements.

Strength-Based Approach

The strength-based approach is a relatively new method of working with individuals and is in stark contrast to the traditional deficit-based models. The, once highly dominant, deficit-based model was concerned with 'fixing' individuals who did not fit society's ideals. Moreover, there was a drive to diagnose, punish, or ignore those who were vulnerable. Unfortunately, this model can lead to individuals being stigmatized and shunned from their community (Maton et al., 2004). With the introduction of positive psychology (Seligman & Csikszentmihalyi, 2000) and resilience theory (Luthar, Cicchetti, & Becker, 2000; Roberts, 2005; Walsh, 2006), the strength-based approach is now much more common and recognized among helping professionals. Maton et al. (2004) and Smith (2006) state that the strength-based approach is based on the positive capabilities of individuals, and that an individual's strengths and assets are the primary focus of any intervention.

Accordingly, Smith (2006) states that strengths can be found in various parts of an individual's life (e.g., cognitive, emotional, physical, and cultural). Further, they can include the belief in one's abilities, coping skills, aptitude, and perseverance (Maton et al., 2004). In order to find an individual's various strengths, one must look at a client's qualities, the unique aspects of the client, how the client has been able to adapt in the past, what resources are available to support the client, and how the client interacts with the environment surrounding them (Smith, 2006). Additionally, Maton et al. (2004) goes on to state that, for communities, these strengths include the opportunity to make satisfying and significant relationships and to create a sense of openness rather than judgment.

Within the strength-based approach to working with clients is the idea that clients are resilient (Roberts, 2005). Resilience has been described as an individual's ability to endure adversity and, further, to be able to adapt and change to counteract these detrimental situations (Luthar et al., 2000; Walsh, 2006). In order for individuals to be able to adapt despite distress and hardships, they must have coping skills and some form of support (Saleebey, 2002). According to Saleebey (2002), however, it is often the case that clients seeking help are either

not accessing these skills, are under-accessing these skills, or are unaware that they possess them. It is, therefore, the obligation of the clinician to bring out these latent abilities (Saleebey, 2002). The capability of building new strengths through the assistance of another can also function as a protective factor in stressful situations (Maton et al., 2004). In this sense, a clinician is a driving force in his/her client's tendency to realize, use, and create his/her own resources to attain individual goals. When clients are able to see that they have capabilities, their confidence, ambition, and feelings of agency often increase.

Crisis theory postulates that a crisis partially results from an individual not having strong enough or appropriate coping skills to resolve the crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962) and there is a large focus on a client's vulnerability. However, it also postulates that depending on how the crisis is resolved, an individual can grow and become stronger (France, 2002). Therefore, although there are elements of the strength-based model in crisis theory, it is mostly dominated by the previous deficit-based approach. Although based on crisis theory, crisis interventions, on the other hand, are much more focused on positives (e.g., client competency, helping clients develop their own skills, and client's strengths; France, 2002, Greene et al., 2005; Roberts, 1991). Further, Mueser et al. (1998) state that the strengths approach, in terms of a crisis case management model, takes into account the client's goals, strengths, and desires when attempting to connect the client with community resources. It is important to note, however, that working from the strength-based approach does not mean that a person's vulnerabilities or problems are ignored. Rather, it means that individuals are recognized by their strengths and that these strengths are integral to increasing his/her resilience and reducing vulnerabilities (Maton et al., 2004).

Many crisis intervention and management programs that employ the various models discussed above (e.g., crisis intervention models, crisis management models, and strength-based approaches to crisis intervention) have been researched and tested. Further, various strengths and weaknesses of these programs have been reported. These program evaluations will be subsequently discussed.

Crisis Intervention and Management Research

Often, any given program's value or worth can be equated with its effectiveness (Fink, 2005). It is therefore, important to not only understand staff's perceptions of a program's value, but clients' appraisals as well. The following is a review of program evaluation research conducted on crisis intervention and management programs.

Crisis Intervention Programs

Effective crisis interventions can help individuals to prosper despite a crisis situation rather than to become more vulnerable (France, 2002). France (2002) reported on several research studies that used client surveys to measure satisfaction with the crisis intervention services that they had received. Although most of these studies focused on client satisfaction, rather than what elements of the program they felt were useful, a few reported on elements of crisis intervention programs that were perceived as valuable by clients. In one study conducted by Donovan, Bennett, and McElroy (1979, as cited in France, 2002), a group format was used for crisis intervention. All participants in this study were experiencing a crisis because of trouble with personal relationships. After the group was terminated, participants had less anxious feelings and felt that the group had helped them to resolve their crisis. A year after the group, participants were contacted again. Based on their recollections of the program, the mutual support that the group format provided, the ability to share their feelings, and being with others who were experiencing similar circumstances were the most frequently cited helpful elements of the group. Another characteristic that clients of crisis intervention programs tend to attribute to effective crisis intervention programs are the crisis workers' perceived listening abilities (France, 2002), as this helps the clients feel heard and understood.

Rather than individuals experiencing a crisis due to a relationship, other crisis intervention research focuses on individuals with severe mental illness (Joy, Adams, & Rice, 2007). The two modes of crisis intervention that provided the focus for this research were home care and standard care. According to Joy et al. (2007), home care involved a team consisting of a psychiatrist, psychologist, nurse, occupational therapist, and social workers. These professionals aided the client in a home-based treatment fashion. Standard care, on the other hand, involved hospitalization of clients. While in the hospital, they received normal hospital care which included access to medication if needed, and professionals such as psychologists, physiotherapists, and occupational therapist. Additionally, after clients were deemed stable

enough to be discharged from the hospital, they were provided with outpatient services. Based on client satisfaction surveys, which were retrieved from the articles reviewed by Joy et al. (2007), individuals who received home care, and their families, rated their satisfaction with the support and services they received higher than those individuals, and family members of individuals, in the standard care group. Furthermore, a year after treatment, more clients in the home care group stated that they felt improved and that they were better able to cope when compared to individuals in the standard care group (Joy et al., 2007). These results perhaps indicate that more supportive environments with a consistent circle of care are an important part of crisis intervention.

Another research study which collected information from multiple sources was completed by Vingilis et al. (2007). Vingilis et al. (2007) sought to evaluate the introduction of a mental health triage and a mental health counsellor for people with mental illness in an emergency department. Information was gathered from psychiatric consultants, psychiatric residents, emergency nurses, emergency psychiatric nurses, the police service, individuals with severe mental health concerns, their families, and a crisis counsellor. The results found by Vingilis et al. (2007) indicated that individuals with mental health concerns, their families, and community service providers felt that the addition of the mental health triage and the mental health counsellor improved services delivered to people with mental health concerns (e.g., reduced waiting times). Furthermore, it was found that after the program was complete, people with severe mental health concerns were more likely to follow up on their treatment plans. As stated by Vingilis et al. (2007), these benefits were largely attributed to the addition of a mental health counsellor who was originally supposed to address the legal, housing, and financial stressors of the persons with severe mental illness, but later altered the evaluation to do a complete mental health assessment. The results of this study indicate that the introduction of professionals whose purpose it is to help those with severe mental illness improves their perception of the services they are receiving.

Other emergency departments have also been subject to evaluations. Dion, Kennedy, Cloutier, and Gray (2010) evaluated a crisis intervention program that was being delivered to youth in a hospital's emergency department. The crisis intervention program consisted of an emergency mental health program, as well as psychiatry coverage in the emergency department. This program was implemented in this particular hospital due to the high number of youth

coming into the emergency department with mental health concerns. Dion et al. (2010) sought to determine the emergency department staff's satisfaction with the crisis intervention program through use of a questionnaire. The emergency department staff that was included in this research included nurses, residents, and physicians. In general, according to Dion et al. (2010), the staff reported that they were satisfied with the crisis intervention program; however, the availability of the crisis intervention workers could have been higher according to nurses and physicians. The results show that the emergency department staff would have found it useful if there were shorter waiting times for patients to see a crisis intervention worker, if there were more crisis intervention workers, and if the crisis intervention workers were available every weekend (Dion et al., 2010). The results also indicate that the emergency department staff found that some of the strengths of the crisis intervention program were a greater awareness of community resources for their patients and the ability of patients to access mental health services.

Crisis Management Programs

When individuals experience hardships and difficulties on an ongoing basis, they are more vulnerable to experiencing additional crises (Krupa, Stuart, Mathany, Smart, & Chen, 2010). These individuals often require crisis management rather than intervention programs as the former are typically more long term (Krupa et al., 2010; Roberts, 2005). Tierney and Kane (2011) sought to determine, through a retrospective program evaluation, participant satisfaction after participating in a Wellness Enhancement and Recovery Program (WERP). The WERP is a psycho-educational program that is organized by people from multiple disciplines (e.g., case managers, psychiatric nurse, and peer specialists) for individuals with serious mental illness. The topics that were included in the WERP psycho-educational component were based on current life concerns of clients and factors that could impact their mental health rehabilitation. Psycho-educational material was delivered in a group meeting format and case managers and peer specialists provided ongoing support to the participants in between group meeting times. Three years after the completion of the program, client satisfaction and quality of life was measured by questions about satisfaction with access, outcomes, general satisfaction, and quality. Results indicate that participants were generally satisfied with the program that they received and felt that they had an acceptable quality of life. Furthermore, many of the participants felt that having a peer specialist, who genuinely knew what the participants were going through, helping with

their case was very beneficial. Some proposed improvements for this program included creating leisure activities for clients, providing information about how to avoid feelings of being lonely and bored, and strategies on how to interact in various social situations. The next study also shows that having someone who knows what the client is experiencing can be perceived as a strength of programs for people with mental health concerns.

Simpson and House (2002) conducted a review of the literature in which service users were involved in the program delivery of mental health services. Importantly, the results indicate that the utilization of service users in the treatment of clients did not have any detrimental effects on the clients. Further, service users were more likely to spend a large amount of time with clients than were professionals or case managers. Additionally, based on the research reviewed by Simpson and House (2002), clients generally felt that their quality of life increased and that they had better social functioning, more satisfaction with life, and lower hospital admission rates. These benefits were, at least partially, attributed to the presence of the service user.

Malla, Norman, McLean, Scholten, and Townsend (2003) focused their study on a program called Prevention and Early intervention Program for Psychoses (PEPP), which uses an assertive case management model. According to Malla et al. (2003) the PEPP program involved integrating medical and psychological help through nurses or social workers, a psychiatrist, a psychologist, an occupational therapist, and a case manager. The case manager worked with the clients' families, formed close relationships with clients, and made connections within the community so that clients could reach his/her full potential. Within this intervention, medication, along with family intervention, group intervention, and individual therapy, were utilized in a phase specific way. Using this model, Malla et al. (2003) found that there were reduced negative and positive symptoms of psychosis and furthermore, that there was a reduction in waiting times for services due to the use of phase specific treatment.

Krupa et al. (2010) conducted their research on a community based crisis-case management service program. To improve the initial crisis intervention program, case management, which is more long term, was added. Since crisis intervention services often provide services to clients beyond the actual crisis situation, this report interviewed staff from both the crisis and the transitional case management service agency. The case management service in this report helped clients seek housing, employment, and other community treatments. Based on staff surveys, it appeared that the addition of a case management service to the crisis

intervention service improved the overall program in some key areas. Importantly, there was an increase in the number of people that could be served, there was more accessibility to other services, and there was more access to the community (Krupa et al., 2010).

Another study which investigated a specific crisis management model was conducted by Bond, Drake, Mueser, and Latimer (2001). The study reviewed the effectiveness of the ACT model of crisis management. Bond et al. (2001) reported on 11 characteristics of 25 randomized control trials of researchers evaluating different ACT programs. In this meta-analysis, they found that the majority of individuals ($\geq 50\%$) reported improvements in the areas of hospital admission, housing permanence, quality of life, compliance with medication, client satisfaction, and family member satisfaction. They also found that the majority of individuals ($\geq 50\%$) experienced no difference in the following areas: mental health symptoms, social adjustment, arrests or time spent in jail, substance use, compliance with medication, and vocational functioning. Importantly, although a majority of individuals saw no improvement or deterioration in these areas, there were some individuals who felt improvements in these areas. Also significant is the fact that very few, if any, reported that these areas became worse after the ACT program. Although 11% of individuals reported that ACT was too intrusive, in general, it seems that ACT programs can provide clients with many benefits.

Representative payeeship and trustee programs. In many crisis management programs, the case worker also acts as a trustee for their clients. This is often the case when the client's vulnerabilities or circumstance make it difficult for them to pay for their daily living needs on their own (Angell, Martinez, Mahoney, & Corrigan, 2007; Conrad, et al., 2006; Luchins, Roberts, & Hanrahan, 2003).

Luchins et al. (2003) evaluated a representative payeeship program for individuals with mental disorders. Luchins et al. (2003) stated that the most common characteristics of individuals that were required to enter the payeeship program included: individuals with substance use/abuse, being homeless, having high hospitalization rates, lack of financial skills, being a danger to oneself or others in his/her own home, and needing motivation to comply with treatment. The role of the crisis management worker was to pay for the primary needs of individuals (e.g., rent, utilities, and sometimes food). Luchins et al. (2003) found that being involved in a representative payeeship program not only helped to meet clients' basic primary needs, but also increased treatment compliance and decreased hospitalization rates. They also

found that clients felt that they were learning budgeting skills, that their money lasted all month, that the program was helpful in maintaining housing, and that it helped to control their substance use. There have been studies, however, that have found negative outcomes for representative payeeship programs.

Angell et al. (2007) conducted a study which examined the effects of payeeship programs and the possible financial leverage that can ensue on the therapeutic relationship. In this research financial leverage meant withholding money if the client did not comply with treatment. The participants in this study all had mental illnesses, were between 18-65 years old, and had their clinician as their trustee. The results indicate that 1/5 of participants felt a victim of financial leverage and, of those, 79% had a clinician as their trustee. Furthermore, with a clinician trustee, participants were more likely to feel like their contacts with their worker were hostile and intrusive. Angell et al. (2007) conclude that the issue is not if clinicians are actually using financial leverage or not, the important piece is whether the client *perceives* there to be financial leverage. Additionally, if financial leverage is felt by clients, it can do damage to the therapeutic relationship (Angell et al., 2007), which can have implications for future treatment and perception of support. With payeeship programs, however, the clinician is not always the trustee of his/her clients. This dynamic is shown through the following study.

Conrad et al. (2006) conducted research which measured the differences between two models of representative payeeship. The experimental group had a trustee who was coordinated with the clients' clinical care staff from the Department of Veterans Affairs whereas the control group's trustee was not affiliated with the clinical care staff. They found that the group of participants whose care was coordinated between these two services had lower substance use, improved money management skills, and felt an increase in their quality of life when compared to those who did not have coordinated services. Conrad et al. (2006) therefore stated that in payeeship programs, collaboration between the trustee and the clinical case worker is pivotal to its effectiveness.

Summary

The research generally demonstrates that clients can benefit from having a peer specialist or other service users as part of their program (Simpson & House, 2002; Tierney & Kane, 2011). This can help clients to feel like they are supported and understood because these individuals have firsthand knowledge of what the client is experiencing. Furthermore, these individuals tend

to spend a larger amount of time with clients than do traditional case management workers (Tierney & Kane, 2011). Another element that has been shown effective, because it helps the client to feel heard and appreciated, is the listening abilities of crisis workers (France, 2002). Ensuring a circle of care for clients is also seen as an important component of crisis intervention. The circle of care (Tierney & Kane, 2011; Vingilis et al., 2007) can help clients to become more connected to a variety of community resources (Dion et al., 2010; Krupa et al., 2010; Malla et al., 2003) and, therefore, feel more supported in their life. Moreover, the ACT model of crisis management appears to produce many positive results (e.g., increased quality of life and housing stability; Bond et al., 2001). There were, however, elements of the above programs that were seen as gaps in program delivery. For example, clients would like to be connected with more leisure activities, would like to have more psycho-education (Tierney & Kane, 2011), and would appreciate learning more daily living skills (Joy et al., 2007). Other service providers would like crisis workers to work on the weekends (Dion et al., 2010) and for there to be more workers, creating more support for their clients. Finally, although programs with representative payeeship do have some benefits (e.g., meeting client's basic needs, increasing money management skills; Conrad et al., 2006; Luchin et al., 2003), it can also cause clients to feel coerced or pressured into treatment (Angell et al., 2007).

Crisis Management Service

Up to this point, much has been said about crisis theory, crisis interventions, crisis management, and the strength-based approach, but in order to understand how these concepts relate to this utilization-focused process evaluation of Crisis Management Service (CMS), a description of CMS and its previous evaluation is warranted.

Saskatoon Crisis Intervention Service (SCIS) is a community organization that helps individuals in crisis 24 hours a day, 365 days a year (SCIS, 2012). This organization encompasses two separate, but connected programs: CMS, which is the focus of this evaluation, and Mobile Crisis, which is a 24 hour call line that aids individuals experiencing a crisis. During the hours that CMS is closed, CMS clients can call Mobile Crisis to obtain the help they need.

CMS currently employs 4.5 FTE crisis management workers (CMWs) and a Coordinator, along with reception staff. CMS differs from Mobile Crisis in that the CMWs are able to form a stable relationship with clients on their caseload. Additionally, CMWs have access to vehicles that are used to facilitate client appointments, service contacts, and working relationships with

client families, friends, and other community agencies. Further, although CMS deals with clients in crisis, it is apparent that its clients also have persistent and pervasive vulnerabilities due to their risky lifestyle, apparent continual state of crisis, and complications with managing mental illness. Many of the CMS clientele have mental illnesses, addictions, legal issues, Fetal Alcohol Spectrum Disorder, and/or Acquired Brain Injury (SCIS, 2012). It is often the case that these vulnerabilities compound to increase the state of crisis the individual is experiencing.

In order to lessen the impact of these situational and personal stressors, CMS connects with its clients on many levels. Part of the intervention involves direct contact with clients in the form of behaviour shaping and management, helping with basic needs (e.g., food, clothes, and shelter), and screening, assessing, and consulting with their clients. Another method that is used by CMS to help its clients is to refer them to other individuals or community organizations. These interventions can include: building a network of support and advocating for their clients; informing, educating, and training others (e.g., other individuals and organizations within the community) about their client population; assisting other frontline workers; making necessary referrals to other agencies; and providing service coordination/case management (SCIS, 2012).

CMS clients are assessed based on 10 ‘work areas’ which include: family, mental health, medical status, substance use, legal, housing, financial, self-care skills, education/employment, and social/recreational. Clients and CMWs decide collaboratively where to focus the majority of their work based on these 10 ‘work areas’. Since each client’s main ‘work areas’ differ, special and general needs characterize the required circle of care for each client. It is, however, always generated by client need, client participation, and service availability. It may include families, friends, other community agencies, family physicians, medical and psychiatric specialists, lawyers, counsellors, and landlords or care home caregivers. CMWs perform various roles in developing and sustaining the formal and informal supports for their clients.

In order to better understand the role of CMS in its clients’ lives, the various goals of CMS and its clients can be broken down into short-term, intermediate-term, and long-term goals. The short-term goals of CMS include providing necessities for its clients such as food, clothes, and shelter, and connecting them with medical professionals, legal aid, and addiction services, for example, through the Saskatoon Health Region. Intermediate-term goals include developing money management and other critical life skills, attending to addictions, medical, and legal issues, and achieving a temporary level of stabilization in their lifestyles permitting them to

better utilize family, community and professional supports. Finally, the long-term goal of CMS is to have its clients achieve an ability to peacefully live at their own optimal level of independence in the community utilizing whatever resources they need.

In order to meet the needs of its clients, CMS requires funding from other organizations and individuals. Under the non-profit corporate umbrella of SCIS, CMS shares some of its funding resources with Mobile Crisis. Primary CMS funding sources are the Saskatoon Health Region (Mental Health and Addictions Services), Saskatchewan Health – SGI (Acquired Brain Injury Program), Community Corrections, and private donations. The funding that is shared between CMS and Mobile Crisis includes contributions from the United Way, Social Services, and the City of Saskatoon.

Previous Evaluation of CMS

A previous program evaluation was completed on CMS in 1988 (*Crisis Management Program: Operational Review*, 1988). This program evaluation was an operational review which was focused mostly on finances and funding. In 1988 CMS was operating under the name ‘Crisis Management Program’ (CMP), but was still subsumed under SCIS along with Mobile Crisis.

This operational review was performed with three goals in mind: the first goal was to establish a future plan for CMP, the second goal was to determine the significance and influence of the program on the community, and the third goal was to determine the funding requirement of CMP for the next three years. Participants for this operational review included five Board Members and six CMP staff members, which included three Community Support Workers. In order to obtain the necessary data to meet these goals, four different methods were utilized. There was a review of the historical data regarding the level of demand of the program, a review of the current caseload of the workers, interviews with various staff, and meetings and discussions with Mental Health Services Branch and the workers. The Mental Health Services Branch was included as this was the only source of funding for CMP at that time.

Based on the data that was collected, numerous results were found. It was shown that CMP was a pertinent and needed program because they provided services which were not replicated by other community organizations. It was also found that the staff were professional and that CMP was functioning at peak proficiency. Although the results show that CMP was very cost efficient, it was found that more funding, more staff, and increased salaries were

required to keep this program operational. Furthermore, a long-term commitment by Mental Health Services Branch, who provides funding, was deemed necessary for CMP to endure.

Since the program evaluation conducted in 1988 there have been some changes to CMS. For instance, CMS now currently receives funding from a variety of sources and shares some of this burden with Mobile Crisis. This is not to say, however, that CMS is experiencing no financial constraints. Furthermore, although salaries have undoubtedly increased, it is not clear if these increases were solely due to inflation. Additionally, there has been an increase of one staff member to total 5.5 staff members who work directly with clients; however, there are most likely many more clients on their caseloads. These changes give the current program evaluation some confidence in terms of utility. That is, it appears that after the last program evaluation was complete that changes were made. Therefore, it stands to reason that changes will also be taken into consideration from the results gained in this study.

Summary

Crisis theory states that certain situations can cause disequilibrium in a person's life. If a person is unable to resolve this situation by using his/her coping skills, he/she can enter a state of crisis (Roberts, 2005). Further, through interventions, new coping skills can be learned and strengthened. Roberts (2005) stated that many people are able to utilize the coping skills that they already have to avert a situation becoming a crisis, however, the clients of CMS have many vulnerabilities which make their ability to cope all the more challenging. Undoubtedly, when the CMS clients are first referred to CMS they are experiencing a crisis. Unfortunately, due to the many confounding factors that CMS clients experience, for example, addiction, poverty, and mental illness, the crises that they deal with may be longer lasting or more pervasive and invasive in their lives. Given that crisis interventions have the potential to resolve a crisis situation, but also, to instill in clients the strength and skills to deal with crises in the future through support and coping strategies (Robert, 2005; Saleebey, 2002), CMS' role is an important one.

Although there are many models of crisis intervention available, and CMS does engage clients in this manner, CMS is more of a crisis management rather than intervention center. Based on the six models of crisis case management as outlined by Bond et al., (2001) and Mueser et al. (1998), CMS does not seem to fit into one model in particular. Rather, it seems as though CMS is based on a mixture of the ACT model, the ICM model, and the strength model.

Although the staff-client ratio at CMS is higher than what the ACT or ICM models call for, there are still many characteristics that are similar between these models. For example, all three models provide services to clients in the community, if one includes mobile crisis (CMS' sister organization) there is 24 hour coverage for clients, case managers are actively involved, there appears to be no time limit to services, and they all help clients in terms of their daily living skills. Furthermore, as in the ACT model there is caseload sharing to ensure there is always one crisis worker available who is familiar with an individual client's case. In terms of similarities between CMS and the strength model, CMS has ten 'work areas' that are assessed with clients. These areas are termed 'work areas' in order to frame them in a strength based way rather than as limitations. Additionally, at CMS, clients have input in what areas they wish to work (C. Briere, personal communication, July 6, 2012), therefore, increasing their agency and independence. By assessing individuals in these areas, case managers can utilize clients' strengths in order to work on their vulnerabilities: a central component to the strength-based approach (Maton et al., 2004).

Although all programs and, therefore, program evaluations differ, the crisis intervention and management literature helps to clarify what elements of programs are seen as strengths and weaknesses. For instance, various strengths found include: building rapport and showing support, creating a circle of care, meeting clients' basic needs, increasing a client's quality of life, improving money management skills, and increasing coping skills. Weaknesses on the other hand, that have been found include: wanting more psycho-education and leisure activities, and wanting crisis workers to work longer hours and to be less intrusive in the lives of their clients. Importantly, none of the programs cited previously are identical to CMS. Despite this fact, many of the strengths and weaknesses found can be thought of in terms of the programming that CMS offers to its clients.

CHAPTER THREE

METHODS AND PROCEDURE

Overview

This chapter outlines the process by which Crisis Management Service (CMS) contacted the Community-University Institute for Social Research (CUISR) and the details on how the research agreement and the work plan were negotiated. Furthermore, the research questions, evaluation framework, methodological rationale, data collection process, data analysis method, trustworthiness, and ethical considerations are explored.

CUISR approached the research team to conduct a program evaluation of CMS in 2011. Upon meeting and discussing the logistics of the potential program evaluation, a research agreement and proposed work plan were agreed upon. The research agreement and the proposed work plan were drafted on October 24th, 2011. Based on the work plan constructed in these meetings, an evaluation framework was constructed outlining the steps for the evaluation.

Given that part of CUISR's mandate is to bridge university research and community utility, and to involve university students in this process (CUISR, n.d.), two researchers were contacted by CUISR to conduct a program evaluation of CMS. Two Principal Investigators from the University of Saskatchewan were also part of the program evaluation team. Initially, meetings were held at CMS to solidify the agreement and to attain a better understanding of what CMS sought from this program evaluation. These meetings were attended by one of the Principal Investigators, the Research Coordinator of CUISR, the Coordinator/Assistant Executive Director of CMS, and the two researchers.

An advisory meeting between three crisis management workers (CMWs) and the researchers took place on December 7, 2011. The purpose of this meeting was to obtain further clarification from the CMWs about the direction of the program evaluation. Some of the information obtained included: CMS' model of care, the staff's perception of program strengths and weaknesses, and elements of the program that have changed since the creation of the Saskatoon Crisis Intervention Service (SCIS) in 1980. By combining the information acquired through the advisory meeting and through the initial meetings between the researchers, CUISR, and CMS, research questions for the program evaluation were formed.

Research Questions

1. What are the clients' experiences with CMS?

As previously stated, a program's value can be paralleled with its effectiveness (Fink, 2005). As such, this research question was constructed to determine the worth participants placed on their CMS programming. Many evaluations on crisis intervention and management programs also tend to focus on staff perspectives (e.g., Dion et al., 2010; Krupa et al., 2010) and, therefore, by obtaining clients' perspectives and experiences of their programming, a gap in the research literature is being filled. This first research question aligns with the strength-based approach as it gives clients a voice in their programming and aligns with the ACT model of crisis management in its emphasis on client choice, preferences, and goals (Bond et al., 2001; Mueser et al., 1998).

2. To what extent are the outcomes of CMS consistent with the services that its clients receive?

The outcomes of a program are the impacts which are seen through the programs activities and outputs (Chapel, 2004). Therefore, this research question seeks to determine the elements of the program that contribute to its success (Smith, 2004) and outcomes. Further, a client's perception of the services he/she is receiving affects his/her evaluation of the program (Vingilis et al., 2007). Therefore, how a client is involved in services, in an effort to reach the outcome goals, is important. Additionally, this research question seeks to determine how the services that clients are receiving are contributing to their quality of life (essential to the long term outcome), which has been found to be important in the literature (Bond et al., 2001; Conrad et al., 2006; Mueser et al., 1998; Simpson & House, 2002; Tierney & Kane, 2011). This question also addresses other aspects of programs that have been found to be essential (Bond et al., 2001; Dion et al., 2010; Joy et al., 2007; Krupa et al., 2010; Luchins et al., 2003; Malla et al., 2003; Tierney & Kane, 2011; Vingilis et al., 2007) and that fit with the outcomes of CMS (e.g., learning skills and connecting with the community). Last, clients have been shown to have many ideas on what activities could improve their program to better reach outcomes (Tierney & Kane, 2011) and this research question seeks to address these possible views.

3. To what extent is the process of client engagement with CMS contributing to the desired outputs of CMS?

Outputs are the "direct products of a program's activities" (Chapel, 2004, p. 637) and are essential in reaching a program's outcomes. Further, when attempting to reach a program's

outputs, engagement, through activities is crucial. Client engagement has been found to be especially important in the strength-based approach (Corcoran, 2005) and, therefore, needs to be examined. One way to engage clients is through active listening and support, which have been shown to be important in crisis interventions (Donovan et al., 1979 as cited in France, 2002; France, 2002). Further, examining how clients would like to be engaged can improve the outputs of a program (Dion et al., 2010; Simpson & House, 2002; Tierney & Kane, 2011).

All three of the above research questions were developed based on the philosophy of a process evaluation. That is, process evaluations are concerned with the execution of plans and activities in order to reach desired outputs and outcomes rather than the actual outcomes that are realized (Stufflebeam, 2000b; Stufflebeam, 2013) in programs that are currently operational (Owen, 2007; Stufflebeam, 2000b). The research questions for the present study seek to explore the activities of CMS, through the eyes of its clients, in its movement toward its outcome of having clients live as independently as possible. Further, the language of the research questions comes from the literature and theory behind logic models for process evaluations (Chapel, 2004). These research questions were a main factor in developing and finalizing the interview questions that were used in the participant interviews.

Evaluation Framework Rationale

Program evaluations are needed in societies that hold people and organizations accountable for producing results. This holds true especially when these programs are funded by external agencies such as Mental Health and Addictions Services, Community Corrections, and private donations, as is CMS. According to Stufflebeam (2001), a program evaluation is “a study designed and conducted to assist some audience to assess an object’s merit and worth” (p.11). This explanation parallels Fink’s (2005) statement that program evaluations are often conducted to ensure a program’s effectiveness in achieving their goals. Furthermore, to be accountable to their clients, stakeholders, and society in general, organizations dealing with crisis situations need to be able to change and adapt to the needs of their clientele (Krupa, Stuart, Mathany, Smart, & Chen, 2010). It is through these tenets that a process evaluation within a utilization-focused (Patton, 1997) framework, using Stufflebeam’s Context, Input, Process, Product (CIPP) model (2000b), was chosen for this research.

A process evaluation, according to Patton (1997, 2002), involves asking participants what their experiences are with their program, exploring the strengths and weaknesses of the program

in its daily functioning, and exploring how the program can be improved. Additionally, process evaluations are concerned with the journey of the participants rather than the outcomes that they attain (Patton, 2002). Further, process evaluations help to create a comprehensive depiction (Owen, 2007; Smith, 2004) of how the program is being implemented and what factors contribute to the strengths and weakness of the program (Smith, 2004). These elements are precisely the focus of the current program evaluation.

The utilization of a process evaluation can be traced back to Stufflebeam's CIPP model (2000b). This model is not based on proving if a program is successful or not, rather it is focused on how to improve a program that is already in place (Owen, 2007; Stufflebeam, 2000b). The CIPP model is applicable for the current program evaluation as CMS seeks to create a just and fair environment for its clients. The CIPP model emphasizes equitableness by including all involved stakeholders in the program evaluation (Stufflebeam, 2000b), which in turn concurs with CMS' direction.

In the present program evaluation, the 'process' portion of the CIPP model is pertinent. According to Stufflebeam (2000b; 2013), some of the goals of a process evaluation include helping program staff acknowledge and make modifications to the activities that they engage in, comparing the program's plan with the activities that are being realized and determining how to unite these components, and identifying how clients measure the quality of the program. With the above explanation of process evaluations in mind, it becomes evident that this is a logical choice for the current evaluation: it mirrors the needs and wants of CMS in its desire to better its programs.

Given the history of program evaluation (i.e., being conducted but not utilized), it is very important that the results obtained through this program evaluation are employed and, therefore, a utilization-focused model was used. Utilization-focused evaluations are grounded in the idea that evaluations should be critiqued based on their efficacy, with the focus being on the "intended use by intended users" (Patton, 1997, p.20; Patton, 2013, p.293). That is, within a utilization-focused framework, the information that will be gathered will be based on the user's desires and, therefore, the information will be utilized to make improvements in the program being studied (Patton, 1997; Patton, 2013). It is in this light that the stakeholders were involved in the interview question generation for the present study so that they would have a stake in this program evaluation.

Methodological Rationale

General Inductive Approach

Inductive analysis, as opposed to deductive analysis, incorporates methods concerned with reading and interpreting raw data in order to develop themes, theories, and models (Thomas, 2006). One tenet of the general inductive approach is that it allows the researcher to look for themes from the data without being tied to one methodology in particular. According to Thomas (2006), “the primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies” (p.238). Further, with the general inductive approach the goal is not to develop a theory, but rather to describe themes that are important in the data (Thomas, 2006).

According to Thomas (2006), there are three intents of the general inductive approach:

1. To condense raw text data into a summary format;
2. To form links between the research objectives and the summary data and to ensure that these links are transparent and defensible; and
3. To develop a model representative of the process that is apparent in the raw data. (p.238)

Based on these purposes, Thomas (2006) has outlined five principles fundamental the application of the general inductive approach:

1. The analysis is achieved through reading and interpretation of the raw data. Although data analysis is guided by the research questions, emergent findings are directly from the raw data.
2. The mode of analysis is the creation of categories from key themes with the intent of forming a model or framework based on the raw data.
3. The findings are derived from multiple readings and interpretations of the raw data. The findings are influenced by the researcher’s assumptions and the researcher must make decisions about the importance of the different pieces of data.
4. Various researchers may discover different findings based on the same data, some of which may not overlap.
5. Trustworthiness can be achieved using similar methods to other qualitative analysis approaches. (p. 239-240)

In terms of its major components, the general inductive approach is most similar to grounded theory. Some of these similarities include forming categories from the data and being able to describe important themes (Thomas, 2006). On the other hand, grounded theory is a method of research that seeks to develop a theory based on the emergent themes. The theory essentially develops through researcher observations and interviews (Patton, 2002) and from the words and experiences of the participant (Jones, 2002). Further, grounded theory uses constant methods of comparison at every level of analysis (e.g., between data and codes, codes and categories, categories and concepts; Charmaz & Henwood, 2008). In this respect, grounded theory differs from the general inductive approach which seeks to describe the most relevant findings and develop a model rather than to develop a theory (Thomas, 2006). Program evaluations, such as the current research, are more suited to the general inductive approach as they are generally not interested in theory development.

Semi-Structured Interviews

A semi-structured interview was the chosen method of data collection for the current research as this technique helps to ensure that the same topics are discussed with each participant (Patton, 2002). Through an interview guide, this approach also allows for a more fluid conversation to transpire so that the process does not feel prescribed. Unfortunately, utilizing an interview guide, as opposed to a closed interview, may cause respondents to answer differently to questions based on the order in which they are asked. Further, because of adherence to questions found in the interview guide, there is less room to personalize the interview to each participant. As in conversational interviews, personalizing interview questions allows for communication between the interviewer and interviewee to be deepened and to be in the here and now (Patton, 2002). The benefit of the semi-structured interview approach, however, is being able to fill gaps in participants' stories or probe a question in a slightly different way (Patton, 2002). Furthermore, given the characteristics of the participants in this program evaluation, some of which had trust concerns, moderate flexibility in questioning was favorable.

The questions that were developed for the participant interviews were formulated by a review of the literature on program evaluations, process focused evaluations, crisis intervention and management programs, and through an advisory meeting with the CMWs. Questions were created to understand the similar and diverse characteristics of the CMS clients including their

individual journey to CMS, to address their perspectives on program strengths and weaknesses, and to have a better understanding of their general experience with CMS.

Data Collection

Participants

Participants included 14 active and assessment CMS clients, as these are the clients with the most interaction with CMS. Characteristics of CMS clientele can include:

1. Hard to serve, difficult to reach clientele;
2. Isolated clientele;
3. High service users;
4. Histories of being undiagnosed, misdiagnosed and having multiple diagnoses; and/or
5. Clients with substance abuse and addiction problems.

The age of potential participants ranged from 25-82 years old. Moreover, all CMWs had clients on the potential participant list.

Procedure

An ethics proposal was sent to the University of Saskatchewan's Behavioural Research Ethics Board on January 6, 2012. Final approval was obtained on February 16, 2012. For data collection, letters of potential involvement, interview consent forms, debriefing forms, and transcript release forms were developed. Prior to contacting potential participants the semi-structured interview guide was sent to the Coordinator/Assistant Executive Director of CMS so that his input could be provided to ensure the questions were in line with the vision of CMS.

Sampling strategy. Although an attempt was made to use purposeful sampling so that information rich data could be obtained (Patton, 2002), due to the number of participants who did not want to participate or who could not be reached, convenience sampling was used. Convenience sampling uses those cases who are essentially the most accessible (Patton, 2002). This strategy allowed the researcher to accept participants who volunteered for the evaluation. Even though purposeful sampling would have allowed for a more representative sample of active and assessment CMS clients, there was an attempt to sample an equal number of females and males, an equal number of clients involved with each CMW, and clients who ranged in ages. This was done to ensure that a diverse set of experiences and perspectives were obtained.

Participant recruitment. Due to the nature of the CMS clientele, some of whom do not have a fixed address, a letter of potential involvement (see Appendix A) was developed for

CMWs to hand out to all active and assessment clientele. The purpose of this letter was twofold, on one hand it gave notice to the potential participants that a program evaluation was being performed on CMS, and that researchers may be in contact with them to ask for their participation. On the other hand, it served as a method to maintain potential participant confidentiality. For instance, by giving a letter of potential involvement to all CMS active and assessment clientele, the CMWs would have no way of knowing which clients were contacted by the researchers for their participation, unless the client self-disclosed to the CMWs. After all clients were given a letter of potential involvement, the Coordinator/Assistant Executive Director of CMS sent a list of all active and assessment clients to the researchers. This list included information such as the name, age, CMS status (active or assessment), CMW name, and contact information for the potential participants.

Based on the sampling strategy outlined, a list of potential participants was formulated to be contacted to participate in this study. Participants were contacted in groups of two or three. When contacting the potential participants, it was verified that they had received the letter of potential involvement and they were asked if they wished to participate in the research study. If the participants agreed to participate, a time was scheduled for an interview. All interviews took place at the Canadian Mental Health Association Saskatoon. This location was chosen as it was a place that many CMS clients were familiar with, and it ensured the comfort and safety of the participants and the researchers. If a potential participant indicated that they did not wish to be part of the program evaluation, they were thanked for their time and were removed from the list of potential participants.

Interview process. Upon meeting participants for interviews, a consent form was provided (see Appendix B). Due to the uncertainty of the mental state and literacy level of the participants, the letter of consent was read to the participants. To ensure that the participants understood the consent form, participants were asked if they had any questions or concerns, which were then dealt with at that time. Participants were then asked to sign the consent form. Although interviews ranged in the amount of time needed, one 60-minute interview was allotted for each participant. A second follow-up interview was not conducted with the participants as it was questionable if participants would be able to meet a second time due to their vulnerability and transient nature. It was, therefore, decided to conduct one interview with each participant to ensure the consistency of the data collection. The participants were told that they could refuse to

answer any questions or could withdraw from the study at any time and they also had the option of not being recorded.

Both researchers were present during the participant interviews. The reasoning for this was twofold. On one hand, it ensured that the researchers' safety was maintained and, on the other hand, it allowed for more accurate recording of the interview in cases where the participant did not want their interview audio recorded. The participants were given 5-10 minutes before the interview commenced to review the interview guide (see Appendix C), which can be traced back to the three research questions (see Appendix D), and to ask any questions. The interview questions were then read to the participants. Upon completion of the interview, participants were given a debriefing form (see Appendix E) which reiterated the goals of the program evaluation and provided the participants with researcher contact information if they had any questions or concerns. On the debriefing form, the participants had two options for their transcript. The first option was to waive their right to review their transcript before it was used in the study. The second option was to have the researchers contact them after the interview was transcribed for their review. Due to the nature of the population in this study, some of whom have no permanent address or telephone number, reconnection with them was a concern. It was explained to participants that if an attempt was made to re-contact them to review their transcripts and if reconnection was unable to happen, their data would still be used in the research study. If the participants wished to review their transcript, they had the option to remove or change any part of their transcript that they wished. After this second meeting, and if the participant was satisfied with their transcript, a transcript release form was signed (see Appendix F). After the completion of each interview, all participants were given an honorarium (i.e., \$15.00) for their time and participation.

Data Analysis

The General Inductive Approach

Interviews were transcribed and analyzed using the general inductive approach (Thomas, 2006). The preliminary analysis began while interviews were still being conducted and transcriptions were still being produced. The semi-structured interviews with CMS clients were considered to be complete when no new raw data themes emerged and it was concluded that theoretical saturation had been achieved (Glaser & Strauss, 1967).

Thomas (2006) outlines the five steps necessary for coding and analysis of raw data using the general inductive approach. These five steps are as follows:

1. Preparation of raw data files – this step involves formatting all data to look the same, printing and/or making a backup copy of the data.
2. Close reading of text – this step involves reading the data in detail until the researcher is comfortable with and understands the data well enough to be able to see themes emerge.
3. Creation of categories – this step involves forming the categories or themes which are evident in the text. In this step upper level and lower level themes will emerge. Upper level themes are those that are formulated from the goals of the evaluation, while lower level themes are those that are formed by reading the text multiple times.
4. Overlapping coding and uncoded text – in this step it is assumed that certain segments of coding may be used in the support of multiple themes and that some segments of coding will not be used at all, if it is not applicable to the objectives of the research.
5. Continuing revision and refinement of category system – in this step the aim is to look for subcategories or data that may show differing viewpoints. The researcher also selects specific quotes that show the essence of that category (Thomas, 2006, p. 241-242).

The results from this analysis are always unique to the data and the participants, and are not generated from any pre-existing hypothesis or expectation (Thomas, 2006).

Controlling Subjectivity

All researchers bring to their studies assumptions based on their own experiences. It is important to be able to reflect on and control these biases or assumptions so that the themes that emerge through analysis are purely from the raw data. This was done in multiple ways for the current study. First, the CMS clients have been described as “hard to serve, and difficult to engage” (SCIS, 2012, Crisis Management Service, para. 1) and, therefore, there was an assumption about the characteristics that participants would portray when meeting them for interviews. It was important that these expectations did not influence how the participants were treated throughout their interview. This was facilitated by the counselling training that the researchers possessed. There was a constant effort to treat each individual in a respectful way while always remembering that his/her voice was an important piece of ameliorating the

workings of CMS. Another way that subjectivity was reduced during the interview process was by following the semi-structured interview questions. Although participants had many interesting things to say, the interview guide was followed to ensure that superfluous tangents were not investigated. Last, a thorough description of CMS was explored prior to client interviews and before analysis began. This information could have influenced the themes and dimensions that emerged from the raw data. To avert this circumstance, there was a consistent effort to stick to the data source when transcribing the interviews, and furthermore, the awareness of the possible influence of the CMS description allowed the researcher to disconnect from it prior to starting the analysis. Essentially, by detaching from this description, the researcher was able to be open to any themes that emerged. Further, consultation between researchers was completed after each interview about the process of the interview and after data analysis to reduce biases.

Trustworthiness

Lincoln and Guba (1985) outline different elements to ensure the trustworthiness of data and themes that emerge in qualitative research. The elements to ensure trustworthiness that were utilized in this research included allowing the participants to review their transcripts prior to them being analyzed. This exercise gave the participants the option to clarify, explain, change, or remove pieces of their transcript to ensure that what was being reported was what the participant meant to convey. This piece of establishing trustworthiness is essentially a stakeholder check. Additionally, inter-rater reliability helped to strengthen the trustworthiness of this research. Inter-rater reliability was checked by having the primary researcher formulate categories from the raw data and then having the second researcher attempt to place raw data into those categories based on descriptions of those categories. This step helped to ensure that raw data was not placed into themes created because of any bias or prior hypothesis that the primary researcher may have had.

Ethical Considerations

As a component of their M. Ed. program, the researchers participated in practicum placements with organizations and institutions that have clientele suffering from mental illness. The practicum placements that the researchers were engaged in, however, do not serve the clientele that are seen by CMS. Since both researchers will be counselling and assessing clients in the future, the possibility exists that participants may encounter the researchers in a professional relationship. Care will be taken in selecting the participants from the client database at CMS to minimize the risk of participants encountering the researchers in other capacities.

Furthermore, clear boundaries will be explained to the participants if they seek counselling or assessment services from the researchers in the future. In the event that a participant is seen by a researcher in a therapeutic capacity, the researchers will immediately explain the implications to the participant and will make a referral to another counsellor.

Second, the participants obtained a monetary honorarium for their participation in the research project. Receiving payment for their participation may have influenced some individuals' drive to participate in the program evaluation. Some of the participants in this study may not have had enough money to take the bus or taxi to meet the researchers for the interview, as well as many other monetary and time concerns; therefore, it seems ethical and logical to compensate participants for their time.

Third, some of the participants may not be literate. For this reason, the consent form was read aloud and explained to all participants. Any questions that the participants had about the consent form were answered. Participants indicated that they understood the consent form and agreed to give consent via a signature on the consent form.

Fourth, the decision was made that, in the event that a participant did not want to be contacted again after the interview to review their transcript or if they indicated that they did wish to be re-contacted but contact was not possible, that their data would still be used. These exceptions were made clear to the participants prior to completing an interview. This decision was made due to the nature of the participants, some of whom have no contact number. Considering the transient living situations of some of the participants, re-connection could prove to be impossible.

Fifth, due to the characteristics of some participants, there was the possibility that their mental illness or alcohol/drug use may have affected their ability to give informed consent. Although care was taken by the CMWs to provide the researcher with a list of potential participants that were fit to give consent, it is possible that the mental health of the participants the day of their interview interfered with their ability to give informed consent. Although it proved to be unnecessary, if this was the case, the researchers reserved the right to refuse to interview a participant both for the good of the participants and for the credibility of the results of the research. If the researchers decided that a participant was unable to give informed consent, they would have still provided the participant with the honorarium for their time and effort.

CHAPTER FOUR

RESULTS

Overview

Crisis Management Service (CMS) is a non-profit organization that deals with clients who have been described as “hard to serve and difficult to engage” (Saskatoon Crisis Intervention Service, 2012, Crisis Management Service, para. 1). CMS connects these individuals with whichever community services are collaboratively deemed to be most important for their independence, safety, and growth. CMS’ role in the community is an important one as they help individuals who would otherwise have little to no support. In order to ensure their effectiveness with these clients, CMS contacted the Community-Institute for Social Research (CUISR) to conduct a program evaluation. Through collaborative meetings, a utilization-focused (Patton, 1997) process evaluation (Stufflebeam & Shinkfield, 2007) was chosen as the approach.

The goal of a utilization-focused (Patton, 1997) process evaluation (Stufflebeam & Shinkfield, 2007) is to explore the strengths and weaknesses of the program based on program participants’ perspectives. Further, it ensures that the outcomes of the research will be utilized by those who sought the evaluation, which can result in stakeholders making modifications to the program.

In forming this evaluation, four intents were constructed. First, this research will help to bridge the gap that is often apparent between university research and community utility. Not only is this the mandate of CUISR, but it also reflects the choice to employ a utilization-focused evaluation. Second, and still in line with the utilization-focused model, the results can be used by stakeholders to improve the accountability of the services that CMS provides. Third, the process of this research affords the clients of CMS the ability to have input in the services that they receive. Last, this research will add to the literature on the merits and weaknesses of crisis management programs.

Research Questions

1. What are the clients’ experiences with CMS?
2. To what extent are the outcomes of CMS consistent with the services that its clients receive?
3. To what extent is the process of client engagement with CMS contributing to the desired outputs of CMS?

These research questions were based on the purposes of this research, the goals of a utilization-focused process evaluation, and the literature on crisis intervention and management programs. From these research questions, an interview guide was formed and transcripts were analyzed using the general inductive approach (Thomas, 2006).

Results

Participant Transcripts

Participant transcripts were obtained through 14 semi-structured interviews which were completed by CMS clients. Although 15 participants were met for interviews, one had to be omitted. The interview with the omitted participant was ended prematurely due to the incomprehensibility of the interview (i.e., the participant appeared confused and his answers were unrelated to the questions posed). The participant was still provided the honorarium for participating. All participant demographic data and results were, therefore, created from the analysis of 14 semi-structured interviews, which allowed for theoretical saturation (Glaser & Strauss, 1967). That is, by the last interview, very little, if any, new information was being added to the transcribed raw data and, therefore, no further potential participants were contacted.

At the end of every interview, participants were provided the option to review their transcripts at a later date; three participants indicated they wished to do so. While attempting to set follow-up meetings, one participant indicated that he no longer wished to review his transcript. Multiple meetings were set up with the second participant to review her transcript; however, none of the meetings were attended by that individual. She then decided to waive her right to review her transcript. This resulted in one participant reviewing her transcript. Importantly, this participant changed only minor details which did not alter the dimensions or themes found in this research. Given this outcome, the validity and trustworthiness of the transcripts remains high despite the lack of participants who wished to review his/her transcript.

Participants

Throughout participant interviews, information was gathered to help the researchers and the reader understand the lives of the participants. Demographic information collected included their age and length of time they have been in the program, see Table 4.1. Other information explored as part of the interview encompassed: by whom and why they were referred to CMS, the background of the participants including their work lives and educational experience, their hobbies and interests, as well as any other information that they wished to share. It is through

this information that one can understand to a greater degree the stories and experiences of the participants.

As Table 4.1 shows, a comparable number of males and females were interviewed. Further, the ages of individuals who participated in this research ranged from mid-20's to early 60's. Therefore, although convenience sampling was used, there was an attempt to interview an equal number of men and women of various ages. Based on the list of potential participants that was received from CMS, the participants who were chosen to be interviewed seemed to allow for varied perspectives. Diverse perceptions of the program were also established by interviewing clients who had been involved with CMS for various amounts of times (under a year to over 21 years).

Table 4.1. Participant demographic information

	<i>N</i>	%
Total	14	100
Sex		
Male	6	43
Female	8	57
Age		
25-34	3	21
35-44	5	36
45-54	4	29
55-64	2	14
Years in program		
0-10	5	36
11-20	7	50
20+	1	7
Unsure	1	7

Individuals can become CMS clients through diverse referral sources including healthcare professionals, their family, or by themselves. Although many individuals in this research indicated that they did not know by whom they were referred, other individuals stated that they were referred by a social worker, by CMS, the hospital, their family, or by personal choice. Participants, however, did appear to have thoughts on why they were part of the program. Participants mentioned joining CMS for a variety of reasons such as: a brain injury, feelings of vulnerability, needing help with living arrangements, mental health concerns, money or budgeting problems, and relationship troubles.

Although all part of one program, CMS clients are unique individuals. For instance, some participants mentioned living on the streets for much of their life, while others mentioned being involved in the military and academia. Moreover, some participants indicated that they were currently working at various organizations around Saskatoon, some with help from CMS. Other interests and hobbies of participants included cooking, crocheting, playing musical instruments, spending time with pets, writing, and pursuing education. As evident by the above information, participants can be described as coming from a variety of backgrounds and as having a range of lived experiences.

Although participants shared various levels of information during their interviews, many participants were open to sharing stories about dealing with their physical, emotional, sexual, and self-abuse, their addictions and road to recovery, and struggles while living on the streets. Also, some participants conveyed personal triumphs, including winning a baseball game when they were younger to overcoming addictions and adversities.

The stories and information above help to show that the participants in this research have many lived experiences and that there is no stereotypical client that CMS serves. All of the people who are supported by CMS are unique individuals with their own strengths and difficulties. Despite the fact that CMS clients and, more specifically, the participants in this research are unique individuals, it is important to remember that they have been brought together under this program due to their similar need of support and guidance.

Themes and Dimensions

The following themes and dimensions were found by analyzing 14 semi-structured interviews using the general inductive approach (Thomas, 2006). Although the general inductive approach makes use of the inductive process of generating themes from reading the raw data, the researcher still uses the research questions to help guide the analysis.

The analysis of the 14 semi-structured interviews reveals eight major dimensions that are made up of 60 raw data themes. The descriptive words that were chosen to illustrate the raw data themes were either selected because participants tended to repeat these exact words often or because they mentioned words that were synonymous or descriptive. The wording of raw data themes was chosen this way to help the reader connect with the exact meaning of what the participants were trying to convey. The eight dimensions created include: Clients' Experience with CMS and the CMS Staff, Interactions Between CMS Workers and Their Clients, Financial

Interactions to Increase Client Independence, Help and Support for Client Needs, Helping Clients Learn New Skills and Client Independence, CMS Support for Clients' Health, Connection to External Resources and Help with Personal Relationships, and Client Perceived Support and Needed Community Support. Although the dimensions are represented as separate data, due to the interconnectedness of CMS and the lives of its clients, many of the dimensions can be linked with other raw data themes and dimensions.

The process in which raw data themes converge to dimensions is through first-order categories and, occasionally, second-order categories as well. To demonstrate how results were obtained using the general inductive approach, the first-order category, CMS Staff Supportiveness, which is part of the dimension, Clients' Experience with CMS and the CMS Staff, is depicted, see Table 4.2.

In order to help the reader understand how raw data themes fit with first-order categories, second-order categories, and dimensions, select quotations from the raw data will be shared throughout the various themes and dimensions below. In the interest of ensuring the confidentiality of the participants and for ease of reading, participant quotations were edited. For example, identifying information such as names were deleted as were filler words such as 'umm'. Any words that were added were to help the reader understand the context or to facilitate the ease of reading of the quotation and are represented by square parenthesis. All eight dimensions have been ordered based on strength of the data, starting with the most robust. For example, a dimension can be considered extremely important and relevant if all participants have mentioned something pertinent to that dimension in their interview. On the other hand, some dimensions contain raw data from less than half of the participants making it a less central, although still relevant, dimension.

Table 4.2. Example of coding category

Component	Description
Label for First-Order Category	CMS Staff Supportiveness
Description of First-Order Category	This Category describes different ways and different levels of support that CMS clients experience when in direct contact with the CMS staff
Example of Text or Data Associated with the First-Order Category	<ul style="list-style-type: none">• “She [CMW] understands what I go through; she’s very understanding”• “I know that there’s all kind[s] of stuff they do, and handle calls, and I don’t know, [they] talk to a lot of people, and people show up for money you know... they help out a lot of people”• “Well they [CMWs] care about you and they want you to do well and they want the best for you”• “Well I live in a group home, but if I ever wanted to live on my own again they would help me, they’d support me”
Relationship of First-Order Category to other First-Order Categories and the Overarching Dimension	CMS Staff Supportiveness is one of three first-order categories that make up the second-order category, Experience with Staff, which is under the dimension, Clients’ Experience with CMS and the CMS Staff. The other two first-order categories under, Experience with Staff, include, Clients’ High Regard for CMS Workers and Client Perception of Staff Interaction. The other second-order category, Experience with CMS, is comprised of one first-order category, Type of Experience with CMS and three separate raw data themes.

Clients’ experience with CMS and the CMS staff. The Clients’ Experience with CMS and the CMS Staff dimension contains raw data from all 14 participants. This dimension was created from two second-order categories, which were constructed from four first-order categories and 16 raw data themes. The second-order category Experience with Staff, was derived from three related first-order categories: CMS Staff Supportiveness, Clients’ High Regard for CMS Workers, and Client Perception of Staff Interaction. These first-order categories are formed from 10 raw data themes: Staffs’ Level of Understanding, Staff Helpfulness, Clients’

Best Interests, Level of Support, Knowledgeable, Staff is Valued, Attentiveness/Engagement, Friendly/Nice, Welcoming Atmosphere, and Level of Involvement. This dimension also contains the second-order category, Experience with CMS. This second-order category was derived from one first-order category, Type of Experience with CMS, and six raw data themes: Good Experiences, Bad Experiences, Varying Experiences, Staff Diversity, CMS is Busy/Uncomfortable, and CMS Helpfulness, see Figure 4.1.

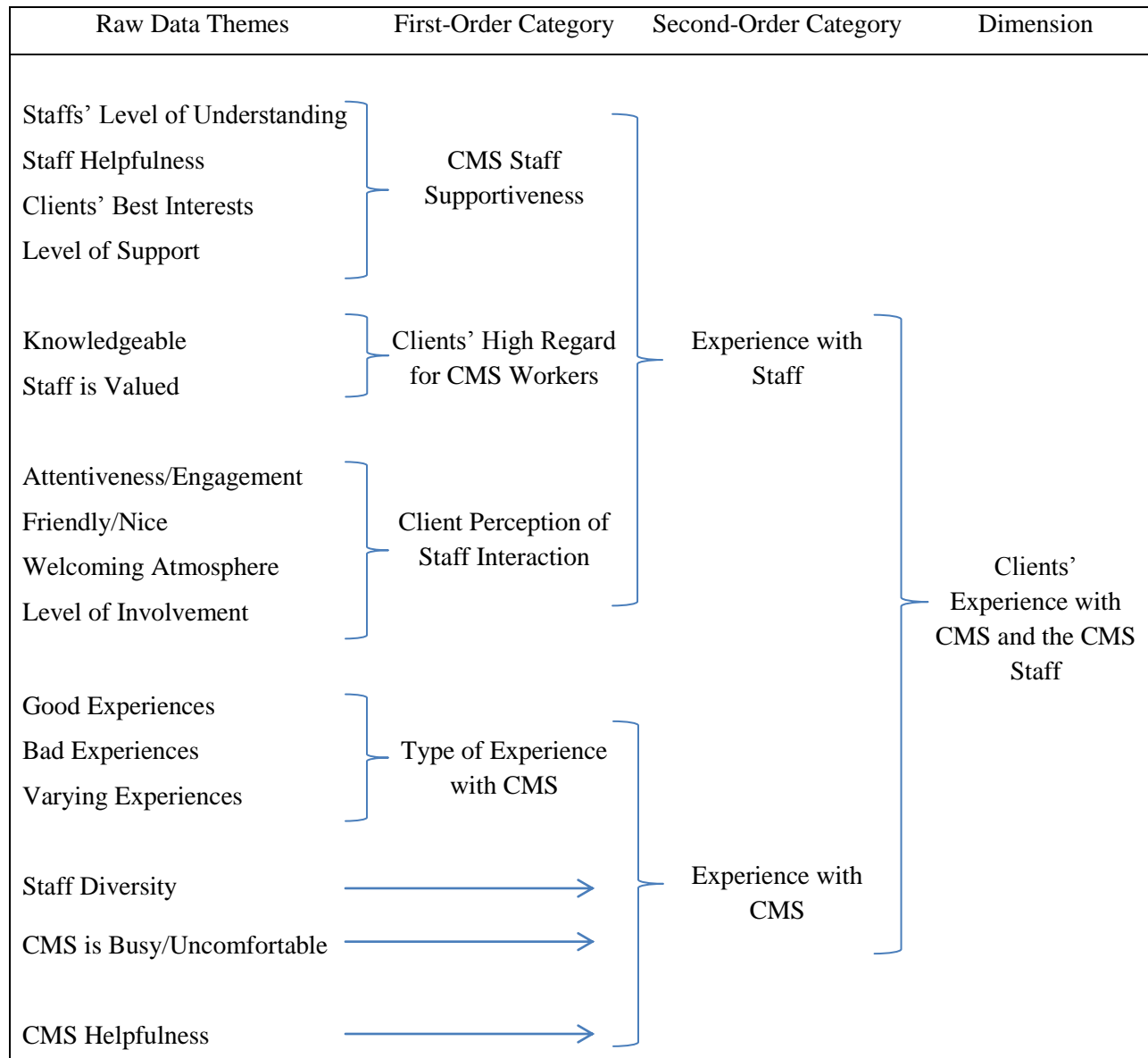


Figure 4.1. Client' Experience with CMS and the CMS Staff Dimension

CMS staff supportiveness. The initial first-order category, CMS Staff Supportiveness, a component of the Experience with Staff second-order category, was formulated from four raw data themes: Staffs' Level of Understanding, Staff Helpfulness, Clients' Best Interests, and Level of Support. This first-order category was composed to describe the different ways that the CMWs support their clients and the different levels of assistance that participants experience when in direct contact with the CMWs.

The first raw data theme, Staffs' Level of Understanding, relates to CMWs' comprehension of the participants' experiences in the community, when relating to others, and their ability to be supportive in those times. Some participants stated that the CMWs understood their experiences asserting, "*[CMS has improved my quality of living because] she [my CMW] understands what I go through, she's very understanding*". Additionally, another participant stated:

It['s] just not knowing, and sometimes people freak out and they're "jeez I need my money" and this ain't the right day and I'm there for something else and they're just yelling and I don't know how they can stand the service, but everybody's got their own set of problems. Crisis is a little more understanding in that sense and where a person comes from.

The first participant in particular was speaking about how CMS has improved his quality of life. According to both participants, however, it seems that having support from someone who understands one's successes and vulnerabilities helps to increase his/her perceived well-being. Conversely, some participants mentioned that the CMWs were not as understanding as they would appreciate. This concept can be shown through the following two quotes, "*When I'm sick, I go there and they get mad at me. I say and do things that I don't remember, like dissociative. They yell at me and I don't know what I did*" and, "*They could be more sensitive and understanding with me... [They could] give me a second chance to prove I'm a different person. I was a witch before*". The first quote depicts an instance where the participant went into CMS when she was feeling psychologically unhealthy. She felt as though she was being attacked by the staff for actions that she didn't remember partaking in. In this sense, the participant did not feel as though the CMWs understood what she was experiencing and, therefore, she did not feel supported. As shown by the second quote, the participant felt as though the CMWs did not understand that she has changed as a person from when she was a young adult. In light of this, it

seems as though the participant felt judged in the present for how she behaved in the past. It appears that this participant would feel more supported and understood if the CMWs would treat her in a way that differs from what her past behavior called for.

The second raw data theme, Staff Helpfulness, depicts the tendency of staff to do many things that help their clients in their day-to-day living or in unique circumstances. For instance, one participant stated:

I know that there's all kind of stuff they do and handle calls and I don't know, [they] talk to a lot of people and people show up for money, you know. [inaudible] the way it's running; like, one day, I was there and a man showed up. He was waiting in his truck and he needed gas to make it home, so I guess we don't even know who he was, just listening to them so they helped him out with gas. So I guess in a lot of ways it can help a lot of people, because I think he was just there for overnight... So I guess in that way they do a lot of the odd stuff... there's a lot of things that they do that I can't really [inaudible]. In real life there is stuff they do, they go out of their way with so many.

As this participant mentions, the CMWs do many things that display their helpfulness and support that other agencies or people may not engage in. Another instance in which the CMWs helpfulness was important to a participant was when a CMW, “*gave me some produce from her garden last year, just as an extra*”. It was apparent through the interview that the act of helping this participant by giving him some food had quite an impact on his life. For example, during the interview he also stated that:

One care home I was in, most of the time, all we got was hotdogs and finally just say well it's sausages or hotdogs or all time. It was sausages or hotdogs or wieners and I was just getting frustrated.

Therefore, this participant's CMW giving him vegetables could be seen as helpful and also showcased the strong relationship that had been formed between him and his CMW.

The raw data theme, Clients' Best Interests, illustrates the concept that clients' needs are central to CMWs when guiding and interacting with them. This raw data theme is captured by the following quote, “[*I've had good interactions with them because*] *they care about you and they want you to do well and they want the best for you*”. This participant felt that her interactions with the CMWs were of higher quality and more productive because they genuinely

had her best interests in mind. In this sense, the participant felt more supported by the CMWs. Additionally, another participant stated:

[Some of the positive things in my life I attribute to CMS because my CMW] hasn't been trying to stop me from living so that's been more than I would have expected. She's good, but she's also fairly nice [and] positive, open to an idea. So that's good.

This quote demonstrates that the participant felt as though he was able to live his life to his own standards and that his CMW supported him in this venture. In this sense, this client felt that his CMW was doing what was best for him and his circumstance.

Finally, the raw data theme, Level of Support, can be characterized by the varying amount of assistance and guidance that CMS clients feel they receive from the CMWs. Some participants felt that they have received considerable support from the CMWs:

[CMS has helped my quality of life because] now I've got my own place and I'm moving into a new apartment with a balcony and I'm really thinking of quitting smoking harder, I have to. But the ladies at Crisis really help guide me. When I feel down or something they help me. So it's really good.

These feelings of being supported appear to have increased this participant's felt quality of life in terms of his ability to obtain and maintain an apartment and contemplate his addictions to a greater degree. Other participants, however, felt that more support from the CMWs would be beneficial:

I would have been really please[d] if [my CMW] show[ed] support of my concept that I'm not schizophrenic, you know? Help me out to potentially work against having a diagnosis that's very limiting in life; it's kept me from getting a lot of good jobs.

This participant was speaking about missing opportunities in life because of his mental illness. Although the presence or absence of a diagnosis would not be the decision of his CMW, in this instance, the participant seems to have felt that his quality of life would have been improved if he could have gotten more support from his CMW in this area.

The raw data themes, Staffs' Level of Understanding, Staff Helpfulness, Clients' Best Interests, and Level of Support, all display varying degrees of CMW supportiveness. For many of these participants, feeling of being supported is a new experience. Oftentimes these participants felt thwarted by society; therefore, having the CMWs supporting them can help them to realize their potential to be healthy and independent. Although many participants had positive

things to say about their worker's ability to be encouraging and responsive to their needs, other participants felt that their CMW could be more understanding and show more support for individual needs and wishes.

Clients' high regard for CMS workers. The first-order category, Clients' High Regard for CMS Workers, which is subsumed under the second-order category, Experience with Staff, is comprised of two raw data themes: Knowledgeable and Staff is Valued. This first order category was created to describe the many areas in which CMS clients appreciate and respect the CMWs when in contact with them.

The raw data theme, Knowledgeable, is comprised of raw data depicting clients' perceptions that CMWs had an understanding of their role and that clients were comfortable in referring others to CMWs because of their comprehensive knowledge. This raw data theme was best revealed through two participants' quotes when talking about their positive experiences with CMS, *"They're [CMWs] just really good people and they know what they're doing"*, and:

They [my experiences] were sad and then they were beautiful and then they were unhappy at times. And going through the few that I had to go through I'd say it was wonderful. But [I had] experiences that I would [say] if anybody had to go through, I'd say go to them because they got what it takes and stuff.

These quotes capture the essence of the CMWs' understanding and knowledge about how to deal with the various needs of their clients. Furthermore, based on the CMWs' knowledge, these participants appear to have a certain level of respect or affection for them. This respect and appreciation was shown through the participant's sense of security when referring his/her friends or family to CMS if needed.

The raw data theme, Staff is Valued, consists of raw data that illustrates participant feelings of closeness, connectedness, and admiration for the CMWs. For instance, one participant stated:

I like Crisis because my own family [and] I don't talk very much, even my oldest brother cut off his phone now and he's my only brother in town. I don't talk to my family very much at all... I'm just having a hard time communicating with my own family and Crisis is more like a family [to] talk to and feel more comfortable [with].

This participant felt that he was not able to connect with his biological family and CMS was able to step into that role for him. For this participant, having CMS as his 'adopted' family helped

him live more independently. In order for these feelings to be so apparent, a high level of regard was directed from the participant to CMS and his CMW. Another participant stated:

I don't want to get involved [in other people's issues] because [you] hear this story or that story and you don't know what to believe half of the time you know, you just don't. Lot of times people make up stories just to better improve their lives but then again, a lot of times they need help and that's what Crisis is there for to assist people so it's good. I hope that that boy got his help, he's talking to [name of a CMW], [he's] a good role model.

This participant was describing an instance when he and another CMS client were waiting in the lobby area of CMS for their workers. The participant felt uncomfortable because the other CMS client was behaving irately. Through this ordeal, it was the participant's hope that the CMW would be able to help that CMS client in part by being a positive and stable role model. This quote also shows the importance that people place on having positive individuals in their lives to help guide and support them. People cannot survive on their own, therefore, through the positive support CMWs provide to their clients, the clients are better able to live healthy and productive lives. Another quote which demonstrates a level of respect is as follows:

They're very pleasant people, they've got a heavy workload because, like I said, when some people are screaming and demanding services and they're not entirely with it, I get worried for them too because [those] people can all of a sudden blow up and, holy man, they've got their lives on the line for that, hey? I really respect them.

This participant felt that CMWs often put their own lives in danger when dealing with incensed clients in an effort to help them. It is possible that the CMWs could be harmed in their interaction with clients, whether they are in the CMS office, in the community, or in the residence of that client. The level of respect from this participant seemed to stem from CMWs taking care of others before they take care of themselves, essentially putting the client's needs first.

The raw data themes, Knowledgeable and Staff is Valued, illustrate the first-order category, Clients' High Regard for CMS Workers. All of these raw data themes portray a positive feeling toward CMWs. Participants tended to feel that the CMWs are well-informed about their work, that they had close relationships with the CMWs, that some staff were positive mentors, and that participants respected the CMWs. Being able to foster these positive feelings

appears to be a central component of being able to make a difference in people's lives. For example, if the participants did not value and respect the CMWs, they would not be so accepting of the CMWs' help and guidance.

Client perception of staff interaction. The first-order category, Client Perception of Staff Interaction, which is subsumed under the second-order category, Experience with Staff, is comprised of four raw data themes: Attentiveness/Engagement, Friendly/Nice, Welcoming Atmosphere, and Level of Involvement. This first-order category was formulated to describe participants' insights, both positive and negative, regarding how and when the CMWs communicate with them.

The raw data theme, Attentiveness/Engagement, is demonstrated by raw data that indicates that participants felt that CMWs were conscientious of, and responsive to, their needs. This raw data theme can be highlighted through two quotes: *"They're [CMWs] all nice and they always say hi and they got a big smile"* and;

Well usually when I phone in they're [CMWs] friendly and they say I'm one of the most friendliest [and] polite [people]. When you go in, there's somebody there to greet you and then as they walk by they always ask if you've been looked after; if you haven't been, they'll look after you.

These quotes illustrate that participants had experienced CMWs being attentive to their presence. In this sense, participants felt respected and valued by CMWs, which, in turn, gave them a positive perception of their interactions with the staff. Some participants, however, felt that some CMWs were not attentive or engaging enough with them, for example:

[Name of two workers] doesn't take time out. Those two don't take time out, but the rest do... If I came in and said something like, "I got a problem here. Could you help me with it?" they could be helping me out with my medical form for school and stuff like that. They'd take time out.

This participant was describing the feeling of being neglected when she needed help. Although the participant stated that some CMWs were eager and interested in assisting her when needed, other CMWs did not have time for her needs. With this in mind, the participant felt as though some CMWs were not attentive or engaging enough for her comfort.

The raw data theme, Friendly/Nice, can be described by participant statements that the CMWs are kind people. For example, participants commented, *"I know [name of CMW] is a*

really lovely person... she's a very nice person I get along with her... Every time I see her she's always smile[ing]. That's what I like" and, *"They've [CMWs] been very kind people all there to help you, and just very kind. I can't say anything bad about them"*. These quotes show the approachable nature of the CMWs. In fact, even when participants felt that the CMWs were stringent with them, they also understood that the staff needed to be firm in order to help. This awareness can be illustrated through the following quote, *"Well they're [CMWs] really nice people there. Sometimes they're a little tough on people but I guess that's their way of helping people"*. This participant seemed to recognize the need for CMWs to be strict at times, especially when clients' safety is the concern. She was also able to recognize, however, that the CMWs were still supportive in their interactions.

The raw data theme, Welcoming Atmosphere, was formed from quotes which describe the CMWs' ability to create a hospitable and inviting atmosphere for their clients through interactions with them. For instance, participants state that:

When I go to Crisis even if [my CMW is] not there, there's the ladies at the front, the receptionists, are very inviting and they say, "Well do you want [to wait] for her or see someone else? And do you have time" hey? And it really helps because if I don't have time and I've got something else to get to, I'd really like to see somebody else and get my money I guess, you know?

and:

When I talk to them [CMWs] they make me feel more at ease because sometimes it's just hard to... I go there and sometimes I feel so out of place and when I go in there, just about everybody that comes by its, "Oh hey, how you doing [client name]? Good morning. How's your day?" They're joyful, hey?

When CMS clients go to the physical CMS location, they often have to wait in a lobby area for their CMW. The act of waiting can make some clients feel uneasy, especially if there are other clients in the lobby as well. Therefore, the welcoming interaction portrayed in the quotations above not only depict feelings of respect for the CMS clients, but also helps them to feel at ease; they feel like they are cared for, acknowledged, and accepted.

The last raw data theme, Level of Involvement, was formulated to describe raw data that either reveals client perceptions that CMWs are adequately involved in their lives or overly involved in their lives. These two ideas are demonstrated in the following quotes: *"[CMS] kind*

of leaves me some friends to talk to and they're good people, really good people", "[What I] least enjoy? For me they want to know everything I do, but without them there's a lot of negative and there's positive. With[out] them I wouldn't have any help" and, "I talk to [my CMW] about my problems, that's basically it. She helps me out, but she gets on my nerves sometimes. I told her, 'You stick your nose where it doesn't belong'". These quotes show that CMWs are in a constant state of negotiation in order to determine what level of involvement is appropriate for each client. This is conceivably a difficult balance to achieve because what some clients are comfortable with, in terms of staff involvement, is quite different than what other clients might be satisfied with. Furthermore, even though some clients may be uncomfortable with certain levels of involvement by their CMW, that level of engagement might be necessary for their best interests.

The raw data themes, Attentiveness/Engagement, Friendly/Nice, Welcoming Atmosphere, and Level of Involvement, all relate to the first-order category, Client Perception of Staff Interaction. Participants seemed to have mixed emotions about how attentive and involved CMWs were, but all agreed that CMWs were friendly and created a warm and inviting atmosphere for the clients. As stated previously, some clients may require more involvement from CMWs than they would like. Unfortunately, there is also the potential for CMWs to be too engaged with clients who are making healthy choices on their own. This could result in the CMWs unintentionally restricting their clients' independence.

Type of experience with CMS. The first-order category, Type of Experience with CMS, which is connected to the second-order category, Experience with CMS, was formed from three raw data themes: Good Experiences, Bad Experiences, and Varying Experiences. This first-order category was created to reveal the level of satisfaction that participants had with CMS as an organization.

The raw data theme, Good Experiences, can be described as participants stating that they were extremely satisfied with their involvement with CMS. One participant stated, *"I feel very lucky and fortunate to be a part of this program"* while another participant cited, *"Well I've had a very good experience. I'm very satisfied and I wouldn't change a thing about the issue, any issues or anything. There's no issues. I wouldn't change anything. It's been [a] very good program"*. Although both participants were content with their experiences with CMS, the second participant, in particular, did not mention anything that needed to be changed about CMS

throughout the interview. As this quote shows, she has had nothing but positive experiences in her dealings with CMS. Conversely, other participants did not share her strictly optimistic view, as can be exemplified through the next raw data theme.

The raw data theme, Bad Experiences, can be characterized as participants stating that they have had a dissatisfactory experience with CMS. Although these experiences were not as common, one participant stated that her involvements with CMS have:

...always been pretty rocky. They get on my nerves. We have trouble getting along; [it] might be a difference in personality. They assume things that aren't true and they are rude. All the staff jumps the gun over little things... They tend to be push[y], stern and strict because of my past when I was wild and rambunctious.

This participant, in particular, stated that she has had a history of not being able to develop a good rapport with the CMWs. She does mention, however, that this might be due to a difference in temperaments rather than something either party is doing.

Finally, the raw data theme, Varying Experiences, can be described as participants who have had both positive and negative interactions with CMS. Many participants defined their experiences as being composed of both positive and negative components. For instance one participant stated, “*Well I say pros and cons to the...I don't know how to fully answer I guess. Like at times damn good and then at times questionable [inaudible] as [I] imagine a number of people would respond*”, however, he was unable to elaborate. Another participant, however, was able to give a specific example of her experience:

There was times when I was very mentally sick... When they come barging in and drag me to the hospital. It goes both ways; I am relieved that I am getting help but I don't want to be locked up and drugged up. I don't like it when I'm hauled away, even though I need it.

This participant was describing instances when she was experiencing psychological distress and her CMW or the police traveled to her house in order to bring her to the hospital for psychiatric evaluation. In some instances this resulted in the hospital, or a psychiatrist, giving her medication to keep her safe. As the participant stated, she resented this because it took some of her freedom away, but she also seemed to understand that it was in her best interest and accepted the decision initially made by her CMW.

The first order category, Type of Experience with CMS, is accurately represented by the three raw data themes: Good Experiences, Bad Experiences, and Varying Experiences. Although most participants either shared that their experiences were positive or a mixture of positive and negative situations, some participants did indicate that their experiences with CMS were mostly adverse. More attention may need to be given to those individuals who have had strictly negative experiences in an attempt to determine how positive experiences can take their place. This change would have the potential to increase clients' tendencies to accept help from CMS and the CMWs because, generally, once people have a positive experience they are more open to other similar experiences.

Staff diversity, CMS is busy/uncomfortable, and CMS helpfulness. There are three raw data themes, Staff Diversity, CMS is Busy/Uncomfortable, and CMS Helpfulness that do not fit within a first-order category in particular; rather, they are related directly to the second-order category, Experience with CMS.

The raw data theme, Staff Diversity, was created to illustrate a participant's desire for CMWs to be from varying cultures. This notion can be shown in the following quote, *"You know the one thing there I really didn't notice in a while? First Nation people there or Métis...the staff"*. Perhaps importantly to note, this participant described himself as Métis at the beginning of the interview. Having a CMW who is visibly Métis may help him to feel understood at a deeper, conceivably more meaningful level. Often times, when one is able to personally identify with an individual, that relationship can grow to be more significant and profound. It is feasible that having stronger relationships with CMWs could help clients reach their optimum level of independence sooner because of the increased feelings of support. Although this participant specifically stated he would like to see more First Nations or Métis CMWs, this may be the case for other visible minorities as well.

The raw data theme, CMS is Busy/Uncomfortable, was devised to demonstrate that the physical location of CMS is often very active with clients entering and exiting the building and meeting with their CMWs. This raw data theme can be accurately shown through one participant's quote, *"The thing is it's like change I want. I'm just thinking that sometimes it's pretty busy...they're busy and you know, [they've got] lots going on so"*. Furthermore, another participant stated:

I don't know; when I talk to them they make me feel more at ease because sometimes it's just hard to go there and sometimes I feel so out of place... Some of the people going in, it's hard to really fathom what the heck is going on in their lives.

Since CMS is involved in many individuals' lives, helping them to be as independent as possible, often workers are busy with other clients. These participants were not only speaking to this fact, but also to the belief that the lobby area is often busy with clients wanting their weekly trustee money or to speak with their CMW. Generally, when waiting areas become too congested, individuals feel uncomfortable or uneasy. By making a change here, clients may feel more welcome and interested in going to CMS to see their CMW.

The last raw data theme, CMS Helpfulness, was formed based on quotes which depicted CMS as a place to fall back on when needed. This raw data theme can be represented through quotes by two participants, *"It's [CMS] a place to go when there's no other place available... It's a good place to go... It's given me a good place to fall back on"*, and:

I think my family doesn't really help me out because since mom died they don't help me out. Actually I drink too much and I'm not [going] to live in a little square box to be with my family because they don't drink and I'm not in that box and I don't want to be in that box. I feel that without them [CMS], I'd be having no help.

These participants' quotes depicted a sense of reliance on CMS as an organization. Furthermore, they illustrated that, to these participants, CMS was a safe place to go for help, support, and guidance. In this sense, CMS seems to fill a gap in society where, if unavailable, these individuals would not know where to go for assistance.

The three raw data themes, Staff Diversity, CMS is Busy/Uncomfortable, and CMS Helpfulness, relate directly to the second-order category, Experience with CMS. While many participants viewed CMS as favorable when they were in need, other participants would have liked to see changes in the areas of staff diversity and level of activity within the physical location of CMS. These changes would have helped to make participants feel more at ease, both with the CMWs and CMS as an organization. These changes could potentially translate into clients feeling more connected to the community and at the same time more able to rely on themselves.

Summary. All of the above 16 raw data themes relate to their respective first-order and second-order categories, which finally formulate the overarching dimension, Clients' Experiences with CMS and the CMS Staff. In general, this dimension showed that participants involved in this research had varying experiences with both the CMWs and CMS as an organization. Some participants felt that CMS and their CMWs were understanding, knowledgeable, friendly, good role models, able to create a welcoming atmosphere, and supportive when they were in need. On the other hand, some participants felt that CMWs could be more understanding, more supportive, less involved in their lives, have more cultural diversity, and create a less hectic atmosphere within CMS. This dimension is somewhat related, but also distinct, from the next dimension, Interactions Between CMS Workers and Their Clients, because interactions that participants have with CMS and their CMWs are a large part of the his/her experience.

Interactions Between CMS Workers and Their Clients. The Interactions Between CMS Workers and Their Clients dimension contains raw data from all 14 participants. This dimension was created from two first-order categories: Social Activities with CMS Workers and Client-Staff Communication. Since both first-order categories can be connected to the overarching dimension directly, a second-order category was unnecessary. This dimension was formed from seven raw data themes: Go Out for Coffee, Birthday Outings, Camp, Involved with CMS, Problems, Enjoy Talking to the Staff, and Communication Amounts, see Figure 4.2.

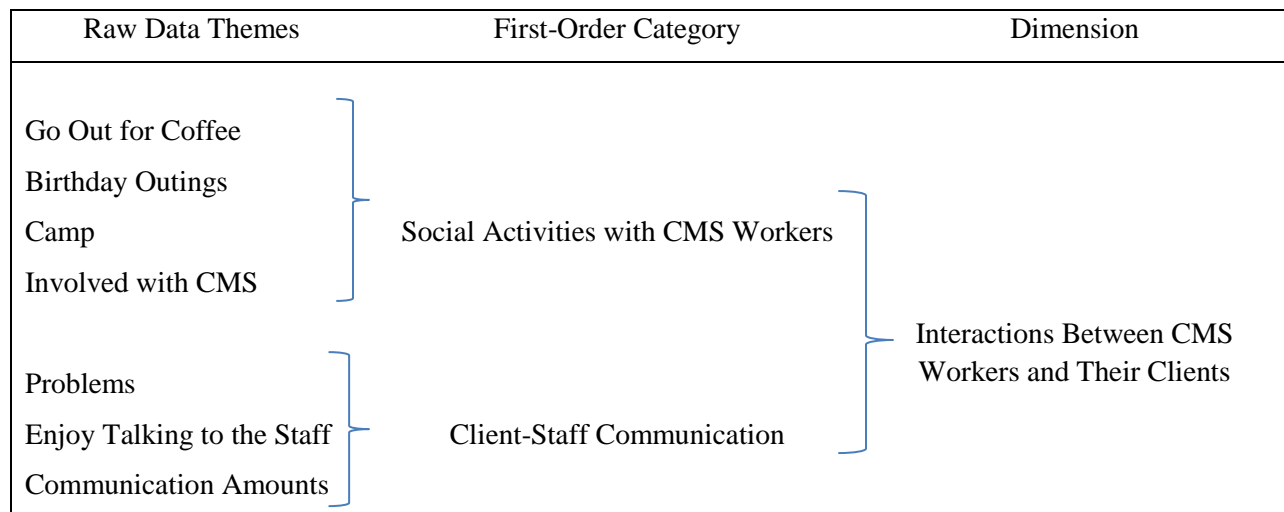


Figure 4.2. Interactions Between CMS Workers and Their Clients Dimension

Social activities with CMS workers. The initial first-order category, Social Activities with CMS Workers, was constructed from four raw data themes: Go Out for Coffee, Birthday Outings, Camp, and Involved with CMS. This first-order category was developed to describe different activities that the CMWs have partaken in with their clients, as well as activities that the participants wish they would have been more involved in. Participating in these various activities can help clients to feel a greater sense of connectedness with their CMWs and also the community in which they live. These activities can, therefore, help to strengthen clients' sense of belonging, independence, and stability. With this in mind, by engaging in various activities with clients, CMWs were using a strength-based approach to promote client perseverance and self-reliance.

The first raw data theme, Go Out for Coffee, reveals CMWs taking the CMS clients out for coffee in an effort to connect on neutral ground. This raw data theme can be exhibited through the following quote, *"Most enjoy? When they take me out for coffee and we discuss what's going on in my life and everything like that...I enjoy that very much"*. This participant was describing her CMW taking her out for coffee to discuss the participant's life. Further, another participant stated, *"They take me out for coffee for a checkup to evaluate how I'm doing"*. Although the CMW may have also had the goal of assessing the client to ensure they were following programming or progressing toward their goals, they were also providing the client with the ability to interact effectively in a social situation. By taking clients out for coffee, the CMWs were also demonstrating to their clients that they genuinely cared about their well-being.

The second raw data theme, Birthday Outings, describes the CMS workers taking the participants out for their birthday for either lunch or dinner. This raw data theme can be shown through one participant's response when asked what the most enjoying part of CMS was for her, *"Birthday lunch!...They [CMW] take us out for a birthday lunch and it's free to us"*. Additionally, another participant mirrored this sentiment, *"Dinner! We've had dinner. They take me out for birthday dinners and things like that"*. As with taking a CMS client out for coffee, taking him/her out for his/her birthday also effectively portrays that CMWs care about their clients. By having this type of support, CMS clients felt valued. Feelings of being appreciated often increase one's self-esteem and, therefore, one's ability to be independent. Consequently,

from these social interactions, CMS clients are able to use their strengths in an effort to reach their goal of living as independently as possible.

The next raw data theme, Camp, was formulated to depict CMWs going to a camp with their clients. One participant stated, *“I’ve really spent a lot of good time with them and I’ve been to camp where the Crisis Management Workers were there and I really had a good time with the Crisis Management Workers”*. This participant was referring to a camp experience that was provided by Mental Health and Addictions Services, Adult Community Services, for clients who are physically located more north than the city of Saskatoon. According to the Coordinator/Assistant Executive Director of CMS, if a CMS client was attending this camp, a CMW(s) would also attend to help with the operation of the camp. Again, this participant was speaking about the feelings of care and support that are associated with spending time socially with the CMWs.

The last raw data theme, Involved with CMS, was created to describe other social activities or programs that CMS offers to its clients that clients sometimes choose not to attend. For example, visiting and spending time with the CMWs or get-togethers around holidays like Christmas. One participant stated:

I don’t know. There’s a lot of program[s] there that I don’t go to, hey? But there is this barbeque, I never went to it, there’s dances that I don’t go to, but I’ve went to a couple. I’m pretty sure up Arlington; I think about Arlington. [I had a] very good time, got some neat presents, and even downtown there one church by the Renaissance [hotel], went there for a Christmas pageant, or party or something like this. It was pretty fun; I knew a couple people there anyway.

This participant’s quote shows that there are many activities that CMS provides for its clients in an effort to help them feel more connected to their community. Although this participant stated that he did not go to some of these social gatherings, feelings of belonging, choice, and independence were being fostered.

The raw data themes, Go Out for Coffee, Birthday Outings, Camp, and Involved with CMS, combine to establish the first-order category, Social Activities with CMS Workers. These raw data themes illustrate that participants generally appreciate and enjoy spending time with their CMW in the community. Even though CMS clients may have viewed these activities as strictly pleasant social gatherings, by spending time with CMWs, who are presumably healthy

and independent individuals, mentorship has a chance to occur. When clients are able to learn how to interact with individuals in the community or the community itself, they are increasing their repertoire of skills and strengths to utilize in their everyday lives. Although not all participants partook in the activities that were made available to them, they still acknowledged that it was a positive way to engage with others. Furthermore, by allowing participants to decide for themselves when and if they wished to engage in various activities, CMS helped to promote a sense of self-determination and self-sufficiency.

Client-staff communication. The first-order category, Client-Staff Communication, is comprised of three raw data themes: Problems, Enjoy Talking to the Staff, and Communication Amounts. This first order category was composed to define different elements of participants' conversations with CMWs. This first-order category depicts clients talking to their CMW about their problems, shows that they enjoy talking to their CMW, and describes the different amounts of communication each participant experiences with his/her CMW.

The raw data theme, Problems, was constructed to reveal participants' experience when they attempt to talk to CMWs about any of the dilemmas that they may have. Participants indicated that some of the predicaments that they discussed with their CMWs were about their family, money, mental health, or living arrangements. Some participants stated that CMWs made time for them, *"Well, they talk to me and they listen to me and I can talk to them about my problems and they're there for me"* and, *"[My CMW] is a really good person to talk to if I'm having any problems"*. While other participants felt that the CMWs were too involved when trying to converse about their problems: *"[I] talk to one of them about my problems. It's like talking to a psychiatrist, but sometimes, just like leave me alone"*. Together these quotes demonstrate the delicate balance between being too involved in clients' problems and being adequately involved. The first two quotes show participants who felt accepted, supported, and assisted by their CMWs. The second quote, on the other hand, depicts a participant who brings up her problems with her worker, but who is not prepared to have a deeper discussion about it. The readiness of this participant to accept what her CMW has to say about the problems is unclear and, perhaps, this is being interpreted by the participant as the CMW being too involved. Again, the CMWs have to be aware of providing enough support to help their clients, but not so much support that it takes their clients' independence away. As illustrated in the previous dimension, CMWs are often seen as family by their clients. It is, therefore, frequently the case

that clients go to their CMW to receive guidance, advice, or to hear another's opinion on a topic. As a result, CMS clients are regularly communicating with CMWs about any issue or problem that they encounter. Unfortunately, it may sometimes be the case that the clients themselves have been on their own for so long without support that any support seems to be too much for them.

The raw data theme, Enjoy Talking to the Staff, was created to describe client views that talking to the CMWs is a welcomed activity. As one participant stated:

[My CMW] talks to me about spirituality and my interest with scientology over the last couple of years, so it's nice to talk, but, you know, it's pretty neutral, neutral positive, kind of real change other than what it would have been I think.

As this quote shows, CMWs talk to their clients about various topics and interests. By talking to their clients about themes other than their issues or problems, the CMWs were helping to build rapport with their clients and were making them feel unique and important: an essential component of building resilience. Another participant stated that part of what made her happy was "...enjoying the staff and being able to talk to them and them being there for you all the time. I needed help". This participant touched on the concept that talking with individuals promotes a sense of support and that he genuinely enjoyed communicating with the CMWs. Similarly, the CMWs were viewed as positive people to talk to. For instance, one participant stated:

I don't agree with my diagnosis, so I'm in a terrible place with the community treatment order but she's [CMW] been a positive person to talk to...It's comforting that there is something like counselling there. Like, I don't have counselling with a doctor or anything, but she's someone I can talk to every once in a while.

This participant had been diagnosed with a mental disorder which he did not agree with. Although he would have liked his CMW to work with him to overturn this diagnosis, he appreciated her ability to listen and support him. In this sense, he saw his CMW as a good person to talk to. Perhaps, this client can learn through his interactions with his CMW how he could proceed in challenging his diagnosis, which could potentially increase his feelings of self-reliance and independence. As with the, Social Activities with CMS Workers, first-order category, communicating with the CMWs can be viewed as an activity that promotes feelings of being valued and belonging. Through this correspondence, individuals were taught and

encouraged to use life skills so that they could more independently solve similar problems in the future; showing the strength-based approach that CMS works from.

The raw data theme, Communication Amounts, can be described as the amount of time on average that the participants and their CMW connect. Responses varied from, *“I am in contact with them every three to six months”* to, *“I get my money weekly on Wednesdays and I talk to [name of CMW] once or twice a week on the phone. Sometimes, maybe once a week or once every two weeks, we go for coffee”*. As these quotes demonstrate, the level of interaction between a CMW and a client varied. As stated previously, client needs and resources are assessed based on 10 ‘work areas’ whereby CMWs use a strength-based approach to work on client vulnerabilities through their assets. The discrepancy in communication amounts, therefore, seems appropriate as those individuals who have the greatest need, or fewest resources, should be in contact with CMS and the CMWs more often than those who have a lesser need and more resources.

The raw data themes, Problems, Enjoy Talking to the Staff, and Communication Amounts, combine to form the first-order category, Client-Staff Communication. Although the amount of communication and interaction CMS clients experienced with their CMWs differed, these raw data themes illustrate that participants enjoyed talking to their workers and conversing with them about various issues. These activities helped to produce feelings of being valued and supported and helped to strengthen participants’ ability to be advocates for themselves.

Summary. The seven raw data themes join to create two first-order categories and the dimension, Interactions Between CMS Workers and Their Clients. As shown throughout this dimension, participants generally indicated that they appreciated being able to spend time with their CMW, the opportunity to be engaged in activities, their CMWs’ ability to listen and help with their problems, and talking with their CMWs. On the other hand, however, some participants indicated that the CMWs did not provide them with enough space and time to deal with their own problems before stepping in and taking over. It did appear, however, that CMWs were in more contact with those clients who have the greatest needs. Therefore, it may have been the case that the CMWs were behaving in their clients’ best interest even if their clients were apprehensive. This dimension is related to the next dimension, Financial Interactions to Increase Client Independence, in that both dimensions demonstrate CMWs helping clients with problems, whether it be general difficulties or financial adversity in particular.

Financial interactions to increase client independence. The Financial Interactions to Increase Client Independence dimension contains raw data from more than half of the participants. This dimension was devised from three first-order categories: Money Based Interactions Between Clients and CMS, Helping Clients Deal with Finances, and Clients’ Ability to be Financially Independent. These first-order categories were constructed from seven raw data themes: Trustee, Weekly Money, Manage My Money, Savings, Money Problems, Independence, and Increase the Money I Have, see Figure 4.3.

Raw Data Themes	First-Order Category	Dimension
Trustee Weekly Money	Money Based Interactions Between Clients and CMS	Financial Interactions to Increase Client Independence
Manage My Money Savings Money Problems	Helping Clients Deal with Finances	
Independence Increase the Money I Have	Clients’ Ability to be Financially Independent	

Figure 4.3. Financial Interactions to Increase Client Independence Dimension

Money based interactions between clients and CMS. The first-order category, Money Based Interactions Between Clients and CMS, was developed from two raw data themes: Trustee and Weekly Money. This first-order category was composed to describe interactions between the CMWs and their clients that dealt solely with finances and how often these interactions occurred.

The raw data theme, Trustee, was formulated to characterize data showing that the CMWs helped their clients to deal with money through a trustee program. For instance, one participant stated, “[CMS] started being my financial advisor after a while and they became very helpful”. Additionally, another participant shared, “I was looking for a way [to] budget my money, like my weekly money, so they [referral source] sen[t] me to Crisis to get a trustee there and they told Crisis that I wanted to budget my money”. Not only was this participant describing how he became involved with CMS, but he was also illustrating one of CMS’ roles. Many of the

CMS clients have CMS as their trustee. This means that CMS essentially acts as their bank, keeping their money safe for them, but also giving them money when they need it. The trustee program was designed to help clients learn to manage and budget their money so that they could be better able to do this independently in the future. This program relates directly to the strength-based approach in terms of its ability to enhance clients' financial capabilities and responsibility. For instance, by using the financial skills that clients already possess or other strengths that are related, CMWs can teach their clients how to effectively manage their money.

The raw data theme, Weekly Money, was created to highlight another interaction centered on clients' capital and CMS' involvement. When individuals are part of the trustee program, they collect their money weekly at CMS with the assumption that this money should last for the week. This also results in the CMWs being able to check up on their clients' well-being at that time. Participants had varying thoughts on obtaining their money weekly. For example, one participant did not like having to go to CMS for her money as can be demonstrated in the following quote, "*[I least enjoy] having to pick up my money once a week... it's not like they're not giving me enough money, it's just I hate going there after work*". In this participant's case, she felt tired after a day of work and did not want to have to go to CMS in order to get her money. Other participants, however, disliked only being able to acquire their money weekly. When asked what they least enjoyed at CMS, one participant stated:

Do I least enjoy? Well we used to be able to get like 10, 20 dollars in between paydays and now [we] can only do that on Wednesday. They used to be able to do that like on any day...But they're saying they're sticking more by the rules now so they can only do that Wednesday.

As shown above, it used to be practice that CMS clients could go to CMS between 'paydays' to get some extra money from their account, this generally, is no longer the case. Part of this change was a result of too many clients coming in to get money advances and the CMWs' time being taken up for this alone (C. Briere, personal communication, February 6, 2012). Therefore, by issuing money once a week, CMWs are more able to support their clients with other endeavors the rest of the week. Furthermore, by only issuing money weekly, there is a greater need for CMS clients to learn to manage their money to ensure that they do not run out before the week is over. This can help to increase clients' self-reliance and independence. Some participants, on the

other hand, enjoyed being able to gain their money on a weekly basis as can be illuminated through the following quote:

When I get paid on a regular basis that[‘s] what’s changed. It was every two weeks, it was split into two, they split it into four, because I was asking for advances so th[ey] said, “Well we’ll just split it into four.” I like that...It’s not as nerve racking, it helps more. I don’t have to wait so long to be without money. With the extra days I’m very happy that they have made the decision for me to keep my money instead of me keeping it. [It] is one of the positive things I think, because I know that if I had it, [it] would be gone in one day. If I got it all in one day, it would be gone in one day. For the longest time it’s been like that, it’s really been its really been soothing, very soothing.

This participant’s quote was in response to the questions of what expectations he felt CMS has met. CMS used to provide clients with money twice a month. When the participant referred to ‘splitting it up into four rather than two’, he was referring to CMS issuing money once a week rather than once every two weeks. This change was seen as a benefit to this participant because he was having difficulty managing his money when it was only distributed every two weeks. The participant called this experience ‘soothing’, that is, he can be more at ease now, knowing that he will be financially supported every week.

The raw data themes, Trustee and Weekly Money, combine to form the first-order category, Money Based Interactions Between Clients and CMS. CMS clients who are part of the trustee program see their CMWs every week in order to collect their money. Although some participants enjoyed going to gather their money weekly, other participants had reservations. Regardless of clients’ thoughts on acquiring money weekly from CMS, this program helped them to learn to manage their money over an acceptable amount of time. That is, a weekly time frame seems to be appropriate for most clients. Perhaps when clients become more skilled in their ability to manage their money weekly, they could be moved to a bi-weekly schedule. This change could help those individuals who find it difficult to get to CMS after a day’s work.

Helping clients deal with finances. The first-order category, Helping Clients Deal with Finances, was constructed from three raw data themes: Manage My Money, Savings, and Money Problems. This first-order category was designed to illuminate the different ways that CMS helps its clients to be more financially secure and responsible.

The first raw data theme, Manage My Money, was created to describe quotes which show CMS helping participants to make use of their money more efficiently. For example, one participant stated, *“Oh I think I benefitted [inaudible] because I’m not too good at managing money and I’m not too good at finding a place, buying and all that. So, I think in a lot of ways it has helped me”*. This participant was describing the perception of being more supported because CMS was helping him to spend his money in more responsible ways, such as paying for his living accommodations. Another participant also expressed his experience with CMWs helping him to manage his money:

[My CMW] helped me to be able to take funds out when I need them and so when I needed a lock for my bike or if I have a bill that has to be paid, it’s just taken care of. It really helps out.

In this sense, CMS was helping its clients to deal with their finances in a way that takes care of their necessities, in the hopes that eventually these individuals would be able to manage their own money to the same standard.

The second raw data theme, Savings, was formed based on quotes from participants that characterize CMS’ role in helping its clients save their money. For example, one participant stated, *“They help me out. I put 25 dollars into savings a month and they hang on to that for me. They don’t let me touch it”* and another participant acknowledged:

Well, the only thing that it has done for me is that I have a chance to save money in my saving. Usually if I’m on my own I never have anything. Like, I have no way to save then... When I go to my savings I can take 20 dollars out, I can take 10 dollars out, you know? ... They help me with my saving and budgeting.

This second quote showed that, without the help and support of CMS, this participant would have no savings account. Moreover, it demonstrated that the client is free to take money out of his/her savings if he/she needs to. By holding clients’ money in savings, it not only helps clients to prepare financially for things they may need in the future, teaching them the responsibility of planning ahead, but also gives them a place where they feel safe to store their money in trust.

The third raw data theme, Money Problems, was established from participant quotes that describe CMS helping participants when they experience problems with finances, but also that CMS clients anticipate that CMS will help them in the future with financial problems. For instance, one participant stated:

Well it got me off the streets because I was pretty destitute before I got to Crisis Management to help me out and that. I was on the streets panhandling and nothing, no money, no income. It's all changed... I don't have to depend on anybody for money anymore because I get a weekly allowance of 50 dollars.

Through this quote, the reader can understand that this participant's life has changed dramatically since CMS has been involved. He defined himself as 'destitute', having not enough money to survive, and having to resort to panhandling. This individual, therefore, had severe money problems. It was through the trustee program at CMS and through their support and guidance that he was able to have access to weekly money and secure an income. Further, one participant stated:

I got a phone from a company and I was charged a lot of money so [my CMW] helped me and she talked to them and told them I have a disability and I couldn't pay for 100 dollars or [a] 200 [dollar] phone bill. So now I only have to pay 30 bucks a month and I get quite a bit of help... She talked to the people at the company and they made an agreement, so she really helped me out.

This quote, along with the previous quote, indicated that CMWs have helped their clients, not only with obtaining money when they have none, but also if they found themselves in a situation where they were unable to pay for something. Other participants, however, felt that they would like more help from the CMWs in order to deal with their money problems. One participant stated, "Well, there was a few problems that I had. I had money problems, I had living situation problems... I hope they're going to do something about it". This participant later described CMS' help with her financial troubles as a 'work in progress'; therefore, this participant was still hoping to see more support for her difficulties. Consequently, although this participant was receiving some support from CMS, more would be required for her comfort.

The raw data themes, Manage My Money, Savings, and Money Problems, form the first-order category, Helping Clients Deal with Finances. Not only is CMS helping its clients to manage their money more effectively and plan for the future in terms of savings, they are also helping them to solve situations when financial problems do arise. Some participants, however, have stated that they felt the need for more support in handling their monetary problems. Since the CMS clients all have different needs and are all at varying levels of independence, it stands to reason that some clients need more support. A logical progression may be more communication

between the clients and the CMWs about what exactly the client needs in terms of support in this area.

Clients' ability to be financially independent. The first-order category, Clients' Ability to be Financially Independent, was devised from two raw data themes, Independence and Increase the Money I Have. This first-order category was created to characterize how CMS clients felt a sense of autonomy based on the monetary help they were receiving from CMS.

The first raw data theme, Independence, is demonstrated by quotes showing that participants were able to be more autonomous in their lives because of CMS' role in helping them with their money. For example, one participant stated, *"Well I don't have to depend on anybody for money anymore because I get a weekly allowance of 50 dollars"*. As evident by this quote, this participant was depending on CMS to give him money. This money was, however, his own, with CMS acting as his bank. Another participant affirmed:

Lately I haven't been on trustee so I've just been spending money. So with being on trustee, it somewhat helps me manage my money and be more independent and try and learn to manage my own money, getting it once a week instead of all in one lump.

Although this participant was not currently on trustee, he felt that when he was receiving financial assistance he was learning the skills to manage his money more effectively. By being part of the trustee program, CMS clients have to be able to decide how much money they have to spend every day in order to make the funds last for the whole week. As this participant stated, being on trustee and learning these skills was essential to helping him live at his optimal level of independence. Having the feeling of being financially independent helps clients to feel more independent in other areas as well. This freedom also helps to create a greater sense of self-worth for individuals because they begin to experience more responsibility for themselves and their role in the community.

The last raw data theme, Increase the Money I Have, was formulated to describe participants having more money than they had prior to their involvement with CMS. Further, it highlights participants wanting more money than they are currently receiving. These two ideas can be illuminated in the following quotes:

I get money for other things besides just welfare money. I was getting money besides that, which has never happened with me before, so that's one of the things. I need money to

live; can't live without money for me. But I knew if I had to, well, I was going to say I wouldn't have money, but that's changed a lot. I used to be broke all the time.

While, on the other hand, other participants asserted, “*Well it would be nice if I had more money*” and, “*The minimal amount of money or one major factor [that I least enjoy]*”. The first quote depicted a participant who was astounded that he was able to receive money from a variety of sources. This speaks to CMS’ role in connecting individuals with other organizations and resources, in this case, to help its clients have more freedom financially. The subsequent quotes illustrated a different idea. Primarily that these individuals would feel more comfortable with their quality of life and level of independence if CMS was able to secure more money for them.

The raw data themes, Independence and Increase the Money I Have, combine to form the first-order category, Clients’ Ability to be Financially Independent. Most participant quotes that contributed to this first-order category demonstrated that participants felt more independent because of having more money and because they learnt the skills to manage their own money. Other participants, however, felt that more support financially is required for these feelings of independence to emerge. These different experiences show that clients have varying levels of need. Therefore, although CMS should be connecting its clients with as many sources of income possible, clients should also be taking as much responsibility for themselves as feasible in their ability to secure their own means of income.

Summary. The Financial Interactions to Increase Client Independence dimension, discussed above, generally indicated that CMS deals with at least some of its clients’ finances. Some participants enjoyed being able to pick up their money weekly from CMS and felt that CMS and their CMWs were helping with money management, financial problems, and their independence. However, other participants thought that picking up their money weekly was a hassle and felt that they needed more support with financial issues and sources of income to be able to feel independent. This dimension is related to the next dimension, Help and Support for Client Needs, since the ability to have and financial comfort and security is an important component of meeting many primary needs of individuals.

Help and support for client needs. The Help and Support for Client Needs dimension contains raw data from more than half of the participants. This dimension was created from two second-order categories, which were built from four first-order categories and eight raw data themes. The second-order category, Help and Support with Primary Client Needs, was derived

from two related first-order categories: Support with Living Arrangements and Support for Basic Living Needs. These first-order categories were formed from four raw data themes: Finding a Place to Live, Communication Regarding Residence, Nutritional Needs, and Clothing Needs. This dimension also contains the second-order category, Help and Support with Secondary Client Needs. This second-order category was derived from two first-order categories: Helping Clients in Their Immediate Environment and Help Clients Make Their Way in Society, and four raw data themes: Personal Items, Housing Items, Societal Items, and Transportation, see Figure 4.4.

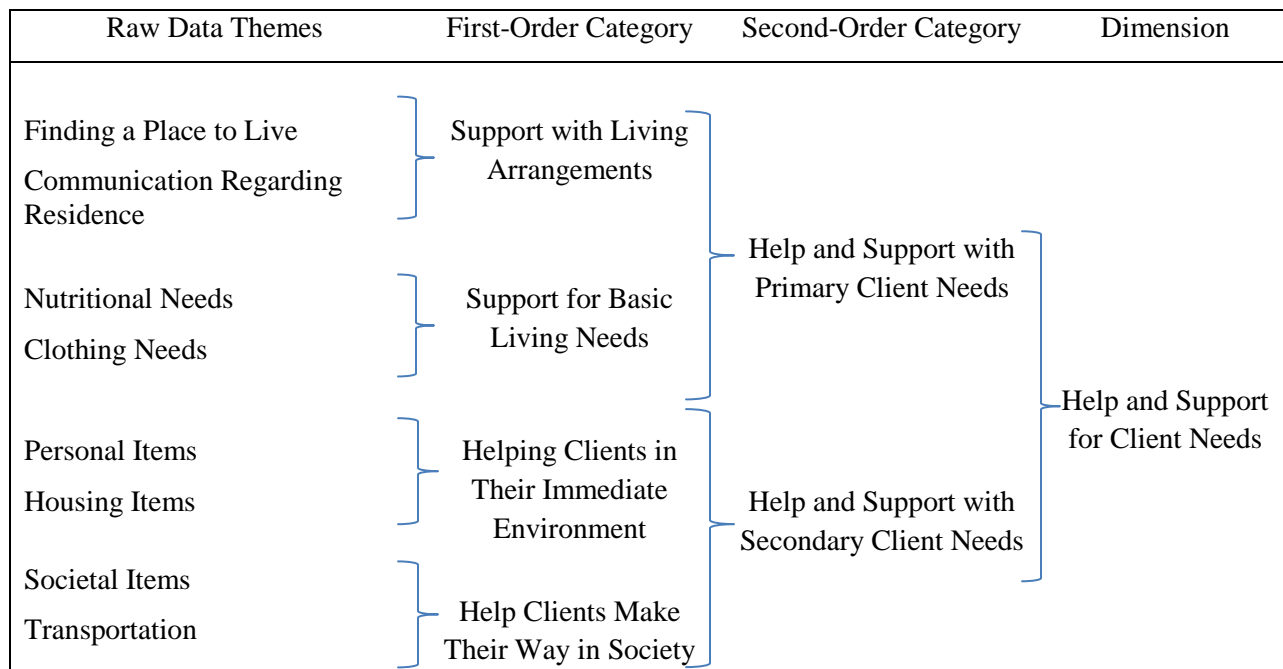


Figure 4.4. Help and Support for Client Needs Dimension

Support with living arrangements. The first-order category, Support with Living Arrangements, a component of the Help and Support with Primary Client Needs second-order category, was formed from two raw data themes: Finding a Place to Live and Communication Regarding Residence. This first-order category was developed to describe CMS' role in facilitating the process of obtaining various living arrangements with its clients, but also its clients' desires for more communication and support between clients, CMWs, and home care providers regarding clients' living arrangements.

The first raw data theme, Finding a Place to Live, was constructed to illustrate CMS and the CMWs helping participants find their own places to live independently, but also places to

live with support from a care home provider. This raw data theme can be shown through various quotes. For example:

[My CMW] was the one who helped me out and after I quit hearing these voices and hallucinating I have my own place now. I can take care of myself, but I'm an alcoholic. That's how I deal with my problems is to drink and I think that the pain will go away, but it doesn't and I have depression I know that.

Even though, as evident in this quote, this participant was still dealing with mental health concerns, her CMW was able to support her in securing her own home. It appears that there were some mental health concerns that were dealt with prior to this participant acquiring a residence. This speaks to the tendency of the CMWs to help their clients move toward more stability and to have them make changes to live more independent lives, but also to meet them at their current level of need. Therefore, with the help of the CMWs and by using their own strengths to overcome some hardships, the CMS clients are able to live more independently in the community. In further support of CMWs helping their clients to live on their own, there are participants who seemed to know that CMS would help them if they wanted their own place. For example, one participant stated, *"I live in a home care... [but] supposing I was looking for a place [to live], they [CMS] would help me... [They] help me do a lot of stuff"*. Even though this participant was currently living in a care home, based on his experience with CMS and the support that he felt he received from the CMWs, he was confident that they would help him if he wanted to find a place of his own. Being supported in this way can help to create a sense of worth and significance. Through these feelings, one can start to feel more empowered and able to take care of oneself: an essential component of being independent. As the above quote showed, not all CMS clients live on their own; some clients live with the support of a care home provider. For instance, one participant stated:

They've [CMS] helped me find a care home to move into, but the one care home I moved into I had to move out of because there was problems there and [name of CMW] thought that it might be a good place for me to live, but we found out it wasn't all that good. So I found a good place to move into and I really like it now.

There are some CMS clients who simply cannot live on their own given their present circumstance. Although the level of support ranges, these individuals may need support from their caregivers to remember to take their medication, to help them with preparing food, or to

help with cleaning their living space. Whatever their needed level of care, CMS and the CMWs help their clients connect with care home facilities in an effort to ensure that they are receiving the best and most appropriate care available. Additionally, as the above quote showed, CMS would also support its clients if they wanted to find a new care home on their own. In this respect, they would be supporting their clients' independence and agency as a person. By meeting the needs of the client, CMS is helping those clients to be as independent as they can at that time in their life.

The raw data theme, Communication Regarding Residence, was created to depict that participants would like more connection between their CMW and their care home provider, between themselves and their CMW, and more support concerning their living arrangements. For instance, one participant stated:

My caregiver he's said he's going to [inaudible] if I keep doing wrong... When I say, "I'm not doing good and make me feel good" and I feel like an idiot for saying that, that's the problem. He's just making a fool of me and if Crisis would step in there.

This participant described an expectation of his that had not been met. According to him, his care home provider's expectations were too high and when they could not be attained he felt inadequate. Essentially he thought that CMS should oversee how his care home provider interacts with him. Since this participant was not seeing this level of monitoring from CMS, he felt as though he was not being supported as much as he should be. Not only would CMS clients like to have more communication between their CMW and their care home provider, but also between themselves and their CMW about their living situation. For example, one participant stated:

Well, for the apartment, that was [something unexpected that I got through CMS] although I've been informed this afternoon [that] I'm being kicked out, I guess. [I'm going to] move with a person. At least I'll be getting fed again anyway... I've been informed to go see the lady and [that's] all I've been informed thus far.

Although this participant was originally not expecting to be able to live in an apartment by himself, he was surprised about having to vacate his apartment and having to experience a new living arrangement. As evident in the above quote, this participant did not have much information about what his new living experience would be. This participant may have benefited from more communication between himself and his CMW, as he had just learnt about the need to

move that morning. Accordingly, this participant may have felt that if he had more warning about the move, he would have been more prepared and would have felt more supported. Importantly, however, throughout the interview it was apparent that this participant struggled with memory and, therefore, his worker may have informed him of the move prior to that morning. Either way, however, this participant felt that more could have been done to support him at this time. Another quote which illustrated that participants would like more communication and support with their living situation is as follows, *“Well, there was a few problems that I had... I ha[ve] living situation problems... I hope they’re going to do something about it”*. In addition, when asked what he would like CMS to do that they haven’t already done, one participant stated, *“Get a new place... My caregivers kind of unruly... That’s what I wish [would be different]”*. This participant felt as though his care home provider was treating him unfairly and with disrespect. Because of this dynamic, he would have liked to live somewhere else, away from his current care home provider. In order to make this move, this participant felt as though he needed more support from his CMW. Both of the above quotes showed that participants would like CMS to intervene and communicate with them to a greater degree. If able to experience this increased support from CMS, it would be possible that these clients would learn to deal with these types of situations on their own, which would increase their strengths and ability to be independent.

The raw data themes, Finding a Place to Live and Communication Regarding Residence, combine to form the first-order category, Support with Living Arrangements. These raw data themes demonstrated that CMS supports its clients by facilitating different living arrangements for them, however, that clients would also have liked to see more communication and support in some circumstances. Further, these raw data themes together illustrated that CMS was able to work with its clients at their varying levels of independence, those that can live on their own, and those that need more support. By assessing their clients on 10 ‘work areas’ to determine their strengths and vulnerabilities, the CMWs, along with their clients, are able to determine the client’s optimal living arrangement. By including the client in this process, a greater sense of independence and autonomy can develop.

Support for basic living needs. The first-order category, Support for Basic Living Needs, which is subsumed under the second-order category, Help and Support with Primary Client Needs, was constructed from two raw data themes: Nutritional Needs and Clothing Needs. This

first-order category was developed to demonstrate that CMS helps its clients to secure the food they need to live and helps them to obtain and maintain their garments.

The raw data theme, Nutritional Needs, was created to describe CMWs helping their clients in the process of receiving food in various ways in the community. One way that CMWs helped their clients to meet this primary need was by giving them rides to and from the grocery store and the Food Bank. This raw data theme is revealed through the subsequent quote:

[An example of how CMS has helped me to live more independently is when] they used to take me grocery shopping. Like, I'd go there by myself and they would pick me up and bring me home. That's a hard one because they make me do most of it by myself".

Not only did this quote show that the CMWs facilitate the client's experience in getting groceries, but it also illustrated that they are supporting her to the extent she needs and not beyond that. That is, the CMWs were not over-supporting her so that she became dependent on them, but rather, they were supporting her to a degree where she was still learning to do things for herself. CMS was essentially helping this participant to increase her abilities and strengths so that she could live more independently in the community. Additionally, another participant stated that some of her expectations about CMS had been met including "getting a ride home from the food bank, getting a ride home from grocery shopping, [and] being shown how to make my way in the community". Some CMS clients utilize the Food Bank because they cannot afford to go grocery shopping all of the time. In these circumstances the CMWs simplify their clients' access to the Food Bank by providing transportation. By supporting their clients in this manner, the CMWs are helping their clients to meet their own primary need of obtaining food and, therefore, their ability to be independent and "make [their] way in the community". Another way that CMWs helped their clients acquire food was by assisting their clients to shop for food. For example, one participant stated:

Crisis Management helped me out with getting the doctor and the drugs going and then after that they helped me shop for groceries and things like that, which was really difficult for me because I am handicapped...I do my grocery shopping... with them.

This client's experience differed from the previous two in that the CMWs were physically in the grocery store with her. Not only was this situation providing the client with opportunities to interact socially, but it was also conveying more support to the client from her CMW. Moreover, not all clients go grocery shopping with their CMW. Perhaps, then, this indicates that the CMWs

are able to meet their clients at their individual level of independence and need. Regardless, by increasing their clients' knowledge of how to effectively get the food they require, these clients will better be able to support themselves in the future.

The raw data theme, Clothing Needs, was composed to describe the help that CMWs gave their clients to meet their primary need of having garments to wear. For example, one participant stated, "*Well it's [CMS] supplied me with...clothes... They buy me clothes... They take care of me*" and another participant declared, "*They've become very helpful. I do my laundry with them... It's been very pleasurable being with Crisis Management*". Often times, given their life circumstance, CMS clients may not have enough clothes to wear or may need clothes for special circumstances (e.g., a job interview). In these circumstances CMWs would help their clients buy the clothes they needed by connecting them to places such as the Salvation Army (C. Briere, personal communication, February 6, 2012). By forming these connections, CMS clients are able to learn where to go to obtain the clothing they require at a price that they can afford. In this sense, the CMWs are helping their clients make their way in the community. Further, as the second quote demonstrated, CMS helps its clients to maintain the clothing they do have by helping them at laundry facilities. By gaining this skill, this participant will be better able to care for herself more independently in the future.

The raw data themes, Nutritional Needs and Clothing Needs, combine to form the first order category, Support for Basic Living Needs. In general, these raw data themes showed that CMS and the CMWs support their clients to their own specific level of need when helping them to secure the food they need to survive and the clothes they need to wear for everyday life and for special occasions. Having access to food and appropriate clothing to wear, especially during the winter months, can be viewed as meeting some of the basic and primary needs of these individuals. By teaching their clients these skills, they will be better able to support themselves and live more independent lives.

Helping clients in their immediate environment. The first-order category, Helping Clients in Their Immediate Environment, which is subsumed under the second-order category, Help and Support with Secondary Client Needs, consists of two raw data themes: Personal Items and Housing Items. This first-order category was created to describe how CMWs help their clients be comfortable in their environment with these individual needs.

The first raw data theme, Personal Items, was designed to illustrate the support that CMWs gave their clients when obtaining items like identification and glasses. These items can be seen as personal because they benefitted the client on an individual level. In terms of help with the personal item of identification, one participant stated that “[CMS] got me my ID... I just recently lost my identification, so they gave me the forms to fill out and they’re going to fax them and everything”. Some form of identification is often required when dealing with organizations that offer services, such as, healthcare and utilities. In this sense, by having identification this participant will be better able to obtain the services she requires in order to make her immediate personal environment more comfortable. Although obtaining identification may seem trivial to some, to others this is a significant barrier to overcome. It is with the support, guidance, and help of CMS that these individuals know where to go and how to acquire identification. CMS has also been shown to help its clients with other personal items such as glasses, sometimes by going through other organizations. For example, one participant stated:

[My CMW] helped me to get some glasses through welfare. I wasn’t sure about who to talk to about the benefits for getting prescription glasses, but she helped me to do that two years ago when I was in the hospital, so it was good.

Not being able to see one’s environment makes it considerably more difficult to be independent. By helping their clients to obtain personal items such as glasses, the CMWs are not only connecting them with other organizations and, therefore, increasing their circle of care, but they are also helping that client to be more independent and comfortable in their environment. In essence, they are increasing their client’s resources: a vital component of the strength-based approach.

The raw data theme, Housing Items, was developed to describe quotes which exemplify CMWs helping their clients with responsibilities in an effort to improve their comfort in their own homes. CMWs were able to help their clients meet this need through various avenues. For example, CMWs assisted their clients in setting up different connections with companies who offer services, such as power and water. For instance, one participant stated, “They [CMS] help me out with stuff like hooking up power if I get on my own and hook up the phone...[They] help me do a lot of stuff”. This participant was describing his CMW helping him to call the power and phone company when he moved out on his own. Although these responsibilities may seem minor, for many of these participants, this is the first time they have had to set up their own

utilities and, therefore, they need some guidance. By helping their clients with these necessities, the CMS clients are better able to live independently in their homes in an enjoyable way. Additionally, CMWs also helped their clients by ensuring that assorted bills are being paid. For example, one participant stated, *“I talk to [my CMW] all the time. Well, [a] couple times a week probably, making sure bills are being paid and that, and she keeps up on it”*. As this participant described it, his CMW checks in with him to make sure that he is paying his bills when they are due. Moreover, as this participant stated, his CMW was good at remembering when his bills were due so that he could be reminded to pay them. Since all CMS clients are working on different vulnerabilities using their strengths, it is possible that some CMS clients pay their bills without being reminded. This participant, however, felt a sense of support and importance from his CMW when being reminded.

The raw data themes, Personal Items and Housing Items, combine to form the first-order category, Helping Clients in Their Immediate Environment. These raw data themes showed that CMS and the CMWs strive to help their clients by supporting them, guiding them, and by connecting them with other organizations in an effort to make their immediate environment more pleasant. Furthermore, the level of support that each client received in these areas is in direct response to their strengths and vulnerabilities. Therefore, as the clients increase their capabilities in these areas, they are given more responsibility and are more accountable for their own lives. These efforts not only help individuals in their immediate environments, but also help them to be independent in their community as well.

Help clients make their way in society. The first-order category, Help Clients Make Their Way in Society, which is subsumed under the second-order category, Help and Support with Secondary Client Needs, is comprised of two raw data themes: Societal Items and Transportation. This first-order category was constructed to highlight CMWs who help their clients with their responsibilities and movements, within and outside the city, in an effort to guide clients to be more integrated members of society.

The first raw data theme, Societal Items, demonstrates CMWs assisting their clients to fill out forms appropriately for various programs and societal duties like filing taxes. For example, one participant stated, *“During the week I just kind of stay in touch with questions about stuff to do on payday. Like, I got [a] SAID program application form... It’s an extra 220 dollars a month. And they help me fill out forms”*. The Saskatchewan Assured Income for the Disabled

(SAID) program provides an income for people who have long-term and substantial disabilities (Government of Saskatchewan, 2013). By having access to this additional income, this participant was able to live more independently because there was less pressure on her financial resources. Therefore, by her CMW helping her fill out this form, CMS was promoting her ability to be more independent. Additionally, one participant stated that one of the things she most enjoys about CMS was that, “[My CMW] helps me do taxes”. For many CMS clients, paying taxes is a new activity. Many of their clients lived on the streets and did not have the means or the resources to pay their taxes. It is, therefore, important to have the CMWs supporting their clients in this manner, helping them to learn the societal obligations that many have never engaged in. Moreover, paying ones taxes can be seen as a step toward being a contributing member of society and, therefore, may increase their self-worth and feelings of being part of something that is larger than themselves.

The raw data theme, Transportation, was created to describe the different ways that CMS facilitates its clients’ ability to make their way around and out of the city for various reasons. CMWs were able to help with this secondary need by helping clients to acquire bus passes, bus tickets, and rides to and from various locations. For instance, one participant stated that one of the things he most enjoys about CMS was *“The way they handle my bus passes. Like, you know, [inaudible] I get a bus pass. But that’s pretty good [to] help me and handle all the bus passes. [They] get it done, so that’s pretty good about them”*. Further, another participant stated that CMS has helped him live more independently by *“Mak[ing] sure I have my bus pass too, even though I have a bike, in case it’s raining or my bike breaks down or my bike is stolen”*. Both of these quotes showed that CMS facilitates its clients’ ability to get a bus pass so that they can make their way around the city. The second quote was in response to how CMS has helped to make the participant more independent. This participant felt that by having various transportation methods available to him, he was more able to be autonomous as he no longer relied as heavily on others to explore the city and to arrive at appointments. CMS was also able to help its clients travel outside of the city by obtaining bus tickets. This level of help can be illustrated through the following quotes, *“Well they buy me... bus tickets... I just have to call them and they’ll take care of it for me”* and, *“Bus tickets to Biggar, whenever I want to go, or P.A. to visit my mother”*. Biggar and Prince Albert (P.A.) are a town and city, respectively, which are not far from Saskatoon. The ability of clients to save enough money and buy a bus ticket, is largely due to the

support that they receive from CMS. As the above quote demonstrated, individuals sometimes have to travel to see their families. An individual's family is often, but not always, a large part of their support system, helping them to be strong and succeed. By helping this client travel to see his mother, CMS was essentially using the client's supports to help reduce his vulnerabilities. CMS and the CMWs have also helped their clients by facilitating rides for them around the city by utilizing the CMWs' vehicles or taxi services. As discussed previously in this dimension, CMS has helped its clients with rides to and from grocery shopping and the Food Bank. As displayed in the following quotes, CMS has also given its clients rides in emergencies and when running errands. For instance, one participant stated, *"They [CMS] do little things for me in case of an emergency, like a ride or something. And then when I do get a ride, they buy me a Tim Hortons coffee"*. Moreover, another participant declared, *"Any appointments, they help me. What I do with them, I go pick up tobacco [and] I get a discount and [my CMW] drives me there to pick it up"*. As exemplified by the first quote, CMWs assisted their clients with rides when they were in a predicament. This interaction also seemed to provide the client and the CMW with a form of social interaction when they went for coffee afterwards. Further, this second quote demonstrated that CMWs would help clients go to a rural community to get tobacco for a reduced price. By being available to give their clients rides, CMWs were showing their clients that they were supported. Being able to ensure that the CMS clients have transportation, especially in the case of an emergency, provided the clients with a sense of safety and also helped to increase his/her well-being. In some cases, rather than giving clients rides themselves, taxi services provide the CMS clients with transportation. For example, one participant stated, *"They help when I call a taxi to cover the cost"*. Although CMS does not pay for all taxi rides that its clients take, there are special circumstances in which they will absorb the cost. For instance, according to the Coordinator/Assistant Executive Director of CMS, they will cover the cost of a taxi ride for their clients in emergency situations. CMS' ability to support its clients when they are in an emergency can be seen as paramount to its clients' feelings of connection and independence. Clients were able to feel connected because they are part of an organization that cares for them, but on the other hand, they were able to feel independent, knowing that if they struggled when trying to be autonomous in society, that they would have support to strengthen them once again.

The raw data themes, Societal Items and Transportation, combine to create the first-order category, Help Clients Make Their Way in Society. Through participant quotes, these raw data themes depicted CMWs helping their clients to fill out various documents and applications in order to help clients increase their independence and become unified members of society. Furthermore, since many of these individuals have never had to fill out applications forms before, having their CMW there to guide them in the process helped the clients learn the various steps and contacts to make in order to ensure that they were receiving the care they need. By learning these steps, the CMS clients will most likely be able to fill out forms on their own in the future with little or no external help. These raw data themes also illustrated that CMS and the CMWs help their clients in many ways to simplify their ability to get around the city and to visit family and friends in other areas of the province. This support is central to helping their clients live as independently as they can in the community, as it allows them to explore and find their own niche in society.

Summary. The dimension, Help and Support for Client Needs, generally depicted that CMWs assist their clients with their primary needs such as their living arrangements, as well as their secondary needs such as components which help them in their immediate environment and in society. They have effectively done this by working at their clients' individual level of independence, but also by teaching them the skills necessary to support themselves. This level of assistance was achieved through connecting CMS clients to outside agencies, by helping them with responsibilities, and by increasing their independence through various avenues. This dimension also highlighted, however, that there was the hope that there would be more communication between CMS and the care home workers, and CMWs and the CMS clients. This dimension is related to the next dimension, Helping Clients Learn New Skills and Client Independence, in that both dimensions exemplify that CMW's are attempting to increase their clients' independence by developing their aptitude.

Helping clients learn new skills and client independence. The Helping Clients Learn New Skills and Client Independence dimension contains raw data from more than half of the participants. This dimension was established from two second-order categories: Learning New Skills and Client Independence, and two first-order categories: Internal Skills and Socialization Skills. This dimension contains information from eight raw data themes: Coping Skills, Growth

and Change, Self-esteem/Confidence, Patience, Friendliness, Learning the Steps of Skills, Quality of Life, and Independence, see Figure 4.5.

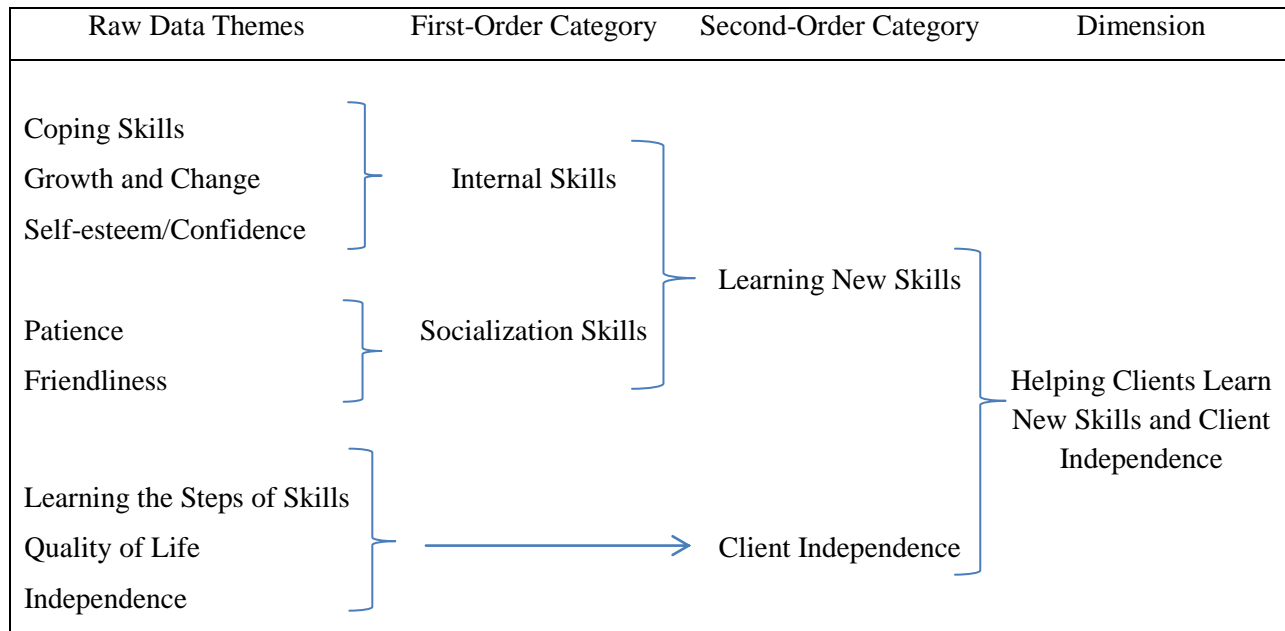


Figure 4.5. Helping Clients Learn New Skills and Client Independence Dimension

Internal skills. The first-order category, Internal Skills, falls under the second-order category, Learning New Skills, and has three raw data themes: Coping Skills, Growth and Change, and Self-esteem/Confidence. The term ‘internal skills’ reflects those skills which affect one’s relationship with the self to a large degree. This first-order category was devised to describe the changes in internal dialogue that participants have learnt as part of their interactions with CMS. Learning these skills relates directly to the strength-based approach that CMS employs because, by increasing ones aptitude, there is a higher likelihood of being able to deal with problems on one’s own.

The raw data theme, Coping Skills, was created to characterize participant views that CMS has helped them learn tools to offset adversity. For example:

[CMS helped me with] coping skills more and stuff like that. Now I can kind of cope with stuff and some of the problems I got, but don’t run to the phone every few minutes and ask for him [CMW], for their help and stuff like this and I don’t you know I don’t go as fast as I used to.

Based on how the participant behaved in the interview and how this participant described herself, it seemed as though she had many anxious feelings. During the interview she appeared nervous by fidgeting with her clothes and speaking quite quickly. In the above quote, the participant stated that she did not have to call her CMW as often as she used to. Based on this participant's interview, it was apparent that she used to call her CMW to ask questions even if they were about small details. This participant alluded to the fact that learning coping skills from her CMW has helped her to take more initiative in her own life and to be more independent. Furthermore, she also mentioned that she no longer talks as fast as she used to, indicating that her coping skills are also helping her to remain calm and regulated. The following quote also shows an increase in coping skills. When asked in what ways CMS has helped her, one participant stated:

It [my life] was going like a roller coaster and when my mom passed away she used to help us. My dad doesn't help us; he thinks we should be bare foot and brained hole and stuff like that, so he was not too much help that way...He didn't support us girls...I can cope with it more. Yah, that's the way to put it, I can cope with it more.

This participant stated that she was not able to experience the same support from her father that she felt from her mother. Through her interactions with CMS, she has been able to cope with her feelings about the situation. By learning this skill, this client was most likely more able to be independent and move on from her past hardships.

The raw data theme, Growth and Change, was formed from data that showed CMS helping clients mature and make changes in the way they conduct themselves. This raw data theme is supported by a quote from one participant, *"Well it's [CMS] changed my life. I was an out of control teenager, and even young adult, but now I've gotten help... I dealt with Crisis and now I don't know what I would have done without Crisis"*. Additionally, another participant stated, *"It [CMS] helped me kind of grow up"*. Both of these participants attributed a change in their way of being and dealing with situations to CMS. Through their dealings with CMS, these participants have taken what they have learnt and applied it to different areas of their lives. This ability is central to the strength-based approach in that these individuals are gaining the competence to solve their own problems successfully.

The last raw data theme, Self-esteem/Confidence, was created to describe participant quotes which illustrate CMS helping them to increase their self-worth and self-assurance. For instance, one participant stated, *"[CMS] got [me] a little bit more self-esteem than I used to*

have”. Based on this participant’s interview it was apparent that she had struggled with self-esteem for much of her life. For example, she stated:

I’ve been doing stuff on my own. It’s like I can’t do nothing. Like he [CMW] says, “[Name of participant] don’t put yourself down you can do quite a bit” and stuff like this and everything. And he said, “That’s hard, so give yourself a hug and tell [yourself] you’re doing fine” and stuff.

Through her interactions with CMS and her CMW, this participant was able to increase her self-worth. Another participant stated, *“It [CMS] makes me feel more confident. It gives me my space [inaudible] [to] try to be honest”*. This quote was in direct response to a question asking the participant what CMS has done to help him live more independently in the community.

Therefore, for this participant, being involved with CMS and its programming had helped him to be more certain of himself. This has consequently strengthened his ability to live more independently in the community and capability of being an honest citizen. Having self-esteem and confidence are central components to succeeding in other areas of one’s life. That is, if an individual feels worthless, they are not likely to try to improve other aspects of themselves.

The raw data themes, Coping Skills, Growth and Change, and Self-esteem/Confidence, combine to form the first-order category, Internal Skills. This first-order category generally revealed that CMS and the CMWs have been able to help participants learn the skills essential to feeling positive about themselves. For example, participants were able to cope with their difficulties, have changed their behaviours, and have been able to increase their self-esteem and confidence. These factors not only help individuals to live more independently, but also speak to the strength-based approach that CMS employs.

Socialization skills. The first-order category, Socialization Skills, which is subsumed under the second-order category, Learning New Skills, is comprised of two raw data themes: Patience and Friendliness. This first-order category was established to describe skills that participants have learnt through CMS that have helped them to socialize with others more comfortably. It also, however, represents those skills that participants would like to learn in the future.

The raw data theme, Patience, was formed to represent quotes that demonstrated CMWs trying to teach the skill of equanimity to their clients. This raw data theme can be further supported through a participant quote:

I'm very patient. Me and [my CMW], [I'm] usually very patient with her, I don't get upset when I'm talking to her. If I do, she's always there to give me a little tap on the shoulder and tell me it's going to be alright.

The above quote illustrated how CMS has helped the participant to live more independently in the community. According to the participant, his CMW was helping him to remember to be patient by giving him a tap on the shoulder when he was becoming frustrated. This physical interaction appeared to be just enough to calm this participant down so that he could enter a frame of mind where he could think more rationally. Furthermore, since learning this skill was helping him to be more independent, it seemed as though he was able to take what he learnt from his CMW and apply it to situations outside the CMS environment.

Last, the raw data theme, Friendliness, was developed from data that shows CMWs helping participants learn the skills to be more approachable. For example, one participant stated, *"I learnt how to be kind. It's a must for me. If someone gets mad at me, I always kind of [inaudible] back it up. I try not to get too upset. It makes sense, hey?"* and, *"Friendly. [They] keep me friendly... I'm more at peace"*. Being kind is an essential component of being able to socialize with others and being accepted by the community. By being more accepted by others, these participants are essentially increasing their circle of support and, therefore, are better able to make healthy choices for themselves. Additionally, clients have indicated that friendliness and friendships are areas in which they wish to continue to improve. For instance, when asked what they would change about CMS one participant stated, *"I don't know if this is right or not but to have more better friendships"*. In order to actualize 'better friendships' for this client, education may need to transpire concerning the skills necessary to interact positively with others. Having this skill is a crucial part of being connected to and supported by individuals in the community and, therefore, the community itself. By increasing the support an individual feels, he/she is better able to become an independent member of society.

The raw data themes, Patience and Friendliness, join to form the first-order category, Socialization Skills. Although it may seem counterintuitive, learning socialization skills is a necessary component of being able to live independently. In life, one always has to interact with others. In addition, by learning new skills, individuals are better able to apply these skills to other areas of their lives, helping them to cope with their own problems when able. In general, participants indicated that, through their interactions with CMS and their CMWs, they were more

able to be patient and friendly with others. They, however, also mentioned that they would appreciate learning how to form more meaningful relationships.

Learning the steps of skills, quality of life, and independence. The second-order category, Client Independence, is comprised of three raw data themes: Learning the Steps of Skills, Quality of Life, and Independence. A first-order category was not required because the raw data themes relate directly to the second-order category. This second-order category was created to illustrate different ways that CMS helps its clients to increase their independence and ability to live in the community using appropriate resources.

The first raw data theme, Learning the Steps of Skills, was formed from quotes that illustrated CMWs helping their clients to learn the various steps in order to accomplish something. When asked how CMS has helped to make her more independent, one participant replied, “[My CMW] used to teach me things, make me do things on my own so I would learn to do them by myself”. By learning the steps to accomplish something, participants will be better able to apply these steps to other endeavors, helping them to become more independent. As previously stated, providing individuals with the skills to solve their own problems is essential to the strength-based approach. Further, a participant mentioned, “*Learning the steps to getting my own place [and] learning the steps to getting my own identification*” when asked if CMS has done things for him that he was not expecting. This quote illustrated a specific example of the types of skills CMS clients are learning. By learning how to obtain his own place and identification, this participant will be more likely to deal with similar situations independently, should they arise.

The raw data theme, Quality of Life, was composed to demonstrate that participants felt that being involved with CMS and the CMWs had improved their general well-being. This raw data theme can be illuminated through the following quote, “*I’m still surprised I’m living the way I’m living now compared to what I used to live like... I’ve gained some pets... I live in a nice apartment now and I’m doing well*”. This participant seemed astounded that her life has improved so much since being involved with CMS. This improved quality of life, although something this participant was expecting, has helped her to be more independent. Additionally, another participant mentioned that CMS has, “*Improved my quality of living...She [CMW] understands what I go through; she’s very understanding. That probably what’s happened.*” This quote revealed that through the CMW’s understanding, this participant’s quality of life had

improved. Often, by feeling more understood, individuals sense that they have more support. Furthermore, by having more support, individuals are more likely to feel a sense of well-being and independence.

Although the idea of independence can be found throughout many raw data themes and dimensions, the raw data theme, Independence, was established to illustrate that participant involvement with CMS is related to his/her feelings of independence. For instance, one participant stated:

It's helped some but I['ve] got to do the rest. Like, he [CMW] says I['ve] got to do the rest before I can get it to be my way and stuff like that. That's the hard part because, when my medication wears down, then I look like I'm going to be a tea pot, short and stout. I want to blow my top... I'm not finished my self-abuse and everything.

Although the above quote demonstrated that the participant's CMW has helped her, the participant also realized that she has more work to do with her self-abuse behaviours. Interestingly, she seemed to know that she has to take ownership of her experiences to ensure she is getting what she needs in her life. This quote exemplified the participant's desire and movement toward being more independent with support from her CMW. Other participants, however, felt that being involved with CMS takes some independence away from them. For example, one participant stated:

Well it [CMS] really helps me be independent, but it kind of takes some of my independence away where I'm paying my bills and that, but kind of leaves me some friends to talk to and they're good people, really good people.

Although this participant stated that CMS has helped him be more independent in some ways, in other ways, the reverse is true. By being involved with CMS there is a greater sense of inclusion. Often, with a greater sense of belonging, there is more pressure to be responsible and to engage in activities like paying one's bills. This participant is speaking about this responsibility. By being involved with CMS and experiencing the benefits, he also has to follow societal norms and rules. This participant, therefore, felt as though some of his independence had been taken away, possibly because of the push to meet his new responsibilities.

The raw data themes, Learning the Steps of Skills, Quality of Life, and Independence, can be combined to form the second-order category, Client Independence. Within this second-order category it was apparent that participants have been able to be more self-reliant because of

their ability to learn the steps of skills, which is essential to them being able to deal with similar situations in the future. Furthermore, clients also felt that their quality of life had increased since being involved with CMS. In terms of feeling independent, some clients stated that they are more independent as a result of being involved with CMS. Other clients, however, felt as though some of their independence has been taken away because of acquiring more responsibility (e.g., having to spend money on items they needed (utility bills) rather than items they wanted).

Summary. The Helping Clients Learn New Skills and Client Independence dimension generally demonstrated that through interactions with CMS, most participants felt like they were learning the steps to attain new skills, were actually attaining those skills, and were increasing their independence. In addition, these clients were learning, not only how to interact with themselves through growth and increasing their self-esteem, confidence, and coping ability, but also how to interact with others. Some participants, however, also felt that they would have benefited from learning how to have more meaningful relationships and that some of their independence was taken away because of the increases in responsibility they were experiencing. This dimension, and more specifically the raw data theme, Quality of Life, illustrated that interactions with CMS were increasing participants' satisfaction with the way they were living. This raw data theme in particular relates to the next dimension, CMS Support for Clients' Health, in that these areas are concerned with the general well-being of the CMS clients.

CMS support for clients' health. The CMS Support for Clients' Health dimension contains raw data from half of the participants. This dimension was created from three first-order categories: Medical/Psychological Crisis, Health Appointments, and Addictions, and eight raw data themes: Hospital, Talking, Travel to Doctor Appointments, Communication with Doctors, Help with Doctor Appointments, Drug Termination, Addictions Programming, and Medication, see Figure 4.6.

Raw Data Themes	First-Order Category	Dimension
Hospital Talking	Medical/Psychological Crisis	CMS Support for Clients' Health
Travel to Doctor Appointments Communication with Doctors Help with Doctor Appointments	Health Appointments	
Drug Termination Addictions Programming	Addictions	
Medication		

Figure 4.6. CMS Support for Clients' Health Dimension

Medical/psychological crisis. The first-order category, Medical/Psychological Crisis, was established from two raw data themes: Hospital and Talking. This first-order category was developed to describe the different ways that CMWs have helped their clients when they were experiencing medical and/or psychological crises.

The raw data theme, Hospital, was formulated to demonstrate CMWs actively taking participants to the hospital when they were in a crisis; for example, feeling suicidal. One participant stated, “*There was times when I was very mentally sick ... [CMS] help[s] me get to a hospital when I am sick*”. This participant was referring to when she was feeling psychologically ‘sick’, however, it is also possible that CMS would take its clients to the hospital if they were severely physically ill as well. Regardless, the support and care that this participant felt from CMS was apparent. Further, a participant stated:

When they come barging in and drag me to the hospital, it goes both ways. I am relieved that I am getting help, but I don’t want to be locked up and drugged up. I don’t like it when I’m hauled away, even though I need it.

Even though this participant did not want to go to the hospital, she realized that CMS was acting in her best interest. Having the CMWs in the lives of their clients and being able to decide when to take them to the hospital is crucial to their well-being and continued improvement and growth.

The raw data theme, Talking, was created to describe quotes that illustrate CMWs trying to talk their clients into a calmer state when they were experiencing a crisis. This raw data theme, along with the previous raw data theme, Hospital, can be supported through this quote: *“When I felt very suicidal...Whenever I did, they brought me right up to the hospital or sat down and talked with me and settled me down and rearranged my thinking”*. This quote demonstrated that the CMWs were able to gauge the situation and determine if going to the hospital is necessary or if the crisis was something that could be managed by talking. It also illuminated, however, that clients were open to talking with their CMWs, that they were able to feel heard and understood, and that they trusted their CMW’s opinion and guidance. Conversely, however, some participants felt that their CMW should take them to the hospital more often. For instance, one participant stated, *“When I was sick...I would talk to them on the phone and see them in person, but they wouldn’t take me to the hospital. They would brush me off”*. As this quote depicted, the participant felt that going to the hospital would have been the best option for her, however, her CMW felt that talking to her would be sufficient. Although it appears that the outcome of talking to this participant was adequate, she seemed to have felt unsupported at the time.

The raw data themes, Hospital and Talking, join to form the first-order category, Medical/Psychological Crisis. Through this first-order category participant quotes indicated that CMS and the CMWs helped their clients when they were in a crisis situation and that clients felt comfortable approaching their CMWs with their serious concerns. It also showed that the health of CMS clients was an important area to focus on to ensure their well-being. By making sure that their clients were medically and psychologically healthy, the CMWs were helping their clients to be more able and ready to be independent persons of society.

Health appointments. The first-order category, Health Appointments, was constructed from three raw data themes: Travel to Doctor Appointments, Communication with Doctors, and Help with Doctor Appointments. This first-order category was formulated to describe the many ways in which CMS has helped its clients with their health appointments and with health care providers.

The raw data theme, Travel to Doctor Appointments, was composed to demonstrate that CMS workers have physically taken participants to their doctor appointments when necessary. This raw data theme can be illustrated through a quote from one participant who stated that her

CMW, “*take[s] me to my doctor; psychiatric and medical doctors*”. Additionally, another participant mentioned:

They [CMS] [inaudible] doctor’s appointment they make sure I made it to the [inaudible] or actually they handle a lot of my doctor appointments, yah. So, they drive me there [inaudible], and that’s what [inaudible] help me do a lot of stuff.

Often times, CMS clients have limited means of transportation because of financial constraints. If clients have a doctor’s appointment and they require transportation to get there, the CMWs will pick them up and drive them to those appointments. This time together also allows the CMWs to ‘check-up’ on their clients to ensure that they are doing well in other areas of their lives. It also helps clients by being able to socialize with a healthy adult and by ensuring that he/she is being attended to medically and psychologically. There are, therefore, many benefits to accommodating their clients in this regard.

The raw data theme, Communication with Doctors, was constructed from quotes which highlighted CMWs connecting with participants’ doctors when they were ill. This raw data theme also depicted CMWs accompanying participants to meetings with their doctors. For instance, one participant stated, “*Sometimes [my CMW] comes into a meeting with me and [name of participant’s doctor]*” and another stated, “*They talk to my doctor when I am sick*”. In both of these statements, it was apparent that the CMWs were supporting their clients. In the first quote, the CMW’s physical presence was providing support while, in the second quote, the CMW’s verbal input was the source of support. Moreover, the participant who produced the second quote felt that her quality of life had improved since her CMW started talking with her doctor when she was ill. If this participant did not have a CMW supporting her in this manner, it is possible that she would not get the help she needs and her quality of life would decline.

The raw data theme, Help with Doctor Appointments, was formed to explain quotes which demonstrated that CMWs have made doctor appointments for their clients and also that CMWs have helped their clients to acquire a doctor. This raw data theme can be illustrated through the following quote: “*I’ve been with them for a long time but I don’t really mind them because, in my case, they help me keep up with my doctor appointments and all that. I have no problem with it*”. Additionally, another participant stated:

Well, I was out living on skid row and they found that I was schizophrenic and I needed drugs to keep my mind going and things like that, so Crisis Management helped me out with getting the doctor and the drugs going.

In this instance, the participant required medication to help with her diagnosis of schizophrenia. CMS helped her to connect with a psychiatrist so that she could have access to the necessary medication. The above quotes indicated that the CMWs were quite involved in keeping their clients healthy. Helping their clients to connect with doctors, both medical and psychological, was an important part of ensuring their health. Furthermore, maintaining one's health is important if an individual is attempting to use his/her strengths to work on his/her vulnerabilities.

The raw data themes, Travel to Doctor Appointments, Communication with Doctors, and Help with Doctor Appointments, combine to form the first-order category, Health Appointments. These raw data themes showed that CMS supported its clients through helping them to take into account and give priority to their health status. By improving their physical and psychological health, CMS clients were more likely to live independent and healthy lives.

Addictions. The first-order category, Addictions, was created from two raw data themes: Drug Termination and Addictions Programming. This first-order category was developed to describe the various stages of addiction that participants experience, but also the help that CMS is giving them at these various stages.

The raw data theme, Drug Termination, was designed to illustrate CMS' role in helping its clients contemplate and quit their addictions. For example, in response to how CMS has helped his quality of life one participant stated:

That['s] a hard one to pin down. I've never really thought about it. Now, I've got my own place and I'm moving into a new apartment with a balcony and I'm really thinking of quitting smoking harder. I have to, but the ladies at crisis really help guide me. When I feel down or something, they help me. So it's really good.

Although this participant had not quit his addiction, he was thinking about quitting. This can be seen as an important step to a healthier lifestyle. Importantly, this participant had described CMS as a driving force in helping him to contemplate terminating this addiction. It stands to reason that this participant felt supported by his CMW in his endeavor to quit smoking. Other participants have been able to quit their addiction because of the support they felt from CMS. For instance, one participant stated:

It's kind of nice to have people around me now. I used to have trouble with that, being around people. I was very upset. I was suicidal for a long time and I used to be on street drugs. I quit street drugs. I quit! Like, I was on LSD, speed, marijuana, heroin. I quit!

As apparent in this quote, this participant was using many strong drugs, but was able to quit through the assistance he was receiving from CMS. CMS not only helps these clients by supporting them, but also by facilitating a change in behaviour and environment in order to improve their health.

The last raw data theme, Addictions Programming, was constructed to demonstrate that CMS has helped participants get involved with various forms of addiction therapy. This raw data theme can be exemplified through the following two quotes: *"They have made me independent... I'm taking a program for alcohol and drugs; doing [an] addiction program where I can be independent for work and things like that"* and, *"They['ve] [CMS] became very helpful...I do my drug therapy"*. As these quotes illustrated, CMS not only supported these clients, but also connected them with organizations specializing in addictions. As the first quote highlighted, being involved with addictions programming has promoted independence in other areas of this participant's life. By helping to increase its clients' capabilities, CMS is assisting its clients to build resiliency and to handle their issues more independently.

The raw data themes, Drug Termination and Addictions Programming, merge to form the first-order category, Addictions. These raw data themes demonstrated that CMS helped its clients deal with addictions. Furthermore, CMS also connected its clients with addictions programming, helping to ensure that its clients were living to their optimal level of health and independence.

Medication. The raw data theme, Medication, does not fall under a first-order category because it is directly related to the main dimension, CMS Support for Clients' Health. This raw data theme was created to illustrate CMS helping its clients with starting their medication, helping its clients with getting their injections, and making sure its clients were taking their medication. This raw data theme can be illuminated through two quotes. One participant stated, *"It [CMS] got me settled into taking my medication and getting my injections"* while another participant stated, *"[CMS] keeps tabs on me to make sure I'm taking my meds"*. Although CMWs do not provide their clients with their medication or injections, they do connect them with professionals who can. By helping its clients with medication, CMS is helping clients with their physical and psychological health. Ensuring the physical and mental health of individuals is

integral to the strength-based approach. If individuals are not healthy, their ability to deal with their problems on their own or to build their strengths is seriously diminished.

Summary. The dimension, CMS Support for Clients' Health, generally showed that CMS was a main factor in ensuring that its clients' physical and mental health needs were met. This was achieved when clients were experiencing a crisis, but also when connecting them with doctors, ensuring medications were being taken appropriately, and when connecting them with addictions programming when they were not in an emergency. This dimension is connected to the next dimension, Connection to External Resources and Help with Personal Relationships, as in both dimensions CMS is connecting its clients with external agencies to increase its clients' independence and feelings of support.

Connection to external resources and help with personal relationships. The Connection to External Resources and Help with Personal Relationships dimension contains raw data from less than half of the participants. This dimension was established from one first-order category, Connecting to External Resources/Relationships, and three raw data themes: Ambition/Ability to Work, Community Relationships, and Personal Relationships, see Figure 4.7.

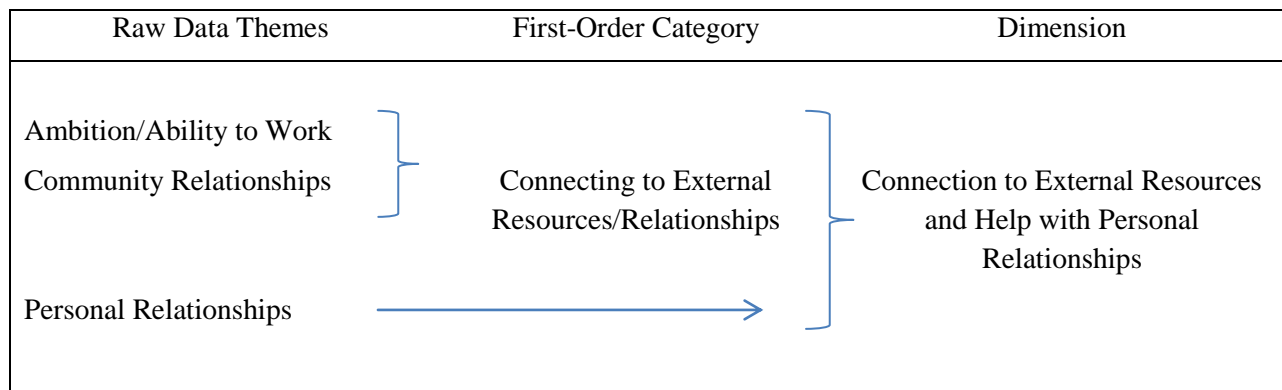


Figure 4.7. Connection to External Resources and Help with Personal Relationships Dimension

Connecting to external resources/relationships. The first-order category, Connecting to External Resources/Relationships, was formed from two raw data themes: Ambition/Ability to Work and Community Relationships. This first order category was devised to describe clients' thoughts and questions as they related to their aptitude and desires to work and also as a representation of the different types of community programs and opportunities that CMS connects its clients with.

The first raw data theme, Ambition/Ability to Work, was constructed to characterize CMWs helping their clients further themselves in the world of work through connections and also revealed clients' questions of why they were unable to work. For example, one participant stated, *"There's nothing they have not done for me. I have done everything they've done for me. I'm hoping to get back to work and Crisis Management helped me forward myself to go to work"*. This participant was expressing the support that she received from CMS in order to be at a place in her life where she could go back to work. For example, before connecting clients with organizations that would supply work experience, CMS would, first, ensure that its clients' primary needs were met, in terms of food, clothing, and shelter. Only after those resources were in place would CMS entertain the idea of the client seeking out work opportunities (C. Briere, personal communication, September 7, 2012). Other participants, however, would have liked to be able to work but had questions regarding their ability to do so. For instance, one participant stated that he would have liked support:

If I was to be in question whether I should be on welfare, maybe I could potentially talk, get [name of CMW] here or go there to talk to an actual social worker to provide some reason for why I'm not able to work... [I have] a diagnosis that's very limiting in life. It's kept me from getting a lot of good jobs.

This participant was particularly concerned with his struggle in finding a job. As shown in the above quote, the participant felt that his diagnosis has prevented him from securing work. Further, the participant referred to wanting to talk to a social worker in hopes of clarifying his troubles with obtaining work. Essentially, the participant wanted to be in contact with external resources with the help of CMS.

The raw data theme, Community Relationships, was composed to describe different types of community programs and opportunities that CMS connects its clients with. The programs that CMS connects its clients with, vary based on the individual clients' needs and are determined by assessing the 10 'work areas' discussed previously. An example of an outside agency that CMS clients are connected with is Welfare Services. For instance, one participant stated, *"I suppose there's a bit of security in my being on welfare with Crisis Management"*. This participant seemed to attribute his accessibility to welfare to his connection with CMS. Furthermore, this participant felt a sense of financial safety because of his ability to access welfare services. Other types of agencies that CMS connects its clients with is work experience programs. For example,

one participant stated, “[CMS] got me experienced in a lot of things [such as the Saskatchewan Abilities [Council], where I’ve learned how to work, so that’s really been my most good experience”. This participant was describing CMS connecting her with the Saskatchewan Abilities Council where they have an employment program to develop skills so that individuals can find work. By helping clients to learn these life skills, they were strengthening the resources that the clients could use to support themselves. In this sense, CMS was helping to create a sense of independence for its clients. Moreover, CMS connects its clients with addiction programming. One participant stated, “They have made me independent...I’m taking a program for alcohol and drugs. [I’m] doing [an] addiction program where I can be independent for work and things like that”. This participant mentioned that she has greater feelings of independence because she was able to participate in addictions programming, which has increased her ability to secure work. Therefore, by connecting participants to addiction groups or programs, CMWs were helping to increase their clients’ strength and independence in other areas. Last, CMS also connects its clients to housing programs as the following quote shows:

Well [inaudible] ever since I was with Crisis they put up with me going on my own and I have done it, but [inaudible] and I guess [inaudible] that’s helping because if I have nobody to help me I don’t know what I’d be doing really [inaudible] right now... They help me find my own home care...They help me a lot.

The participant touched on, both, living on his own and with support from a care home. By making connections to landlords or care home providers, CMS has afforded its clients relationships with these community members as well. These connections can help to strengthen the support that clients feel and their ability to strive in the face of adversity.

The raw data themes, Ambition/Ability to work and Community Relationships, combine to form the first-order category, Connecting to External Resources/Relationships. There are some participants who would have liked to see more support in actively pursuing their work interests. Together, these raw data themes illustrated how CMS strives to connect its clients with resources external to them. As the data highlighted, many participants attributed their increased well-being to CMS connecting them with these various resources. Through connections to various agencies, CMS clients were able to build their resiliency and, therefore, their ability to be independent.

Personal relationships. The raw data theme, Personal Relationships, does not fall under a first-order category because it is directly related to the main dimension, Connection to External Resources and Help with Personal Relationships. This raw data theme was constructed to demonstrate instances where CMS and the CMWs had helped their clients with a variety of issues that came up with personal relationships. Some of the relationships that participants spoke about were with their spouse, various abusive relationships, and relationships with their parents. For instance, “*I was also in an abusive relationship for ten years and they [CMS] helped me with that too*” and:

[My CMW] helped me through my marriage and then, because I was emotion[ally] abused, physical[ly] abused, and sexual[ly] abused... he [CMW] got me a divorce without even signing the papers. He [ex-partner] wouldn't sign my papers so that was beautiful and I didn't think [my CMW] could do it and [my CMW] just said, “Say no if you don't want it anymore”, and [my CMW] got my papers so fast. Then, the beautiful part was that he got everything done so fast.

These participants were describing troubling and distressing relationships with their ex-partners. Although many individuals struggle with leaving their partners when they have been abused, these participants sought support, care, and guidance from their CMWs. The second quote illustrated a participant that was so appreciative of how her CMW dealt with the situation that she called it a ‘beautiful’ experience. In these circumstances, the CMWs were helping their clients to start re-building their own lives while promoting independence and strength. Additionally, participants spoke about their relationships with their parents:

Me and my adopted mom didn't get along very well ...She's [CMW] helped me with my adopted mom. My adopted mom won't talk to me but she'll talk to [name of CMW]. Me and my mother write letters, so if it weren't for [name of CMW] I probably wouldn't even have any communication with my adopted mom at all.

Families can be a strong and main support for individuals who are experiencing hardships. Often, if this type of support is in place, the hardships that the individual may experience can be lessened. Unfortunately, as this participant stated, her and her adopted mom's relationship had been strained for many years. The communication between her and her mom through the CMW was, therefore, most likely, helping her to be more resilient and to feel some sort of support from or connection to her mother. The above quotes revealed that CMWs strive to keep their clients

safe in relationships, but also that they attempted to help their clients have healthy relationships. It is the ultimate goal that, through these healthy relationships, CMS clients will feel more supported and increase their strengths in an effort to be more independent.

Summary. The dimension, Connection to External Resources and Help with Personal Relationships, was formed from three raw data themes. This dimension demonstrated that participants felt that CMS and the CMWs helped them connect with, and form, relationships with various community supports, such as, with addictions programming and welfare services. These connections helped to increase participants' level of independence. Moreover, it has been shown that CMWs help their clients engage in healthy and safe personal relationships. By increasing a client's supports, whether it be through external or personal relationships, CMS was working with a client in a strength-based manner. Other participants felt that they need more support from their CMW in order to pursue their preferred work path. Although this dimension depicted CMS connecting its clients to community resources, as the next dimension, Client Perceived Support and Needed Community Support, illustrates, participants also feel that more community supports are needed than what is currently offered.

Client perceived support and needed community support. The Client Perceived Support and Needed Community Support dimension contains raw data from less than half of the participants. This dimension was created from one first-order category, Client Perceived Logistical Support from CMS Staff, and three raw data themes: CMS After-Hours Support, Caseload Sharing, and Needed Community Support, see Figure 4.8.

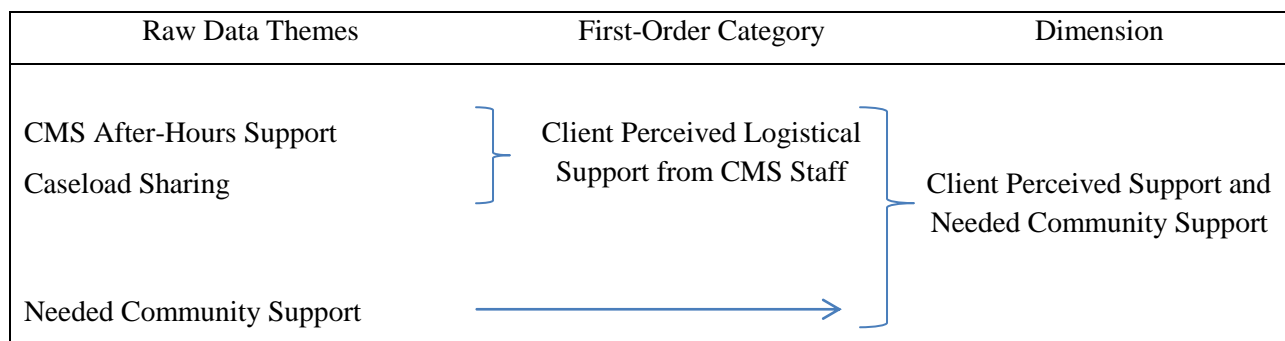


Figure 4.8. Client Perceived Support and Needed Community Support Dimension

Client perceived logistical support from CMS staff. The first-order category, Client Perceived Logistical Support from CMS Staff, was formulated from two raw data themes: CMS After-Hours Support and Caseload Sharing. This first-order category was devised to describe support that CMS clients receive when their CMW is unavailable.

The raw data theme, CMS After-Hours Support, was composed to show that participants wanted CMWs to work longer hours. For example, one participant stated:

...and CMWs, it seems like they're, "Oh I have to work 9 o'clock to this time and so I'm done", but whose going to be there for the time when it's 9 to 5 o'clock that you work after 9, after 5, whose there for them or for me...After hours there's message managers or whatever they're called there's nobody there to talk to. "I'll just leave you a message for this one when she or he comes in", and in the middle of the night I want to, I haven't committed suicide for about 6 years now but after hours when I want to commit suicide whose going to be there for me?

Further, another participant stated, *"Well they work 10 hour shifts a day from 9 until 7 at night and then Mobile Crisis takes over, but I wish that Crisis Management workers would work longer hours"*. Both participants acknowledged that Mobile Crisis or 'message managers' as the first participant puts it, take over when CMS is closed. The first participant, however, also mentioned that she does not approve of their method of support. She alluded to the fact that when she has called Mobile Crisis in the past, they simply take a message for her CMW rather than help her in the here and now with her issue. This was another factor which contributed to this participant wanting the CMWs to work longer hours, as she would feel more supported. Part of this reasoning may be due to the lack of relationship between clients and the Mobile Crisis workers and their comfort and familiarity with their own CMW.

The second raw data theme, Caseload Sharing, was developed to represent participant quotes that describe what happens when a participant's CMW is not available. For instance, participants mentioned, *"[Name of a CMW] drove me to the doctor's office yesterday because [name of my CMW] wasn't working"* and, *"They're all nice and they always say hi and they got a big smile and hi and if he's [my CMW] not there he [another CMW] helps me too and stuff like that"*. Further, another participant stated:

It [has] been pretty much, you know, entirely going for coffee with her [CMW]. [I] went with someone else once, I remember, a couple years ago, but it was only one time. I think he drove me some place, maybe, but it's been pretty much it.

These quotes illustrated that when a client's CMW is not available for them, because they are either busy with another client or because it is their day off, other CMWs step in and cover their client caseload. By sharing client caseloads, CMWs were able to fill a gap that would otherwise be apparent and perhaps damaging to clients. The ability to share one's caseload helps to promote a sense of support, care, and also strengthens clients' ability to form close relationships with other individuals because they are not feeling abandoned.

The raw data themes, CMS After-Hours Support and Caseload Sharing, are merged to form the first-order category, Client Perceived Logistical Support from CMS Staff. Although clients felt that CMW should work longer hours, no one can work 24 hours a day. Clients may need to form closer relationships with the staff who work at Mobile Crisis so that they feel more at ease and supported when talking to them. Alternatively, additional staff could work alternating hours to support the clients with this need. Participants also mentioned that other CMWs have stepped in to support them when their CMW is unavailable, further creating a circle of care.

Needed community support. The raw data theme, Needed Community Support, does not fall under a first-order category because it is directly related to the main dimension, Client Perceived Support and Needed Community Support. This raw data theme was created to exemplify statements which indicated that CMS should be helping more people in the community. Participants generally felt that more support for community members should be centered on housing, finances, addictions, and for people who are displaced. For instance, one participant stated:

[I'd like] for them [CMWs] to do house visits on caregivers. The caregivers they, I don't know if their doing it for the money, [but] you're supposed to care for people if you're going to be in that, But, I don't see it.

The above quote highlighted the need for additional support from CMS for community members living in care homes. The participant would have liked the CMWs to check up on the care home providers to ensure that the clients' needs were being met. Based on this participant's statement, she felt as though the caregivers did not truly care about her well-being. Although care home provision is separate from CMS, this participant would have felt more supported if the CMWs

could intervene in these circumstances. Additionally, other participants would have liked to see more financial support for people who do not have enough money to live in the community. One participant stated, “*Well one thing I have to bring to an abrupt state [is] they never have enough pesos... I’d prefer; I’d like that*”. Another concern of participant’s was support for community members with addictions and for those who were homeless. When asked if there was anything specific that CMS could do differently to help the participant live more independently in the community one participant stated:

There should be more help there... I see other those people that stay in a care home, they’re in a street, you know bumming around and there’s lots of them that smoke pot and you know, they’re, you know, fucked up. There, I see them on the street. Where’s the help for that?

This quote not only touched on the fact that people needed more support in care homes and financially because they were panhandling, but it also touched on the idea that, even if people live in care homes, they were still living on the streets at times and were struggling with substance use. It was unclear if this participant was speaking solely about CMS clients or community members in general. Regardless, however, she would have liked more support in this area so that she could live more independently in the community, perhaps in an effort to feel safer and more able to integrate into her community. Unfortunately, providing more support for clients and for other community members who are not currently involved with CMS would cause strain on CMS financially and in terms of staff availability.

Summary. The Client Perceived Support and Needed Community Support dimension discussed above showed that participants generally felt that CMS needs to provide more support for the people in the community. Although some participants stated that other CMWs have helped them when their CMW was not available, other participants felt that the CMWs should work longer hours and support them more with their care home workers. Moreover, participants indicated that they would like more housing, financial support, and health support for homeless individuals. If CMS was able to provide more support to people living on the streets, there would likely be less of a strain on other community resources and more of a felt connection between individuals and the community in general.

Conclusion

A utilization-focused (Patton, 1997) process evaluation (Stufflebeam & Shinkfield, 2007) provided the framework for this research. By acquiring client perspectives on the program they are engaged in, and by involving stakeholders in various parts of the evaluation process, results will be more likely to be employed. Transcripts were analyzed from 14 participant interviews using the general inductive approach (Thomas, 2006). The three research questions guided the analysis and the emergence of the themes and dimensions from the raw data. Eight dimensions were found: Clients' Experience with CMS and the CMS Staff, Interactions Between CMS Workers and Their Clients, Financial Interactions to Increase Client Independence, Help and Support for Client Needs, Helping Clients Learn New Skills and Client Independence, CMS Support for Clients' Health, Connection to External Resources and Help with Personal Relationships, and Client Perceived Support and Needed Community Support. In addition to these eight dimensions, throughout the interviews, the lived lives and uniqueness of the participants was evident. Even though there appeared to be many differences between the participants of this study, there is a main factor that brings them together: the need for support and guidance in their lives.

In general, these dimensions illustrated that participants felt supported and appreciative of the time they spent with their CMWs. Many benefits that participants mentioned as a result of being involved with CMS included: being part of the trustee program, having their primary and secondary needs met, experiencing more independence, and learning new skills. Many of these positive experiences were met by connecting CMS clients with diverse external resources and by reinforcing relationships with various people in the lives of the participants. There were, however, changes in the program that participants would like to see. For instance, some participants wanted less involvement from their CMW, while others wanted more support, especially with their care home providers. Additionally, clients would like to see more staff diversity, a less congested atmosphere at CMS, more personal money, and a change in their ability to acquire their trustee money. Last, participants would like CMWs to work longer hours and would like to see more support for other community members.

CHAPTER FIVE

DISCUSSION

Overview

Although advancement has been made in society's acceptance of mental illness, for individuals with behavioural problems, addictions, and who lead risky-lifestyles, stigma still remains. Interestingly, the more contact people have with individuals who have mental illnesses, the less stigma they are likely to feel toward them (Boyd, Katz, Link, & Phelan, 2010). Therefore, helping merge these vulnerable individuals into their community could benefit all involved.

Given the stigma that individuals with mental illnesses or other hardships face on a daily basis, programs like Crisis Management Service (CMS) are necessary in communities. CMS deals with individuals who are "hard to serve and difficult to engage" (Saskatoon Crisis Intervention Service, 2012, Crisis Management Service, para. 1). They often lead risky lifestyles, have mental health concerns, and have other vulnerabilities such as addictions, legal issues, lack of housing, and behavioural problems. These vulnerabilities often lead to individuals being in a constant state of crisis. To reduce the impact or experience of these crises, CMS engages its clients in many interventions, learning opportunities, and supportive relationships while working from a strength-based approach.

The crisis management workers (CMWs) employ a strength-based approach by using 10 'work areas', as previously discussed, to assess the needs and strengths of their clients. A strength-based approach according to Roberts (2005), is one in which clients are seen as resilient. This resilience transfers into clients having, within themselves, the skills and abilities to disentangle their own problems. In terms of CMS, the 'work areas' are integral to collaboratively determining the focus of programming for each client. This method allows clients to use their strengths in order to work on areas of most need, with the goal of living at their optimal level of independence utilizing community supports appropriately.

Although there has been a shift in the treatment of crises from being conducted in hospitals to in the community (Joy, Adams, & Rice, 2007), there still exists a gap in the provision of services to individuals in need. The fact that CMS deals with clients who have strained relationships with other community organizations, who would typically provide them support, speaks to CMS' ability to fill this gap.

As long as programs continue to be developed and continue to change, program evaluations will be essential. It has been 25 years since the last program evaluation of CMS and changes have been subsequently made. Due to CMS' important role in society and the significant part they play in the lives of its clients, a program evaluation was necessary. Therefore, through meetings between the CMWs and the research team, it was collaboratively decided that a utilization-focused (Patton, 1997) process evaluation (Stufflebeam & Shinkfield, 2007) of CMS would be undertaken.

Utilization-focused evaluations help to ensure that the results of the program evaluation will be employed by the anticipated users (Patton, 1997; Patton, 2013). In this case, the results will be used by the CMS staff to change their program so that it better meets the needs of their clients. To guarantee this outcome, it was imperative that the CMWs be engaged in many aspects of the program evaluation. Not only were they involved in determining what type of program evaluation would be utilized and what type of client would form the participant pool, they were also involved in the review process of the research questions and questions for the interview guide. By including the CMWs in this process they were able to develop a shared interest in the results, which will ultimately increase the likelihood that they will make necessary changes to the program based on the outcomes of the evaluation.

It was also determined that a process evaluation would provide CMS with the type of outcomes that they had envisioned. A process evaluation obtains the perspectives of participants about a program's strengths and weaknesses and how the program can be improved (Patton, 1997, Patton, 2002). The 'process' component of Stufflebeam's (2000b) Context, Input, Process, Product (CIPP) model provided the main framework for this evaluation. Specifically, the 'process' element in the CIPP model determines how clients assess the value of their program, how staff can make adjustments to their program through the activities they engage in, and how the program's plan compares to the activities that are being employed. These elements are mirrored by the purposes of this study.

The objectives of this study were threefold: first, to explore clients' experience with CMS, second, to determine the extent that the outcomes of CMS are consistent with the services its clients receive, and third, to determine the extent that the process of client engagement with CMS contributes to the anticipated outputs of CMS. The first step in meeting these objectives was to interview 14 active and assessment CMS clients. All interviews were transcribed and

analyzed using the general inductive approach (Thomas, 2006). This approach allows for themes to emerge from the raw data without being constrained by more rigid methodologies. The findings from this analysis, as well as an integration of the research literature, will be explored.

Findings

Though the eight dimensions that emerged from analysis of the raw data have been discussed, illustrated, and supported in the previous chapter, the discussion below will integrate the research literature (e.g., Angell, Martinez, Mahoney, & Corrigan, 2007; France, 2002; Roberts, 2005; Smith, 2006; Tierney & Kane, 2011) to these findings. The headings that are used to organize the findings include: Experience with Program and Workers, Relationships, Trusteeship, Needs of Clients, Skills, and Staffing Needs. These headings were created as they accurately reflect the major dimensions of the current study as well as prominent themes of the literature on crisis intervention and management programs.

Experience with Program and Workers

The participants in this study had many varied experiences with CMS and their CMWs. Many of the participants' perceptions have been demonstrated in the research literature. For example, in Donovan, Bennett, and McElroy's (1979, as cited in France, 2002) evaluation of a group format crisis intervention program, results indicated that participants credited their improvement, in part, to the reciprocal support that they received from other participants and also their ability to share their feelings. Although CMS does not deliver education in group settings, the participants of this study generally indicated that the CMS staff were supportive. Further, whereas participants in this study did not specifically state that they appreciated the ability to share their feelings, many participants stated that they enjoyed talking to the CMWs. The ability to share one's feelings has also been shown to be an important component of the theory of crisis intervention. For instance, Roberts' (1991) third stage of crisis intervention deals with a client's feelings and emotions. Through this stage, individuals can feel more supported because their experiences are being listened to. Similarly, a service provider's listening ability has been demonstrated to be an important factor in treatment of crises (France, 2002; Tierney & Kane, 2011), which is similar to CMS clients' verbalizations that their CMWs are good at listening to them about their problems.

Malla, Norman, McLean, Scholten, and Townsend (2003) evaluated a program based on the assertive case management model and identified positive results. This model has similarities

to the model of care that CMS uses. The resemblances between the assertive case management model evaluated by Malla et al. (2003) and CMS programming include: focusing on the medical and psychological care of its clients, assessing its clients and creating treatment plans, building close relationships with the client and their family as well, and linking clients with other community organizations. There are, however, differences between these two models. For example, in assertive case management models there are more time constraints, group interventions, and there is no utilization of housing programs or long-term disability aids. However, since one of the factors of the assertive case management model is to develop a close therapeutic relationship with clients, it is possible that this factor weighed on the outcomes found.

The close relationship that CMS forms with its clients is evident in the current findings through many dimensions. Generally, clients indicated that the CMWs were supportive, that they respect and value the CMWs, that interactions were positive, and that CMWs were helpful. Given the results of Malla et al.'s (2003) research, the positive and trusting relationships that the CMWs are formulating with their clients may impact their clients' attainment of their goals in a favorable way. The importance of establishing rapport and a relationship with clients who are experiencing a crisis is also displayed in the second component of Roberts' (1991) crisis intervention stages. Creating this relationship helps to show respect, acceptance, and support to the client. Undoubtedly, this support can transfer into a greater attainment of the goals of the clients.

Similar to the assertive case management model (Malla et al., 2003), Bond, Drake, Mueser, and Latimer (2001) investigated the outcomes of Assertive Community Treatment (ACT) programs in the form of a meta-analysis. In general, those individuals who had been part of an ACT program had a higher satisfaction with the services they received as compared to a control condition, which was not part of the ACT program. The same authors note that, often, the ACT model results in a struggle between a client's best interests and his/her preference or goals, but that it generally increases client choice. Increasing client choice and having clients be active members in their treatment has been highlighted, not only in crisis intervention theory and models (France, 2002; Greene, 2005; Roberts, 2005), but also in crisis management models (Mueser, Bond, Drake, & Resnic, 1998).

Although CMS does not follow the ACT model precisely (i.e., the staff-client ratio is higher at CMS than what ACT endorses), there are many similarities. These similarities include: providing services to individuals in the community, having 24 hour coverage (with Mobile Crisis), having case managers be actively engaged, having no apparent time limit to services, helping clients with daily living skills, and incorporating caseload sharing. As indicated in the results of the present study, most clients were generally satisfied with the services that they were receiving, while some clients stated that they had mostly adverse experiences. Further, one client specifically stated that his worker wants what is best for him and another felt that her CMW was too involved in her life. These statements reflect the negotiation of ensuring that the clients' best interests are being accounted for and, at the same time, allowing them to be independent individuals capable of making their own choices. These results reflect the findings of many ACT programs (Bond et al., 2001).

Still related to the clients' impressions of the services they are receiving, Vingilis et al. (2007) evaluated the introduction of a mental health triage and a counsellor to an emergency department. The professionals surveyed indicated that the addition of the mental health counsellor improved their perception of the services that clients were receiving. Though this study only sought professionals' input, the results do emulate how many clients felt about the services they were receiving from CMS. For instance, participants of the prevailing study have voiced their uncertainty of what they would do without CMS. In this sense, having a CMW to guide and support them may improve the level of care they feel they are receiving. The perception of being supported is also an important component of the strength-based approach. For example, the ability to build on one's strengths while being supported by other person can act as a protective factor in stressful situations (Maton et al., 2004).

Whereas many participants in this research believed that they were receiving favorable services from CMS and that their worker was adequately involved in their life, some participants felt that their CMW was overly involved. Interestingly, the theme of over-involvement was also discovered in the research literature. Specifically, Bond et al. (2001) revealed that 11% of clients in a study that assessed clients' feelings with the staff of ACT programs found them to be too involved or intrusive. The perceived level of over-involvement was a sentiment that was also expressed in the current research and may be a consequence of CMS working from a model that is similar to the ACT model.

As crisis theory postulates, a person's perception of a situation has large effects on what that client actually experiences (Roberts, 2005). Accordingly, the perception of CMS workers being too involved may have implications for how participants experience the services that they are receiving from CMS. Furthermore, people who are experiencing a crisis rely on the coping mechanisms that they have recognized to be useful in the past (France, 2002; Roberts, 2005). It is possible that feeling like their worker is too involved has roots in a previous coping skills of isolating themselves when experiencing a crisis. Consequently, it may take time for the CMS clients to feel comfortable with other individuals helping them when they are experiencing a crisis.

One way to improve the level of comfort of a client in a crisis intervention program is through shared experiences. Tierney and Kane (2011) stated that clients of a program for people with severe mental illness felt that having a peer specialist, someone who genuinely knew what the clients were going through, was beneficial. CMS does not use peer specialists in the delivery of their program, which raises questions about its clients' ability to connect with them. Specifically, one client mentioned that he would like to see people of Métis decent working at CMS. This client described himself as Métis and, therefore, this suggestion may have been made so that he would feel connected with the CMWs on a deeper, cultural level. This need to connect with others who are similar to oneself reflects Tierney and Kane's (2011) results. Further, the need to connect to others is reflected in the literature on crisis intervention theory. These similarities can be found in Roberts' (1991) second component of the seven stages of crisis intervention. The importance of building rapport is essential to the client feeling connected to and comfortable with their worker.

Feelings of connection can also be fostered by clients and workers interacting in a positive way toward each other. In fact, many participants in the current study attribute their increased quality of life, or general well-being, to their interactions with their CMW. Other program evaluations have also reflected similar results. For instance, clients experiencing an increased quality of life were observed in programs that dealt with people with severe mental illness (Tierney & Kane, 2011), programs that included service users in the delivery of programs (Simpson & House, 2002; Tierney & Kane, 2011), programs that provided trusteeship services (Conrad et al., 2006), and in programs that follow the ACT model of treatment (Bond et al., 2001). France (2002) states that, if an individual experiences a crisis and if that crisis is resolved

in a timely manner, people can mature and become stronger individuals. In a general sense, an increased quality of life means that many areas of an individual's life have improved and, consequently, that they have become more resilient. It also shows that the disequilibrium that was experienced due to the crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962) has mostly been shifted into a state of equilibrium. This highlights one of the goals of effective crisis intervention (Greene, 2005). These improvements (e.g., increases in coping skills and support) can not only help individuals thrive despite hardships (Saleebey, 2002) and feel more positive about themselves, but they can also increase their independence in the community in which they live.

Taken together, the research literature available on crisis theory, crisis intervention, the strength-based approach, and crisis intervention/management programs seems to support the many and diverse experiences that CMS clients have had in their interaction with CMS and the CMWs. Particularly, many of the similarities between the current research and the results of previous research are those that are focused on ACT models, the model of care that CMS most resembles.

Relationships

Although CMWs form relationships with their clients, this program has also helped with external connections and personal relationships. Importantly, as crisis theory and crisis intervention theory states, by connecting people with other individuals and programs, the instability caused by the perception of a crisis can shift to a state of more stability (France, 2002; Roberts, 2005).

Many of the external connections that were experienced by the participants of this study included housing assistance, employment programs, mental health and addictions programming, and other community services. The research literature on crisis intervention and management programs also report on connecting their clients to similar external agencies (Dion, Kennedy, Cloutier, & Gray, 2010; Krupa, Stuart, Mathany, Smart, & Chen, 2010; Malla et al., 2003; Vingilis et al., 2007), which can help clients to live more comfortably and independently in the community. Additionally, according to the strength-based approach, in an effort to determine the strengths of a person, one must look at what resources are available to support that client (Smith, 2006), which can include community resources. CMS partially explores its clients' resources when assessing its clients on 10 'worker areas'. Further, by connecting with community

resources, new relationships are actualized and there are fewer feelings of judgment and greater impressions of acceptance and openness (Maton et al., 2004).

Many participants also spoke about CMS helping them to connect and cultivate relationships with other professionals, therefore, increasing their circle of care. When clients spoke of these connections it was mostly in a positive light, although some clients wanted more connection and communication. The ability to create a circle of care reflects a strength of programs that help individuals through crises (Conrad et al., 2006; Joy et al., 2007; Malla et al., 2003; Tierney & Kane, 2011). For instance, increasing one's circle of care can help individuals learn new coping techniques so they can effectively deal with potential crisis situations (France, 2002; Greene, 2005, Roberts, 1991; Roberts, 2005). Moreover, a circle of care can provide an individual with more support and alternative resources to access when attempting to resolve future crises. This element mirrors the sixth component of Roberts' (1991) crisis intervention stages whereby an action plan is created.

Another type of relationship that CMS helps its clients with is personal relationships. One of the key components of the Prevention and Early intervention Program for Psychoses (PEPP) that Malla et al. (2003) evaluated was case managers working with clients' families to enhance their recovery. Albeit not specifically attributed to the work they did with the families, there were positive results in terms of reductions in client symptoms after this program. Despite not all CMS clients being affected with psychoses, they do have mental health concerns (e.g., depression, anxiety), some of which can include a psychosis component (e.g., schizophrenia, bipolar disorder). As in the study by Malla et al. (2003), CMWs work with their clients' families and are often the bridge connecting two individuals who have been separated by conflict in the past. Although CMWs are a support for their clients, an individual's personal relationships can be a critical resource for a person experiencing a crisis. In this sense, CMS is utilizing the strength-based approach to determine and strengthen its clients' resources while reducing their vulnerabilities (Saleebey, 2002; Smith, 2006). More specifically, in terms of crisis workers helping with relationships, Vingilis et al. (2007) reported that the mental health counsellor in an emergency department assessed clients' legal stressors, which could conceivably include instances of impending divorce. Not only does CMS evaluate these areas through their assessment of 10 'work areas', but they have also been described as specifically helping clients with marital strain and through the process of divorce.

Even though CMWs try and help their clients directly the best they can, they also help their clients by connecting them to other resources and by improving the informal resources they already have through their personal relationships. Though some clients stated that they would like more connection or clarification from external resources, many participants felt that these connections were helping them to live more independently in the community. Regardless, based on the research literature, it appears that connecting individuals to external resources and including personal relationships in the process of care is integral to effective crisis management and can help increase an individual's available coping methods.

Trusteeship

Another element that is often the focus of crisis management programs is clients' financial resources and skills. For example, in a study by Vingilis et al. (2007), the mental health counsellor assessed his/her clients on many areas including their financial standing. Those clients indicated that they positively perceived the services they received. Many CMS clients are part of a trustee program where CMWs obtain and distribute the client's money for housing, rent, and living allowance. Similar to the results obtained by Vingilis et al. (2007), CMS assesses its clients on 10 'work areas', one of which is 'financial'. Many participants had positive reports about their participation in the trusteeship program provided by CMS. Among clients' statements were that they were able to manage and budget their money more efficiently, accumulate savings, and increase their independence. These positive outcomes are encouraging since crises can result from financial strain (Roberts, 2005). Furthermore, according to crisis theory, if tension can be resolved in a timely manner, through trusteeship in this case, the individual can grow and become healthier (France, 2002).

Many of the same experiences have been reported in the literature. For instance, Luchins, Roberts, and Hanrahan (2003) found that many clients who were part of a representative payeeship program felt that it had increased their budgeting skills and had helped their money last all month. Moreover, Conrad et al. (2006) revealed that the money management ability of clients had increased 12 months after a representative payee program was coordinated with participants' psychiatric care.

As crisis theory states, not having the appropriate coping skills to deal with a situation, financial or otherwise, can increase the likelihood of experiencing a crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). The ability to build new strengths and coping

skills through the assistance of another (i.e., payeeship programs; Maton et al., 2004) in and of itself reflects the strength-based approach, however, it also highlights a key point of crisis management and intervention (France, 2002; Mueser et al., 1998; Roberts, 1991; Roberts, 2005).

Unfortunately, not all participants in the current study liked only being able to receive their money weekly and felt that they should be able to access it more freely. In the literature, there have also been negative reports from clients with mental illnesses about trusteeship programs. For instance, some clients felt that when their clinical case worker managed their money, they were using it as leverage to change other behaviours (Angell et al., 2007; Luchins et al., 2003). Further, with a case manager as their payee, clients are more likely to feel a sense of hostility and intrusiveness toward them (Angell et al., 2007). These negative feelings toward workers emphasize the necessity of forming a close relationship between the client and the worker when attempting to resolve crises (Roberts, 1991).

Although, in this research, participants did not indicate that they had these same feelings of hostility, some participants did indicate that their CMW was too involved in their life. This noted level of over-involvement may have connections to the CMWs being the trustee of some of their clients. Additionally, however, the perception of worker over-involvement may be related to clients not finding meaning in being financially independent and responsible. For example, as the literature on crisis intervention theory predicates, clients are more likely to be invested in new skills if they are meaningful to them (Greene, 2005; Roberts, 2005). Therefore, if clients do not want to learn the skill of being more financially independent or do not wish to be supported in this manner, they may indicate that their worker is over-involved in their life.

Notwithstanding the benefits of being on trusteeship that are apparent both in the current study and the literature, there also appears to be some drawbacks to this element of programing. These drawbacks seem to be particularly impactful on the relationship between clients and their case worker when that case worker also is their trustee.

Needs of Clients

According to crisis theory, a crisis can occur because of a threat to one's goals, which causes instability if it cannot be resolved (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). A possible threat to a person's goals can include not having one's primary and secondary needs met. The participants of this research have indicated that CMS assists them with many of their primary and secondary needs (e.g., food and transportation respectively). Other

crisis management programs (Bond et al., 2001; Krupa et al., 2010; Luchins et al., 2003; Mueser et al., 1998; Vingilis et al., 2007) and trusteeship programs (Luchins et al., 2003) also have attempted to meet the needs of their clients (e.g., food, clothes, financial stability). These factors have been unveiled to be important in service delivery to clients.

Although CMS is appointed as trustee by the Ministry of Social Services to pay the rent and utilities of its clients, they also assist clients in securing other forms of income which are distributed to clients once a week to use at their own discretion (C. Briere, personal communication, February 2013). As in the research literature, CMS clients have positively commented on the many needs that CMS helps them meet (e.g., housing, food, clothes, personal items, bills, taxes, and transportation). Having these resources helps to improve the coping techniques that individuals have and their ability to deal with future situations, as is expected with effective crisis intervention and management (Bond et al., 2001; France, 2002; Greene, 2005; Mueser, 1998; Roberts, 1991; Roberts, 2005). There were, however, some participants who would like more support and communication with their care home provider or other housing arrangement. Unfortunately, as crisis theory asserts, if these clients are feeling unsupported while dealing with their crisis they could become more vulnerable if it is not resolved promptly (France, 2002). Nevertheless, many clients indicated that having CMS there to assist them has helped to make them more independent.

A large part of ensuring that clients' needs are met is by providing support for their health. It was observed that CMWs facilitate this by assisting clients with transportation (e.g., to the doctor or hospital), by communicating with doctors, by making connections to addictions programming, and by ensuring their clients are complying with their medication. One outcome of these activities has been CMS clients contemplating and following through with quitting drugs. These changes are important in leading a healthier lifestyle with fewer vulnerabilities and more strengths.

There is ample support in the research literature for many of the factors mentioned above that help increase a client's health. For instance, ACT programs, which include professionals working together to help individuals in the community, a low staff-client ratio, 24 hour coverage, no time limits on service, and caseload sharing (Bond, et al., 2001), as well as representative payee programs (Luchins et al., 2003), are effective in decreasing hospital admission rates. This accentuates the effectiveness of the programs in meeting the needs of their clients so that hospital

admissions are unnecessary. Further, these programs have been shown to decrease substance use and addictions (Bond et al., 2001; Conrad et al., 2006) and can increase treatment compliance (Bond et al., 2001; Luchins et al., 2003). Providing support for clients' health when they are experiencing a crisis can help to stabilize their lives and can teach them new coping skills. These elements are important when working with clients who experience crises (France, 2002; Greene, 2005; Roberts, 1991; Roberts, 2005) whether they are crises that can be resolved promptly or crises that are more pervasive.

Another important factor of crisis intervention and management programs is helping clients to make their way in society. An essential component of being able to do this is learning daily living skills that help individuals connect to the community. In the current study, participants verbalized that the CMWs helped them to learn these skills (e.g., filling out forms, completing taxes, transportation in the community). Learning daily living skills is an integral component of the ACT and intensive case management (ICM) models of crisis management (Bond et al., 2001; Mueser et al., 1998). Further, Bond et al. (2001) state that meeting clients' needs through ACT programming is an extremely effective treatment strategy for integrating people with severe mental illness into the community due to its ability to decrease hospital admission rates, increase housing stability, and increase social adjustment, among other factors. This is an important outcome because, as people are more integrated into society, they feel part of something larger than themselves. Additionally, being connected to one's community may help to increase feelings of worth, ownership, and independence, thereby increasing one's strengths (Roberts, 2005). Therefore, as CMS helps its clients to meet their basic needs and connects them with their community, their repertoire of coping skills increases. Moreover, as the strength-based approach for crisis management models postulates, it is vital to connect individuals to their community when learning these skills (Mueser et al., 1998).

CMS and the CMWs have been described as successfully providing support and help so that clients have their primary and secondary needs met. Although some participants would like more support with housing and their mental health, by helping clients with their needs and general health, clients will be better able to be contributing members of society. Furthermore, by helping clients integrate into the community and build other relationships, a secondary effect of reducing the stigma associated with mental illness that others in the community may experience will be realized (Boyd et al., 2010). Importantly, these outcomes are essential for the strength-

based approach in communities (Maton et al., 2004) and, as stated previously, this will help clients to be more independent and feel a sense of pride and purpose.

Skills

Knowing what skills to reinforce when helping an individual experiencing a crisis can partially be determined by identifying how the individual interacts with his/her environment. This strategy is central to the strength-based approach (Smith, 2006) and crisis intervention models (Roberts, 1991) as it helps to determine what approaches an individual has used in the past to overcome crises. Many participants in the current research have mentioned CMS helping them in some way with internal skills (those skills that affect one's relationship with the self to a large degree (e.g., self-esteem)) and socialization skills (e.g., patience). For instance, participants attributed their enhanced coping skills, self-esteem, confidence, patience, friendliness, and personal growth to their involvement with CMS.

Even though clients usually possess the necessary coping skills to avert crisis situations, they are unaware of them or are underutilizing them (Saleebey, 2002). Therefore, helping clients with internal skills is a component of many crisis intervention and management programs. For example, Donovan et al. (1979, as cited in France, 2002) mentioned that one year after a group crisis intervention program had ended, participants felt less anxious and depressed. Further, Joy et al. (2007) found that individuals with severe mental illness preferred a home care system in which coping skills were taught as opposed to a standard care system in which they were not.

When working from a strength-based approach, it is the crisis worker's duty to bring out the latent abilities or skills of his/her clients (Saleebey, 2002). Given the results of the prevailing study, with participants indicating that CMS is helping them with enriched coping skills, personal growth, self-esteem, and confidence, it appears that CMWs are doing precisely that. Helping to develop a client's coping skills has also been unveiled as being a major component of other crisis intervention models (France, 2002; Roberts, 1991; Roberts, 2005). Therefore, it seems that teaching these types of internal skills is important for effective crisis management programs and helping clients to be more independent.

Participants in this study also indicated that CMS has helped them increase their social functioning (e.g., patience and friendliness). Improvements in social functioning can be seen as a daily living skill that helps someone to better maneuver his/her community. Learning these skills is an important part of the ACT and ICM crisis management models of care (Bond et al., 2001;

Mueser et al., 1998) and can effectively increase coping skills (France, 2002, Greene, 2005; Roberts, 1991; Roberts, 2005). Improvements in social functioning following a crisis intervention/management program have also been evident in the research literature (Bond et al., 2001; Simpson & House, 2002). Additionally, participants in the current research as well as other studies (e.g., Tierney & Kane, 2011) stated that they would like to learn more social interaction skills, showing the importance of these skills to participants of these programs.

Many of these socialization skills can be modeled to clients through the time CMWs spend with them. Participants in the present study enjoyed interacting with their CMW when going out for coffee, going out for their birthday, and attending different programs. These elements highlight the importance of rapport in crisis intervention and management programs (Roberts, 1991) so that clients can feel supported and valued. Interestingly, Simpson and House (2002) found that when service users, who were able to spend large amounts of time with program members, were involved in the delivery of services to clients, they felt more supported. These findings are similar to what participants of the current study claim. It is conceivable that the more time a client has to interact with his/her worker, the more chance there is to practice socialization skills and to have appropriate interactions be modeled to him/her. Further, one of the improvements that clients of the WERP program desired was to have more leisure activities available to them (Tierney & Kane, 2011). This request could create the opportunity for individuals to interact socially and connect more with other members of society. It seems that CMS is meeting the needs of its clients in terms of providing social interactions and activities for clients to practice these skills. Accordingly, by forming new connections with members of society, CMS clients are essentially increasing their repertoire of effective coping skills because they will have others to look to for support; this reflects the desirable outcomes of crisis intervention (France, 2002, Greene, 2005; Roberts, 1991; Roberts, 2005).

Improvement of internal skills (e.g., self-esteem) and social skills (e.g., patience) are important components of feeling comfortable with oneself and with others in the community. As crisis theory states, if an individual's crisis is resolved in a timely manner that person can grow and become stronger (France, 2002). Therefore, learning these skills is essential to the livelihood of the CMS clients and will strengthen their resolve when trying to solve crises in the future (France, 2002; Roberts, 1991). The coping skills that CMS is attempting to foster will help its clients to be more independent while, at the same time, supporting them in becoming merged

with society. The more integrated into the community an individual can be, the more resources will be at his/her disposal, therefore, increasing his/her circle of care.

Staffing Needs

The availability of crisis workers for people experiencing a crisis is essential. They can guide the individual through the stages of crisis intervention (Roberts, 1991) so that the situation can be resolved. Without a crisis worker's assistance, an individual may experience further hardships and may become more vulnerable (France, 2002). Staff availability was a main component of the results found in this research. For instance, participants would like to see more help from CMS for other community members and CMW support after hours. These changes were voiced despite CMWs already sharing their caseloads and Mobile Crisis taking over for CMS after they are closed.

Similar opinions have been established in the research literature on crisis intervention and management programs. For example, in an emergency department's crisis intervention program for youth, Dion et al. (2010) reported that staff felt that more crisis intervention workers were necessary and would like them to work on the weekend as well. Moreover, according to staff of another crisis intervention program, the addition of a case management service to their program and, thus, the addition of staff resulted in more people in the community being able to be helped (Krupa et al., 2010). Additionally, according to Bond et al. (2001) and Mueser et al. (1998), a characteristic of ACT models, which have been shown to be effective, is a low client-staff ratio (e.g., 10:1). Unfortunately, each CMW has more than 10 clients and, consequently, their availability to support clients may be strained. These pieces of research reflect the requirement of ample staffing when helping to meet the needs of clients who are experiencing a crisis.

The outcomes of insufficient staffing also have implications on crisis theory and crisis intervention models. According to crisis theory, if a crisis is not resolved, it causes instability in a person's life (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962) and the individual can become more vulnerable (France, 2002). Given that the individuals in this study shared that they do not feel supported enough by Mobile Crisis, if they experience a stressful situation while the CMWs are unavailable, they may experience a state of crisis and breakdown. Consequently, with more CMWs who work staggered hours, CMS clients would feel more support and would be more likely to remain stable when experiencing difficult situations. The heavy reliance of participants on CMS does, however, illustrate the strong relationship that was

built between clients and their workers, an essential component of crisis intervention methods (Roberts, 1991) that needs to be more fully supported.

Based on the results of the current study and the research literature, it appears that in order to appease the dissatisfaction of CMS clients with staff availability, more CMWs would have to be hired. If there were more CMWs, there would be a lower client-staff ratio and it would allow staff members to work alternating hours. Taking this action would cause more financial strain on CMS and it would undoubtedly require more funding. Alternatively, perhaps more attention needs to be paid to forming an action plan (Roberts, 1991) so that clients are able to deal with crises in the future on their own. Further, forming closer relationships with the staff at Mobile Crisis may help clients to feel more supported when dealing with them. Furthermore, concentration on a client's strengths is vital to reducing his/her vulnerabilities and increasing his/her resilience (Maton et al., 2004); accordingly, emphasis here could result in CMS clients experiencing fewer crises to begin with.

Summary

Components of crisis theory, crisis intervention, crisis management programs, and the strength-based approach can be demonstrated throughout the major findings of the prevailing research. The literature on crisis intervention and management program evaluations shows themes of support for clients' experience with their program and case workers, external and personal relationships, trusteeship, the needs of clients, the development of skills, and staffing needs. These same elements were observed through the eight dimensions that emerged in the analysis of this study's raw data: Clients' Experience with CMS and the CMS Staff, Interactions Between CMS Workers and Their Clients, Financial Interactions to Increase Client Independence, Help and Support for Client Needs, Helping Clients Learn New Skills and Client Independence, CMS Support for Clients' Health, Connection to External Resources and Help with Personal Relationships, and Client Perceived Support and Needed Community Support. While most participants had positive things to say about their experiences with CMS, there is room for some improvements, primarily in the areas of greater support, more psycho-education, greater communication, more staff diversity, and worker involvement and availability.

Model of CMS Based on Client Accounts

Based on the findings of the current study, a CMS logic model emerged, see Figure 5.1. This logic model is based solely on CMS client perceptions of their programming and can be described through four related, but distinct, components: Initial Interactions, Engagement, Outputs, and Outcomes. Taken in its entirety, the logic model accurately reflects the support that CMS provides its clients in all areas of their lives and reveals the results of those efforts.

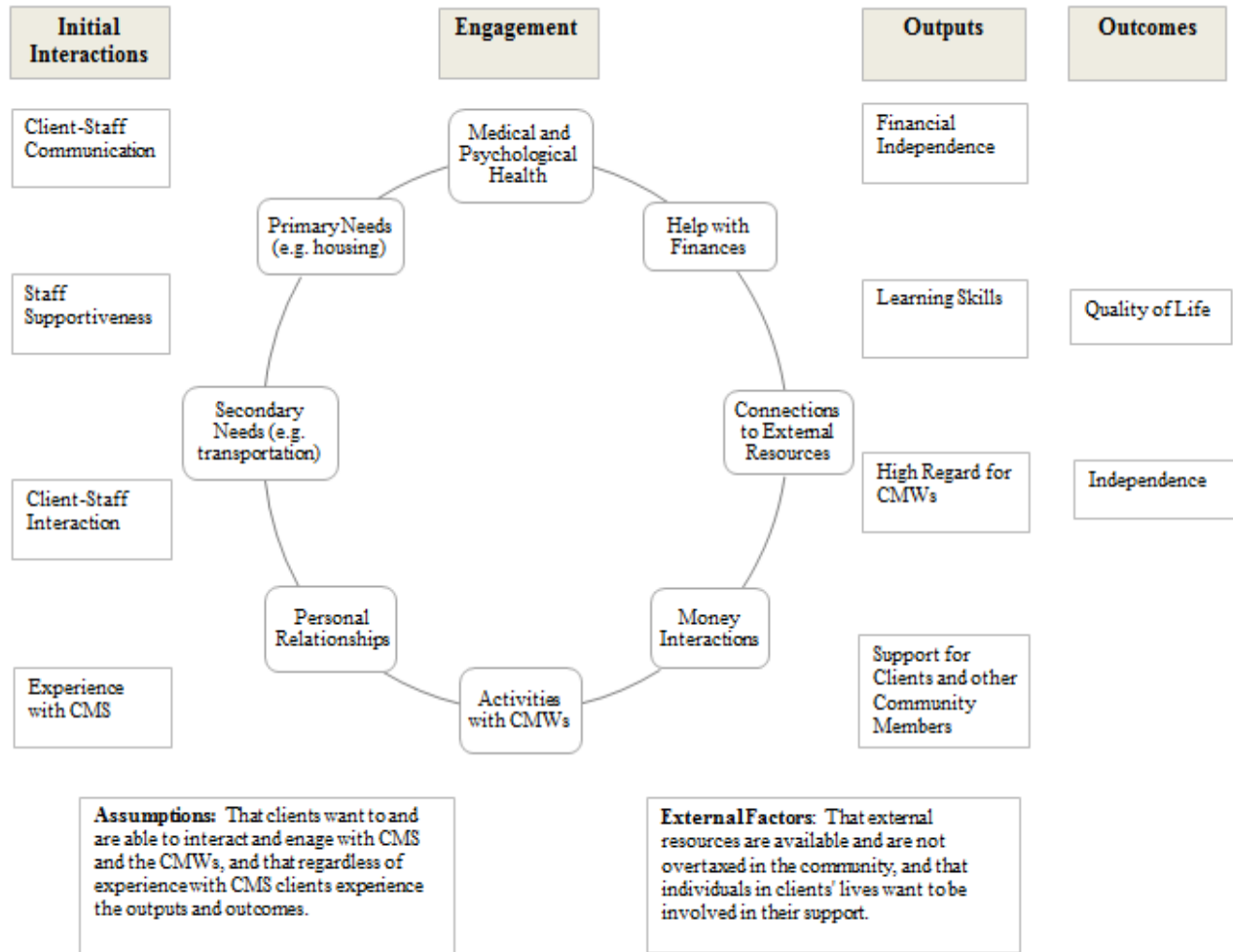


Figure 5.1. Client Generated Logic Model

Initial Interactions

The way in which CMS and the CMWs relate to, form relationships with, and initially support their clients characterizes the Initial Interactions portion of the logic model depicted. As the findings on Client-Staff Communication illustrate, clients generally enjoy conversing with

their CMWs. Further, although participants indicated that they talk to their CMW about their problems, some stated they would prefer less communication. Regardless, as evident by the participant interviews, based on their level of need, clients experience different levels of communication with their CMW. The second component, Staff Supportiveness, focuses on how the CMWs are able to show their commitment to helping their clients. This support is seen in a variety of ways, for instance, participants of the current research have stated that CMWs have their best interest in mind, are understanding, and are helpful. The third component is the Client-Staff Interaction element. As discussed previously, these elements include partaking in social outings with CMWs, feeling that staff members are knowledgeable, friendly, and valued, and money based interaction between the clients and the CMWs. The last element of the Initial Interactions portion of the logic model is Experience with CMS. Though clients had varied experiences and would like to see some changes in terms of diversity and the level of client activity at CMS, many participants thought that CMS was an important support in their lives.

Even though the different techniques used to establish positive interactions between clients, their CMW, and CMS, occur throughout the relationship, the initial contact sets the stage for productive work to occur. Without a solid relational foundation, clients would be unwilling to engage with their CMWs and may not participate in programming to the extent that they are currently. Roberts (1991) highlighted the importance of the relationship between a worker and client when he stated that developing rapport with a client is about illustrating respect, acceptance, and support to that person. Additionally, it is only after this stage of Roberts' (1991) model of crisis intervention that there can be a thorough exploration of new coping mechanisms that may be beneficial to the individual experiencing a crisis. The Initial Interactions element of the client generated logic model, therefore, sets the stage for the work that CMWs do with their clients in an effort to reach their goals. Further, these interactions allow the CMWs to look at a person's qualities to find his/her strengths, an important element of the strength-based approach (Maton et al., 2004).

Engagement

The second portion of the clients' CMS logic model, Engagement, demonstrates the fluid nature of CMS' involvement in its clients' lives. Participants in this research indicated that they were engaged on many levels with CMS and their CMW. For instance, participants reported being supported by CMWs in different ways to ensure their medical and psychological health, to

help them with their finances, and to introduce them to different activities. Furthermore, participants stated that CMS connects them to external agencies, offers assistance with their personal relationships, and helps to meet their primary and secondary needs. These forms of client engagement increase the likelihood that CMS clients will attain their goals and will become more stabilized and, thus, less likely to experience a crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). Further, this level of client engagement has many similarities to the ACT model of crisis management (e.g., helping with housing, medications, and finances; Bond et al., 2001) and helps to increase the resources available to the client. Additionally, by attempting to increase client resources by using the client's current strengths to work on his/her vulnerabilities, CMS is applying the strength-based approach (Maton et al., 2004; Smith, 2006).

Outputs

Based on their initial interactions and engagement with CMS, participants appeared to experience different results. The Outputs portion of the CMS client logic model highlights clients' experiences of greater financial independence, learning various skills, having appreciation for the CMWs, feeling supported, and wanting more support for other community members. These results are directly related to how CMWs engage their clients. For instance, as crisis theory states, individuals attempt to use coping mechanisms that they have used in the past, even if they are insufficient to resolve the crisis (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). This is precisely one of the reasons for individuals' involvement with CMS. Therefore, through engagement and crisis intervention, CMWs are attempting to increase the repertoire of skills that an individual has so that he/she can better cope with similar problems in the future (France, 2002; Greene, 2005; Mueser et al., 1998; Roberts, 1991; Roberts, 2005). Further, focusing on the strengths that an individual has, as can be seen through the Engagement portion of the model, results in outputs reflecting the amelioration of vulnerabilities and increased resilience of individuals. These components highlight the strategies of the strength-based approach (Maton et al., 2004). Consequently, without the support and acceptance that CMS clients feel from CMS, the positive Outputs seen in the client generated logic model would not be realized.

Outcomes

The aforementioned Outputs lead directly to the Outcomes which were seen by CMS clients as the final results of being involved with CMS. They included an increased quality of life and greater independence. Given that without any intervention individuals experiencing crises either withdraw or experience a breakdown (France, 2002; Roberts, 2005), these results and CMS' involvement are important. By intervening in these individuals' lives, CMS clients have learnt how to deal with future potential crisis situations on their own (Roberts, 2005), therefore, increasing their independence. CMS clients also have more skills and strengths in their repertoire (France, 2002; Greene, 2005, Roberts, 1991) to increase their quality of life. An improvement in quality of life and an increase in independence have also been shown to be outcomes of other crisis intervention and management programs (Bond et al., 2001; Conrad et al., 2006; Mueser et al., 1998; Simpson & House, 2002; Tierney & Kane, 2011), thus reinforcing their importance. Not only do the outcomes found reveal that CMS is helping to improve the lives of its clients, but they also reflect CMS' mandate of helping clients to live at their optimal level of independence while using community resources appropriately.

Summary

Throughout client accounts of their experience with CMS and their CMW, elements of crisis theory, crisis intervention, crisis management models, and the strength-based approach are apparent. Moreover, whereas many of the clients experienced different circumstances and situations with CMS, not all of which were positive, the majority of the participants indicated that their involvement with CMS had beneficial results. As evident in the literature on crisis intervention (Roberts, 1991) and counselling strategies (Alberta & Wood, 2009; Corcoran, 2005), individuals place a high importance on the relationship and interactions with their worker, or CMW in this case. Additionally, the methods of client engagement that CMS and the CMWs employ are essential for effective crisis resolution and future success of their clients. For instance, participants mentioned that these activities were important to them and to their movement toward skill attainment, a healthier lifestyle, greater quality of life, and increased independence. It appears, therefore, that, through CMS programming, participants' lives are being improved on many levels (e.g., achievements, having needs met, improvements in health and relationships) and that these improvements are broad and widespread (e.g., financially, improved quality of life, and increased independence).

Implications for Future Research

Although there was much support for the dimensions that emerged through this research, gaps remain in the literature on crisis management service programs. The following suggestions for future research could bridge those gaps.

First, it has been reported that peer specialists in the delivery of program services to clients are warranted because they help clients feel that their service providers genuinely know what they are experiencing (Simpson & House, 2002; Tierney & Kane 2011). The ability to connect with those who are similar to oneself can also be extended to the cultural or ethnic background of individuals. Importantly, research has been conducted to demonstrate these effects (e.g., Cabral & Smith, 2011; Ziguras, Klimidis, Lewis, & Stuart, 2003). Based on this research, there exists little benefit when an attempt is made to match the cultural background of the helper to the client on the outcomes of programming (Cabral & Smith, 2011).

Given the results of studies matching the cultural background of clients and workers to try and ensure feelings of connection, perhaps more concentration should be placed on working in a culturally sensitive way with clients. Many models have been put forth to develop the knowledge of practitioners on this topic (e.g., Abreu, Gim Chung, & Atkinson, 2000; Carpenter-Song, Schwallie, & Longhofer, 2007). However, empirical evidence on frameworks that put these principles to practice is needed. For instance, Alberta and Wood (2009) outlined a process from which helpers can work in a culturally sensitive way; however, no research on this model's effectiveness is available. This is an important area for future research as cultural competency has been found to be an important component of effective practice in mental health professions (Kwong, 2011).

Second, some research asserts that crisis management workers can be perceived as being too involved in their clients' lives. These results, however, were in the context of clients feeling that their workers had leverage because they also controlled their money (Angell et al., 2007; Luchins et al., 2003) or because of the ACT model itself (Bond et al., 2001). The ACT model produces the most benefits to its clients when compared with other crisis management models (Bond et al., 2001; Mueser et al., 1998); therefore, more research on the specific elements that cause clients to perceive ACT as being too intrusive would be beneficial. If this area of research was explored in more depth, improvements to ACT based programs could be made in terms of its effectiveness in helping those people with the most pervasive vulnerabilities.

Last, future qualitative research is needed in the area of community crisis management services for adults, specifically assessing client perspectives. Most of the current research on program evaluations emphasizes quantitative methods (e.g., surveys; Dion et al., 2010; Krupa et al., 2010; Tierney & Kane, 2011) or meta-analyses (Bond et al., 2001; Joy et al., 2007; Simpson & House, 2002). Very few studies use a qualitative or mixed methods design to determine program strengths and weaknesses (Vingilis et al., 2006). While there is much merit in quantitative research, qualitative research allows for a more in-depth view of any given phenomenon (Patton, 2002). Additionally, most of the available research addresses crisis interventions (Dion et al., 2010; Donovan et al., 1979, as cited in France, 2002; Joy et al., 2007), which are more short term than crisis management programs (e.g., 4 to 6 weeks; Roberts, 2005). Further, other research underscores interventions for youth (Dion et al., 2010), who differ developmentally from adults, or focuses on assessing staff or professional perspectives (Dion et al., 2010; Krupa et al., 2010). Although program staff and other professionals offer an important perspective, clients can offer a unique outlook because they are the individuals immersed in the program. Accordingly, by focusing on adult client perspectives of the crisis management service, a relatively unexplored area of research could be investigated.

Implications for Counselling Practice

The results of this study raise important considerations for people in helping professions (e.g. crisis workers, nurses, counsellors, and psychologists). For instance, wanting more staff diversity so that clients feel understood by their worker raises the concept of being sensitive to clients' cultural background. The therapeutic alliance, or the ability to formulate rapport between a helper and client, has been revealed to require special attention when it is being established between a therapist and a client of a minority group (Vasquez, 2007). Vasquez (2007) also reports on research illustrating that minority clients are more comfortable with therapists who are comparable to them; however, this does not guarantee that a better therapeutic alliance will form. Vasquez (2007) states that clients may be more comfortable with helpers similar to them because they feel they do not have to 'edit' their reactions to situations and because there is less room for cultural and religious misunderstandings.

The Practice Skills Model of Multicultural Engagement (Alberta & Wood, 2009) represents a method of developing skills so that helpers can work in a culturally sensitive style. The authors outline four skills that can be learned to increase this sensitivity: empathic

communication, relationship building, diunital reasoning, and observation. These skills are then joined to a single method by a fifth skill: model management. It is this fifth skill where clinicians use the information that they have attained to compose a more comprehensive view of cultures that they are inexperienced in. It stands to reason that clients would feel more comfortable and understood if their clinician was able to use these skills, therefore, perhaps strengthening the therapeutic relationship.

The current research also brings up the notion of strength-based counselling. As stated previously, a strength-based approach takes into account a client's goals and wishes during his/her progression through treatment (Mueser et al., 1998). Throughout this model clients are seen as resilient (Roberts, 2005) and as having many strengths (Smith, 2006). It is the responsibility of the clinician to bring out these strengths as skills, as they are sometimes hidden from view (Saleebey, 2002). It is through clients' realization of their skills and strengths that they become more self-confident and more able to work on areas of greater vulnerability.

Corcoran (2005) has outlined a Strength-and-Skills Building Model for working with clients that utilizes the strength-based approach. The goal of this model is to support client motivation and resources, in part by taking a client's skills into account. The Strength-and-Skills Building model combines solution-focused therapy, motivational interviewing, and cognitive behavioural therapy (CBT) into six phases of helping: engagement (forming a therapeutic alliance and involving clients in the process of change), exploring the problem, exploring the solution, goal setting, taking action (teaching skills), and evaluation and termination. When moving through these stages, there is a conscious effort to work in a collaborative way, recognizing clients' strengths while working on their vulnerabilities. The skills and techniques that are employed by the clinician working from this model include some of the strategies used by the three frameworks it is based on (solution-focused, motivational interviewing, and CBT). They include: reframing, normalizing, asking coping questions, aligning with the client's perspectives, exploring past attempts to appease the problem, finding exceptions to the problem, and finding individual strengths, among others. Emphasizing client engagement and collaboration through a model that utilizes the strength-based approach may have implications for clients' feelings about the level of worker involvement in their lives. Further, by utilizing this approach, clients may feel as though they have more agency and will be better able to navigate society independently.

Limitations

Through this research, four limitations became apparent. The first limitation reflects the use of the interview protocol itself. Semi-structured interview guides help to maintain a moderate amount of flexibility in the order of questions posed while, at the same time, ensuring that all questions are asked. Unfortunately, it does not allow for other areas of participant interest to be explored in detail and, therefore, is not comprehensive in scope. Second, the quality of the interviews, and by extension the data that could be extracted, was dependent on the mental health of the participants. For example, one participant's data could not be used because his answers were incomprehensible and unrelated to CMS. Third, not all participants wished to review their transcript to ensure its accuracy and not all participants who requested a review made themselves available for this meeting. The lack of willingness to review their transcript negated any changes that they would have otherwise made, which could have altered the raw data found. Last, although there was an attempt to reassure clients that their responses would remain confidential, some clients may have been uncomfortable in voicing their opinion. Furthermore, some participants chose not to answer some questions at all, which could have potentially narrowed the breadth of the results.

Delimitations

Some restrictions were placed on this research in the form of delimitations due to logistical and time restraints. First, only active and assessment clients were contacted to participate in this study as they are the ones who receive the most interaction with CMS and the CMWs. Second, convenience sampling was used when choosing CMS clients to contact for participation. Unfortunately, the two delimitations above do not ensure that the individuals who were chosen to participate represent the CMS clientele as a whole. Third, only clients' perspectives were sought for this program evaluation. The CMS staff and other stakeholders could have also contributed their insights about CMS, which would have increased the quantity and characteristics of the data obtained. Fourth, only the 'process' component of Stufflebeam's CIPP model was used as part of the framework for this study. Though not unusual to use only one component of this model, if other components were applied as well, the program evaluation would have been more extensive. Fifth, only one data collection tool, interviews, was used to gather information about CMS. By adding another data collection tool (e.g., a survey), a mixed methods approach could have been employed allowing for more comprehensive results. Last,

due to the uniqueness of the CMS program, its staff, its clients, and the community in which they reside, the results of this study may not be generalizable to other programs in other geographical locations.

Conclusion

In conclusion, CMS is a non-profit community organization that helps clients who have been described as “hard to serve and difficult to engage” (SCIS, 2012, Crisis Management Service, para. 1). These individuals would most likely be forgotten in the system and would receive little help if CMS were not a part of the community. Many of these individuals struggle with mental illness, live risky lifestyles, are in a persistent state of crisis, and have other unique needs. Part of CMS’ role is to help meet these needs and to provide interventions for its clients’ crises so that clients can live more independently in the community.

As crisis theory postulates, the experience of a situation becoming a crisis depends on a person’s perception about the situation (Roberts, 2005), available coping mechanisms (France, 2002; Roberts, 2005), and that person’s personality traits (France, 2002). Further, if appropriate coping mechanisms are unavailable, the individual can experience instability and become more vulnerable (France, 2002; Golan, 1978, as cited in Roberts, 2005; Rapoport, 1962). Crisis intervention and management programs are important in these cases, as they strive to increase coping skills, to help individuals stabilize their lives, and to connect them to society (Bond et al., 2001; France, 2002; Greene, 2005; Mueser, 1998; Roberts, 1991; Roberts, 2005). Individuals can also feel as though they have more agency and independence when they are involved with programs that work from a strength-based approach. The strength-based approach accentuates the positives of individuals to teach them skills and connect them with other resources in an effort to reduce their vulnerabilities (Maton et al., 2004; Saleebey, 2002; Smith, 2006). This method is precisely the way in which CMS works with its clients.

This research was based on a utilization-focused process evaluation framework which sought to investigate and understand the experiences of CMS clients. This framework was chosen as it underscores clients’ perspectives of the strengths and weaknesses of their program, while including stakeholders in the process to ensure their investment in the results.

The general inductive approach (Thomas, 2006) was applied to the analysis of 14 client interviews which depicted client thoughts about CMS programming. From this analysis, eight dimensions emerged: Clients’ Experience with CMS and the CMS Staff, Interactions Between

CMS Workers and Their Clients, Financial Interactions to Increase Client Independence, Help and Support for Client Needs, Helping Clients Learn New Skills and Client Independence, CMS Support for Clients' Health, Connection to External Resources and Help with Personal Relationships, and Client Perceived Support and Needed Community Support. Through these dimensions, positive client experiences, as well as areas of concern, were explored. Additionally, based on these perceptions, a logic model was developed and explored.

Many of the current findings were supported by research literature on crisis theory, crisis intervention and management models and programs, and the strength-based approach. This study did, however, highlight future research areas and different strategies for working with clients. It is through the strength-based approach that CMS employs that clients will be able to utilize their assets to bolster their vulnerabilities so that they can live more independent and fulfilling lives.

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APPENDIX A

Letter of Potential Involvement

Dear Crisis Management Service client,

This is a letter to request your involvement in a program evaluation for Crisis Management Service (CMS). This is a research study being conducted on behalf of CMS by the Community-University Institute for Social Research (CUISR), University of Saskatchewan. The student researchers Terra Quaife and Laurissa Fauchoux from the Masters of School and Counselling Psychology program in the College of Education are supervised by the principal investigators for this study, Dr. David Mykota and Dr. Isobel Findlay, University of Saskatchewan.

CMS aims to provide the best service and care for their clientele. One way that programs can continue to meet client needs and to ensure that they are providing adequate services is through a program evaluation. A program evaluation is a method of collecting and using information about a program provided by service users to determine its effectiveness. The CMS evaluation will give you the opportunity to confidentially talk about the services and your level of satisfaction.

Ten to fifteen CMS clients will be contacted and asked to participate in this research study. People who choose to participate in this study will be invited to an interview at a location and time convenient to you that will take approximately 60 minutes. They will be asked only questions about the CMS services and no personal information will be collected. For your participation in this study you will receive \$15.00 compensation. Any information provided by participants will be used confidentially and your comments will remain anonymous; the staff at CMS will not know who has been chosen for interviews.

This letter is simply to inform you that you *may* be contacted to participate in the study. If you do not want to be contacted, please inform CMS staff by visiting the office or by calling 933-8234. You are not required to participate and your acceptance or refusal to participate will *not* affect the services you are currently receiving from CMS.

If you do not indicate otherwise, the student researchers will follow up this letter with a phone call. Meantime, if you are interested in learning more about this study, please contact Dr. Isobel Findlay or Dr. David Mykota:

David Mykota, Head
Educational Psychology & Special Ed
Room 3102, Education Building
University of Saskatchewan
Phone: (306) 966-5258
David.Mykota@usask.ca

Isobel Findlay, University Co-Director, CUISR
Associate Professor, Edwards School of Business
Room 89, PotashCorp Centre
University of Saskatchewan
Phone: (306) 966-2385
Email: findlay@edwards.usask.ca

The proposed research project was approved by the University of Saskatchewan's Behavioural Research Ethics Board on February 16, 2012 (BEH# 12-14). If you have any

questions about your rights as a participant, please contact this office at 306-966-2084 or ethics.office@usask.ca.

Sincerely,

David Mykota and Isobel Findlay

APPENDIX B

Consent Form

You are invited to participate in a research project entitled: *Program evaluation of Crisis Management Service (CMS) in Saskatoon, Saskatchewan*. Please read/listen to this form carefully, and feel free to ask questions you might have.

Researcher(s): Laurissa Fauchoux, CUISR student researcher, (306) 966-2651, and Terra Quaife, CUISR student researcher, (306) 966-2651. Supervisors: Dr. David Mykota, Head, Educational Psychology & Special Education, University of Saskatchewan, (306) 966-5258; Email: David.Mykota@usask.ca; and Dr. Isobel Findlay, Management and Marketing, Edwards School of Business, University of Saskatchewan, 25 Campus Drive, Saskatoon, SK S7N 5A7; (306) 966-2385; Email findlay@edwards.usask.ca.

Purpose and Procedure: The purpose of this research study is to give you the opportunity to express your thoughts and feelings about Crisis Management Service (CMS) and the programming that you are obtaining through them. This data will be used to create an evaluation report and for Terra Quaife's thesis.

You are being asked to participate in an interview which will take approximately 60 minutes with Laurissa Fauchoux and Terra Quaife (the researchers). These questions will deal only with CMS programming and your satisfaction with it. Prior to the interview you will be given 5-10 minutes to look over the questions that we will be discussing. If you agree, the interview will be audiotaped to ensure that we have an accurate record of what was said. After the interview you will be given a debriefing form and will be given the opportunity to ask any questions that you have and the option to decline reviewing your transcript. If you do not decline reviewing your transcript, you will be given a written form of the interview once it is produced in order to ensure its accuracy and sign a transcript release form. If you feel changes need to be made to the transcript, you will then have the opportunity to do so. If we are unable to contact you to review the transcript, the data will still be used; however, no identifying information will be included. Although the transcript will be used to provide data for the report, your name will not be included in the report to ensure that your information is kept confidential. Data included in the report will either be in summarized form or direct quotations.

Potential Benefits: Though we cannot guarantee these, potential benefits for your involvement in this study include:

1. Receiving \$15.00 for your participation
2. Having a voice in improving CMS with your personal expertise and involvement
3. Helping to gather information that can be used by staff to improve CMS services
4. Help present and future clients of CMS, and society in general to obtain the best services possible

Potential Risks: The cost/inconveniences/risks of this study may include:

1. The time requirement by you to participate in the study (travel time, approximately 60 minutes for the interview, time to review the transcript). You will be compensated for your time with the \$15.00 (as described above)

2. Although we are using caution to ensure confidentiality there is the possibility through direct quotes confidentiality may be compromised; however, steps are taken to ensure this is not the case
3. You may feel pressured to participate in the study given your relationship with CMS; however, there is no requirement for you to participate in order to keep accessing CMS services. Furthermore, CMS staff will not know whether you have agreed to participate in the study or not.

There will be an opportunity for debriefing after the interview; if it appears that further support is required, information will be given about supportive resources external to CMS. The researchers reserve the right to terminate the interview if we become uncomfortable at any time.

Storage of Data: At the conclusion of the research study, the information that has been collected, including consent forms, audiotapes, transcripts, and transcript release forms, will be stored in a locked file cabinet in the principal investigator's (David Mykota) office. This data (consent forms separated from other data to protect your confidentiality) will be kept there for a minimum of 5 years after the completion of the research study. After 5 years the data will be destroyed beyond recovery.

Confidentiality: The data from this research project will be published as a Community-University Institute for Social Research report; however, your identity will be kept confidential. Although we will report direct quotations from the interview, you will be given a pseudonym, and all identifying information will be removed from our report. Because you have been selected from a small group of people, all of whom are known to the CMS staff, it is possible that you may be identifiable to other people on the basis of what you have said, even though no identifying will be included in the report. After the interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. There is no guarantee that you will personally benefit from your involvement. The information that is shared will be held in strict confidence and discussed only with the research team. You may withdraw from the research project for any reason, at any time, without penalty of any sort and this will not compromise your services with CMS or relationship with the CMS staff or researchers. Furthermore, you will still be entitled to receive the monetary compensation (\$15.00) for your time. Your right to withdraw data from the study will apply until April 30, 2012. After this it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data. Upon request to withdraw your data, your data will be destroyed.

Questions: If you have any questions concerning the research project, please feel free to ask at any point; you are also free to contact the researchers or the university research ethics board at the numbers provided if you have other questions. This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on February 16, 2012. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.

Follow-Up or Debriefing:

After you complete the interview you will be given an opportunity to ask questions and a debriefing form will be given to you. If you wish to receive a copy of the final report please ask the researchers (contact information below) and a copy will be made available to you.

Consent to Participate:

I have read and understood the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

(Signature of Researcher)

APPENDIX C

Interview Guide

1. What is your name?
2. As part of the evaluation for Crisis Management Service, we would like to know a little bit about you, would you mind telling us about yourself?
 - a. Probe: How old are you?
 - b. Probe: How would you describe your cultural/ethnic background?
3. Can you tell us a little bit about your story and how you came to Crisis Management Service?
 - a. Probe: Did you refer yourself? Or were you referred by someone else?
 - b. Probe: How long have you been in the program?
 - c. Probe: What brought you to the program?
4. Suppose we were with you for a week, what would your interactions with Crisis Management Service look like?
5. How would you rate your experiences with Crisis Management Services?
 - a. Probe: Would you say your experiences have been very good, good, bad, very bad?
6. Since joining the program, what has the program done for you?
 - a. Probe: How has the program helped your quality of life?
 - b. Probe: Has Crisis Management Service helped you live in the community more independently?
 - i. Probe: Can you give examples of how the program has helped you to live more independently in the community?
7. Have you benefitted from this program in ways that you were not expecting?
 - a. Probe: What were the benefits that you received that you were not expecting?
8. Have your expectations for the program been met?
 - a. Yes Probe: Would you mind explaining what your expectations were that were met?
 - b. No Probe: Can you give us examples of expectations that you had, but that were not met?
9. What about the program do you most enjoy?
10. Can you tell us a little bit about your experience with the staff at Crisis Management Service?
 - a. Probe: When you interact with the staff do you usually have a positive or negative experience?
 - i. Probe: Can you tell us more about those experiences?
11. Since joining the program, what has Crisis Management Service not done for you that you would have liked it to?
 - a. Probe: What could Crisis Management Services do differently to help you live more independently in the community?
12. How could the program change to improve your quality of life?
13. What about the program do you least enjoy?
14. If you had the opportunity to improve the Crisis Management Program, what would you change?
15. How would you summarize your experiences with CMS?

16. Is there anything else that you think we should know about Crisis Management Service?

APPENDIX D

Alignment of Research Questions and Interview Questions

Research Questions

1. What are the clients' experiences with CMS?

Interview Guide Questions

3. Can you tell us a little bit about your story and how you came to Crisis Management Service?

a. Probe: Did you refer yourself?
Or were you referred by someone else?

b. Probe: How long have you been in the program?

c. Probe: What brought you to the program?

5. How would you rate your experiences with Crisis Management Services?

a. Probe: Would you say your experiences have been very good, good, bad, very bad?

9. What about the program do you most enjoy?

10. Can you tell us a little bit about your experience with the staff at Crisis Management Service?

a. Probe: When you interact with the staff do you usually have a positive or negative experience?

i. Probe: Can you tell us more about those experiences?

13. What about the program do you least enjoy?

15. How would you summarize your experiences with CMS?

16. Is there anything else that you think we should know about CMS?

2. To what extent are the outcomes of CMS consistent with the services that its clients receive?

6. Since joining the program, what has the program done for you?

- a. Probe: How has the program helped your quality of life?
- b. Probe: Has Crisis Management Service helped you live in the community more independently?
 - i. Probe: Can you give examples of how the program has helped you to live more independently in the community?

7. Have you benefitted from this program in ways that you were not expecting?

- a. Probe: What were the benefits that you received that you were not expecting?

8. Have your expectations for the program been met?

- a. Yes Probe: Would you mind explaining what your expectations were that were met?
- b. No Probe: Can you give us examples of expectations that you had, but that were not met?

16. Is there anything else that you think we should know about Crisis Management Service?

3. To what extent is the process of client engagement with CMS contributing to the desired outputs of CMS?

4. Suppose we were with you for a week, what would your interactions with Crisis Management Service look like?

11. Since joining the program, what has Crisis Management Service not done for you that you would have liked it to?

a. Probe: What could Crisis Management Services do differently to help you live more independently in the community?

12. How could the program change to improve your quality of life?

14. If you had the opportunity to improve the Crisis Management Program, what would you change?

16. Is there anything else that you think we should know about Crisis Management Service?

Demographic Questions:

1: What is your name?

2. As part of the evaluation for Crisis Management Service, we would like to know a little bit about you, would you mind telling us about yourself?

a. Probe: How old are you?

b. Probe: How would you describe your cultural/ethnic background?

APPENDIX E

Debriefing Form

Thank you again for participating in this program evaluation. Your knowledge and expertise are an important part of the improvement of Crisis Management Service and ensuring that present and future clients are receiving the best care possible. Our aim for this research was to determine program strengths, weakness, possible avenues for growth, and your satisfaction as a client with the program.

If you have any question or comments or would like to obtain results of the evaluation, please contact Laurissa Fauchoux or Terra Quaife. If you have any questions regarding the ethics of this research study please contact the University of Saskatchewan Behavioural Research Ethics Board. All contact information is below.

___ By checking here, I choose to allow the researchers to use my transcript without contacting me to review and make changes to it.

___ By checking here, I choose to have the researchers to re-contact me in order to review my transcript.

Laurissa Fauchoux: 306-966-2651

Terra Quaife: 306-966-2651

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University
Saskatoon SK S7N 4J8
306-966-2975

APPENDIX F

Transcript Release Form

Title of study: *Program evaluation of Crisis Management Service (CMS) in Saskatoon, Saskatchewan*

This transcript form is to give acknowledgement that the interview data accurately reflects what was said in the interview with Laurissa Fauchoux and Terra Quaife (researchers). This data may be included in the final report.

I, _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Laurissa Fauchoux and Terra Quaife. I hereby authorize the release of this transcript to Laurissa Fauchoux and Terra Quaife to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

Name of Participant

Date

Signature of Participant

Signature of Researcher