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The role of a clergyperson within an assertive case management outreach team

Rachel Adrienne Lee Fayter
Wilfrid Laurier University

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The Role of a Clergyperson within an Assertive Case Management Outreach Team

by

Rachel Adrienne Lee Fayter
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Abstract

Mental health consumer/survivors living in urban poverty are generally marginalized and devalued by society. To aid in the process of recovery they require a holistic form of treatment to meet their physical, emotional, psychological, and spiritual needs. The current exploratory study investigated the role of a pastor as part of a multidisciplinary team engaged in mental health outreach work and the impacts of this role for people experiencing urban homelessness. Multiple qualitative methods were used to collect data from different stakeholder groups. From multiple participant perspectives, the findings indicate that there are many unique spiritual, relational, and moral aspects of an outreach minister's role. The unique roles of the outreach minister occur within the context of client needs and translate into various responses which positively impact program consumers. The outreach minister responds to client needs affectively, spiritually, instrumentally, and through mental health problem-solving. The findings indicate that the unique spiritual, relational, and moral characteristics of an outreach minister's role within a multidisciplinary team potentially entail significant benefits for consumer/survivors experiencing urban poverty. Limitations include the context specific nature of a qualitative case study, which restricts the degree that the findings can be transferred and applied to other settings. Additionally, due to the temporal constraints of the project the time spent in the field was moderate and consultations with program consumers were not possible during the planning and data collection phases. Implications involve the potential to create a framework for developing a holistic model of care which integrates faith and spirituality into mental health outreach teams in other settings.

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value of simply listening and being present for people in need from my time engaged in fieldwork. Thank you for providing me with insight into your outreach ministry.

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Personal Prologue

My personal interests in spiritual beliefs, religious practices, and faith communities stem from my upbringing. I am a Caucasian, middle-class, young woman who was raised by parents who were both ministers of the United Church of Canada. All four of my grandparents were Salvation Army officers who dedicated their lives to working with disadvantaged people. My personal faith in Christianity stemming from my familial background informs my values and my actions. Some of these values include tolerance, forgiveness, respect, and justice for impoverished and marginalized people, honesty, and a non-judgmental attitude. Throughout my life I was taught to respect diversity, be generous and thoughtful, care for others, to not place strong value on material possessions, and to not judge or demean someone who may not share the same privileges I was afforded. My family was a good model of what they taught me.

Along with the caring and compassion I learned from my grandparents, my father has had the most positive impacts on my intellectual and personal development. Being both an ordained minister and a university professor, he has shown me that religion and science are equally important areas of study. Complementing one another, they provide a holistic and comprehensive understanding of human existence. Throughout my childhood I was always encouraged to work hard in school, while taking a critical perspective on everything I learned. Learning critical thinking skills at a young age enabled me to look at the world with diverse perspectives and question social and political injustices.

Having attended church regularly for the first half of my life and spending years living in large urban centres such as Toronto and Hamilton, I have witnessed extreme poverty. Additionally, I have close family friends who have either overcome or are currently

living in poverty. These individuals are some of the kindest, most generous, and loving people I have met.

One of the reasons I initially became interested in the field of community psychology (CP) was from reading articles about the systemic barriers people face when attempting to overcome poverty. I became aware that these individuals experience severe societal and political injustices, and that CP can offer mechanisms for improving or changing the current conditions of repressive systems.

I was intrigued by the common threads linking CP and spirituality, so for my undergraduate honours thesis I decided to pursue these interests. In my past research I looked at the qualities and outcomes of personal spiritual beliefs and participation within a faith community for people who live in urban poverty. I thoroughly enjoyed working with and listening to the stories of people living in impoverished conditions. It was inspiring to learn how much resiliency these individuals have and how influential their religious participation and personal faith have been in helping them overcome obstacles.

My current interest in homelessness, community mental health, and the humanistic approach of the clergy builds on my past research and allows me to explore issues of personal interest and relevance. Community mental health is an area of CP with which I am not very familiar and that I would like to learn more about. Aside from my professional development in the field, I am personally interested in community mental health care because there is a history of mental health issues within my family, some of whom have struggled with depression. Witnessing loved ones' struggle with mental health issues and using their religious faith and spiritual approaches to cope with these

problems inspired me to learn more about the topics of mental health and spiritual approaches to recovery.

Along with the significance of my personal motivations for conducting this project, my educational and professional background plays a role in my choice to use qualitative methods. I believe that no research is purely objective or value-free. I am aware that my subjective biases and personal values will influence the research data and my interpretations of them. To ensure that my own perspectives did not alter the voices of my participants, I practiced reflexivity in this project. I used a personal journal as a consciousness-raising tool to reflect on my assumptions and values related to my proposed plan of study. Furthermore, I approached the data analysis in collaboration with my primary stakeholders, and facilitated a feedback discussion with clients to ensure that my interpretations accurately reflect the participants' voices.

Introduction

For generations now, psychological research and practice have tended to favour the biomedical model, which generally conceives of human functioning in a narrow and mechanistic manner, while either ignoring or reductively analyzing other, equally important dimensions of human life, including the moral and the spiritual. Reductionistic, deterministic, and mechanistic methodologies and metaphysics were adopted by behaviourists (early to mid 20th century) and evolutionary and neuropsychologists (late 20th century) in part due to a perceived need to legitimize the field as a "true" empirical discipline, modeled on the natural sciences (Allen, 1975). An ironic and little understood aspect of this development is that even as physics – the paradigmatic natural science –

abandoned classical mechanism as inadequate, practitioners of the life and social sciences rushed to embrace it as a new orthodoxy (Barbour, 2002).

Despite the diversity of theoretical approaches available in the field, the single-minded scientism of many mainstream psychologists devalues alternative perspectives, including qualitative research. In the early 21st century, many psychologists are recognizing the need for multidisciplinary and holistic perspectives, for a philosophy of human functioning that more adequately represents the complexities, depths, and richness of lived reality.

Recently, for example, community psychologists have demonstrated the research value of integrating insights drawn from the academic study of religious belief and spiritual practice embodied in faith communities (Maton, 2001). Unsurprisingly, given the trajectory of professionalization in psychology since the 19th century, efforts to combine religious and psychological scholarship have proven challenging. The popular view that the worlds of "Science" and "Religion" are separate, incompatible, and conflicting emerged from the ideology of Victorian scientific naturalism in the same era that psychology emerged as a social scientific field distinct from philosophy but related to biology (Barbour, 1997; Moore, 1979). Naturally enough, psychologists sought to dissociate themselves from the "taint" of theology, employing a biomedical perspective to better align themselves with the natural sciences that increasingly acquired social prestige and authority (Brooke, 1991). This false dichotomy of science and religion is recently being acknowledged and addressed in psychology due to the awareness that spiritual health is a key aspect of personal wellbeing. Furthermore, the importance of

religious and spiritual practices to human societies transcends cultural boundaries and can be seen throughout recorded history (Barbour, 1997).

Religious knowledge, values, experiences, beliefs, and behaviours are deeply personal and social. Given the mythic claim that scientific investigation is disinterested and "objective," such forms of knowledge, experience, and expression have usually been labeled "subjective" and regarded with suspicion by mainstream psychologists. The recent openness of community psychologists to human spirituality and religion in social context can be explained by a refusal to fear or to pre-judge religion as unhealthy or merely subjective. Although many community psychologists continue to conduct research within the positivist and post-positivist paradigms, primarily using a quantitative approach to data collection, this sub-discipline of psychology seems more open to alternative methodologies than more traditional areas of psychology. In recent years, community psychologists have been increasingly open to employing qualitative research methods, which includes subjectivity as a positive complement, or even an alternative to, quantitative approaches. For example, Kidder and Fine (1997) advocate for qualitative inquiry in psychology and consider a strictly qualitative approach necessary for researching areas that are previously unexplored, as the researcher is not constrained by a predetermined set of variables.

There is a significant amount of overlap among the core values and social action efforts of community psychologists and faith-based organizations. Although the former group operates from a secular, academic approach, whereas the latter tend to work within the worldview of a specific religious denomination and are more grassroots oriented, the two groups have similar goals. For example, community psychologists and many faith-

based organizations are committed to social justice and are interested in assisting marginalized and oppressed groups, such as people living in extreme destitution and those experiencing serious mental health issues.

In our role as social analysts, community psychologists are interested in researching current systemic issues occurring in the social environment and creating theoretical frameworks for addressing these issues. As activists and interventionists, we work towards the goals of equality and social justice, designing programs and influencing policy to address long-term societal problems. Poverty is a significant and persistent social issue relevant to community psychologists. The issue of urban poverty is an increasingly common social problem within Canada (Lee, 2000). As a result of increases in the amount and severity of poverty and limited access to affordable housing, many single men, women, and families with children are experiencing homelessness (Shinn, 2001). Additionally, deinstitutionalization has led to former mental health patients being discharged to poor living conditions and homelessness for many (Nelson & Prilleltensky, 2005). Due to limited community resources, a lack of government support, multiple stressors, challenges in daily living, and various other contextual factors, many homeless individuals are living with mental health issues.

In the following paragraphs, I will attempt to show that there is a significant amount of overlap between religion, spirituality, and community psychology. Following the discussion of this integration between religion and community psychology, I will offer an overview of some approaches to community mental health and demonstrate how spirituality and a faith-based approach can be incorporated into working with people who

are experiencing serious mental health issues, including the role of a pastor as a frontline mental health worker.

Assertive Community Treatment (ACT) is a widespread approach to community mental health outreach work, especially within North America, the UK, and Australia. Although religious and spiritual issues have more recently entered the field of community mental health, they have yet to be integrated within the ACT model. From a review of the literature I will provide a brief overview of ACT and discuss some of its present limitations. I then explicate the research questions that guide this exploratory project. The methodology for examining the research questions is explained in detail, including a description of the urban community where I gathered data, an overview of the Hamilton mental health outreach team, the sampling procedure and participants, and a rationale and discussion of the research design. The details surrounding data analysis and feedback to the participants are outlined, followed by a consideration of possible risks to participants and means to alleviate these risks. Lastly, I highlight the action component of the study and mention some potential impacts this research will have on the community.

Literature Review

Commonalities between Community Psychology and Religion, Faith, and Spirituality

Central to the study of community psychology is the ecological perspective (Bronfenbrenner, 1979), which posits that individuals exist within layers of social relationships. The concept of ecological levels of analysis is also critical to the study of religion and spirituality because the importance of the interaction between individual and environment is stressed (Mankowski & Rappaport, 2000). Similarly, Pargament (1997) described the importance of studying people in the context of their families,

organizations, and communities. Faith-based communities are of particular importance to community psychologists, because they foster a strong sense of community among their members (Hill, 2000). Pargament and Maton (2000) noted how religion as a social institution provides a sense of community and belonging with its distinctive assets in building interpersonal community.

Spirituality is an integral part of community psychology because spirituality encompasses both human and community development (Dokecki, Newbrough, & O'Gorman, 2001). Individual and community building are two critical domains of spiritual and religious influence (Maton, 2001). The incorporation of religion and spirituality into community research and action can contribute towards social change efforts (Kloos & Moore, 2000; Mankowski & Rappaport, 2000; Moore, Kloos, & Rasmussen, 2001). Many social action efforts within faith-based organizations are focused on fundamental social systemic change. Social action can occur through involvement in community organizations and participation in social policy formation (Pargament & Maton, 2000).

Critical to the field of community psychology is personal or psychological empowerment, especially for individuals within oppressed or marginalized groups. Empowerment entails a sense of personal control and well-being. Maton (2001) advocates for the incorporation of religious and spiritual domains of the larger community so that oppressed individuals can achieve a sense of personal empowerment. Many faith-based organizations emphasize the strength of their members, which is consistent with an empowerment perspective (Kloos & Moore, 2000). The spiritual aspect of personal empowerment is the development of an intimate relationship of

members (of the religious group) with God. Underlying the spiritual aspect of empowerment is the idea of a loving, caring, and powerful deity that provides comfort and personal strength in times of great need (Pargament & Maton, 2000).

Mankowski and Rappaport (2000) discussed how religious narratives represent a resource for increasing personal empowerment. As these narratives are repeatedly told, they become internalized and enacted, thus giving them significant power to shape individual life. Narratives are an important tool for understanding the relationship between individual experience and social processes within spiritually-based settings (Maton, 2000). These personal stories related to religion and spirituality also play a major role in how we define ourselves (Kress & Elias, 2000) and can be a source of our personal values (Walsh-Bowers, 2000).

Perhaps the most critical and influential aspects of spirituality and a faith-based approach to mental health outreach are the psychosocial qualities of a clergyperson that directly lead to individual and group empowerment. Pastors of religious communities have been found to be welcoming, supportive, accepting, and tolerant (Brodsky, 2000), possess a non-judgmental attitude and encourage diversity (Mankowski & Thomas, 2000). This unconditional acceptance that is characteristic of many Christian clergy can be traced within the religion to the words, actions, and parables of Jesus who spoke about including the poor, outcast, and marginalized in the "Kingdom of God"[1] (e.g., Matthew 22:1-14; 35:31-46). The historical fact that religion has often served as an important symbol and source of strength and hope for marginalized groups in society and people

[1] The term "Kingdom of God" is a political metaphor that represents the vision of a new world based on justice and righteousness. Rooted in the Jewish prophetic tradition, it was the central theme of Jesus' preaching, according to the Gospels.

who have been disempowered (Pargament, 2002), forms the basis of this exploratory research project.

Contributing to individual personal empowerment, religion effects healing and growth through multiple mechanisms, including intrapsychological transformations in self-value, self-acceptance (Maton, Dodgen, Domingo, & Larson, 2003) and self-esteem (Neumann, 1995). The internal role of religion and personal faith provides religious individuals with inner strength, creating and fostering a sense of personal growth (Brodsky, 2000; Mankowski & Thomas, 2000). In a review of recent literature, religious coping (i.e., using one's religious beliefs to assist in coping) was shown to increase feelings of personal efficacy in people that rely on their religion for solace during stressful times (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Finally, religion and spirituality are associated with life-satisfaction (Johnson, Tompkins, & Webb, 2002).

Religious beliefs and spiritual practices seem to be especially valuable in extremely stressful situations (Pargament, 2002). Religious rituals have been linked to the alleviation of distress during troubled times (Tarakeshwar, Stanton, & Pargament, 2003) resulting in lower levels of psychological distress (Neumann, 1995). Spirituality and faith-based organizations have commonly provided individuals with enhanced coping abilities, acting as buffers to life stress (Maton, 1989; Maton & Pargament, 1987; Pargament, Maton, & Hess, 1992; Pargament, Tarakeshwar, Ellison, & Wulff, 2001; Butter & Pargament, 2003).

One final commonality between the domains of community psychology and religion and spirituality lies in the ability of religion as a social institution to reach and provide access to poor and minority groups (Pargament, 1997; Pargament & Maton, 2000). Urban

poverty is an increasingly devastating social problem (Allen, 2000). This issue holds many implications for community psychologists, such as their involvement in designing, evaluating, and implementing programs that seek to eliminate poverty, enhance mental health, and create social change.

Community Mental Health and Spirituality

In recent years there has been a renewal of interest in religion and spirituality in North American culture. As a result, mental health practitioners are being urged to take seriously their clients' spiritual issues and interests (Frame, 2000). Faith-based community organizations are valuable and relevant contexts for the involvement of psychologists-of-faith. The unique objectives, values, and constituencies of faith-based organizations create opportunities for applications, adaptations, and innovations in psychological perspectives and methods (Canning, 2003).

An important and central value for holistic health promotion and faith-based community mental health centres is the recognition that the consumer of mental health services is a full human being and has physical, emotional, psychological, sexual, and spiritual needs. Furthermore, consumers/survivors have voiced their preference to have their culture and religion integrated into service delivery models (Mason, Olmos-Gallo, Bacon, McQuilken, Henley, & Fisher, 2004).

Churches, synagogues, and mosques naturally serve as community centres for millions of people in North America. Additionally, religious writings and spiritual practices bring solace, support, sharing, practical wisdom, and guidance for dealing with myriad challenges, transitions, and losses. People with serious mental health issues may come to trust religious organizations far more than community health services (Goldman, 2005).

High quality care for people who complain of psychological issues and challenges in daily living involves addressing religious experience. Religious involvement may support behaviours that are more conductive to health. Indirect health benefits may accrue from involvement in the church and community (Young, Griffith, & Williams, 2003).

With the emergence of the community mental health movement in the 1960s, some researchers, practitioners, and clergy recognized that this contemporary movement could be an effective vehicle for all religious denominations to once again become an integral part of the social mechanism for dealing with issues of poverty, homelessness, and mental health (Harris, 1969). The work of clergy represents a significant mental health resource for people lacking sufficient access to needed care (Young et al., 2003). In the past, "healing was most often given by priests...and religious teachers with medical professions... sponsored in the Middle Ages by the church" (Johnson, 1973, p. 32). Increased mental health issues in our society warrant widespread involvement by the church and community mental health programs (Goldman, 2005).

If both current and historical perspectives on community mental health and spirituality have advocated for the integration of these domains, then why has the ACT model not yet incorporated religion, faith, and spirituality into its mandate? In October, 2005 and again in August, 2006 I conducted a literature search with the following search terms using the PsycInfo database: "assertive community treatment" and "community mental health" and "spirituality" or "faith" or "religion". Utilizing these aforementioned terms in this way yielded absolutely no results. There is obviously a significant gap in the literature on community mental health approaches and the actual practice and application of outreach services. Through this exploratory study I sought to fill this void.

Recently, an Assertive Case Management Outreach (ACMO)[2] team in southern Ontario acknowledged the importance of addressing spiritual issues with its clients and hired a clergyperson to engage in this role. As of August 2006 the City of Hamilton is the only ACMO team to employ an ordained minister[3] (PsycINFO search and personal communication with Valine Vaillencourt, 2006). This multidisciplinary team was the partial focus of my research investigation.

Overview of Assertive Community Treatment (ACT) Model

Assertive community treatment (ACT) emerged in 1974 (previously called training in community living) from an understanding that to effectively address the revolving door hospitalization phenomenon, mental health practitioners would have to move away from the hospital and into the community (Dixon, 2000). Community treatment initially focused on assisting people with mental health issues in developing skills for coping with problems of living in the community. The outreach team worked collaboratively with a variety of community resources (McGrew & Bond, 1997). The approach expanded to include more specific programs designed to build skills and secure housing and employment for people with serious mental health issues. Multiple referrals are also made to doctors, self-help groups, and other appropriate community services (Hampton & Chafetz, 2002).

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[2] "Assertive Case Management Outreach" represents an alternative, but similar approach to the ACT model. ACMO is a more empowering and less paternalistic approach to mental health outreach. This point will be elaborated further in my discussion regarding the critiques of ACT and throughout the overall findings of this project.

[3] Valine clarified that ministers throughout the world have been conducting outreach work for many years and some may be engaging in their outreach ministry with other disciplines. Focusing specifically on the ACMO model and ACT models of mental health outreach, there are no such teams in North America that have actively integrated a clergyperson into the team's model. I was able to gather further evidence for this claim through my research of the available literature on the subject, which involved searching the PsycINFO database and utilizing the Google internet search engine for ACMO teams and the integration of clergy.

ACT is a highly intensive form of case management. Its outreach activities are designed to facilitate a network of social and psychiatric services with the objective of maintaining an individual's stability within the community (Minghella, Gauntlett, & Ford, 2002). Practitioners involved with this approach conceptualize ACT as "a service delivery vehicle or system designed to furnish the latest, most effective and efficient treatments, rehabilitation, and support services conveniently as an integrated package" (Dixon, 2000, pp. 761-762).

ACT has shown to have relevance to community psychology. Specifically this model can incorporate multiple areas of CP including an ecological approach, an advocacy orientation, promotion of competence, prevention of psychopathology, integration of services, and systems theory (Mowbray, 1990). Despite the positive potential for a CP values-based service model, evaluations and efficacy for ACT have been mixed. Some small-scale randomized controlled trials have demonstrated that ACT clients were able to live and work autonomously, their symptoms did not worsen, and they were not transferred to live with family members or in community institutions (Dixon, 2000). Results of a mixed-methods longitudinal study conducted by Ben-Parath, Peterson, and Piskur (2004) indicate that clients and family members were satisfied overall with ACT services, but family members reported greater satisfaction than clients in all areas assessed.

Critiques of ACT

Many clients of ACT have reported that initially they were ambivalent about the help being offered and the coercive interventions were experienced as an attack on their personal identities (McGrew, Wilson, & Bond, 2002). Furthermore, clients have reported

feeling that their voices have not been heard during interactions with psychiatric service providers. This finding has resulted in an increased level of concern around issues of power (Watts & Priebe, 2002). Some mental health advocates and researchers assert that ACT is paternalistic and coercive (Gomory, 1999). This approach has been shown to have potentially harmful effects such as creating a state of dependency and powerlessness within the consumer/survivor (Gomory, 2005). Also, a number of ethical issues arise such as whether delivery of a service to people who are refusing it and are not legally bound to accept it can be justified (Williamson, 2002).

The ACT model emerged from the idea that in order to prevent people with mental illness from continually returning to mental health institutions, practitioners would have to work within the community[4]. The major difficulty with the above belief serving as the foundation of a model for mental health outreach is that the purpose of the ACT program was not intended to promote recovery from mental illness or even to reduce symptoms and improve quality of life. The main objective identified by the founders of ACT was strictly to keep people out of the hospital, therefore reducing healthcare costs. This means that consumers of ACT are subject to the same paternalistic control, coercion, and lack of power that their institutionalized counterparts experience within the confines of the hospital.

ACT team members are not concerned with their clients need for empowerment, choice in treatment options, or hope for a life free of mental illness. Instead, these practitioners are driven by the traditional biomedical model of care, which seems to

[4] This idea of moving medical-based treatment out of the hospitals and into the community mirrors the 1960's deinstitutionalization movement, which was unsuccessful largely due to a lack of preparation. In hindsight we can observe that replicating institutional and coercive medical treatment within a community-setting is no more beneficial for a consumer/survivors' well-being than discharging people from a hospital and simply placing them on the streets.

justify control of consumers' lives through pharmaceutical coercion. Not only are ACT clients forced to take psychotropic medication (or risk being involuntarily hospitalized), they are often assigned mandated financial payees who control the individual's finances (Gomory, 2002). Diamond (1996) described the significant number of clients that were assigned a financial payee who allowed the client to obtain spending money (from their own personal funds) only after participating in specific aspects of treatment. Participants of the ACT program are required to attend professionally assigned employment sites and maintain their employment to the extent that community practitioners will frequent the client's home and physically take them out of bed and to the job site (Diamond, 1996). Perhaps even more disturbing is the fact that clients' housing is often contingent on continuing a specific treatment program or taking prescribed medication. Many of the goals of the program, such as obtaining paid employment and taking medication, appear to be a professionally driven value that is often in conflict with the consumer's own preferences.

Returning to the foundation of the model, the originators of ACT (i.e., Arnold J. Marx, Arnold M. Ludwig, Leonard I. Stein, and Mary Ann Test), based their original research on the belief that people with mental health issues are "tough, formidable adversaries" who "use their insanity to control people and situations" and "become chronic simply because they choose to do so" (Ludwig & Farrelly, 1967, pp. 737-741). In an earlier publication Ludwig and Farrelly (1966) describe their perspective on patient wellness (within a mental health institution) by asserting that the person experiencing mental illness must "think, feel, and behave as persons similar to staff" and that "health and sanity as defined by staff would rule" (pp. 566-567). These arbitrary, subjective,

condescending, and biased opinions of people living with mental health issues and perspectives on how these individuals should "live" are at diametric odds with the current prevalent viewpoint within the field of community mental health relating to consumer recovery and empowerment (Nelson, Lord, & Ochocka, 2001b; Nelson & Prilelltensky, 2005; Trainor, Pomeroy, & Pape, 2004).

From the current critiques and ethical implications of the ACT approach it is evident that some changes are necessary to improve service delivery and ultimately empower the mental health consumer to regain control of his/her own life. It is clear that incorporating spirituality into mental health treatment and recovery models might produce positive outcomes for service users. The ACT model and similar models of mental health outreach programs has the potential to be enhanced by incorporating the spiritual and humanistic approach of a clergyperson. As a society we need to move away from our steadfast adherence to the Western biomedical model and shift our thinking to a new paradigm of empowerment and recovery.

Personal Empowerment and the Process of Recovery

The concept of empowerment suggests both individual self-determination and democratic participation within the local community. Therefore, empowerment as a psychological construct conveys both a sense of personal control and a concern with social influence, political power, and legal rights (Rappaport, 1987). "Empowerment is an intentional ongoing process occurring within a community, involving mutual respect, critical reflection, caring and group participation, through which individuals lacking an equal share of valued resources are able to gain increased access to and control over these resources" (Cornell Empowerment Group, 1989, p. 2). This construct encourages us to

think in terms of wellness versus sickness, and strengths or competencies as opposed to needs and deficits. Nelson, Lord, and Ochocka (2001a) define empowerment as referring to opportunities for and conditions that promote choice and control, community integration, and valued resources. Empowerment also includes a personal dimension of both perceived and actual power. Empowerment as personal control is an involved process of social engagement that is influenced by both relationships and context (Nelson, Lord, & Ochocka, 2001b).

Theories of empowerment include both processes and outcomes, which suggest that actions, activities, or various structures can be empowering, and the outcome of such processes culminate in a level of being empowered (Perkins & Zimmerman, 1995). Empowerment theory, research, and intervention link individual well-being with the larger sociopolitical environment. As a construct, empowerment connects individual strengths and competencies, informal helping networks, and proactive behaviours to social policy and social change (Rappaport, 1981). Empowerment-oriented interventions enhance health and well-being while seeking to ameliorate problems, provide opportunities for participants to gain knowledge and skills, and engage professionals as collaborators rather than experts. Theoretically, the construct links mental health to mutual-aid and the desire to create healthy, cohesive communities (Perkins & Zimmerman, 1995).

The current public health care system, and to a greater extent the mental health system, needs to critically evaluate its dogmatic adherence to the traditional biomedical model and look towards contemporary paradigms which embrace consumer empowerment and strive to facilitate, rather than inhibit recovery from mental illness. With its cumbersome

and hierarchical bureaucracy, dominated by the interests of the medical profession and insurance and pharmaceutical corporations, it is difficult to imagine an institution that is more disempowering than the health care system (Perkins, 1995). In a study on consumer/survivor empowerment, Nelson, Lord, and Ochocka (2001a) found that power imbalances between consumers and medical professionals, and a lack of control over treatment options, were frequently identified by participants as inhibiting mental health.

Mental health can be defined as the development of choice, control, and community integration and the attainment of valued resources (Nelson, et al., 2001a). This definition of mental health was conceptualized within the empowerment-community integration paradigm put forth by Nelson et al. (2001b) and is consistent with general conceptions of empowerment as discussed above. Within an empowerment worldview, mental health is a construct that must be addressed beyond the narrow scope of the mental health system. Political and community changes are necessary to enhance empowerment and mental health (Nelson, et al., 2001a).

Rappaport (1987) asserted that an empowerment approach is fundamentally ecological in nature and addresses issues within multiple levels of analysis. Empowerment is a transactional process occurring between individuals and their immediate social environments in such a way that empowering factors at different ecological levels occur simultaneously to influence mental health (Nelson et al., 2001a; Zimmerman, 1995).

The process of empowerment is very similar to the process of recovery. Chamberlain (1999) as cited in Nelson et al. (2001b) makes this connection by explicating that recovery is about becoming a unique individual and an active citizen within the community who has access to necessary supports and resources, while empowerment is

about being in control of one's life and having choices. Recovery has been defined as a deeply personal and unique process of changing one's attitudes, values, feelings, goals, and roles within the community (Jacobson, 2003). It is a way for consumer/survivors to live a satisfying, hopeful, and contributing life. Recovery therefore involves the creation of a new meaning and purpose in life as the individual transcends the label of being mentally ill.

According to Carpenter (2002) the most fundamental premise of the recovery paradigm is that persons with mental health issues can and do recover. The concept of recovery refers to the lived experience of individuals as they accept and overcome the challenge of their illness (Deegan, 1998). Recovery represents the acceptance of research findings which demonstrate that the prognosis of serious mental health issues does not inevitably follow a downward spiral (Kloos, 2005). The process of recovery emphasizes themes of hope, healing, empowerment, and social connections, a sense of self, and coping strategies (Trainor, Pomeroy, & Pope, 2004; Young & Ensing, 1999).

Opportunities for self-determination and community involvement, the development of a social support network, and gaining access to valued resources have all been identified as contributing to the recovery process (Young & Ensing, 1999). Recovery has been described as an active process in which the individual assumes responsibility for his/her own recovery (Carpenter, 2002). However, achieving recovery also requires the support of one's family and friends, community and consumer organizations, and any relevant professional services (Trainor et al., 2004).

The concept of recovery does not entail being "cured" from mental illness. Instead, the process is distinguished by its emphasis on the individual's active participation in self-

help activities. It refers to regaining a sense of purpose after a significant disruption in one's life (Kloos, 2005). Some recovery-oriented self-help activities include alternative health-care practices. Self-report data from individuals with serious mental health issues have indicated the common practice of religious or spiritual practices such as prayer, worship attendance, and religious or spiritual readings. Researchers found that these types of alternative practices appear to promote a recovery process beyond the management of emotional and cognitive disabilities by enhancing social, spiritual, and self-functioning (Russinova, Wewiorski, & Cash, 2002). This finding demonstrates the positive potential for the integration of spirituality and a faith-based approach into a recovery-oriented system of mental health care.

The Role of Clergy as Front-line Mental Health Workers

Clergy from various faith communities and diverse backgrounds can serve as an invaluable mental health resource, both within the parish and the community in general. In the past, the mental health care system has given limited attention to clergy services (Vandecreek, Carl, & Parker, 1998). There is a virtual absence of published research on the role of clergy in mental health journals (Weaver, 1998). In the past many clinical and research psychologists perceived religion as having a negative impact on mental health. (Maton, 2001; Weaver, 1998). However, due to recent research demonstrating the benefits between religion and mental health, this perspective is changing. Clergy can have multiple roles within the mental health system and are slowly beginning to engage in collaborative relationships with psychologists, psychiatrists, and psychiatric facilities.

Many clergy serve as front-line mental health workers. In general, clergy spend approximately 15% of their working time in pastoral counseling duties. Millions of North

Americans seek assistance from clergy when they are experiencing mental health concerns (Oppenheimer, Flannelly, & Weaver, 2004). An individual with a mental health issue is more likely to seek help from a clergyperson than from both psychologists and psychiatrists combined (Weaver, 1998). Frequent reliance on clergy as a mental health resource may be due to their availability, accessibility, and feelings of trust. Weaver (1998) found that young adults rate clergy higher in interpersonal skills such as warmth, caring, stability, and professionalism than psychologists and psychiatrists.

Clergy are part of and represent the faith communities within which many mental health consumers live. Furthermore, clergy are based in traditions that emphasize community. Home and hospital visits are common when a parishioner is ill. This unique feature of the clergy's vocational tradition can contribute to the current health care system which encourages early hospital discharge and outpatient treatment (Vandecreek et al., 1998). Clergy can thus serve as an intermediary between marginalized communities and mental health professionals. Certain parish-based clergy function as a major mental health resource to communities that have limited access to professional mental health care (Mollica, Streets, Boscarino, & Redich, 1986). Similarly, clergy can assist mental health professionals in gaining access to people in crisis who would otherwise not receive psychological care (Weaver, 1998).

There is currently a need for greater collaboration and mutual learning between clergy and mental health professionals. Psychologists and clergy could benefit from mutual training and reciprocal education to exchange information, skills, and knowledge (Weaver, 1998). A lack of professional collaboration and disparate values and beliefs between psychologists and clergy have contributed to the limited trust between these

helping professionals. When clergy and mental health professionals do engage in collaborative relationships, referrals tend to be unidirectional with clergy referring individuals to psychologists (Oppenheimer et al., 2004). Authors of a literature review by Interfaith Health Care Ministries (1997) concerning religion and mental health resources concluded that clergy and mental health professionals can work effectively together in a mental health care setting. However, this proposition has generally failed to be implemented because traditional mental health professionals often deter clients from seeking the help of clergy due to negative perceptions and stigma regarding religious influences.

Ethics of Pastoral Community-based Outreach[5]

As an ordained minister of The United Church of Canada the outreach pastor has a legal, moral, and spiritual duty to provide outreach services from the ethical standpoint of the United Church (along with the policies mandated by the City of Hamilton Public Health and Community Services Departments).

The United Church aims to work collaboratively with others to create communities of trust and safety, enabling people to learn and grow without fear of exploitation. The pastor exhibits compassion and grace to all people he/she works with. In a position of leadership the clergyperson is legally obligated to follow the "*Duty of Care*"[6] principle, protecting people from harm and facilitating equal power relationships. Any individual accessing pastoral or professional services of the church (whether this person is a member or not), is offered the right to full protection under United Church policy.

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[5] The following information was summarized from various pamphlets describing the ethical standards and policies of the United Church. This information is available to the public and can be accessed through any United Church of Canada conference office or the national website at http://www.united-church.ca.

[6] *Duty of Care* is a legal principle that was implemented as United Church policy to ensure the safety of each individual who accesses the programs and services associated with the church.

Some examples of values of practice which must be followed by United Church clergy include community outreach and social justice, commitment to the community, and pastoral care. An excerpt from the most recent revision of the United Church's *Standards of Practice* (September 17, 2005) provides an overview of the important principles mentioned above:

5.2.2 Community Outreach and Social Justice
Ministry personnel with The United Church of Canada, a church committed to social justice, and global and community outreach ministries, have responsibility to:

a) engage people with a vision of gospel that recognizes and responds to needs beyond their own
b) encourage and support the development and pursuit of social justice and outreach programs
c) encourage the support of the Mission and Service fund of the United Church of Canada
d) facilitate knowledge about outreach projects and activities of the United Church
e) encourage people to know and understand United Church policies as they apply to social justice issues
f) encourage lay leadership on social justice and outreach programs.

5.2.4 Denomination and Communities
Ministry personnel have responsibilities as members of The United Church of Canada to the denomination, the wider church, their communities, and the world. As such, they:

a) honour the organization, governance and policies of the United Church
b) participate in the courts of the church as set out in *The Manual* of The United Church of Canada (session/official board or equivalent, Presbytery/District, Conference, and General Council)
c) respond in appropriate ways to needs beyond the ministry in which they serve
d) participate in ecumenical[7] and multi-faith activities as possible and appropriate
e) maintain an active connection with the wider church
f) represent the United Church in the larger community.

5.2.7 Pastoral Care
Ministry personnel are responsible for the pastoral care of persons they encounter through the ministry in which they serve. As providers of pastoral care, ministry personnel:

a) provide a supportive presence for, and are accessible to people in times of change and crisis

[7] *Ecumenical* is a term referring to the Christian movement to promote cooperation and better understanding among different churches and other faiths around the world.

b) encourage and facilitate a process to ensure that pastoral care occurs on a regular basis

Theological Perspective of Ethical Standards

The ethical and legal guidelines that have become United Church policy for pastoral work were created from the theological standpoint of Christ's teachings in the Bible, and modeled after God's vision of *shalom.* The United Church operates from a Christian perspective which calls for respect and love to one another, and to the world (John 13:34-35), to share our gifts and resources, and to build a community of mutuality and respect (Acts 3: 44-47). Their primary duty as a church is to care for those who are marginalized, less powerful, or vulnerable in our community (Deuteronomy 10:17-19, Isaiah 61:1&2).

The United Church advocates for the inherent right of all people to be treated with dignity, respect, and be protected from harm. Followers of Jesus must therefore demonstrate love, respect and honour for one another, for Jesus taught that as we do to the most vulnerable among us we do unto him (Matthew 25: 35-40).

In its active work to create a community of trust and safety, the United Church states that it is being guided by God's vision of *shalom. Peace* is the general English translation of the Hebrew word *shalom.* However, from the original biblical and theological meaning of the word, shalom entails much more than peace. Peace is often understood on an individual level, such as someone achieving inner peace. Politically, peace tends to be defined as the absence of war. Shalom is not simply the absence of war and conflict, but also represents the presence of justice and social peace. The term *shalom* is holistic and should be understood as operating within and between multiple ecological levels.

God's vision of *shalom* is a world in which there is no war or violent conflict, and people live together in healthy, happy communities. Shalom is the absence of violence

along with the active presence of respect, compassion, forgiveness, inclusion, and safety. Shalom encompasses healthy relationships with people, animals, and the natural environment.

A secular analogy that accurately portrays the vision of *shalom* is the World Health Organization's (WHO) definition of health. The WHO defines health holistically. According to WHO policy, *"health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity"* (WHO official records, p. 100, 1948).

These ethics of pastoral outreach along with the theological perspectives of the ethical standards are important for my study because they underlie and guide the work of the team's outreach minister. A clear ethical standpoint is especially important when working with marginalized and oppressed individuals who are vulnerable to systemic and professional abuse. Ethics and values are central to both the work of the clergy and the field of CP. Furthermore, in psychological research involving human participants an understanding of relevant ethical standards must be explicit and adhered to.

From the above discussion it is clear that clergy can have a significant and positive influence when working with disadvantaged people experiencing mental illness. In working with marginalized groups, clergy are respectful to their clients' needs by following a comprehensive guideline of ethical standards. Despite the rich history of clergy serving as an informal source of support to people with mental illness, and the potential for collaboration among clergy and mental health professionals, there is an absence of research literature in this area. To promote greater understanding regarding the role of the clergy in mental health treatment and to fill a gap in the literature, I

conducted an exploratory study of the unique roles of an outreach minister on a multidisciplinary team, and the impacts of this role for clients.

Research Questions

The purpose of this research was to investigate, explore, and analyze the role of a clergyperson within an assertive case management outreach team and the impacts of this approach for homeless individuals experiencing mental health issues. Throughout the duration of this study I sought to answer the following two questions:

a) What role can a clergyperson take with regards to mental health service delivery and what are the unique aspects of this role when compared to other mental health professionals?

b) What are the impacts of the outreach minister's role for program clients?

Methodology

Description of Community Setting

Hamilton, Ontario is located on the southwestern end of Lake Ontario and has a population of approximately 500, 000 people. Hamilton has the second highest rate of poverty in Ontario (Toronto has the first), with 22% of community residents living below Statistics Canada's low income cut-off (LICO) (Fraser, 2004), which exceeds both the provincial and national averages of 18% and 20%, respectively. The downtown core has the highest concentration of poverty within the city with a disproportionate number of female-led, lone-parent families and single-person households. Hamilton's downtown is one of the most economically distressed areas of any city in Canada with many extremely impoverished areas that are home to "street people" of all ages, boarding houses, women's shelters, and working class families (Needs Assessment Committee Report,

2005). Many of the housing units available for rent in this area are in need of major repairs and there are increased numbers of people living in substandard housing (Brown & Todd, 2000).

The need for decent and affordable housing is growing with thousands of people on waiting lists and an average of 450 new applicants for social housing each month. Thirty-six percent of these applicants are homeless families, often single parents with children (Needs Assessment Committee Report, 2005). According to City housing officials these homeless applicants may remain on waiting lists for several months, and when an apartment does become available they are extremely difficult, if not impossible to contact.

Homelessness and poverty are inextricably intertwined. For people living in extreme destitution the barrier to finding safe, affordable housing is directly linked to income, rather than the cost of shelter per se. An increase in low-wage part-time jobs and temporary contract positions with no benefits has contributed to the economic instability in Hamilton. There comes a point when it does not matter how affordable housing is, because if one's income is too low it is still unaffordable.

For those depending on government income security benefits the cost of basic food and shelter is greater than the monthly maximum income security benefits provided through Ontario Works (OW). Please refer to Table One below for a comparison of the cost of a nutritious food basket and the average rent in Hamilton in relation to monthly income security benefits.

Table 1- Social Service Assistance versus Cost of Living

Maximum Income Security Benefits versus the Cost of Rent and Food - 2002

Household Type	Monthly Benefits	Monthly Cost of Food Basket	Average Monthly Rent	Remainder
Single male (25-49 yrs)	$536	$187	$495 (bachelor apt.)	-$146
Lone parent female (25-49 yrs.), boy (10-12)	$1,106	$212	$737 (1 bdrm. apt.)	$157
Family of four – man & woman (25-49 yrs), girl (10-12), boy (7-9)	$1,452	$514	$872 (2 bdrm. Apt.)	$66

Source: Monthly Ontario Works benefit rates – City of Hamilton Public Health and Community Services Department 2004
Source: Cost of a nutritious food basket – City of Hamilton Public Health and Community Services Department 2004
Source: Average monthly rents – Canadian Mortgage and Housing Corporation - 2003
Source: NCB and Child Tax Credit rates – 2004

It is important to note that these basic food and shelter costs do not take into account other necessities such as heat, hydro, clothing, toiletries, transportation, telephone, medical care, cleaning supplies, and other unexpected costs of living. Individuals living in poverty often have to make the impossible decision of choosing to pay rent or purchase food. Due to the extreme destitution in Hamilton, service agencies have experienced an increase in the number of people utilizing food banks and emergency meal programs (Brown & Todd, 2000). Approximately 14, 600 people frequent Hamilton food banks each month (Hamilton Community Foundation, 2005), but the food banks struggle to meet the high demand for food. Furthermore, it is virtually impossible for food banks to provide fresh fruit, vegetables, frozen foods, and milk products. Worse, people who access these food banks do not have a stove to prepare the food.

Due to the widespread prevalence and depth of poverty in Hamilton, and the lack of safe and affordable housing, homelessness is an increasingly major social problem within

the city. According to a 2004 press release from the Hamilton Community Foundation, on any given night in November 2002 approximately 396 people stayed in an emergency overnight shelter. This was a 15% increase from 2001 and a 125% increase from 1998 shelter use rates (Wingard, McCormack, & Neigh, 2003). A significant number of individuals experiencing homelessness are also living with serious mental health issues. Many psychiatric consumer-survivors are unable to find the much needed supports required to remain connected to family, social support, and shelter.

Low Income Cut-offs (LICOs)

Due to the lack of a nationally recognized definition of poverty, Statistics Canada has created an unofficial definition based on Low Income Cut-offs (LICOs). This is the term that is supported by the Canadian Council on Social Development (CCSD). People living in households with incomes below the LICO are considered to be living in "straitened circumstances" (Lee, 2000). In a wealthy country such as Canada straitened circumstances are considered to be poverty.

To calculate LICOs, Statistics Canada initially estimates the percentage of gross income spent by the average household on food, shelter, and clothing. Statistics Canada then argues that if a household spends 20% more of its income on these basic necessities than the average Canadian household, it is considered a low-income household. Please refer to Table Two for an analysis of LICOs in urban and rural areas.

Table 2 – Low Income Cut-offs: Urban areas (population)

Size of Family Unit	500 000 and over	100 000 to 499 999	30 000 to 99 999	Less than 30 000	Rural areas
1 person	$16 874	$14 473	$14 372	$13 373	$11 661
2 persons	$21 092	$18 091	$17 965	$16 716	$14 576
3 persons	$26 232	$22 500	$22 343	$20 790	$18 129
4 persons	$31 753	$27 235	$27 046	$25 167	$21 944
5 persons	$35 494	$30 445	$30 233	$28 132	$24 530
6 persons	$39 236	$33 654	$33 420	$31 096	$27 116
7 or more persons	$42 978	$36 864	$36 607	$34 061	$29 702

Source: Lee (2000, p.99)

The identification of households living below the LICO takes into account the size of the community where they reside and the number of people living in the house. Adjustment of community size is based on the assumption that a larger community has a greater cost of living (Lee, 2000).

Overview of Mental Health Outreach Team[8]

The City of Hamilton's assertive case management outreach team engages with marginalized individuals to assist them in accessing health, housing, and social services. The services are primarily focused on people living with serious mental health issues who are homeless, or at risk of being homeless, and are not currently accessing social, health, and housing services.

This collaborative community-based intervention program involves partnerships with 17 local social service and faith based organizations. The multidisciplinary/multiagency structure of the team makes these partnerships distinctive due to the close relationships

[8] The information regarding the overview of the City of Hamilton's mental health outreach team was provided by unpublished program documents and personal communication with Program Manager Valine Vaillancourt.

this team has with a number of grassroots and government funded helping agencies in Hamilton. Staff are thus able to bring to the team not only their discipline specific knowledge, but also the values and specialized resources of their agency. The community advisory board, which provides direction to the outreach team, is composed of 50% mental health consumers/survivors and 50% partnering agencies.

Although there are many similar mental health outreach teams in North America (generally utilizing the ACT model) Hamilton's team is unique in two important ways. Firstly, according to the team's Program Manager, the City of Hamilton is the only team using a capacity-building framework for its design. Secondly, this is the only mental health outreach team to employ an ordained minister. I will elaborate on each of these distinctive factors in the following paragraphs.

According to program documents, a capacity-building framework enhances both the individual clients' and greater community's knowledge and skills. This approach increases the community's capability to support the delivery of high quality services to address the complex and multifaceted issue of homelessness. The community's ability to problem-solve and respond to novel and unfamiliar situations is also enhanced by bridging grassroots agencies with a multidisciplinary professional team to work towards a common goal. The assertive case management outreach team members include: public health and psychiatric nurses, social workers, housing workers, a minister, harm reduction worker, youth worker, family worker, sexual assault counselor, addiction counselor, and an Aboriginal health care worker.

The team members are employed by a community-based grassroots organization, and join the mental health team to deliver outreach services. Program staff spend a set amount

of their hours at their "home" agency and the remainder of their time engaging in outreach work. This latter role maintains the staff person's connection with the culture and values of his/her agency.

The general duties of the outreach staff are to support individuals, families, and groups, in order to promote the optimal health and well-being among local adults who are experiencing severe and persistent mental health issues. Some specific roles and activities include crisis intervention, supportive counseling, advocacy, collaboration and coordination of services with appropriate community agencies, and assistance in reconnecting individuals with their families.

It is well documented in the health literature that practitioners of health promotion, illness prevention and treatment for disease need to take a holistic approach, which includes mind, body, and spirit. The guiding belief for the management of this outreach program is that the best approach to working with clients is to acknowledge the mind, body, spirit connection to wellness and quality of life (personal communication with Valine Vailancourt, 2006). For these reasons the team's management believed it was important to employ a clergyperson as part of the front-line outreach staff.

As outlined above, all team members have similar core functions they provide to clients. They then bring to the team their discipline-specific knowledge. The clergyperson must engage in the aforementioned tasks, while also performing some unique functions. The outreach minister brings her or his grief counseling skills, ability to perform spiritual services, and the capacity to assist individuals in working through any spiritual issues. Along with the general duties and qualifications necessary to provide comprehensive and effective mental health treatment, the outreach minister must have several important

personal qualities. This individual must be compassionate, trustworthy, and committed to the goal of social justice. As the program documents indicated, the unique role of the clergyperson in this outreach ministry, theoretically involves connecting people with a spiritual community, applying a holistic framework to understanding and enhancing mental health while acknowledging social, psychological, spiritual, and medical needs, and finally employing a humanistic approach to outreach work acting as both a companion and friend (personal communication with Valine Vaillancourt).

Research Methods and Data Collection

I used a mixed-methods, emergent design for data collection, incorporating an ethnographic approach. A pragmatic outlook ensured that each method matched the research question of interest while allowing the flexibility to alter the methodological approach as new questions and findings emerged throughout the course of the study.

I conducted this research project from within a participatory, action-oriented framework. I created a summary document that was presented by the administrative assistant of the outreach team to the primary stakeholders from the Community Advisory Board (CAB) during their board meeting in June, 2006. (Please refer to Appendix A for a copy of the invitation to board members and the summary document.) This document provided an overview of the purpose and methodology of the study. Consumer board members were invited to be active participant-researchers in the study, to consult and assist with data analysis, and to contribute to interpretation. I reported my research plan and progress to the CAB in the aforementioned document, and then invited their constructive and critical feedback, respecting their voice and making any necessary changes. During the analysis stage I facilitated a Data Interpretation Workshop, in which

interested key stakeholders reviewed a summary of the preliminary data analysis and had an opportunity to provide feedback and shape the emerging themes. These participant-researchers received a modest monetary honourarium and pizza lunch as compensation for their assistance.

I altered and adapted the involvement of the consumer group in this study from the original proposed methods due to various practical constraints. Initially, I had intended on inviting these key stakeholders and program consumers to participate in the study at an earlier stage. I attempted to arrange a meeting with the consumer members of the CAB prior to data collection. The purpose was to present my research proposal, facilitate a discussion regarding my proposed data collection methods, and invite a few consumers to volunteer as participant-researchers in the study to assist with recruiting participants, facilitating the focus groups, and analyzing data.

After consulting with the outreach program director we agreed that it would be difficult to schedule a meeting with the board members outside of their regular quarterly board meetings. Consumer members are difficult to contact at times, as many do not own phones or stay in the same place of residence for extended periods. Due to practical constraints, scheduling conflicts between the CAB and me, and the pressure I felt to commence the research, I began data collection before consulting the CAB.

During the data collection phase I used a personal journal to reflect on my interviews, observations, and the research topic in general. From my insights, new questions emerged which I incorporated into the professional service-provider interviews. For example, I began thinking critically about the role of the outreach pastor and his approach with clients. I was interested in examining whether the outreach team's level of

involvement and their relationship with clients could facilitate dependency of clients upon outreach workers. I added some questions to the original interview guide and asked team members to think critically about their approach with clients and consider ways to prevent clients from becoming dependent upon this relationship.

Methodological and data triangulation strengthened the study and enhanced the quality of the data. According to Brewer and Hunter (1989), multiple methods have non-overlapping weaknesses and complementary strengths. Studies strictly using a single method are more vulnerable to errors due to limitations linked with that specific method. Different types of data gathered from multiple methods can provide cross-data validity checks (Patton, 2002). Utilizing different methods for data collection can potentially yield contradictory results for the same research question as alternate forms of inquiry are sensitive to certain real-world occurrences. Understanding these inconsistencies in findings across multiple forms of data can be viewed as strengthening the results, because they offer opportunities for deeper insight into the issue being studied. I will examine the overlapping findings across data sets, along with areas of divergence, in my discussion of the third-level analysis.

Because this is an exploratory study and there are currently no theoretical frameworks or research studies regarding the role of a clergyperson within any type of assertive community or case management outreach team, it was necessary to employ a qualitative research approach. Qualitative methods included eight sessions of ethnographic field observations lasting approximately four hours each (i.e., job shadowing), a review of archival data (i.e., job descriptions, service records), individual interviews with five service providers and three key informants, one individual client

interview, and two semi-structured focus groups with individuals living in poverty or homelessness and experiencing serious mental health issues who also have had contact with the assertive case management outreach team.

I facilitated individual interviews with Bill and four additional outreach staff from the ACMO team. (Please refer to Appendix B for a copy of the interview guide that I used for Bill and Appendix C for the interview guide that I used for the other professional service providers.)

I conducted individual interviews with three key informants from different stakeholder groups. Please see Appendix D for a list of the stakeholder groups. Key informants included a representative from the Hamilton AIDS Network, an urban minister of a Presbyterian Church, and a Public Health nurse from the housing division of the City of Hamilton. (Please refer to Appendix E for a copy of the key informant interview guide.)

As a secondary focus of the study I looked into differences across people from various ethnic backgrounds by incorporating questions related to faith and ethnic diversity into the interview guides. Due to some practical constraints and a limited number of ethnically diverse clients, I was unable to hold independent focus groups for clients from different backgrounds. In Canada there is an overrepresentation of minorities in the urban homeless population (Lee, 2000). I was attentive to this issue of diversity by selectively interviewing people from different backgrounds. Participants included males, females, adults from various age groups, Indigenous people, an African-Canadian, and people with different faith backgrounds. Because the outreach minister is a Christian, it was important to question the relevancy of the pastor's approach for individuals from diverse faith backgrounds.

The primary method of data collection used to answer the research question related to client impacts was two consumer focus group interviews. (Please refer to Appendix F for a copy of the client interview guide.) A focus group is "a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (Krueger, 1988, p. 18). The use of a focus group as a method of data collection can be especially valuable when conducting research with extremely marginalized and oppressed individuals. People with serious mental health issues who are living in extreme poverty may be more open to discussion and feel less threatened when they are with peers rather than talking individually with a privileged researcher. However, arranging a group of consumers and clients of the outreach team was not possible due to the transient nature of this client group and some other practical limitations. Most clients did not know one another and were uncomfortable meeting with a group of people they were unfamiliar with to discuss personal issues. Also, most of the team's clients do not have phones and are difficult to contact. To address these challenges I arranged one individual interview with a client and then held two focus groups at urban church drop-in centres. Consumers attending these weekly drop-in centres met the criteria of being in contact with members of the outreach team, living in extreme poverty, and experiencing mental health issues. These individuals were comfortable coming together in a group because they knew each fairly well from attending the church meal programs each week. Furthermore, it was relatively easy to schedule and keep a meeting time for the discussion, as the focus group occurred during the same hours as the regular drop-in times.

Ethnographic Field Observations

In order to comprehensively understand the complexity of the experiences of people who are involved with the mental health outreach team, direct interaction and observations were necessary. There are limitations to how much can be learned strictly from what people say during interview sessions. By going into the field and immersing myself in the community, even for a brief time, I was able to more fully understand and describe both externally observable behaviours and internal conditions such as participants' values, attitudes, and opinions.

Understanding the overall context of the program is essential to a holistic perspective of urban mental health outreach work, the integration of spirituality, and its impact on clients. Regarding length of time in the field, Patton (2002) simply states that fieldwork should be conducted long enough to get the job done and answer the questions under study. However, due to the time constraints and limited resources of this research project, my presence in the field was moderate. I accompanied the outreach minister for half of a regular workday (i.e., approximately four hours) over the course of eight observation sessions. I also attended a workshop on homelessness among immigrants in Hamilton and two outreach team meetings. These sessions occurred at different times in regularly distributed intervals throughout my data collection phase. Although the time in the field was moderate, when linked with the other methods being employed, the number of observation sessions allowed enough time to answer the research questions under study.

The people involved in the field observations included the outreach minister, several outreach team members, and various program consumers. The observations occurred within the downtown urban core of Hamilton. Observation settings included St.

Joseph's Hospital, a Tim Horton's coffee shop, clients' apartments, the local YWCA, City of Hamilton offices and board rooms, the Housing HELP Centre, and two downtown churches.

Initial observations had a fairly broad focus. Therefore I observed the social environment, formal and informal interactions, language, and nonverbal communication. Additionally, I considered the meanings of what was being observed based on the words of program clients (through direct quotations).

My observational protocol was emergent and flexible. The focus of my observations changed slightly at times throughout the duration of the study. The first observation session served as a foundation to guide future observations and influence my level of involvement with clients. Initially, I kept an open-mind, sat on the periphery of the group, and absorbed all of the information being presented to me, aiming to focus my observations more narrowly in later sessions.

I observed the outreach duties of the pastor in the urban setting, concentrating on how he interacted with clients and his approach when working with other mental health professionals. I also paid attention to how accessible he appeared to be and what types of services consumers were offered.

My observational focus and methods evolved throughout the course of the study. My level of involvement and interaction with people changed depending on whether the focus of my observations consisted of the minister interacting with clients or other professional service providers. I attended a total of five sessions in which the focus of the outreach minister's work was on professional development and meetings. During these sessions I tended to sit peripherally to the group and observed the way professionals

interacted with one another and listen to their perspectives on client and program issues. The level of my involvement and participation did not change during the course of these observations.

My first observation session involving program clients was similar to that of the professional sessions discussed above in the sense that I observed as an "outsider" by locating myself on the edge of the room and limiting my interaction with clients. I initially focused on the physical details of the setting, the social environment, structure and agenda of the outreach program, staff and volunteers involved, and activities taking place. Specifically focusing on the outreach minister, I paid attention to how he approached clients, how accessible he appeared to be. I also observed how he communicated with clients both verbally and non-verbally. As I continued my field observations with the outreach minister and program consumers, the focus of my observations became more specific and narrow and the level of my involvement with consumers increased significantly. This unplanned change in observational methods emerged gradually, naturally, and unexpectedly.

During the next four observation sessions involving clients I continued to consider issues of accessibility and pay attention to verbal and non-verbal communication styles. However, since later job-shadowing sessions consisted of visits and outreach calls with primarily individual clients, I was able to focus more specifically on the content and direction of the conversations. By closely observing the way in which Bill interacted with clients I was able to gain some insight into the nature of these relationships, which added depth to my understanding of client/pastor interactions. As I became immersed in the job-shadowing sessions, my involvement with program clients increased. I found that by

sitting in close proximity to the consumer and engaging in some informal conversations, we began to develop a sense of rapport and trust. This relationship development may have also been due to the significant amount of trust that clients have placed in the outreach minister. Clients spoke comfortably with me regarding their issues, confided in me with personal crises, and asked for my perspective on certain topics. The level of trust and comfort in speaking with me increased significantly when I met with a client on more than one occasion.

The overarching research questions were used to guide my observational focus. I was attentive to the unique aspects of the clergyperson's role, looking for outreach activities that other professionals are not generally engaged in. I was specifically interested in consumers' experiences with the outreach pastor and how they appeared to react to the pastors' presence. I paid close attention to the words and meanings that were most prevalent among the people being observed.

As a guiding framework for organizing my observations I used what Patton (2002) identifies as *sensitizing concepts*. These are loosely operationalized concepts that can provide some initial direction to research as an individual investigates how this idea is given meaning in a particular setting. For the purpose of this study sensitizing concepts that I used included: spiritual issues, religion and faith, support, power and control, choice, communication patterns, relationships, stigma, poverty and homelessness, and mental illness.

To increase the authenticity and credibility of my observations I actively engaged in critical self-reflection by recording my inward observations in a section of my field notebook. I reflected on how I was affected by what I saw and experienced, along with

how I, as the observer, was affecting those being observed. Specifically, I considered how my background, beliefs, and values may have constrained what was being observed and how it was being understood. I utilized this journal to highlight my personal emotions, reactions, and reflections about the significance of what was observed.

Rationale for Research Methods

In order to answer my first research question regarding the role of a clergyperson in the context of mental health service delivery and recovery, I used several qualitative research methods. Through job shadowing, I was able to observe first-hand the day to day activities of the outreach pastor and how he interacts with clients. During this process of field observations I took detailed notes to review at a later time. I also conducted individual interviews with the pastor himself, other outreach team members, and various key informants. Through this series of individual interviews I was able to ask more specific questions about the nature of the pastor's work and build on my field observations. Conducting several interviews with different individuals enabled me to gather multiple perspectives on the issue, thus gaining a more comprehensive understanding about the professional role of the clergyperson within a mental health outreach team. In addition to observations and interviews, I reviewed the outreach minister's job description and relevant service records.

To learn about the unique aspects of the outreach minister's role I engaged in a similar process of field observations and individual interviews as described above. Additionally, I facilitated a focus group with participants from the primary stakeholder group and listened to their experiences and perspectives of the clergyperson's role. I specifically asked the mental health consumers questions surrounding how the pastor's

professional presence and approach to service delivery differs from that of the other outreach team members.

The participation of my primary stakeholders was critical for answering my second research question. To learn about the individual's experiences with the outreach minister I primarily relied on carefully listening to the voices of consumer/survivors during the focus-group sessions. Involving participant-researchers from the CAB in data interpretation and analysis allowed me to gain a comprehensive and more accurate perspective of the important work that is being done by the outreach minister. I also accompanied the clergyperson in his outreach ministry on several occasions and observed some critical impacts of this work. Through the course of key informant interviews I was able to gather some outsiders' perspectives regarding the impact of the pastor's mental health outreach.

Sampling and Participants

I employed purposeful sampling techniques in order to select information-rich participants. Initially I asked Bill if he would be interested in being involved in this study. I was aware of his unique position within the outreach team due to his affiliation with First-Pilgrim United Church, of which my father is the senior pastor. (Please see Appendix G for a copy of the information letter to the outreach minister and Appendix H for a copy of the consent form[9].) I extended an invitation to all members of the mental health outreach team to participate in an individual interview. I selected key informants through a process of snowball sampling. I contacted various local service providers, outreach team members, and professionals from faith-based organizations and asked them to suggest or refer individuals who are particularly knowledgeable about the urban

[9] The consent forms were the same for each participant group.

homelessness community, community mental health, and religious issues. Prior to participation, I ensured that key informants were aware of the purpose and focus of the study, the issues and questions under investigation, and the kind of information that are needed and most valuable by sending participants a copy of the interview guide and an email providing details about the study (Patton, 2002). (Please see Appendix I for a copy of the information letter to PSPs.)

Recruiting and retaining program participants were somewhat challenging due to the nature of their situation (i.e., being homeless) and the extreme marginalization and oppression these individuals have experienced from the wider community. It was critical to gain primary stakeholders' trust by engaging directly with the community. In order to gain entry into the homeless community I spent several days frequenting two urban-church outreach programs in Hamilton to meet potential participants and to explain the purpose of this study and highlight my personal values and motivation for conducting this type of research. Additionally, I spent several days job-shadowing the outreach minister, which also allowed for data collection in the form of direct field observations. I also asked outreach team members to invite consumer/survivors to participate in the study.

I facilitated two in-depth focus groups at Centenary United Church and First-Pilgrim United Church with four and nine participants in each session respectively. Before the interview commenced, I asked participants to sign a consent form agreeing to be digitally-recorded and participate in the research. I described the form in detail with the group. (Please refer to Appendix J for a copy of the information letter.) The requirements for participation included the following: the individual must be currently homeless or at risk of becoming homeless, experiencing mental health issues, be involved with the

services of the mental health outreach team, and have had significant contact with the outreach minister. As compensation for participation, I supplied refreshments during the focus group meetings and provided each participant with a five-dollar gift certificate from Tim Horton's coffee shop.

Data Analysis and Feedback

I digitally recorded each focus group and individual interview and transcribed them for coding. I organized field observation notes and journal reflections by date and type of outreach duty (i.e., professional development, team meeting, church drop-in, or outreach call). I then used my field notes as peripheral data to add context and greater depth to the findings obtained through interviews and focus groups. I organized journal notes into general codes and themes. I coded interview and focus group data inductively using grounded theory and the constant comparison method. Data analysis, feedback, and further gathering of data occurred through a cyclical process. As new questions and themes emerged from the data, I found it necessary to alter the interview guides to incorporate these new questions and to clarify themes with program participants.

Grounded Theory and Constant Comparison

Grounded theory is a general methodology for developing theory that is grounded in data systematically gathered and analyzed in an inductive manner. It is concerned with the generation, elaboration, and validation of social science theory. Glaser and Strauss' (1967) inductive perspective stemmed partly from their dissatisfaction with the prevalent hypothetico-deductive practice of testing theories. Grounded theory therefore comes from a rejection of positivism and reductionist thinking. The term "Grounded Theory" was

chosen to express the idea of theory that is generated by an iterative process involving the continual sampling and analysis of qualitative data gathered from concrete settings.

A grounded theory approach to community research works well within the qualitative paradigm because of several distinct, shared characteristics. Both qualitative and grounded theory methods emphasize the importance of viewing the meaning of behaviour and experience in context. In this approach, the scientific process is able to generate working hypotheses, as opposed to immutable empirical facts. Furthermore, grounded theory and qualitative researchers share an attitude towards theorizing that emphasizes the grounding of concepts in data rather than their imposition in terms of *a priori* theory.

Grounded theory methodology emphasizes the importance of viewing the meaning of experience and behaviour in context (Pidgeon, 1996). Strauss (1987) contends that theory should be developed in an intimate relationship with the data, with the researchers fully aware of themselves as instruments for developing the grounded theory. This relationship entails clarifying and being aware of one's assumptions.

The cyclical methods of data gathering and analysis require the grounded theorist to actively engage with the community of interest. After data are gathered and analyzed the findings are conveyed to the community for interpretation and this new information is then used to develop further research questions, which feed the research process. When using grounded theory methodology the researcher is constantly gathering, analyzing, and reflecting on the data, and then using these findings to develop additional research questions. Theory development evolves through a continuous interplay between data analysis and collection (Glaser & Strauss, 1967).

Grounded theory depends on methods that take the researcher into close contact with real-life settings so that the results and findings are grounded in the empirical world. A major feature of this methodology is that multiple perspectives must be systematically sought during the research inquiry. Glaser and Strauss (1967) encouraged a combination of sources and data types including interviews, focus groups, observations, and document review among other things. The goal of early data collection is to generate a "rich" set of materials. Grounded theory techniques were developed to increase researcher's awareness and help control the intrusion of bias into the analysis, while at the same time retaining sensitivity to what is being conveyed in the data.

The central features of the grounded theory methodology, according to Strauss and Corbin (1994), include asking theoretically oriented questions, theoretical coding, constant comparison, and theory development. Asking theoretically oriented questions requires that the researcher asks questions that will provide flexibility and freedom to explore a phenomenon in depth. The questions are refined and focused as the research process proceeds. In theoretical coding, the researcher attempts to understand the relationships between codes and categories. The interrelations of these codes are conceptualized by generating hypotheses for integration into the emerging theory. The grounded theory is discovered through constant comparison between incidents and properties of a category. The researcher attempts to observe as many underlying similarities and differences as possible. This is one of the most central concepts in grounded theory.

The data-theory interplay is a major feature of this methodology and distinguishes it from other qualitative approaches (Strauss & Corbin, 1994). Grounded theory methods

involve a dynamic relation between data analysis and data collection. Researchers often move between steps, and the steps merge into one another as the analysis proceeds (Glaser & Strauss, 1967).

The process of theory generation moves from a basic description of the phenomenon of interest to actual theorizing. Initially, data may be organized according to themes. These themes are generally summaries of words taken directly from the data. Next comes the conceptual ordering. This step involves organizing the data into discrete categories according to their properties and dimensions and then using description to make these categories clear. Finally comes theorizing, which is the process of conveying ideas or concepts and then formulating them into a logical, systematic, and explanatory scheme (Glaser & Strauss, 1967).

Some critical advantages to a grounded theory approach include the following:

- Grounded theory is versatile.
- It is helpful for studies involving phenomenon in which current theories are lacking or non-existent.
- Some people may find the balance between objectivity and subjectivity appealing.
- It provides a structured and systematic way of breaking down a large body of data into a concise conceptual framework that describes and explains a particular phenomenon.

Despite the several advantages of using grounded theory, and the potential to utilize this framework within the critical paradigm, there are also several limitations and critiques to be aware of. Some qualitative researchers may find the process too structured, thus limiting the researcher's flexibility. Such a highly structured approach may predispose the researcher to identify categories prematurely.

Pidgeon (1996) cautions that researchers who are new to the technique are often unable to theorize beyond the everyday phenomenal and local interactional contexts of their basic data and area of inquiry. Under these circumstances grounded theory becomes a glorified form of content analysis.

Charmaz (2003) claims that Glaser's position is close to traditional positivism, with its assumptions about an objective, external reality that can be discovered by a neutral observer using reductionist methods. Strauss and Corbin assume a similar objective external reality that can be discovered with technical procedures, but they do propose giving voice to their respondents, and recognize that both creativity and science come into play. Furthermore, Charmaz believes that the majority of grounded theorists are objectivist in orientation.

In an attempt to address some of these current critiques and limitations, Charmaz (2003) proposes a constructivist approach to grounded theory that reaffirms studying people in their natural settings and redirects qualitative research away from positivism. In a constructivist grounded theory causality is suggestive and incomplete. It looks at how variables are grounded. Participants' meanings and actions are given priority over researchers' analytic interests. This is the approach that I adopted.

Open Coding and Thematic Analysis

Prior to commencing data analysis, I separated all interview and focus-group data into three distinct data-sets to preserve the unique perspectives of participants. I organized key informant data according to occupation. I analyzed the Presbyterian minister's data with Bill's interview to create the "clergy data set." I combined the representative from the Hamilton AIDS network and the Public Health Nurse's data with the outreach team

participants into the "professional service provider data set." Finally, I grouped all client focus-groups and the individual interview within the "client data set." I coded each data set independently and inductively. I used a different area of the memo book and developed new code names and descriptions to maintain each group of participants' unique frame of reference.

The first stage of analysis involved the process of open coding. Open coding is primarily descriptive, seeking to break down and reduce the data (Strauss & Corbin, 1998). Coding is a process of categorizing qualitative data and describing the detail and implications of these categories. I recorded and described each category in detail in a "memo book" which served as the audit trail for this project. To create the initial categories, I considered the data in minute detail. Data being coded into the same category converged with each other, while data coded into different categories diverged from one another. Please refer to Tables 3, 4, and 5 on the following pages for an outline of the categories developed from open coding from each of the three data sets (i.e., clergy, PSPs, and clients).

The first rule for the constant comparative method is that "while coding an incident for a category, compare it with the previous incident in the same and different groups coded in the same category" (Glaser & Strauss, 1967, p. 106). I found that an initial set of codes emerged from the data. I analyzed the transcripts a second time and coded incidents into the same category on the basis of what "looks right". The second stage in constant comparison consisted of axial coding or thematic analysis (integrating categories and their properties). This step is necessary to bring all the details together and help make sense of the data with respect to the emerging theory.

Table 3: Categories from Open Coding - Clergy Interviews

Roles of the outreach minister

- Links with Outside Agencies
- Advocacy
- Companionship, Listening, and Presence
- Comprehensive Understanding of Mental Health Issues
- Bereavement Issues
- Performing Spiritual Ceremonies
- Pastoral Care/Spiritual Support
- Accessible to Everyone
- Accompanying Team Members/Support for Team Members
- Value for all Human Beings
- Practicing Theological Values
- Critical Reflection on Religious Influences
- Critical Self-reflection
- Unique Challenges for Clergy Engaged in Multidisciplinary Collaboration
- Accepting and Tolerant of Diverse Faith Perspectives
- Sharing Power
- Critical Skills for Successful Mental Health Outreach
- Virtuous Moral Code
- Ecumenical Spirit
- Recognition of Systemic Issues (looking at issues from multiple levels)
- Social Resources
- Fosters a Sense of Community

Table 4: Categories from Open Coding – PSP Interviews

Roles of the Outreach Minister

- Relationship Building
- Spiritual Dimension
- Spiritual Connection
- Companionship, Listening, and Presence
- Safety and Trust
- Collaboration
- Reciprocal Learning
- Personal Engagement
- Recognizing Strengths
- Power Sharing
- Respect for Cultural and Faith Differences
- Utilizing Church Resources
- Facilitating a Sense of Personal Empowerment
- Social Consciousness-raising
- Value for all Human Beings
- Access to Information
- Performing Spiritual Ceremonies
- Pastoral Care/Spiritual Support
- Liaison Work/Connections to Resources
- Practicing Theological Values

Impacts on Clients

- Sense of Hope
- Transcendence
- Self-value/Self-acceptance
- Availability/Accessibility
- Community of Support

Table 5: Categories from Open Coding – Client Interviews

Role of the Outreach Minister

- Companionship, Listening, and Presence
- Dedicated Leadership
- Value for all Human Beings
- Compassion and Empathy
- Friendly and Welcoming Atmosphere
- Fosters a Sense of Community
- Practical Supports
- Access to Information
- Humanistic Approach (non-medical approach)
- Pastoral Care and Spiritual Support
- Facilitates and Sense of Personal Empowerment
- Inspirational Leadership

Impacts on Clients

- Friendly and Welcoming Atmosphere
- Perceived Spiritual Assistance
- Sense of Community
- Sense of Coherence/Understanding
- Knowledge of a Higher Power
- Practical Supports
- Access to Information
- Opportunities to Provide Help and Participate
- Positive Impacts of Social Support
- Inner strength
- Self-value and Self-acceptance
- Sense of Hope
- Reciprocal Helping
- Personal Faith
- Safety and Trust
- Lower Levels of Substance Abuse/use
- Life Skills
- Acceptance and Tolerance
- Influences Cognitions and Emotions in a Positive way
- Value in the Work of the Clergy
- Sense of Personal Empowerment
- Inspirational Leadership

At this stage, I ensured that category properties were clearly defined and I made judgments to determine if each quotation fit into the specific category that I had previously assigned it to (Glaser & Strauss, 1967). Within the clergy data set, which included data from Bill and the Presbyterian minister, I organized the 19 categories that were derived from open coding into five overarching themes regarding Bill's role as an outreach minister. Secondly, from the PSP data set, I arranged the 20 codes that were obtained from open coding into three overarching themes relating to Bill's role, and arranged the five codes relating to client impacts into two overarching themes. Finally, within the client data set there were 12 categories originating from open coding that I classified into three themes relating to Bill's role, and I classified the 18 categories regarding client impacts into four larger themes.

I conducted the thematic analysis, or the organization of open codes into larger themes, independently for each set of data. I began the process by labeling the open codes in terms of whether they described Bill's role as an outreach minister (i.e., roles) or the impacts of his role for clients (i.e., impacts). Focusing specifically on roles, I reviewed the table of categories derived from open coding and noted some common themes that were evident from the data, such as pastoral duties, social support system, and committed leadership. I then drafted a table to organize the codes into larger overarching themes. For any remaining codes that were not immediately grouped, I reviewed the raw data and code-descriptions to determine how or if these codes were related, and in what way they could be organized. Some of the more prevalent themes had many codes associated with them and had to be divided into smaller sub-themes to ensure clarity and a more accurate understanding of what actually occurs in Bill's position. For example, a majority of

codes relating to Bill's role referred to some type of pastoral duty or approach. I then reorganized the theme of pastoral duties into the following sub-sections: integration of spirituality, relational aspects, and inspirational belief system.

Data obtained from PSP and client groups demonstrated some of the impacts of Bill's role for clients. Reviewing the findings related to impacts, my thesis advisor and I decided that there were four major functions of Bill's role that determine how he responds to clients' needs. I organized all of the categories from open coding that referred to client impacts into the following four themes: affective response, instrumental response, spiritual response, and mental health problem-solving.

Third-Level Analysis

The purpose of the third-level analysis was to compile the data and categories across the three participant groups to determine any points of overlap or convergence among the data-sets and examine where participant perspectives from each group diverged from one another. To begin the third analytic process (the first two consisted of open coding and thematic analysis), I returned to the foundation of the analysis by revisiting the original open-coding tables, code descriptions, and sample-quotations for each data set. My goal was to determine where the basic perceptions of Bill's roles and client impacts converged across all participant groups and to describe the specific instances of shared understanding.

I printed each open coding document on a different coloured paper and then cut out the code descriptions and example-quotations into "puzzle pieces." (Please see Appendices K, L, and M for the open coding documents that were used for each data-set.) I spread the "puzzle" on a table and attached each code to a piece of Bristol board

depending on the level of convergence. Board number one consisted of codes overlapping across all three data sets (i.e., PSPs, clergy, and clients). Board number two was made up of codes converging across any two data sets (i.e., PSPs and clergy; PSPs and clients; clients and clergy). Lastly, I reserved board number three for clusters of codes that offered unique perspectives and differing code descriptions but generally similar ideas.

There were several remaining isolated codes that did not directly converge or overlap with any of the other groups or clusters. I loosely appended these codes to other groups of codes where appropriate. Remaining isolated codes are not any less important than overlapping groups of codes. I will examine these further in my discussion of the third-level findings below.

Data Interpretation Workshop and Feedback Sessions

I extended an open invitation to the consumer members of the CAB to ask for volunteers to participate in a half-day mini-workshop to review the findings from client data and enrich my interpretations with their informed "insiders" perspective. The outreach team's administrative assistant presented the summary document and invitation to CAB consumer members during their quarterly meeting in June. The administrative assistant to the outreach team acted as a liaison between me and the CAB volunteers. I was given the names and contact information for three individuals who were interested in being involved in the data interpretation. I made initial contact with these volunteers to introduce myself, explain the purpose of the meeting, and schedule a time and place to meet.

The data interpretation workshop occurred on August 8, 2006 at First-Pilgrim United Church in Hamilton. Two of the three volunteers attended and we met for approximately three hours. (Please refer to Appendix N for a copy of the agenda.) I provided participants with a summary of the study and goals of this meeting. I then gave a brief overview of some qualitative research methods and explained in general terms which data collection and analytic methods were used in this project. I described how I organized the raw data into categories and larger themes, based on my interpretations of program users' words and stories. I explicitly discussed the limitations of my views as an "outsider" and encouraged participants to offer their own personal perspectives on the issues discussed in the client interviews. I then gave participants the opportunity to look over focus-group transcripts and ask any questions before proceeding to data interpretation.

In preparation for this meeting I inserted client data in the form of sample-quotations onto cue cards and placed flipchart paper with theme headings around the meeting room. I divided the quotes into two piles and distributed them equally between the two participants. I asked each volunteer to take turns reading a quotation to the group and then facilitated a discussion between participants. I took detailed notes of our discussion and paraphrased their views after each quotation to ensure that I understood their perspectives. It is interesting to note that for the most part, consumer interpretations of client data were consistent with my own understanding. Later, in my analysis and resulting discussion of the client data, I integrate the consumer interpretations with my own to provide a more holistic and balanced understanding for the reader.

This data interpretation workshop with the two consumers constituted the feedback session to client participants. Due to some practical constraints it was impossible to locate

and arrange a feedback meeting with the clients who participated in focus groups within the timeline of this project.

I was able to facilitate a feedback session with Bill to review the categories obtained through open coding and discuss my descriptions of the codes. Following preliminary data analysis I met with Bill to discuss the clergy open-coding document, which summarized the code descriptions and sample-quotations. In general, Bill agreed with my interpretations of his words. He clarified a few points of discrepancy to ensure we could develop a mutual understanding of the issues. Unfortunately, time constraints prevented any feedback sessions with PSP participants due to a conflict of schedules.

Possible Risks

Although the proposed study had few risks associated with it, there were several potential uncomfortable situations that could have arisen and had to be considered. The participants may have felt uncomfortable talking about their experiences with a privileged, white, middle-class, female graduate student. To reduce these potentially negative feelings I was completely open and honest about my research interests and I clearly articulated my personal values. Additionally, I attempted to obtain the support of the CAB to act as both research consultants and assist with co-facilitating the focus groups. I wanted these individuals involved so that I would have a more accurate idea of what daily stressors they face, their experiences with regards to the mental health outreach team, and more specifically their perceptions concerning the role of the clergyperson and the impact of this role on client interactions. Unfortunately, I was unable to meet with the CAB prior to data collection due to some practical and temporal constraints. I involved all participants in the research process by asking for their feedback

regarding the focus group and verifying the findings with consumer members of the CAB. I aimed to have a democratic, egalitarian relationship with the participants to the extent possible within the bureaucratic and time constraints of this project. My working relationship with all participants was ethical, respectful, and occured within a participatory, action-oriented framework.

There was also the risk that my research could have facilitated self-doubt of participants within this particular social group. Individual deficiencies that are made explicit might have caused feelings of inferiority and thus contributed to a negative self-perception within participating program consumers. This negative self-evaluation might have occurred when participants were asked to describe the daily stressors they face from living in poverty. By being aware of this risk I instead focused on the strengths of participants. The problems and daily stressors they face were only discussed in relation to how contact with the outreach minister impacts their lives and whether their involvement with the outreach team serves as a buffer to various negative social-environmental factors. The main focus of the research was on describing, analyzing, and evaluating the role of the clergyperson within the assertive case management outreach team.

The final identified risk involves psychological stress. Patton (2002) explains that an interview can open old wounds as part of being taken through a directed, reflective process. This potential consciousness-raising activity might have left individuals knowing things about themselves that they previously did not know. It was also possible that the interview process could have brought up painful memories. To protect against this problem I was aware that the sole purpose of a research interview is to gather data and I recognized that I should not attempt to be a therapist or make judgments, but instead stay

focused on the purpose. It is critical to balance the value of a potential response against the potential distress for the respondent (Patton, 2002).

Community Ethics and the Research Relationship

Beginning fieldwork: entry issues. Prior to soliciting the participation and involvement of members of the outreach team and key informants in the greater community I was required to engage in meetings and negotiations with "gatekeepers" of the program regarding the nature of my fieldwork. I began my involvement in the field by developing a working relationship with Bill the outreach minister. As I mentioned earlier, I was introduced to Bill through my father due to Bill's affiliation with First-Pilgrim United Church. After several phone conversations and email exchanges, I accompanied Bill and several parishioners and outreach volunteers on a day-long tour of faith-based outreach programs in the City of Toronto. During this excursion Bill and I were able to talk about issues of interest to both of us (i.e., homelessness, poverty, addictions, mental health issues, faith-based outreach services) in a relatively informal manner as we observed the activities of other programs, ate lunch together and conversed over coffee.

I met with Bill several times after our initial meeting to discuss the nature of my proposed study, my interests in this area of research, his involvement in the study, and the participation required of his colleagues and clients. Having Bill on board for this study was the most important entry issue as my research was focused on his roles as the outreach minister on the team and the direct impacts his role has for clients.

The second gatekeeper I negotiated with was Valine Vailencourt, the program manager for the team. I arranged a meeting with Valine and Bill to review my proposed research plan and motivations for this study. Valine was interested about the level of

involvement that would be required of her staff and reviewed relevant issues of ethics and confidentiality. It was also necessary for me to review and sign the policies and procedures with regards to working with the outreach team, as mandated by the City of Hamilton. At this stage I was conscious of the importance of developing relationships with those involved in my study based on mutual respect, trust, cooperation, and reciprocity. I assured Valine that this research will benefit the work of the outreach team by demonstrating the unique integration of spirituality into mental health outreach and exploring Bill's role and the impacts of this approach for clients. I promised to provide a hardcover bound copy of my final thesis document to keep on record for the team and Bill. I also discussed the possibility of presenting my findings at professional conferences, publishing an article in a relevant academic journal, and devising a summary document in the future to communicate the information to the general public. By communicating these findings to the academic and local communities the profile of the team is increased and their unique, holistic approach to outreach work is made apparent to the wider population.

I made contacts with key informants in the community and with other members of the outreach team through what Patton (2002) refers to as the "known sponsor approach". This method of commencing fieldwork and gathering information-rich participants for my study allowed me to use Bill's legitimacy and credibility to establish my own relationship with his colleagues. Bill introduced me to the members of the outreach team during visits to his office and while I sat in on team meetings. When I extended an open invitation to the team to participate in a series of individual interviews, the response I received was positive and energetic. I had more volunteers then I expected. To recruit key

informants, Bill suggested several professionals in the Hamilton community that were appropriate for the study and made the initial contact, asking each individual to respond directly to me via email. Through Bill's professional connections I was able to recruit enough participants for my study in a timely manner.

When initially entering this urban community it was necessary for me to build trust and rapport with the program consumers whom I was observing and working with. Bill again acted as my "known sponsor" and introduced me to clients when I accompanied him on outreach calls and during his time at the church outreach programs. After gaining entry into this setting I continued to introduce myself to outreach clients and became familiar with two church outreach programs prior to recruiting study participants. I attended the church drop-in centres during their outreach programs on multiple occasions to meet the volunteers, observe program operations, and to eat and talk with people in an informal manner. Reciprocity and mutual exchange were central at this stage of the research process so that consumers felt that their contribution to this project to be worthwhile. I conveyed to participants that the purpose of my research was to learn about their experiences with the outreach team and to discover if and how their needs were being met. At this time I also informed participants that their input was critical for the success of this study and their participation was extremely valuable. I let them know that their contribution would assist in the creation of an action plan in a future project, which could be used for social-change efforts to enhance the outreach program locally and possibly influence other teams across Canada.

Bulk of fieldwork/data collection phase. According to Patton (2002) fieldwork is the central activity of qualitative inquiry. The goal of qualitative research is to aim for depth of understanding about the phenomena of interest. Therefore, during the data collection phase which constituted my time in the field, I had to remain focused, disciplined, and aware of relevant ethical issues.

I attended to the relationships with my participants and the way in which they changed over the course of my involvement. Initially, I had to develop an understanding of the relationship between myself and those being observed. I established personal engagement with the setting through direct and personal contact with program participants and outreach staff in their own environments to observe their daily activities. The purpose of fostering these relationships was to enrich my understanding of the program and learn about the experiences of program clients.

I was close to the participants in my study in terms of physical proximity and through the development of nearness in the social sense of shared experience, empathy, trust, and confidentiality. With the emergence of a strong feeling of connection with the clients involved in my study, I came to understand some of the issues they face on a daily basis such as isolation, anxiety, depression, violence, hunger, and stigmatization. Understanding some of their challenges and feelings allowed me to identify with their lives, hopes, and struggles. Developing this level of intimacy with the mental health outreach program and its consumers required me to be cautious about becoming overly emotionally-involved with client and program issues. Personally, I am a very empathic and caring person. When I witness injustice and share in people's struggles, I tend to lose the focus of my primary task and allow my anger, sadness, and frustration to take over.

Below is an example from my thesis work that demonstrates how my emotional proximity to a client's issues interfered with my role as a researcher, causing something of an ethical dilemma.

An unexpected learning opportunity arose during the process of collecting client data. I had scheduled an individual interview with a female client named Jane[10] in her apartment. Jane is living with serious mental health issues, is a recovering substance abuser, and has experienced significant personal trauma in the past. When I arrived at her apartment she immediately began speaking of some recent challenges and issues she was experiencing. Instead of an interview session I spent two hours supporting Jane through a personal crisis. I felt extremely uncomfortable during this visit and was fully aware that I was in no position to act as a support person for Jane. However, my own conscience along with my professional training in working with people in crisis caused me to remain for a period of time until she was somewhat emotionally stable. From this experience I learned about the importance of boundary maintenance with participants when conducting community-based research. If I had met Jane in a public place, it is unlikely that a similar incident would have occurred.

During my immersion in the field it was critical for me to be concerned with ethical issues relevant to conducting research with people. Although the following considerations apply to both professional participants and program consumers, I will focus on the contract and research relationship that I developed with clients. I chose to highlight my interactions with clients, because they are the primary stakeholder group for this research study and I spent the majority of my time in the field interacting with clients

[10] All client names mentioned in this document and any identifying information have been altered to protect anonymity and confidentiality.

of the program. Furthermore, I believe that ethical issues should be a central focus when working with marginalized and oppressed individuals. People living in straitened circumstances and experiencing mental health issues are often devalued in society and abused by the government, health care systems, and social service agencies.

With regards to ethical considerations, I obtained informed consent from all participants prior to conducting the interviews and focus-groups. I also obtained verbal informed consent from participants before I engaged in any field observations during the job-shadowing sessions.

I was honest about my research interests and personal values regarding the topic area. Specifically, I identified that I was interested in conducting research in a participatory, action-oriented way so as to include the voices of the program participants. I clearly explained that I intended to take participants critiques and suggestions regarding the outreach program seriously and would use these discussions to form recommendations in order to improve service delivery and accessibility. I clearly stated my personal/professional values to the consumer members of the CAB participating in the study and focus group/interview participants prior to data collection. Some of these values include a respect for diversity, cultural sensitivity, a holistic understanding of mental health, social justice for marginalized and oppressed groups, community health and wellbeing, active participation of primary stakeholders, equality, and a strong commitment to addressing social issues such as homelessness and poverty.

Prior to commencing the focus group, I clarified to participants that it is important to keep the entire group discussion confidential and not talk about what was mentioned during the session with anyone outside of the group. I also informed everyone that,

although I would honour the confidentiality of all participants, other people in the group might not adhere to this standard. I also laid some ground rules at the beginning of the focus group sessions so that people felt safe and comfortable to talk. I facilitated a safe and respectful environment, while encouraging participants to listen to one another and refrain from making any value-judgments.

I reviewed the information letter to participants and informed clients of the option to not allow their data to be included in the final research project. I also carefully reviewed with all participants other ethical issues such as the right to refrain from answering questions, the right to withdraw their participation at any time, and issues of confidentiality.

It is important to note that, aside from my experience with Jane as described above, there were no ethical issues that arose throughout the duration of this project. Several participants exercised their right to withdraw participation by not attending previously scheduled focus-group sessions. One consumer from the CAB who had volunteered to participate in the data-interpretation session did not attend. These participants who withdrew from the study did not negatively impact my research process.

Leaving the field: exit issues. I prepared for disengagement with the outreach program staff and clients by clearly establishing a timeline for my involvement in the field and communicating it to all involved parties before beginning the bulk of the field research. Providing feedback to participants and creating agreements for when the final results and document would be available to the setting were central concerns during this stage of the research. As I discussed earlier in my data analysis and feedback section, it was not possible to arrange a feedback session with all focus group participants due to a lack of

any contact information. The data interpretation session with consumer members of the CAB constituted the feedback to program clients. I was not able to provide feedback to PSP participants because of the time constraints with this project and a conflict of schedules. I met with Bill several times following our initial interview and several job shadowing sessions to review my interpretations of his words and my observations of his work with clients. Two key informants requested a final draft of this project via email. I also negotiated a date for providing a hardcover copy of the final thesis document to be kept on record with the outreach team's program manager.

Definitions

For purposes of clarity it is essential to define some terms that were used throughout the research project. I used William James's definition of religion and incorporated personal faith into his classification of the term. Religion (and personal faith) thus refer to "the feelings, acts, and experiences of individual men (*and women*) in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine" (James, 1958[1902], p.42). The relation James describes can be moral, physical, or ritual.

For the purpose of this research, spirituality was distinguished from religion as one of its parts. Spirituality represents the key and unique functions of religion and can be defined as a search for the sacred. In this sense spirituality does not depend on a collective or institutional context (Pargament & Mahoney, 2002). Sacred refers to a divine being, higher power, or ultimate reality, as perceived by the individual (George, Larson, Koenig, & McCullough, 2000). Spiritual practices refer to any action (e.g., prayer, Bible study, communion, helping others) that individuals perform as a result of

their personal faith and spirituality. Finally, a faith-based organization is considered a religious congregation; an organization, project or program that is sponsored or hosted by a religious congregation; or a nonprofit organization founded by a religious congregation or religiously-motivated incorporators and board members (Faces Toolkit, 2003).

James's definition of religion is similar to Pargament's definition of spirituality. This is because in a theological sense, religion and spirituality are intimately related (religion representing the organized practice of spirituality). However, in recent years people have tended to separate religion from spirituality claiming that religion is institutional, dogmatic, and restrictive, whereas spirituality is subjective, personal, and life-enhancing (Pargament & Mahoney, 2002). I adopted James's definition, because I disagree that religion *per se*, is dogmatic or restrictive, but I do agree that some religious institutions can be.

Main Findings

Unique Roles of the Outreach Minister: Clergy Data

From the clergy interview data set, including data obtained from both Bill and the Presbyterian minister, I was able to integrate the 19 categories derived from open coding into five overarching themes. These themes highlight Bill's unique roles as an outreach minister within the ACMO team. Please refer to Table 6 on the following page for a chart of the findings regarding the roles of an outreach minister.

Pastoral Duties

These are the specific ministerial roles and duties that are unique to the pastor's position within the outreach team. This particular pastoral position involves an

Table 6: Unique Roles – Clergy Interviews

Open Codes	Themes
▪ Bereavement Issues ▪ Performing Spiritual Ceremonies ▪ Pastoral Care and Spiritual Support	Pastoral Duties: a) Integration of Spirituality
▪ Practicing Theological Values ▪ Companionship, Listening, and Presence	b) Relational Aspects
▪ Value for all Human Beings ▪ Sharing Power ▪ Virtuous Moral Code	c) Inspirational Belief System
▪ Accessible to Everyone ▪ Accepting and Tolerant of Diverse Faith Perspectives ▪ Ecumenical Spirit	Committed Leadership: a) Accessible
▪ Links with Outside Agencies ▪ Advocacy ▪ Housing Emergencies	b) Organizational Talent
▪ Social Resources ▪ Fosters a Sense of Community	Social Support System
▪ Social Consciousness	Social Consciousness
▪ Critical Reflection on Religious Influence ▪ Critical Self-reflection	Critical Thinking

integration of spirituality into mental health outreach, relational or interpersonal aspects of the job, and an inspirational belief system.

a) Integration of spirituality. As the team's outreach minister Bill integrates a spiritual approach into his work. A critical component of his work is the spiritual support, counselling, and guidance Bill offers his clients concerning issues of bereavement, death, and loss. The immediacy of dealing with such difficult issues was evident when Bill discussed a client who *"had just had five stillbirths, one after the other and really needed some bereavement work around that."* Bill also performs specific spiritual services such as a memorial service or guided prayer for clients at their request. During our interview session Bill offered an example of a time when he conducted *"a memorial service at one of the lodging homes on the Mountain...there had been a sudden death of one of the residents."* He is available for all clients of the outreach team and will meet with any of his colleagues' clients if they request some type of religious or spiritual support.

Pastoral care is provided within the church drop-in settings or anywhere in the community. Any discussion of religious issues or faith-based questions is initiated and controlled by the client. Bill spoke about a long-term client of his who is currently living with schizophrenia and often feels unimportant and deserving of punishment. Bill generally has the same type of dialogue with this individual: *"Usually one of the things that come up for him are some things he's doing which he thinks he's being punished for, that God is angry with him, so it's often the same conversation we have; he just needs to be hearing it again, that God loves him regardless of his illness."* Bill's approach is to

make himself accessible and available to clients without forcing any discussion of religion. Bill offers clients care, comfort, consolation, and counselling.

b) Relational aspects. There are also important relational aspects of Bill's role. A significant feature of Bill's position within the outreach team is one of companionship, listening, and presence. This unique approach to outreach work enables Bill to simply be present with the client during times of crisis and need without any formal professional agenda. This type of informal support was apparent when Bill stated that he *"can spend six hours sitting with someone in, at the hospital waiting to be assessed."* Acting as a companion and truly listening to the person lets the client know that someone is there to support them during difficult times.

Bill's role within the team and his unique approach are guided by his personal faith and theological values which underlie his work. These theological values are intertwined with his own personal and professional values. In response to a question related to values and ethics Bill offered a Biblical illustration that guides his work: *"Jesus talking in the temple about, I come to proclaim good news to the poor. Matthew 25 about feeding the sick and visiting people in prison...Those are the ones that I don't think about consciously but they sort of underline what I do."* Bill lives and practices these theological values without necessarily talking about them explicitly.

c) Inspirational belief system. Finally, Bill's inspirational belief system guides his ministerial work. This system of belief involves a general way of living one's life in accordance with the teachings of the church and Christ. Bill has a strong intrinsic value for all human beings, which is central to his role as an outreach minister. The clergyperson serving as a key informant to this project explained that a common

ministerial approach *"is simply to attempt to treat them as people, know their names, at least their first names and not have any pre-conditions for dealing with them."*

Despite ample frustration, Bill does not discharge a client or give up hope even when a client has relapsed *"for the 59th time because I always have to live with the hope that there's going to be a 60th time and maybe that time it works."* This expression of hope is an allusion to a lesson on forgiveness taught by Jesus in the Gospel of Matthew. The only situation in which a client would be discharged from Bill's services is if this individual was involved with the outreach team for a specific reason and he/she no longer requires assistance. For example, if Bill is working with someone to secure housing or find a family doctor and these tasks have been completed then he/she will be discharged.

A salient aspect of Bill's belief system is power sharing. Rather than taking the role of the "expert", Bill acknowledges that clients are experts in their own lives and things can be learned from them. This learning opportunity is most evident in his work with diverse clients. Bill explained his tendency, *"to look at it as I've got something to learn here, from these folks more than they have anything to get from me because we're so ignorant here about other faiths for the most part and I look on that as opportunities to learn something for myself."* Bill's relationship with clients is based on reciprocal learning and equality. Indicating the importance Bill places on allowing his clients to have control, power, and choice, he stated, *"when you have literally nothing, at least give them the dignity of making a choice."*

Ethics and values are critical to outreach work with marginalized and oppressed individuals. At the core of Bill's outreach ministry is a virtuous moral code based on the best interest of the client. Bill conveyed his moral standpoint by clarifying that in his

opinion *"the client is always number one...most of us will sort of go that extra mile to uphold that and that's a value I think that, everything that we're doing here is supposed to be focused on the client."* This statement implies that the well-being of the individual client guides Bill's work. Rather than coercing a client to follow some professionally-determined treatment plan he ensures that their own preferences and personal goals are central to their relationship.

Committed Leadership

Bill is committed to his vocation and to his clients' health and wellness. Bill's accessibility and organizational talent are both expressions of this commitment.

a) Accessibility. Within a traditional church setting a minister is available to the congregation at all times. In the context of the outreach team Bill must work within a set timeframe, although he is available at other times outside of his regular scheduled work week for emergency situations. Efforts are made to ensure that spiritual services are easy to access and people feel safe doing so. In reference to the local church drop-in centres Bill explained that, *"most people seem to be fairly comfortable and safe coming there even though it is a church and they may not have any interest or allegiance to the religious community, but they feel safe coming."* Increasing accessibility, Bill is willing to perform spiritual services and conduct pastoral counseling in clients' homes and other settings outside of the church.

Bill is accepting and tolerant of diverse faith perspectives and exhibits an ecumenical spirit. Diverse faith perspectives or the absence of faith is not a salient issue for the client/minister relationship. Bill described that his *"relationship with any of the clients is sort of irrespective of whether they have a faith perspective or not."* Different religious

beliefs are valued and respected. Similarly, clients are also accepting of Bill having a different faith background than they might have. However, efforts are made to link clients with professionals from similar ethnic backgrounds, if requested.

Bill is ordained within the United Church of Canada, which has a strongly ecumenical ethos (i.e., the church is driven by the values of diversity and inter-faith collaboration). Efforts are made to promote greater understanding and cooperation among diverse faith-perspectives and across religions. Bill's ecumenical spirit was evident when he communicated that, *"Many of us, certainly in the United Church, tried for years to do things collaboratively with the other downtown churches...I think the future of collaboration is probably more interfaith than just within the Christian community itself."*

b) Organizational talent. Organizationally, Bill demonstrates his talent by providing community referrals, doing advocacy work and dealing with housing emergencies. Bill indicated his role as a client advocate when he described accompanying "*people to their appointments with Ontario Disabilities or with program workers when there's a lot of, sort of, mediating and troubleshooting with clients who are having difficulty with their Ontario Works or ODSP."* As a general aspect of his outreach role Bill also assists individuals and families to find housing or temporary shelter when they are on the streets.

Social Support System

This is the general support system and social resources offered by the outreach team. Supports contribute to client's overall quality of life and their ability to deal with daily stressors. Part of Bill's role is to provide practical supports such as bus tickets, meal vouchers, and clothing. Social resources meet an individual's basic needs of socializing.

Part of Bill's role is to help build healthy relationships with clients and model positive social skills so they can have positive relationships with others and be able to trust. Bill revealed the value he places in social engagement by offering his opinion on the subject:

> *I think the engagement piece that we do with folks, is often the most important thing that we do. It's fine to work on their housing and get people bus tickets and all of that, but if you can have a positive trusting relationship then it's often a good spin off from that, leads to better health.*

Clients perceive the provision of social resources as being extremely important to their individual health and well-being. Bill strives to engage clients with support groups and peers to reduce their feelings of isolation. Social support fosters a sense of community among consumers. Recognizing the importance of belonging to a community, Bill works to *"get them involved in a group, or encourage them to go to drop-ins where they're going to meet some people and not feel so isolated."* Efforts are made by Bill, other clergy, and volunteers to facilitate the creation of a "community of support" in which clients feel safe and trusting of one another.

Social Consciousness

In order for the outreach minister to be successful in his role he must exhibit a high level of social consciousness and possess the capacity to situate mental health issues within a larger sociopolitical context. In working with extremely marginalized and oppressed groups it is important for Bill to understand issues from multiple levels, looking beyond the individual. Bill demonstrated a comprehensive understanding of mental health issues by reflecting on some systemic and sociocultural factors that impact consumers. Bill offered his views related to deinstitutionalization:

> *As far as mental illness is concerned, a bad mistake was made when they decided to release most of the patients that they had in institutions back into the community. This was grossly miscalculated because there weren't enough places in the community for people to go.*

Social issues that are relevant to the client population (e.g., crime, poverty, homelessness) are also understood as occurring within the community due to an interaction of various factors within multiple levels of analysis. Looking beyond the individual, the role of the family, community, and social policies are taken into consideration.

Bill possesses a general understanding of the clinical signs, symptoms, and impacts of mental health issues and recognizes the importance of holistic care to facilitate the process of recovery in consumer/survivors. Bill demonstrated this holistic view of mental health by explaining that he shares *"a view of health overall as mental and physical and spiritual and [I] try not to separate them."* By looking at social problems and mental health issues from multiple levels Bill avoids "blaming the victim" and demonstrates a value of the person rather than simply labeling the problem and losing the unique individual behind this label.

Critical Thinking

The first facet of this theme has to do with institutional critical reflection and represents Bill's capacity for holding his professional role of an outreach pastor in context. The second aspect demonstrates personal critical reflection and shows Bill's capacity to evaluate his own strengths and weaknesses to fulfill this role.

Bill's unique position within the mental health outreach team requires him to possess critical thinking skills so that he is able to successfully collaborate with mental health professionals from different fields and continually "shape" his approach in order to have

a positive impact on clients. Many traditional mental health professionals are apprehensive about the value of a minister working in the capacity of an outreach worker. In response to a statement related to people generally feeling more comfortable and trusting discussing personal issues with a minister as opposed to a psychiatrist, Bill expressed a critical understanding of this psychiatric/religious tension by explaining that *"there are probably an equal number of people who don't trust the religious community for the same reasons – bad experiences."* Bill recognizes that neither of these professional approaches is perfect and many people have had negative experiences with both members of the clergy and psychiatrists.

Some clients with serious mental health issues may experience religious delusions, which could be perceived as being perpetuated by the clergy. Furthermore, many religious institutions and churches have been guilty of causing harm to oppressed and marginalized groups. Some clients may fear the church and the clergy due to negative experiences in the past. Acknowledging the fact that not all of his clients are comfortable within the institution of the church, Bill described how *"once in awhile there's someone who doesn't come in because it is a church and it's just going to bring back bad memories for them or somebody's told them something that makes them nervous."* Recognizing and understanding that some people are cautious about clergy and religious institutions is important so that further harm can be prevented and the services of the outreach minister remain accessible to all clients. This critical reflection on religious influences is also necessary so that Bill can demonstrate to other professionals that he is aware of the potential of causing further harm to clients and he is working to avoid this.

Bill also has the capacity for critical self-reflection. He is able to recognize both his strengths and areas in need of improvement. Examining his personal values and professional approach from a critical perspective enables Bill to grow as an outreach minister and continually improve himself. Recognizing that some of his own values or personal background may come into conflict with his work is important so that he can avoid imposing his own beliefs and biases onto the clients he works with. Bill's capacity for critical self-reflection is evident in the following statement: *"I do have some recognition of the privilege I have of being that and of being in the majority, and I guess some sense that if somebody wants to talk to a colleague who's black or aboriginal, I'll try and make that happen."* Bill's capacity for critical self-reflection also reduces the power imbalance between Bill and his clients by acknowledging that all individuals come from different backgrounds and each has unique strengths and shortcomings.

Unique Roles of the Outreach Minister: PSP Data

Within the PSP data set, I incorporated the 20 categories derived from open coding into three overarching themes related to Bill's role within the team. Please refer to Table 7 on the following page for an overview of the findings regarding the unique roles of the outreach minister.

Pastoral Duties

These are the specific ministerial roles and duties as identified by selected PSP's as being unique to Bill's role as an outreach pastor. Bill's pastoral duties involve an integration of spirituality, relational aspects, and an inspirational belief system.

a) Integration of Spirituality. One of the most salient and unique aspects of Bill's role is that he integrates a spiritual or faith-based approach into his mental health outreach

Table 7: Unique Roles - PSP Interviews

Open Codes	Themes
▪ Spiritual Dimension ▪ Spiritual Connection ▪ Pastoral Care and Spiritual Support ▪ Performing Spiritual Ceremonies	Pastoral Duties: a) Integration of Spirituality
▪ Practicing Theological Values ▪ Personal Engagement ▪ Companionship, Listening, and Presence ▪ Non-aggressive Pastoral Approach	b) Relational Aspects
▪ Respect for Cultural and Faith Differences ▪ Value for all Human Beings	c) Inspirational Belief System
▪ Recognizing Strengths ▪ Relationship Building ▪ Power Sharing ▪ Facilitating a Sense of Personal Empowerment	Committed Leadership: a) Interpersonal Talent
▪ Collaboration ▪ Connections to Resources ▪ Access to Information ▪ Utilizing Church Resources	b) Organizational Talent
▪ Social Consciousness-Raising ▪ Reciprocal Learning	Education and Learning

work. PSPs identified a distinct spiritual dimension to Bill's position within the team. In response to a question regarding the unique aspects of Bill's role compared to other team members, one of his colleagues replied, *"what is different is that Bill does bring a spiritual dimension to the work."* In general, the mental health system recognizes that to achieve personal wellbeing and for an individual to recover from mental health issues, interventions need to take into consideration the psychological, physical, emotional, and environmental aspects of people's lives. Many traditional mental health professionals tend to ignore spiritual and religious issues or perceive them as being less important than the physical and psychological.

One key informant articulated the significance of multidisciplinary work and a holistic view of health, when she said,

> *The beauty of Bill or any clergy on a team, is that it is so ingrained...he's a social worker in his work as well, but he has this extra dimension and I think it's wonderful because for years and years we never recognized...we recognized the mental, the emotional, the physical, the environmental...but we don't look at that spiritual part that is part of all of us as human beings.*

By incorporating a spiritual dimension into this work Bill has facilitated the creation of a more holistic approach to mental health outreach. In general, the outreach team recognizes that spiritual needs are important for their clients. This common perception was evident when a team member stated, *"I think there's a core of our humanness that has a connection to the spiritual."* Although Bill recognizes that his clients have spiritual needs, he allows them to guide the process and does not force any type of discussion on faith-based issues.

Because client's view Bill as being a spiritual leader he is able to make connections with clients in situations where other team members may not be able to. An outreach staff

mentioned that some clients, *"...saw him as a religious, spiritual leader and so just having that on our team is so unique and unlike anything anyone else can bring to the table. And it does mean that we can connect with some of the clients we wouldn't be able to connect with, or as easily."* Bill's fellow team members acknowledge the importance of his ability to form a bond with hard to reach clients and link them with outreach services strictly due to his professional stance.

For some people living on the street with mental health issues making that spiritual connection is the only way that this person is going to be able to relate to an outreach worker. Bill connects with his clients through faith, not a specific religion or church denomination. This individualized form of spiritual connection is extremely important when working with people who have been stigmatized and oppressed. A key informant in the study articulated that consumer/survivors,

> *need to find their own way back to their spirituality, whether they find it through drawing and painting, whether they find it through Gestalt, whether they find it through talking as you would with your psychiatric counselor or whether they find it in a form of worship that is not the one they were born with.*

If desired by his clients, Bill can assist them in reconnecting with their personal beliefs and help them find unique ways that are good for them to meet this need.

Part of Bill's position within the team is to offer clients pastoral care and spiritual support and guidance around faith-based issues. One key informant explained that people involved with the outreach team tend to seek pastoral support for a sense of safety and nurturance: *"In terms of pastoral influence in outreach, it's critical because people will look to whatever their definition of spirituality is for safety, consent, uh, support, uh, a place from which to learn and be nurtured far more than they will for any governmental*

agency." The validating support and nurturance that Bill provides is especially important for individuals who have had challenging lives and have been abused or neglected by social welfare and medical institutions. Recognizing that people tend to question their faith in difficult times, a key informant articulated,

> *There's probably an awful lot of people out there who say, 'God, why me?" you know, "why am I in this situation'. There's very few people who might be able to answer that with any kind of responsiveness. A clergy person, if they're worth their salt, could at least help the client find out why.*

Addressing clients' faith-based issues and spiritual questions is important for their mental health and recovery. Bill uses pastoral counseling to complement more traditional forms of mental health treatment. Finally, as an outreach minister he is able to perform spiritual ceremonies and services for clients.

b) Relational aspects. The relational aspects of Bill's pastoral duties involve the way he combines his personal, political, and professional lives. In his role as an outreach minister he integrates his professional work with his theological and personal values. Rather than preaching, Bill acts as a model of how one should live. A colleague on the outreach team demonstrated awareness of his positive role-modeling when she explained, *"It's how you live... I think that the person who does this kind of work, like Bill, it's his modeling, and his, his acceptance and his treatment of people. That's how he preaches, that gentleness, that kindness, that compassion, that's how he preaches. It's not with words."* Bill's approach with clients is based on his beliefs of kindness, compassion, forgiveness, and generosity.

To build trust with clients, PSPs explained that outreach workers must be personally engaged with their work: *"When you're doing outreach... the big issue is trust... if you*

expect them to spill their guts to you, but you give nothing of yourself. Now, I'm not saying you spill your guts to people, but if you don't share a little bit of yourself and who you are with them, it ain't gonna happen." Trusting any type of professional is one of the foremost issues for people living on the street. Therefore, in order for clients to build a trusting relationship it is critical for Bill to show part of who he really is to his clients.

Bill's strong interpersonal skills and calming approach are vital to his work. PSPs recognized companionship, listening, and presence as an important component of Bill's role. A public health nurse involved in the study differentiated between the ways a traditional mental health professional and a minister listens to a client. Showing a preference for her teammate's approach she explained that, *"actually hearing the person and hearing their experience is beneficial and certainly I think clergy would do that. They would focus more on, on what's going on for you and what are your emotions than what's your diagnosis, cause ultimately who really cares."* His excellent listening skills allow Bill to be fully present emotionally for the person in times of need. Appreciating the value of truly hearing clients, one of Bill's team members observed that he, "*really listens to people. And I mean really listens. He really lets them speak and backs off about all the things he knows. He just keeps to himself and he just hears the person speak. Not just their words, but everything about them."* Bill's calming presence enables him to support clients and focus on their emotional and spiritual needs without pushing a professional agenda.

Consistent with his calming presence, Bill takes a non-aggressive pastoral approach in his work as an outreach minister. With regards to discussions of religion and faith, an outreach team member felt, *"Bill is just so low key with that. He does not bring it up at*

all." Bill does not preach to his clients or pressure them into accepting any specific religious beliefs. Other team members presented similar observations and valued the fact that, "*Bill does not preach whatsoever. But if there is that connection he will go from there. It's sort of where they're at."* Respecting their autonomy and differences in faith beliefs, he does not attempt to convert clients from different religious backgrounds or "push God" on people. Valuing the importance of allowing clients to guide the process and respecting diverse faith beliefs, a key informant explained,

> *If somebody asks you to pray with them you can pray with them. But you can't say to somebody, it's not therapeutic to say to somebody, perhaps you'll feel better if we pray, so let's pray. That's not necessarily that client's values... you don't know if they're Muslim or if they're you know, Jewish or what and it's not up to me to put my values on clients. So I think that there's caution.*

Instead of imposing his own views on others, Bill allows the client to determine his/her level of religious involvement and guide any discussions of faith-based issues.

c) Inspirational belief system. Bill's system of belief guides his ministerial work within the outreach team. This inspirational belief system involves a way of living one's life that is consistent with the teachings of Christ and is based on compassion and unconditional love. Bill values the inherent worth and dignity of all people despite differences. A key informant perceived caring about humanity on a spiritual level as a foundation for outreach work: *"No money can buy it, no family can replace it, no law is going to sanction it. I think without that basic theory, essential humanness being validated at a spiritual level, very little else is possible."* His values reflect the idea that everyone is important and should be respected as unique individuals. Outreach staff observed that Bill's personal values are consistent with his professional affiliation,

because *"the United Church is pretty accepting and their door as far as I can tell is pretty well open to all people."*

Along with his value for all people, Bill demonstrates a deep respect for cultural and faith differences. PSPs reported that honouring a client's cultural and faith traditions are critical for successful outreach work: *"I think if you're going to do this kind of outreach with this sort of population, you have to be prepared to honour the cultural and religious traditions that person grew up with, at least as a starting point."*

Bill respects all clients despite differences in faith, ethnic background, or cultural practices. At the very least, PSPs believe that an openness to learning about other cultural traditions is necessary. One participant explained that, *"You don't have to know every culture...but just that...respect and willing to learn, you know, especially if you're going to their homes."* According to PSPs, Bill exhibits a willingness to learn about and respect differences in others. This reverence for cultural variability and the honouring of different faith beliefs is consistent with the ecumenical approach of the United Church.

Committed Leadership

Bill is committed to his vocation as an outreach minister and is dedicated to helping his clients achieve personal wellbeing. His dedication to this work is evident from his many interpersonal and organizational talents.

a) Interpersonal talent. An essential aspect of Bill's role involves his interpersonal talent which enables him to build trusting relationships with clients. With his good sense of humour and friendly demeanor, Bill is able to engage clients so they are willing to work with him. One of his team members commented that Bill often *"meets people on the street in that whole outreach role, engaging people and relationship building...that's*

how I see outreach...that relationship building and then bridging them to the help they need." Relationship building is imperative to mental health outreach because unless there is a sense of familiarity and rapport, clients will not trust Bill or be willing to work with the team.

Bill is successful in developing relationships with his clients, because he takes a strengths-based approach and is willing to give up power. Bill recognizes strengths in all of his clients and assists them to see these strengths within themselves. This type of approach is important in outreach work, because *"when you step back and look at those strengths, there's respect for that person."* A colleague highlighted the value in recognizing assets by communicating that "*the greatest way you can help another human being is to bring forth their strengths. Not by complimenting [them] all the time, but making them see their own strengths."* Rather than focusing on his clients' shortcomings and working to change their deficits, he helps to bring forth their strong points.

In his outreach ministry, Bill gives up his role as the expert and shares power with his clients. He is willing to learn from and truly listen to the person. A key informant revealed that when engaging in outreach work it is necessary to be aware that "*you're coming from a different culture and that's again why it's so vital to sit back and listen, because you have to learn and you know just that in itself, learning from them and not seeing yourself as the expert."* Bill acknowledges that clients are *"experts of their own lives...only they can know and only they can choose those different avenues."*

By highlighting their strengths, sharing power, and allowing individual choices to be made, Bill facilitates the development of a personal sense of empowerment within his clients. As a team, Bill and his colleagues "*want to the greatest possible extent to help*

people empower themselves, to be independent and to live independently." When clients feel empowered to take control of their own lives and make positive changes they are more able to function and live relatively independently.

b) Organizational talent. Along with his several interpersonal talents, Bill is also talented organizationally. His organizational skills include collaboration, facilitating connections to resources, access to information, and utilizing church resources.

Collaboration is perceived as essential for outreach work with marginalized people because these individuals often require multiple and varying types of support. As a member of a multidisciplinary mental health outreach team, a central piece of Bill's role is collaborating with other professionals. Bill's colleagues value his position within the team. As one participant explained, *"Bill is just one other petal on the flower, but the flower would be incomplete without Bill."* Bill will seek the help of other team members for their professional expertise. Because of Bill's professional role as a clergyperson he is able to complement other professional approaches to create a more holistic type of care. Outreach workers believe that *"a traditional Western medical model benefits from [a] more holistic approach, adding a spiritual component to that."* Bill's position allows him to connect secular services to more faith-based approaches. Perceiving the importance of this connection, a key informant commented that

> *social services tend to be secular and separated from religion so to be able to facilitate that connection is really important and ...requires a multidisciplinary team of clergy, mental health experts...[people with] emergency response training, psychologists and/or psychiatrists who have access to appropriate medication and also to educational resource material to provide to the client.*

Within a holistic model of mental health outreach the client is cared for mentally, physically, emotionally, and spiritually.

Part of Bill's role is to connect clients to resources within the community such as doctors and other social services agencies. Bill offers his clients multiple options and does not force them to access these resources. A key informant depicted the importance of *"building bridges...and getting them the help that they need. And it has to be in their time...you can't force people if they choose not to."* Bill also has access to information that is seen as beneficial for clients. He will meet with clients to offer suggestions and problem solve around financial and housing issues. He is knowledgeable about community resources and will point clients in the right direction if he does not have the information they need. Finally, Bill's unique role allows him to access and utilize the resources of the urban church he is affiliated with. His colleagues greatly value this connection to church resources. One of the outreach staff provided an example of a situation in which she was thankful for Bill's affiliation with the church:

> *The other thing that I've been extremely grateful for Bill, and I think, largely because he's a minister... but I have had clients die, for example, and I mean Bill's connection with the church... we couldn't find this person's family and Bill just persevered and persevered and kept writing ministers who could look up baptismal things*

Through his diligent work and use of connections Bill was successful in assisting his colleague to locate her client's family. He is also able to use the space of the church for meeting clients and making initial contact.

Education and Learning

Bill's unique position within the team allows him to act as both a teacher and a student. As an outreach minister Bill is able to raise awareness about social issues and address these issues from multiple levels by educating the religious community and congregation. Bill has the opportunity to raise large-scale discussions of social issues

with members of the congregation in the church he is affiliated with during sermons and committee meetings. This particular team member discussed the issue of Bill raising social-consciousness within the community:

> *What is distinct, I think, in terms of having a minister, is sort of in addressing issues in a broader context, hopefully with a longer term actual solution rather than a series of band aids...and you could have very many informed, thoughtful discussions around what has created the homelessness, what had created the drug addiction, what has created the sex trade workers and that those venues within churches are good educational forums for, I suppose, in which to broaden people's awareness.*

Along with working on client issues at an individual level, Bill is able to attend to issues of poverty, marginalization, and inequality in a broader context. His role as a minister and connections with the church enables him to find longer term solutions to these issues by raising community awareness. He can speak about his front line work with members of the church congregation so that others are aware of these critical social issues.

Being on an interdisciplinary team allows for reciprocal learning opportunities between Bill and his colleagues. Both Bill and his team members value such an occasion. Commenting on the development of the team, one participant observed, *"because a clergyperson is on the team, I think the team has grown because they've learned from him. Now, he's learned from them too. That's the whole idea."* This unique learning exchange allows Bill and the other team members to gain knowledge of other professional perspectives and approaches and learn from people who have had different educational backgrounds.

Unique Roles of the Outreach Minister: Client Data

From the client data set I combined the 12 categories derived from open coding into three larger themes. These themes encompass client perspectives on the unique roles that Bill engages in as an outreach minister. Please refer to Table 8 on the following page for an overview of the findings regarding Bill's position as perceived by clients.

Pastoral Duties

Similar to the findings from the other two participant groups above, these involve the general ministerial roles and duties that are unique to Bill's position within the outreach team. According to the primary stakeholder group, pastoral duties involve an integration of spirituality, relational aspects, and an inspirational belief system.

a) Integration of spirituality. As an outreach minister Bill incorporates a spiritual approach into his work. Part of his role within the team is to offer support to clients in the form of pastoral counseling and spiritual guidance around faith-based issues. One client often goes *"to him for spiritual guidance and he has some good things to say. Something to put on the shelf."* Clients perceive Bill as being more *"worldly"* than other mental health professionals and his positive suggestions are valued by program participants.

b) Relational aspects. A clergyperson must have strong interpersonal skills and be able to relate to and work with marginalized and oppressed individuals. A relational aspect of Bill's role as an outreach minister involves a humanistic or non-medical approach. Many clients of the outreach team tend to feel uncomfortable having their thoughts and behaviours constantly recorded and evaluated by traditional mental health professionals. One program consumer articulated his apprehension of psychiatrists by

Table 8: Unique Roles - Client Interviews

Open Codes	Themes
▪ Pastoral Care and Spiritual Support	Pastoral Duties: a) Integration of Spirituality
▪ Companionship, Listening, and Presence ▪ Humanistic Approach (non-medical approach)	b) Relational Aspects
▪ Value for all Human Beings ▪ Inspirational Leadership	c) Inspirational Belief System
▪ Dedicated Leadership ▪ Facilitates a Sense of Personal Empowerment	Committed Leadership a) Interpersonal Talent
▪ Access to Information	b) Organizational Talent
▪ Compassion and Empathy ▪ Friendly and Welcoming Atmosphere	c) Accessibility
▪ Fosters a Sense of Community ▪ Practical Supports	Social Support System

explaining,*" if you go to a psychiatrist they're marking everything down, they're putting that all on a file too, okay, for medical access for other people to access."* For this reason, clients value the humanistic approach that Bill takes. Clergy treat their clients and parishioners as people first and do not spend time writing notes and putting information into a file during their meetings.

Additionally, instead of simply focusing on surface-level issues, Bill works to prevent further problems from occurring and seeks to address underlying issues. Elaborating on the reasons that most consumer/survivors prefer more informal types of support, such as that of the clergy, a client explained, *"they don't want to drug you up and stuff like this and cause another problem instead of getting to the real issue. And this is what I find, by talking to ministers. It's more fulfilling to me."* Program consumers identified this humanistic and transformative approach as a superior method for dealing with certain client problems. A psychiatrist does not often pay attention to underlying social issues such as marginalization and poverty, whereas ministers recognize that along with practical and medical needs there are also emotional, social, and spiritual needs.

Consistent with the findings from the clergy and PSP interviews, clients also identified that an extremely critical relational aspect of Bill's role is one of companionship, listening and presence. This common pastoral approach to outreach work enables Bill to truly be there for his clients in times of crisis. Clients feel appreciated and respected by Bill and describe him as *"a friend who doesn't judge you."* They view him as someone whom they can develop an on-going relationship with.

Clients voiced that when compared to a psychiatrist, a minister is more caring and less likely to judge others or make them feel nervous about their problems. One of his clients

revealed, *"the reason that people would rather much prefer go to a minister instead of a psychiatrist or a psychologist is because they listen to you...you feel calm."* During the data interpretation with consumer members of the CAB, participants identified this key role of companionship to be the most important aspect of the outreach pastor's faith-based approach to mental health service delivery. Consumers described the importance of someone reaching out to them and *"coming to their level"*. People need to feel valued. They need someone who is caring and compassionate. Consumer board members felt that this type of social support and companionship to be more important in the recovery process than any type of medication.

c) Inspirational belief system. Finally, Bill's work as an outreach minister is guided by his inspirational system of belief. This belief system involves a way of living one's life modeled on the teachings of Christ. Clients describe Bill's leadership approach as inspirational. He sets an example that people want to emulate. During an individual interview a long-term client reflected on the magnitude of Bill's presence in his life by expressing that, *"he makes me, from a man's point of view, want to be more like him."*

In his interactions with clients Bill conveys a strong intrinsic value for all human beings. He is described as being respectful, non-judgmental, and non-threatening. He values the inherent worth and dignity of all people. After spending time with Bill, clients feel valued and cared for. A consumer participant explained that *"there's certain days that there are certain people just feel like they want to give up. They come here, and they talk to Pastor Bill or they talk to the clergy and it just makes you change."*

Due to his multiple talents and compassionate, faith-based approach, clients perceive Bill as being an inspiration. One of the focus group participants explained that she enjoys

returning to the church drop-in centre, because *"when you get down in the dumps they bring you right back up, you know they make you happy, they joke with you."* They respect and value his perspectives, and admire the type of person he is.

Committed Leadership

As an outreach minister Bill is committed to his chosen vocation and to his clients. Client data reveal three aspects of this theme: interpersonal talent, organizational talent, and accessibility.

a) Interpersonal talent. A significant characteristic of Bill's interpersonal talent involves his dedicated leadership skills. Clients perceive Bill as being a source of help that they can rely on and someone whom they can trust to bring their problems to. He is described as *"always kind and supportive"* and *"a very kind man who wants to help you."* Bill's problem-solving approach facilitates the creation of a sense of empowerment within the client. Rather than being directive or paternalistic, Bill listens to the client and guides them into making their own decisions. There is no authoritarian leadership. Individuals are empowered to create their own choices and determine their own level of involvement. A consumer described Bill's supportive guidance by revealing that *"Bill's more intent to listen to you and sort of let you find the answer"* The importance of this empowering approach for outreach clients is that it assists individuals in gaining self-confidence and self-esteem. They feel capable and respected.

b) Organizational talent. Along with his interpersonal talents Bill is also talented organizationally. Part of his role as an outreach minister involves providing impoverished people with information to assist them in accessing necessary services. A female program consumer explained that when facing life challenges a person should *"talk to Bill. Talk to*

the minister. Talk to the volunteer. That's what they're here for, to help you get the information for the services that you need." Clients view Bill as a helpful and dependable individual who is informative and intelligent.

c) Accessiblity. A significant aspect of Bill's role as an outreach minister with this marginalized client group is the accessibility of his services. Many traditional mental health professionals and social service workers do not understand the types of issues that impoverished people face. Bill is viewed as *"more understanding"* and he *"has a heart for people."* Consumers describe him as a compassionate person that can relate to *"street people"* and see them as unique individuals because *"he knows where we come from."*

Along with being easily approachable Bill attempts to create an environment within the church drop-in centres that is easily accessible and comfortable for clients. When attending church outreach programs, clients *"come into a place where they feel accepted and not judged and they can just relax."* With regards to this positive atmosphere one man agreed, *"you walk in the door. They say 'hi' to you right away. They know you."* Program participants acknowledge that everyone needs to feel wanted and accepted and this welcoming atmosphere allows them to feel this way. They do not have to worry about having problems or be ashamed of past mistakes.

Social Support System

This is the general support system and social resources that are facilitated by Bill's role as an outreach minister. Practical supports such as food, bus tickets, clothing, and shelter are offered to clients within two downtown church outreach programs. Bill also offers food vouchers and bus tickets on an individual basis. Recognizing the importance of social support, Bill attempts to foster a sense of community within program consumers

by encouraging them to attend these church outreach programs. Clients explain that drop-in centres *"gives you a sense of belonging. Like you were saying about family, and a lot of the street people don't have that."* Clients come together as peers to experience reduced isolation and to build friendships. Participants describe a feeling of togetherness as they reach out to others. Through on-going participation in these programs clients experience an overall sense of belonging to a larger community with a greater purpose.

Impacts of the Outreach Minister's Role on Clients: PSP Data

From the PSP data set I was able to incorporate the five categories originating from the process of open coding into two larger themes regarding the impacts of Bill's role on clients. Please refer to Table 9 on the following page for an overview of the themes related to client impacts, as perceived by PSPs.

Spiritual Response

Bill's role as an outreach minister enables him to respond to client's spiritual needs. This type of spiritual response leads to feelings of transcendence and a sense of hope within clients.

Based on their personal faith and through their relationship with Bill and other clergy, people living on the street with mental health issues often experience a sense of transcendence or belief in something beyond themselves. Even those who deny any religious belief tend to possess a spiritual dimension and seem to be reaching out to find something more. A key informant involved in the study explained that,

"you meet the odd person that will say, 'I'm an atheist. I don't believe in God. I don't believe in an afterlife of any kind'...yet when they talk there's still this kind of searching

Table 9: Client Impacts – PSP Interviews

Open Codes	Themes
▪ Transcendence ▪ Sense of Hope	Spiritual Response
▪ Availability/Accessibility ▪ Community of Support ▪ Self-value and Self-acceptance	Affective Response

for something more. Transcendence. Something greater than what we have here." Although these individuals may not have any allegiance to a specific religious faith or institution they evidently possess a spiritual element to their lives and are seeking to comprehend exactly what that is.

For those clients with personal faith or spiritual beliefs their resulting sense of hope is something very important that they hang on to, even when they have nothing else. An outreach team member revealed that some of their clients "*really have this belief in God out there, a higher being...and for some of them that is the only hope in their life, they kind of hang on to that even if they have nothing else."* Mirroring this concept, another PSP participant responded to a question regarding people living on the street potentially having greater faith then others:

> *I think homeless people are just like the rest of society. I think we hear it more because people who are homeless have lost so much...I think these people have lost everything, or many of them have lost almost everything, so when you've lost everything there's that one thing you can hang on to, that kind of hope...*

Although clients may not be affiliated with any specific church or formal religion, their sense of hope is linked to their relationship with Bill and their own belief in a higher power.

Affective Response

Bill's affective response to client's emotional needs leads to him being perceived as available and accessible. Through his outreach ministry Bill also facilitates the creation of a community of support among clients, and feelings of self-value and self-acceptance within his clients.

PSP participants observed that Bill is perceived by his clients as being easily approachable, readily available, and accessible to people in the community. Bill's relationship with an urban United Church increases his accessibility due to the rich history and tradition of the church connecting with marginalized people. Describing the significance of Bill's religious affiliation one of his team members communicated her view that "*the church in general has a long history of reaching marginalized people, people in poverty. Just to have that opportunity to meet with those people is really valuable.*" Another of Bill's colleagues believed that his background and religious connection is an asset to the team. Valuing Bill's work, this individual expressed how *"bringing all of that, the tradition of helping people who are marginalized into our work, from sort of that religious background is really useful."* His presence at the church outreach programs allows him to build connections and be available to people with whom he might not have come into contact otherwise.

Part of Bill's role is "*building a community of support for these people*" (i.e., clients) and facilitating their connection with this community. He informs clients of the opportunity to attend church outreach programs so they can meet peers, socialize, and access food. With regard to the local church drop-in centres, a key informant commented that "*clients are going for the experience of whatever program they're providing and that includes the food, socializing and just kind of the religious aspect, too. That's another kind of unique aspect of the work he brings to the table.*"

From their relationship with Bill, connections with peers, and their personal faith beliefs clients are able to gain self-value and recognize that they deserve to be happy, healthy, and alive. Self-acceptance is extremely important for the process of recovery

among consumer/survivors. Some PSPs regard feeling confident and having a sense of self-worth as the foundation for achieving overall health and wellness. One of Bill's colleagues expressed her view that *"if there's that spiritual okayness, just a solid place to stand in terms of 'I deserve to be alive in this world,' then I think everything else can come from that."*

Impacts of the Outreach Minister's Role on Clients: Client Data

From the client data set I organized the 18 categories arising from the process of open coding into four overarching themes related to client impacts. According to the program consumer group there are four major functions of Bill's role. He responds affectively to clients with his excellent human relations skills. He responds instrumentally to clients' practical needs. Bill also responds spiritually by living the Christian values of faith, hope, and charity. He models forgiveness, tolerance, and love for all human beings to his clients. Finally, Bill engages in mental health problem solving by helping clients diagnostically and in terms of their general treatment. Please refer to Table 10 on the following page for an overview of the themes concerning the impacts of Bill's role within the outreach team for clients.

Affective Response

Clients experience a sense of community (SOC) and belonging with their peers, which is a direct impact of the social support system that is facilitated by the Bill's human relations skills. Highlighting the positive impact Bill has on program participants, one individual described feeling "*great after talking to the minister. He's dynamite. I don't need any drugs. He'll support me. He'll drive me to Toronto.*" Within this community of support, clients attending the church drop-in centres experience positive

Table 10: Client Impacts – Client Interviews

Open Codes	Themes
▪ Fosters a Sense of Community ▪ Positive Impacts of Social Support ▪ Self-value and Self-acceptance ▪ Safety and Trust ▪ Influences Cognitions and Emotions in a Positive Way ▪ Facilitates a Sense of Personal Empowerment	Affective Response
▪ Opportunities to Provide Help and Participate ▪ Life Skills	Instrumental Response
▪ Perceived Spiritual Assistance ▪ Sense of Coherence/Understanding ▪ Knowledge of a Higher Power ▪ Inner Strength ▪ Sense of Hope ▪ Reciprocal Helping ▪ Personal Faith ▪ Acceptance and Tolerance ▪ Value in the Work of the Clergy	Spiritual Response
▪ Lower Levels of Substance use/abuse	Mental Health Problem Solving

impacts of social support. Observing the impacts of the supportive environment at the church outreach programs a consumer participant witnessed "*a real change in people, the peace, some people their health actually got better. Especially if they had somebody good to talk to that could life up themselves.*" Program participants perceive this type of support as being extremely meaningful and contributing to their overall sense of well-being.

Another important outcome of this supportive community environment is that clients feel a sense of safety and trust, within both the church outreach programs and their individual relationships with Bill. One woman explained the development of her relationship with Bill: *"like with any person at first you're a little timid and shy and you got to build the trust factor but after that I feel I can tell [him] anything and I usually do."* Clients are able to build trust, *"feel real comfortable with the guy"* and feel safe confiding in Bill, which allows them to experience a personal sense of security. Consumers value this safe and trusting relationship, because they recognize that it has nothing to do with any preconceived notions of importance (e.g., having money). Rather, Bill values each individual client for who he/she is.

An important outcome identified by clients is that their relationship with Bill, church outreach, and their own personal faith influences their cognitions and emotions in a positive way. Depicting the significance of his personal faith, one consumer participant stated: *"it makes you change your way of thinking so you can carry on with the rest of the day."* The outreach minister, other clergy, the church, and spiritual practices all make a difference in one's thinking patterns. This integration of spirituality in turn assists people to have an increasingly hopeful outlook on life. Through these positively altered thinking

patterns, clients experience greater self-value and self-acceptance. One woman explained that through her involvement with outreach she finds herself *"with self-esteem. I find that's the most important thing."* From this statement it is clear that the faith-based approach of the outreach minister improves individual clients' self-esteem. Another participant demonstrated the significance of her relationship with Bill and church outreach programs by explaining that, *"its all been good because I was very private, was into myself, very, very low self-esteem. I just feel better now."* Clients learn to love themselves and feel value for their life. Having an improved self-esteem is considered by clients to be a central aspect of achieving personal health and wellness.

Instrumental Response

To meet client's practical needs Bill responds instrumentally by providing clients with opportunities to provide help and participate within the community. Clients have the chance to volunteer at various outreach programs with which they are linked. In response to a question about participation within a faith community, one woman enthusiastically replied, *"I volunteer here. I volunteer at the Olive Branch, Friday, Saturday, and Sunday. We have two coffee rooms, for men, women and children, so when things come it, so go through them, sort them all, hang them up and I serve food at lunchtime and talk to people."* Consumers identify the opportunity to contribute and be involved as a way of meeting their needs of belonging and self-fulfillment. Program volunteers feel needed in their volunteer role and feel as though they are making a difference.

People living in poverty are generally devalued by society and are therefore not given many opportunities to help others. Instead, they often become dependent on others, which

may cause them not to want to help or be helped. The church outreach programs involved in this study encourages its participants to volunteer in a helping capacity.

From attending church drop-in centres, participation with the outreach program, and through their relationship with Bill clients learn basic lifeskills (e.g., budgeting, finding a job/apartment). Participants feel that *"life skills are very important and that is what you basically learn when you come to these outreach programs."* Consumers are also able to discover new problem-solving skills to achieve better outcomes and resolve various conflicts in their lives. During a discussion of how participants' lives have changed as a result of working with Bill, one man commented, *"I've learnt to get a better perspective on my problems, to learn how to deal with them better. You know, instead of striking at somebody, you know, looking at the problem and dealing with it, knocking it down, rebuilding it."* From these findings related to Bill's instrumental response, it is clear that clients experience several concrete practical gains as a direct impact of their relationship with the outreach program.

Spiritual Response

Individuals have a strong personal faith based on their relationship with Bill. Clients generally have a unique faith perspective and understand religious issues in their own way without having faith pushed on them. Their faith gives them strength to deal with their mental health issues and other daily struggles. For some, faith helps them more than any type of medication. Describing his relationship with clergy, one man expressed, *"they just give us faith. That's a drug in itself. Well, it's not a drug, but you know what I mean."* Someone with a strong personal faith knows in his/her mind that God, or some other supreme being exists. Expressing her personal faith, a female participant said, *"I*

know there's something out there. I know things that come across in front of us, it's these things we shouldn't be ignoring." Their faith is not blind, but informed. Articulating her *"spiritual grasp"* on the world one woman elucidated, *"sometimes I look at the world and the universe and say like this, something did this. It's too beautiful, too mind-boggling."*

Consumers explained that some people need to have a sense of faith and hope in a higher being. For some, simply knowing that God exists makes them feel loved and gives them hope. In response to a question regarding whether faith and spirituality gives one hope, a consumer participant replied, *"Yes. Positively. Certainly, because there's a yellow brick road somewhere up ahead."* Depicting the significance of her personal faith and perceived spiritual assistance, one woman explained: *"I believe it got me through a lot. I don't know why I held back. Somehow I've gone back, I don't know why. Like, I talk to God."* Perceived spiritual assistance is the idea that the church, clergy, and personal faith have helped an individual in a general way.

Consumers described understanding they are more than simply physical beings. Participating in a spiritual environment helps individuals to find personal faith that works for them. People with a strong personal faith and "street people" who seek assistance with regards to food, shelter, and clothing needs demonstrate a desire to both give and receive help. The significance of being able to help others in need was evident from one man who simply stated: *"I was giving back to what you were giving me."* Through involvement in outreach programs and their own personal faith, participants came to value reciprocal helping relationships and gained positive attitudes toward providing help to others. A woman revealed her feelings about this issue to the group: *"I volunteered*

here for, you know, about a year and a half, two years, and if I could help one person, you know, that was more payment to me." They are rewarded for their helping by feelings of warmth, generosity, and contact with others. They enjoy assisting people and do not feel as dependent as they would if they were solely receiving help.

Acceptance and tolerance are direct impacts of Bill's spiritual response to client issues. Through their involvement in church outreach, volunteer programs, and their relationship with Bill, clients are accepting of others and have a tolerant, non-judgmental attitude. A program consumer mentioned that participation with outreach *"helped me to open up and accept other people and faith and spirit in other people and the ministers."* Consumers recognize that nobody is perfect and that every person deserves respect despite religious, ethnic, physical, and other differences. As one consumer explained, *"it doesn't matter what religion you are, the Bible's the Bible, it's a written word."* Building on this notion, another focus group participant elaborated, *"he says he's Catholic, somebody else is protestant. Um, you could have somebody else come in and be something else. But everybody has respect for everybody. We're all, has to look at each other, we're all one. We're all the same."*

Clients highlighted the existential value of personal faith. They experience a sense of coherence and understanding through their relationship with Bill and their own spiritual beliefs. One woman commented, *"we're all here for a reason, most definitely. Maybe we don't know what it is and we find faith along the way."* Consumers explained discovering a higher meaning and sense of purpose in life that they may not have had otherwise. Faith *"gives you a reason, a reason why you exist. Because if you don't know where you come from you have no reason to be here."* Consumers are able to make sense of a world that

seems inconsistent. With an increased sense of understanding spiritual individuals are provided with a type of framework and receive answers to existential questions.

Personal faith, along with the compassionate approach of the outreach minister provides individuals with a sense of inner strength. Clients expressed feeling a greater ability to survive difficult times and continue on with life despite challenging situations. Highlighting the magnitude of spirituality in her life, a woman communicated, *"of course, there's a reason why we wake up and it's to have the spirituality and the faith that gives us the personal self-esteem to continue on with life. As hard as it can be at times."* Individuals who are ready to give up feel stronger as a direct result of their relationship with Bill. The faith-based approach of the outreach minister provides individuals with a sense of hope. Clients feel more optimistic about their lives knowing that they are important and valuable individuals.

Due to Bill's successful approach as an outreach minister, clients truly value the role of the clergy and view this position as *"a definite asset to the team."* During a discussion of social services in Hamilton an individual commented, *"I think it's a central part of the Hamilton work. Without Bill they'd be lacking...and there are people out there that are hurting, that have a spiritual void."* Individuals will make an effort to meet with Bill due to the many positive impacts his role has for clients. Consumer/survivors communicate their satisfaction with Bill's outreach services to their peers. One man explained, *"I've seen him help people all over the city. And I try to tell everybody else about it too. Pass it on."* They do not feel hopeless or abandoned and clients know where to turn for help. All participants agreed that Bill is an asset to the team. This general consensus was evident

from the participant who stated: *"Well, I just thank God we got people like Bill who seems to be there for people like ourselves and help us out."*

Mental Health Problem-Solving

An important impact of Bill's role involves his mental health problem-solving skills. Many clients experience lower levels of substance use and abuse. Individuals feel that they are able to overcome substance abuse problems with the support of the outreach minister. An individual who had a long-term relationship with Bill communicated his success story to the group: *"I came here 13 years ago and I met Pastor Bill and he was the reverend at the Wesley Centre and I knew him at the police station. He helped me sober up. I'm sober 11 years with Pastor Bill's help."* Participants explained that personal spirituality and a faith-based approach can assist someone to reduce or cease using a substance. Their relationship with Bill gives them hope that they can change bad habits and lead a healthier lifestyle. In response to a question about lifestyle changes as a result of working with Bill, one man replied that, *"the main one is staying clean and sober. Staying clean and healthy."* This finding is consistent with research showing that compared to the general population, religious individuals experience fewer substance use disorders (Johnson, Thompkins, & Webb, 2002).

Needs Identified by Clients

Although these findings regarding client needs were not part of the initial research investigation, throughout both of the focus groups consumer participants identified some important issues related to social service delivery. The following categories consist of critical needs identified by clients that must be met by outreach workers, and other social

service professionals, in order for them to build an effective working relationship and to facilitate the client's journey towards recovery.

Lived experience. Social workers, mental health professionals, and others working with mental health consumer/survivors and people living in poverty, need to walk in their clients' shoes and have the ability to look at issues from their clients' perspectives. As a general consensus among program consumers, participants felt that social workers *"don't understand poor people...they haven't walked in our shoes."* Clients agreed that social service professionals need to be more informed in what they are doing and develop empathic responses when working with consumer/survivors and "street people". Elaborating on this point, one individual suggested that, *"part of the training is they should have to live on the streets for a year, with no help. And find out what it's like."* Although this suggestion is somewhat unrealistic, it effectively illustrates the general dissatisfaction that clients feel towards social service personnel as a result of having their experiences and feelings invalidated.

Trust, respect, and acceptance. Clients need to feel trusted and respected by the professional service providers that are involved in their lives. During our focus group discussion one individual expressed that she feels *"not believed by social workers. They think we're all lying."* Another participant exclaimed in agreement: *"they treat us like criminals. Absolutely!"* Generally referring to government employed social service workers (i.e., ODSP, OW, Children's Aid Society (CAS), and hospital staff) consumers agreed that these professionals need to listen to their clients and treat them with dignity rather than automatically assuming they are liars and criminals. Explicating what the role of a social worker should be, one participant asked rhetorically: *"why not turn around*

and listen and help out as much as possible cause that's exactly what you're supposed to do." From these above statements it is evident that clients accessing social services do not feel trusted, respected, or accepted.

Right to privacy. To retain a sense of dignity and humanity clients need to enjoy a right to privacy. They do not want to be forced to provide personal information such as their SIN, mental health diagnoses, or birthdays to soup kitchens and food programs. Consumers feel that any mental health issue is information that only the individual and his/her doctor should have. During a discussion of negative experiences that individuals have had with regards to accessing meal programs and shelters, someone gave an example of a "street person" turning down food and shelter from a local organization, because he was expected to provide identification and answer several questions. In response to this issue a male participant revealed that he *"...can understand. Cause when your trust has been trashed so many times and people have used and abused you, you don't want to give that information out anymore."* Consumers who are living in straitened circumstances are forced to exist in undignified conditions (on the street, hungry, marginalized, and stigmatized). Therefore, being able to keep personal information private and choose who has access to this information is very important to their sense of dignity and self-confidence.

These identified client needs of lived experience, trust, respect, and acceptance, and the right to privacy are all consistent with the literature on self-help/mutual aid and the process of recovery for consumer/survivors. An empowering social service worker is empathic to the lived experience of his/her clients, and trusts, respects, and accepts clients for who they are while respecting their right to privacy. To aid in the recovery from

mental illness and achieve a sense of personal empowerment, it is critical for clients to have a healthy working relationship with social workers who exhibit the above characteristics.

Empowerment is a prevalent theme in the literature on recovery and self-help for consumer/survivors. Rappaport (1987) asserted that empowerment is about achieving a sense of personal control and having choice, power, and legal rights. Exerting one's right to privacy would likely bring about a sense of personal control.

The above needs identified by client participants are similar to Nelson, Lord, and Ochocka's (2001a) findings that power imbalances between mental health professionals and consumers and a lack of control in one's life were commonly reported as barriers to mental health. Working with a professional who is empathic and understanding of client needs and offers the client trust, respect, and acceptance, would therefore reduce the power imbalance and facilitate recovery from mental illness.

Barriers and Challenges to Outreach Work

According to outreach team members a barrier to this type of work is that many of their clients do not acknowledge having a mental health issue. This lack of self-acceptance regarding clients' own mental illness makes facilitating the treatment and recovery process extremely challenging and tedious for outreach staff. The problem of the client not recognizing a personal mental health issue becomes serious, when this person requires psychotropic medication or temporary hospitalization to stabilize before being able to focus on other issues such as housing and employment.

Another factor that inhibits the effectiveness of the outreach team is clients not showing up for appointments. A significant majority of the meetings that Bill and other

team members schedule with their clients occur in the community, as opposed to an office setting. For example, Bill often meets clients at local Tim Horton's coffee shops. According to Bill, some of his clients only show up for appointments with him fifty percent of the time or less. When these clients do not attend their meetings with Bill it is sometimes impossible to locate them as they may not have any stable housing or contact information.

With regards to Bill's position specifically, several of his clients are not aware of his role as a clergyperson. Most clients associate Bill with the church drop-in centres, but his professional function as an outreach minister is not necessarily known to all of the individuals with whom he works. Although Bill's ministerial role always informs the work he does with clients, this unique position is not always on the table from the client's perspective.

Finally, another significant barrier to mental health outreach work in any community setting involves various external social factors. Despite any effective social intervention or professional and informal support network, a consumer/survivors journey of recovery can be impeded due to various ecological factors. At the individual level a client may experience addictions, or mental health issues such as depression and anxiety, which can prevent the person from attending appointments and meetings. Poverty, homelessness, mental health issues, and discrimination can eat away at an individual's self-confidence and reduce her or his personal motivation or desire to achieve health and wellness. Many consumers are socially isolated and do not have any family or friends to offer support. At the community level consumer/survivors may be stigmatized and oppressed by the general public. There is a lack of safe, affordable housing and limited access to clothing,

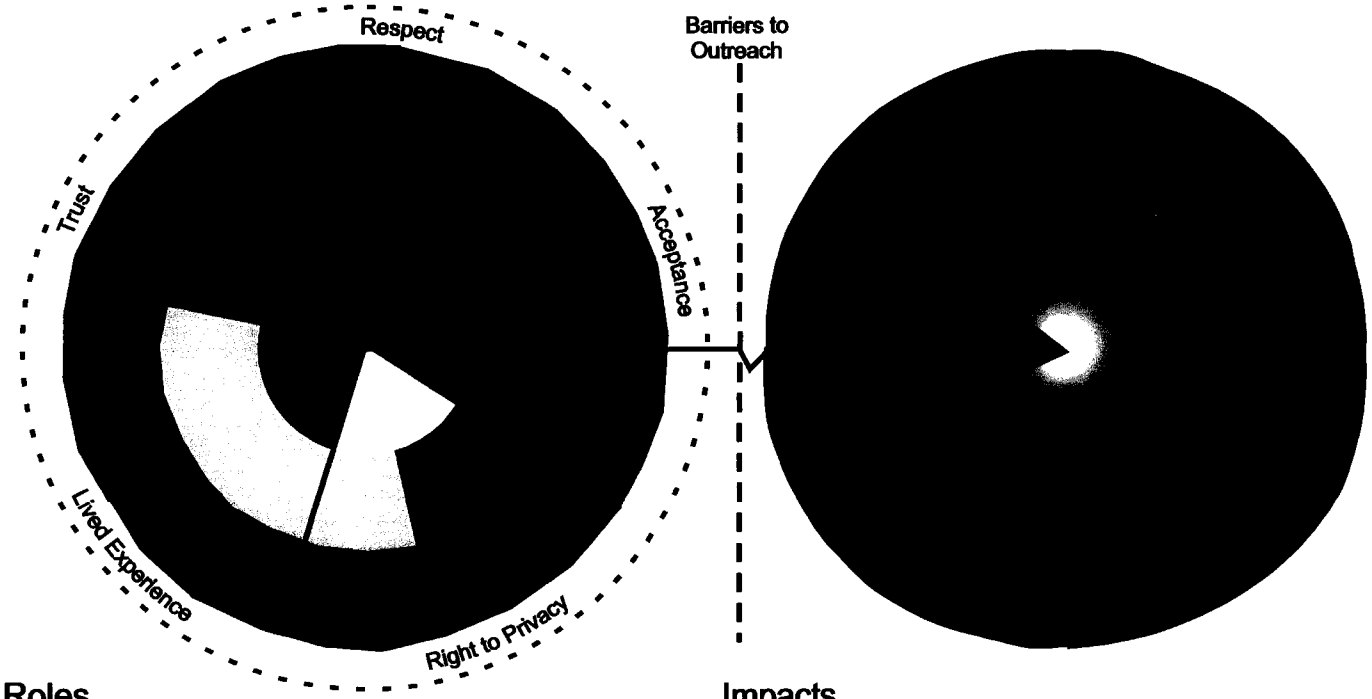
food, and shelter. Inadequate public transportation can also make attending necessary engagements challenging, at best. At the governmental level, conservative social policies and a lack of funding for social programs maintains the status quo by continuing the cycle of poverty. Prevention/promotion interventions and alternative or holistic health care programs are under-funded and generally devalued by those in power.

Summary and Integration of Main Findings

Please refer to Figure 1 on the following page for a diagram of the main findings. The following diagram demonstrates the importance of the ecological perspective (Bronfenbrenner, 1979) which is significant in the study of both community psychology and religion and spirituality. This figure illustrates the interaction between the multiple perspectives of different stakeholder groups within a specific environment. The figure shows the different perspectives from various stakeholders on Bill's unique roles within the context of client needs, and demonstrates how these roles translate into different responses that positively impact the program consumers.

The centre circle with shades of orange and yellow represent clergy data, the middle circle consisting of shades of green represent PSP data, and the outer ring with shades of blue and violet represent client data. The structure of the diagram represents the idea that Bill's roles and duties as an outreach minister occur within the framework of a larger team that works collaboratively to meet client needs. Bill is located within the centre of this framework and his efforts radiate outwards as responses to the needs of his clients. These responses are then transformed into impacts that his colleagues and clients observe.

Figure 1: Diagram of Roles & Impacts



Roles

- Pastoral Duties (CL)
- Committed Leadership (CL)
- Social Support System (CL)
- Committed Leadership (PSP)
- Pastoral Duties (PSP)
- Education & Learning (PSP)
- Pastoral Duties (CY)
- Committed Leadership (CY)
- Social Support System (CY)
- Social Consciousness (CY)
- Critical Thinking (CY)

Impacts

- Affective Response (CL)
- Instrumental Response (CL)
- Spiritual Response (CL)
- Mental Health Problem Solving (CL)
- Spiritual Response (PSP)
- Affective Response (PSP)
- Bill - Roles of the outreach minister

(PSP) = Professional Service Provider Data (CY) = Clergy Data (CL) = Client Data

Beginning with the left-hand side of the diagram, the inner-most circle consists of the overarching themes pertaining to Bill's unique roles as understood by the clergy participant group. As an outreach minister Bill works within a larger multidisciplinary team. The middle ring is comprised of the themes regarding Bill's roles as perceived by his colleagues, or the PSP participant group. The outer ring is made up of the themes relating to client perspectives of Bill's roles. The words *acceptance, trust, respect, right to privacy,* and *lived experience* surrounding the roles, are some needs identified by clients that are necessary for social service professionals to meet and be aware of in order to facilitate consumer/survivors' process of recovery.

The arrow leading to the circular formation on the right illustrates how Bill's work is translated into specific responses to clients' needs. The fragmented arrow beginning past the screen of barriers and challenges symbolizes that Bill's roles and responses do not lead to positive impacts for clients in a linear fashion. The effectiveness of Bill's outreach work is impeded due to specific barriers that occur at multiple ecological levels. Bill's responses occur within a framework of PSP and client perspectives regarding the impacts of his outreach ministry.

The inner circle on the right represents the collective understanding of the roles and responses of the outreach minister, across all participant groups. The middle ring on the right depicts the PSP group perceptions regarding the impacts of Bill's responses. Finally, the outer ring on the right consists of the themes of the impacts or outcomes that clients experience through their relationship with Bill, as understood by program consumers.

Findings and Discussion of Third-Level Analysis

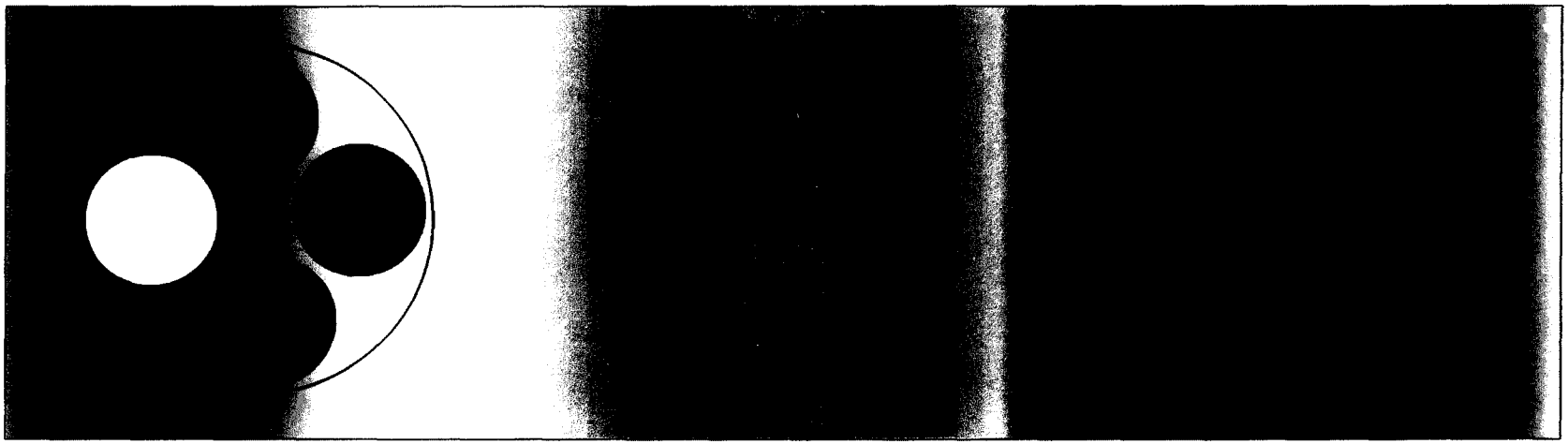
The purpose of the third-level analysis was to return to the data obtained from the first level of open coding and determine the level of convergence across the three participant groups. I reduced the themes from each participant group into the original categories that were derived from open coding. I examined each category in minute detail and reorganized them based on whether they overlapped or were related to a similar category from a different data-set.

For all converging or overlapping codes, participants from different groups (i.e., clergy, PSP, or clients) generally expressed a similar understanding of Bill's role and client impacts, with shades of meaning and from unique perspectives. Each participant group understood and identically described the more concrete or practical areas of Bill's work, such as access to information and performing spiritual ceremonies.

In the sections discussing convergence across two and three data sets, several of the sub-headings for groups of categories have two or three titles associated with them separated by semi-colons. The purpose of the multiple titles for these sections is to demonstrate the unique framework that guides participants' understanding of similar issues. Although I personally created the titles for each of these categories, I chose my wording based on the language and quotations from the particular participant group.

Please refer to Figure 2 on the following page for a visual representation of the third level findings. This "spectrum of understanding" illustrates the continuum of knowledge that was developed from examining the data and categories across all participant groups. The choice of colours and design of this figure are meant to symbolize the spectrum of light. I chose this specific diagram to demonstrate how social phenomena can be

Figure 2: Spectrum of Understanding



understood on a continuum when there are multiple perspectives involved stemming from the unique vantage points of various stakeholders. Moving from the isolated codes and clusters of codes towards convergence across two data sets, and finally to the overlapping themes among three data sets, it is clear that all participant groups exhibited a shared knowledge of Bill's roles and impacts. Participants' comprehension of Bill's outreach ministry flows from differentiated views towards a common consensual understanding.

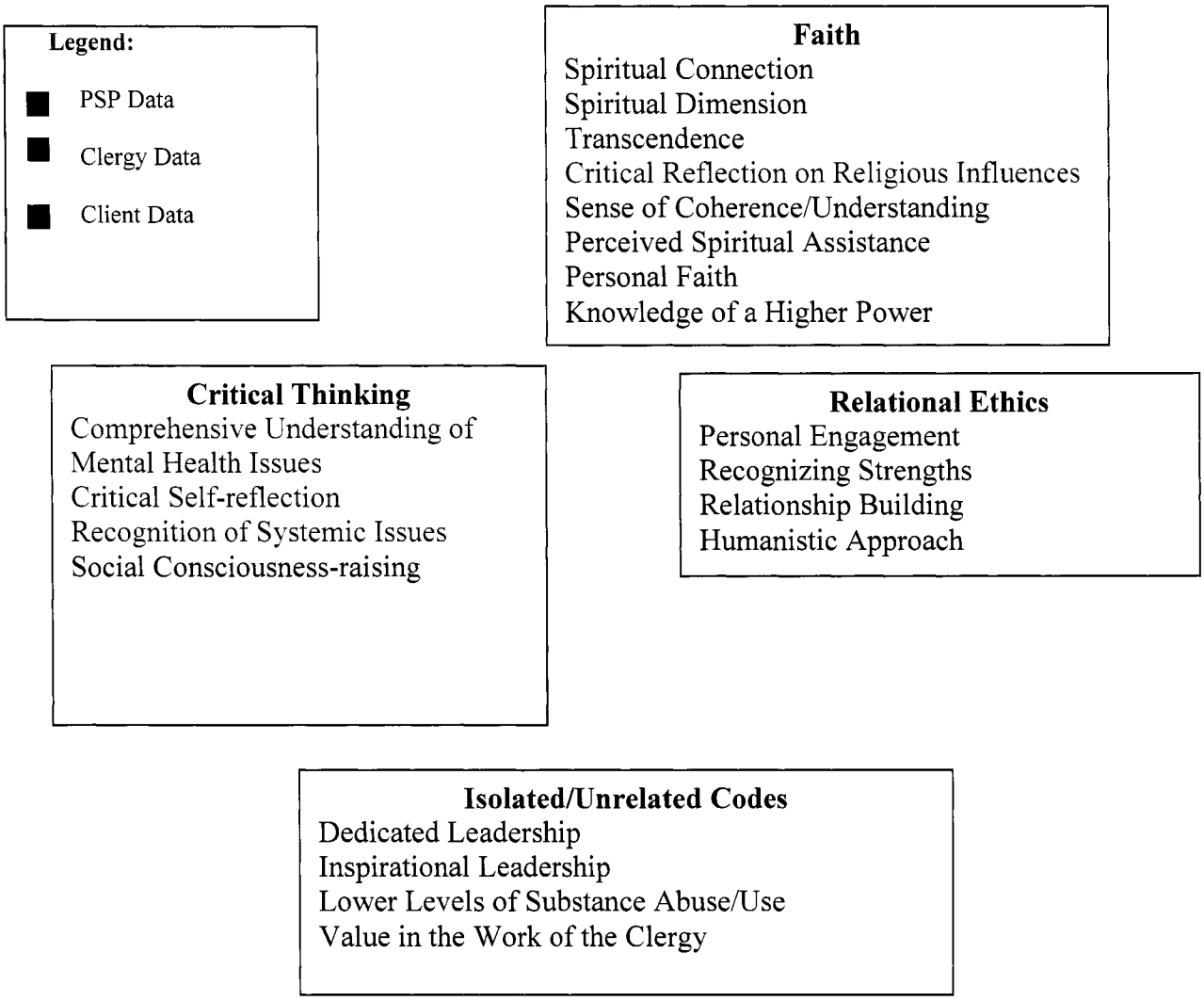
Clusters of Codes and Isolated Codes

This set of data consists of clusters of codes from across all three participant groups. These codes do not directly overlap or converge with another category. Instead they are organized based on having similarity with the other codes in the group. These clusters offer complementary perceptions. The codes are not identical, but are in the same "ballpark" with unique vantage points. Please refer to Figure 3 on the following page for an overview of the clusters of codes.

Faith. Bill's ability to critically reflect on religious influences places him in a good position to make spiritual connections with his clients. These roles lead to impacts related to a client's personal faith. Perceived spiritual assistance helps provide consumers with a sense of coherence. Clients' resulting personal faith affords them with a sense of transcendence and knowledge of a higher power.

Critical thinking. Bill has the potential to raise social consciousness and engage congregations to address problems within the community, because he looks at issues from multiple levels, has a comprehensive understanding of mental health issues, and engages in critical self-reflection. These categories associated with the theme of critical thinking stem mostly from clergy perspectives and to a lesser extent from the PSP group.

Figure 3: Level Three Analysis - Clusters of Codes



The absence of client input in this area may be due to Bill's critical thinking skills being an underlying and generally unobservable trait, that guide his work but are not apparent to his clients.

Relational Ethics. Bill is personally engaged in his work. He recognizes strengths in clients and he seeks to build relationships. All of these characteristics overlap with his humanistic or non-medical approach with clients. These aforementioned roles are approaches that traditional mental health professionals do not take, but they enable Bill to be a successful outreach minister and treat the client as a person first. The data regarding this theme of relational ethics emerged from the client and PSP group. It is important to question why Bill's perspectives are not present in this theme. From my limited relationship with him, observations of how he interacts with program staff and clients, and through discussions with his colleagues, I believe Bill to be a very modest person. The above characteristics which he possesses consist of underlying values which guide his work. He does not consciously think about adopting a humanistic approach, recognizing strengths, becoming personally engaged in his work and building relationships. Bill simply works in a capacity that is consistent with his personal and professional values, and is not aware of the significance of his interpersonal skills and relational ethics.

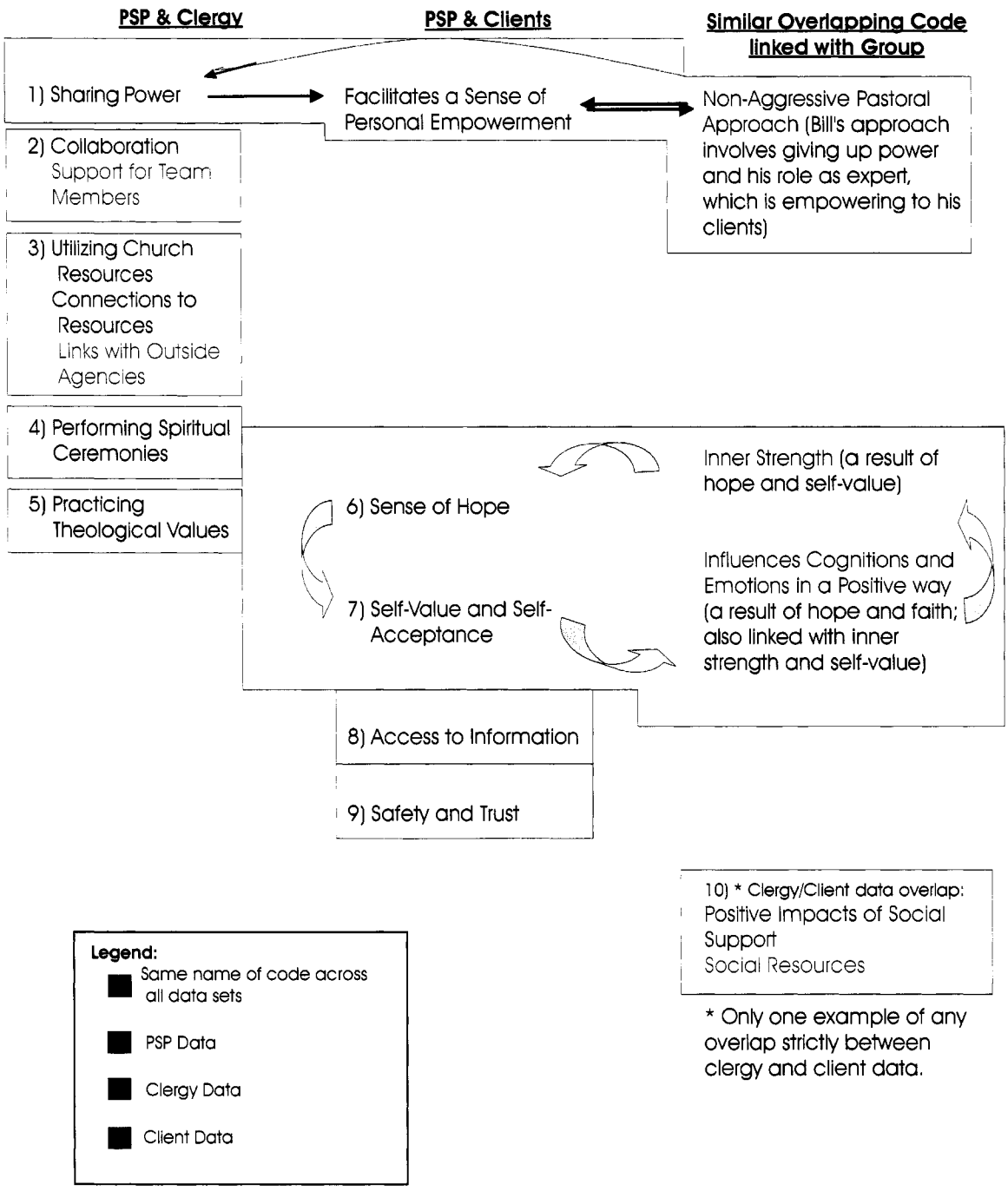
Isolated codes. This group of codes from the client data set are isolated codes that do not overlap or converge with any cluster or set of categories created during the third level analysis. These isolated codes include dedicated leadership, inspirational leadership, lower levels of substance abuse/use, and value in the work of the clergy. Although these codes could not be linked or even loosely associated with any of the other clusters and

categories, they should not be considered to be any less important or relevant to Bill's work as an outreach minister. The isolated codes simply represent aspects of Bill's role and client impacts that were only discussed by the consumer participants in this study. The reason for these unique client perspectives of Bill's work may be due to there being a greater number of consumer participants in the study than any other involved parties. By obtaining data from 14 individuals in the client group as opposed to a total of seven people across the clergy and PSP groups, it makes sense that I would be left with more unique client perspectives. Another reason for these isolated codes from the client data set is that since the consumers are directly impacted by Bill's work, they may be able to offer greater insight into his role and the outcomes of this position. If there were more time to continue this study I would use these codes as a basis to create another interview guide. I would then facilitate an additional interview with each of the clergy and PSP participants and ask questions related to the isolated codes to determine the extent to which these issues identified by clients are actually occurring in the setting.

Convergence Across Two Data Sets

This section of the discussion consists of convergence across any two participant data sets. Categories that overlap with similar categories from one other data set are grouped together to show the shared understanding between participants from two distinct vantage points. There are some differences in the shared knowledge among the relevant participant groups. Each group agrees on some of the more concrete issues, but there is some distinctiveness present. Please refer to Figure 4 on the following page for an overview of the findings related to convergence across two data sets. The numbers beside each of the headings below corresponds to specific sections on Figure 4.

Figure 4: Level Three Analysis Convergence across two Data Sets



1) Sharing Power; Facilitates a Sense of Personal Empowerment; Non-Aggressive Pastoral Approach:

Bill's non-aggressive pastoral approach is linked with both sharing power and facilitating a sense of personal empowerment. By allowing clients to have choices and not placing any pressure on them to conform, he is sharing power and giving up his role as the "expert." Bill's non-aggressive approach to outreach ministry, and his desire to share power with consumers, leads to facilitating a sense of personal empowerment within individual clients.

2) Collaboration; Support for Team Members:

Bill described some specific examples in which he assisted his colleagues by providing some type of pastoral support to their clients or accompanying his team members on outreach calls. His expertise is often requested by other members of the outreach team if a client has certain spiritual needs or faith-based questions.

In the PSP interviews, collaboration was a very common and salient theme discussed by every participant. The outreach team perceives collaboration as being critical to this type of work with marginalized people. Although any type of multidisciplinary team is collaborative, the unique aspect of Hamilton's team is that Bill is able to serve as a link between secular services and more faith-based organizations. As an outreach minister, Bill is able to complement other professional approaches to create a holistic form of mental health treatment in which the client is cared for mentally, physically, emotionally, and spiritually.

Despite the importance and value of multidisciplinary collaboration when working with marginalized groups, the potential for structurally determined sources of conflict

between professionals within the team is present. The outreach team does work very well together. However, in his pastoral role Bill adheres to a different set of values and ethical standards than other professionals on the team. For example, team members who are medical professionals will approach emergency situations with clients in a different manner than Bill might. All team members place the clients' safety and well-being as the first priority. Bill is likely to focus on being present for a client and offer moral support while encouraging the individual to seek medical attention, whereas a public health nurse is likely to assess the client's need for hospitalization by asking a standard set of clinical questions. Although a balance of different methods of working with clients is an asset for the team, the conflicting professional standards and values may be an issue in certain situations.

During my work in the field and throughout the series of interviews, this conflict between professionals was not salient. I believe that in any type of human service work, especially when addressing sensitive issues with disadvantaged clients, some disagreement between the staff team is likely, and arguably beneficial. In future research I would focus my observations on looking for conflicts of interest among team members when working with clients and explicitly ask interview questions concerning this issue.

The PSP category of "Reciprocal Learning" can be linked with the above codes of "Collaboration" and "Support for Team Members." PSPs described the learning exchange that occurs between team members as a result of being involved with an interdisciplinary team. Co-workers are able to benefit from their colleagues' knowledge and their associated agency resources. Multidisciplinary collaboration allows for

reciprocal learning opportunities, while also facilitating a greater capacity for outreach workers to help and support one another in their work with clients.

3) Utilizing Church Resources; Connections to Resources; Links with Outside Agencies:

Bill mentioned some specific agencies that he provides client referrals to. During our interview he highlighted the relationship or rapport he has with staff at various community organizations. PSPs spoke about Bill's role of "building bridges" and connecting clients to resources within the community. PSPs felt that Bill's ability to access and utilize church resources is important for the success of the team. Through his connections and religious affiliations he is able to make initial contacts with potential outreach clients and utilize the church space for meetings.

Bill's role as an advocate for clients can be tied to his links with outside agencies. Because he is well known within the greater community and has established relationships with various agencies and professionals, Bill has a greater capacity to advocate for his clients. Bill serves as a mediator between the client and other social service workers or medical professionals. He also attends appointments with clients to offer his support and problem-solving expertise.

4) Performing Spiritual Ceremonies:

Clergy and PSP participants all mentioned the act of performing spiritual ceremonies to be a central and valued aspect of Bill's work. The most common example of a religious service was memorials and funerals for deceased clients.

5) Practicing Theological Values:

Clergy and PSP participants discussed practicing theological values and using these values as a foundation for Bill's work. During our interview session Bill provided

specific biblical examples which demonstrated values by which he lives but does not consciously think about on a regular basis. Similarly, PSPs observed how Bill acts as a model of how a person should live by integrating his professional work with his theological and personal values of kindness, compassion, generosity, justice, and acceptance.

6 & 7) Sense of Hope & Self-Value and Self-Acceptance:

Clients and PSPs identified a sense of hope as being a direct impact of Bill's faith-based approach to mental health outreach. Individual personal faith beliefs are central to clients feeling hopeful about their life.

Clients expressed the view that spiritual beliefs and practices, along with a faith-based approach to service delivery, influence one's cognitions and emotions in a positive way, while also providing the individual with inner strength. Clients' thinking patterns become more positive and hopeful. They felt a greater ability to deal with life-challenges after experiencing this spiritual hopefulness. Clients' increasingly positive cognitive and emotional reactions, along with their renewed sense of inner strength, are linked with greater self-value and self-acceptance. PSP and client participants noted that clients' involvement with Bill and the church outreach programs has led to improved self-esteem and a greater sense of self-worth.

8) Access to Information:

Clients and PSPs described Bill's role of providing people with access to information. He assists them in contacting necessary services and offers suggestions and options at the request of the client.

9) Safety and Trust:

Safety and trust was another common thread discussed among PSPs and clients. Both participant groups described Bill's non-threatening attitude. Clients are very comfortable around Bill and are able to feel safe confiding in him. PSPs observed that clients are able to place a certain amount of trust in Bill simply due to his professional stance as a member of the clergy.

10) Social Resources; Positive Impacts of Social Support:

Interestingly there is only one example of any overlap strictly between the client and clergy data-sets. Bill's role of providing social resources through the outreach team and church drop-in centres leads to positive impacts of social support for his clients, such as a sense of community, connectedness and belonging among peers.

Convergence Across all Three Data Sets

This final section of the discussion from the third-level analysis consists of converging themes among all three participant groups. These groups of categories constitute a shared understanding of Bill's work among clients, clergy, and PSPs. The following categories are the most salient aspects of Bill's role within the team. There were several overlapping categories relating to Bill's unique roles and impacts on clients across all of the data sets. This level of convergence offers a substantial amount of evidence for common themes and characteristics of Bill's role. Participants all expressed a similar understanding in different ways. All stakeholders involved in this study came together on the categories discussed below. Several of the themes below were clearly evident from my field observations. In this section I use my field notes as peripheral data to enrich comprehension of these aspects of Bill's role and to provide some context. Please refer to

Figure 5 on the following page for an overview of the convergence across all participant groups. The numbers beside each of the headings below correspond to specific sections of Figure 5.

1) Pastoral Care and Spiritual Support:

All participant groups discussed Bill's role of providing pastoral and spiritual support. Bill provided examples of faith-based discussions he had with clients and highlighted the importance of care, comfort, consolation, and counseling. Marginalized people with mental health issues at times may feel either abandoned by God, or have disappointed God in some way and are not worthy of God's love.

Clients specifically mentioned that they go to Bill for spiritual guidance or supportive counseling. Client participants added that Bill never starts any spiritual discussion but instead allows the client to bring up this type of conversation. He only offers spiritual support at the request of the client.

PSP participants expressed the importance and significance of pastoral care in outreach work. According to PSPs, the value of pastoral counseling lies in its ability to complement more traditional forms of mental health treatment and provide safety and nurturance to clients.

Bereavement issues overlaps with this converging group of data. Dealing with loss, death, and dying is an aspect of pastoral care, but is coded separately within the clergy data, because it is a specific type of care that is commonly provided to clients.

During my work in the field I accompanied Bill on an outreach call to a local hospital. He was meeting a male client named Greg who is in his mid-forties and is dying of liver disease due to excessive drinking and substance abuse throughout his life. Greg was

Figure 5: Level Three Analysis Convergence across all Data Sets

Converging Codes

1) Pastoral Care/Spiritual Support

2) Companionship, Listening, and Presence

3) Availability/Accessibility
Friendly and Welcoming Atmosphere

4) Community of Support
Fosters a Sense of Community

5) Value for all Human Beings

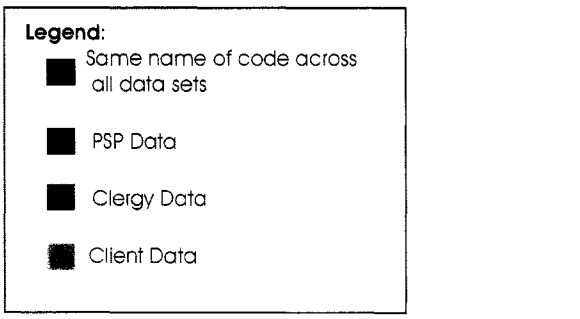
6) Respect for Cultural and Faith Differences
Accepting and Tolerant of Diverse Faith Perspectives

Similar Overlapping codes Linked with Group

(an aspect of pastoral care, but more specific)

Compassion and Empathy (important characteristics of Bill and qualities of his companionship role.)

Ecumenical Spirit (The spirit & value of the United Church overarches & links Bill's roles of respecting differences and his value for all human beings.)
Virtuous Moral Code (Bill's virtuous moral code underlies his work and serves as a foundation, linking his value for humanity and respect for differences.)



diagnosed almost two years ago and the doctors did not believe he had much time to live. Greg does not have much family other than a 17-year-old son who lives in Quebec with whom he has limited contact. Bill has acted as a companion and social resource to Greg. He also assisted Greg in creating a will and offered a substantial amount of spiritual support around terminal illness and dying at a fairly young age. Greg disclosed that he is not a very religious person but when he knew he was dying as a result of abusing his body, he had some spiritual issues and questions of faith to work through.

2) Companionship, Listening, and Presence:

Across all participant groups Bill's calming presence and friendly approach with clients was commonly discussed. In his outreach work Bill is able to be fully present emotionally for the client without any specific professional agenda.

During his interview, Bill provided a specific example of waiting at the hospital with a client for six hours. Clients reported that Bill is their friend and he "actually listens" to them. PSPs focused on Bill's excellent listening skills and the fact that he truly hears where the client is coming from and cares about their experience.

Compassion and empathy are important characteristics that Bill possesses that enable him to be present and listen to the client while acting as a companion and friend. Compassion and empathy was coded separately from the category of "Companionship, Listening, and Presence" within the client data-set, because program participants pointed out his understanding and caring nature as being very important to them.

This theme was extremely salient on multiple occasions during my field work. From direct observations of Bill interacting with clients on an individual basis and in a group setting at the church outreach programs, I found that Bill's non-verbal body language was

consistent with his friendly and supportive demeanor described by clients and PSPs. For example, when meeting with program consumers Bill was very relaxed, often smiling and nodding, making eye contact, facing people with an open stance, and changing his facial expression based on the topic of conversation.

During my hospital visit with Greg as described above, Bill acted as a companion and a friend. He spent most of his time listening to Greg and casually talking. It is important to note that Bill also discussed some relevant practical issues with Greg such as housing concerns and contacting a lawyer, but his presence with Greg was more of an informal support than a professional service provider.

Another example of Bill's role concerning companionship, listening, and presence is evident from his relationship with Jane. Bill first introduced me to Jane during a routine meeting at a Tim Horton's coffee shop. This was a very casual and informal session. Bill bought coffee for all of us and asked Jane how she has been doing lately. Jane spoke about her recent dental and doctor appointments, new medication, and her apartment. She also conversed about her pets and family on the East Coast. During this time with Jane, Bill presented himself as a supportive friend.

A final example of witnessing Bill's role of companionship, listening, and presence occurred during an emergency outreach call to a client's apartment after this individual's landlord contacted the outreach team. Peter is an older man in his sixties residing in a senior's residence. He is a struggling alcoholic with whom Bill has been working for several years. On this occasion Peter had been drinking for about six days straight and had not left his apartment. He has limited mobility and when he is inebriated it is virtually impossible for him to walk, even to the bathroom. Bill asked one of the public

health nurses on the team to accompany him on this call to determine if Peter would require any medical attention. By observing Bill's approach with Peter when compared to that of the public health nurse, it was clear that Bill interacted with clients in a distinct way from other members of the team. His colleague's intentions were simply to assess Peter's mental and physical health and decide if he needed to be hospitalized. Her role as a nurse was obvious by her focus on clinical questions and medical issues.

Bill had an entirely different presence in this situation. As a companion and friend, aside from being a form of support, Bill entered Peter's apartment first to speak with Peter alone and prepare him for visitors. During our visit with Peter, Bill spent time speaking with him in a calm and nurturing manner about his family, future housing options, and other positive issues in an attempt to keep Peter conscious and cooperative. Bill was laughing with Peter and being friendly and encouraging. It was clear that Bill was genuinely concerned with his client's wellbeing. Bill also did simple tasks that mirrored the actions of a friend, such as helping Peter sit up and put some clothes on, walk him to the bathroom, find his cigarettes, and pick some garbage off the floor.

Bill was also concerned with Peter's health and safety, but instead of relying on clinical questions to determine if Peter should be seen by a doctor, Bill relied on his past experiences with Peter and qualitative observations of his environment. There were a significant number of empty liquor and beer bottles on the ground. Peter had not been able to get out of bed for several days, so he was surrounded by garbage, cigarette butts, and feces. Peter had not eaten during his drinking binge. According to his vital signs and responses to clinical questions, the public health nurse did not feel Peter required emergency medical attention. She explained that the hospital would keep him until he

was sober and then treat him for delirium tremens and discharge him from their care. Despite this short-term solution Bill felt that medical intervention was necessary, because of the length and severity of Peter's drinking binge. The above examples clearly illustrate Bill's unique role of companionship, listening, and presence and differentiate his professional approach with clients from that of his colleagues.

3) Availability/Accessibility, Accessible to Everyone, Friendly and Welcoming Atmosphere:

Clergy participants described the church outreach programs as being a comfortable and safe place where everyone is welcome. Bill makes a conscious effort to ensure that his support and the services of the church programs are easy to access. PSP participants explained that simply because of Bill's role as a minister, he is perceived by clients as being readily available and easy to access. PSPs also observed connections being made with clients simply due to his religious affiliation. One of the outreach team members described how Bill's membership within a church community increases his accessibility due to the church's history of reaching marginalized groups.

The friendly and welcoming atmosphere described by clients is directly related to the accessibility codes described by clergy and PSPs. The atmosphere of the church drop-in centres was described as being comfortable and relaxing. Clients did not specifically discuss the accessibility of Bill's services per se, but did feel that they are welcome in the church that Bill occupies during the outreach program.

4) Fosters a Sense of Community; Community of Support:

Clergy and client participants described Bill's role of fostering a sense of community among consumers. Bill helps to engage clients with a group of peers through

the church outreach programs. Clients reported that they attend the church drop-in centres to reduce their feelings of isolation and loneliness. Many clients do not have contact with family members and fulfill their social needs through these outreach programs. In our discussion, client participants described feeling a sense of belonging through their involvement with the urban churches.

PSPs explained the idea of Bill working to create a "community of support" for clients. Not only do clients achieve a general sense of belonging to a community, but they feel supported by Bill, other clergy or church volunteers, and peers.

My observations of the social environment of the church outreach programs are consistent with participant data regarding sense of community. The outreach programs had a friendly and welcoming atmosphere and program consumers appeared to exhibit a sense of cohesion and belonging. People were friendly with one another and made efforts to interact with others who came in alone. Clients seemed to "own" the program and value the space they are provided. Many clients served as volunteers and those who did not formally volunteer assisted to clean up and help others. While conversing and eating with clients they spoke about enjoying the program, because they feel like they belong somewhere and they are with family. Clients were aware if a person who comes on a regular basis does not attend. At one of the church drop-in centres, program consumers were involved in a fund-raising effort to fix the church's roof. Even though they could not afford to donate much money, they took pride in being able to contribute something to the church.

The client categories of "Reciprocal Helping" and "Opportunities to Provide Help and Participate" can be loosely appended to the overlapping codes relating to sense of

community and community of support. Being a part of a community entails a sense of belonging and value for that community. Within their community of support clients have the opportunity to participate and are able to both give and receive help (i.e., reciprocal helping). Being actively involved in their community encourages social interaction and reduces feelings of loneliness and isolation. Clients feel a greater sense of purpose and importance, because they are able to help others in need rather than solely being the recipient of good will.

5) Value for all Human Beings:

All participants spoke frequently throughout the interview and focus group sessions of Bill's value for all human beings. In my interview with Bill he sincerely expressed the value of treating people with dignity and fairness, and never giving up on a person. Clients expressed that they feel respected and welcome in Bill's presence. They explained that he has never judged, intimidated, or belittled them. PSP's talked about the openly accepting attitude and welcoming policy of the United Church. Bill's colleagues believe that an important aspect of an outreach minister's role is to value the inherent worth and dignity of all people. Although this is a critical value for any social service professional to have, it becomes even more important when working from a faith-based approach.

All of my experiences and observations of Bill in the field are consistent with the finding of his value for all human beings. Bill respected, supported, and listened to every client that he came into contact with despite any hygiene issues, substance abuse problems, ethnic or faith diversity, or mental health concerns. As I discussed above, Bill treated Peter with the same respect and dignity that he would if Peter had not been

severely intoxicated. From informal discussions with program participants I heard that Bill is perceived as a very approachable, down to earth person who is accepting and respectful to all people.

6) Respect for Cultural and Faith Differences; Accepting and Tolerant of Diverse Faith Perspectives; Acceptance and Tolerance:

Bill's accepting and tolerant attitude and respect for cultural and faith differences described by clergy and PSP participants directly leads to the impact of acceptance and tolerance within clients. Bill noted that his relationship with clients is independent of the client having any religious or spiritual beliefs. Different perspectives are valued and respected. PSPs highlighted the importance of honouring the cultural and religious traditions of outreach clients and demonstrating a willingness to learn from them. In turn, Bill mentioned that his clients from different cultural and religious backgrounds are accepting of his difference of faith. Several client participants reported that their involvement with the church and their relationship with Bill have helped them to open up to others and be accepting of people regardless of where they are coming from. They are taught about tolerance and observe Bill's accepting and open-minded attitude. Clients attending church outreach programs have mutual respect for one another and feel that they are "all the same".

Link between 5 & 6: Ecumenical Spirit and Virtuous Moral Code

The ecumenical ethos and value of the United Church overarches Bill's roles of respecting cultural and faith differences and his value for all human beings. Interfaith collaboration is a goal and value of the United Church. Diverse perspectives are valued and incorporated into Bill's outreach work. Similarly, Bill's virtuous moral code

underlies his work and serves as a foundation to link his value for all human beings with his respect for diversity.

The findings from the convergence across all three data sets represent meaningful issues for this setting and transferability to other settings. These six groups of categories embody the most prominent, and arguably most important, aspects of Bill's outreach ministry as evidenced from all participant groups and throughout my field observations. The themes that developed from the overlapping categories represent fairly significant features of Bill's work. Thus they can be used in future research to serve as a foundation for a model to integrate religion and spirituality into mental health outreach teams in other communities. I will elaborate on using these overlapping findings as a basis for a holistic model of care in my discussion of action, implications, and future research below.

Discussion of Main Findings

The findings from this research fill several gaps in the literature concerning pastoral roles in mental health care and the integration of faith and spirituality into assertive community outreach teams. The ACMO model and specifically Bill's role as an outreach minister are arguably superior forms of mental health care than the more prevalent ACT model. Furthermore, the findings from the current study are consistent with the literature on consumer/survivor empowerment and recovery, and complement this growing literature base.

There is a virtual absence of published research on the role of the clergy in mental health journals (Weaver, 1998) despite the fact millions of north Americans seek assistance from clergy when they are experiencing mental illness (Oppenheimer, et al., 2004). Additionally, there is a need for greater collaboration and mutual learning between

mental health professionals and clergy (ibid.). From a community psychology perspective, the findings from this study demonstrate that clergy are important sources of informal support and positively complement other approaches to mental health care. Bill's outreach ministry serves as a link between secular services and faith-based organizations to create a more holistic type of care.

An overlapping theme among clergy and PSP participants in my study was collaboration and support for team members. Hamilton's ACMO team and key informants in the community perceived this multidisciplinary collaboration as being critical to outreach work with marginalized people. Bill's expertise in pastoral support and his ability to perform spiritual ceremonies are valued by the team, especially when their clients have faith-based concerns or needs. Similarly, Bill benefits from the knowledge and insight his colleagues possess in their disciplinary backgrounds of medicine, social work, and public health to name a few. Communicating the effectiveness of this collaboration to an audience of psychologists will facilitate mutual understanding between clergy and traditional mental health professionals while promoting greater interest in this area of research.

As I discussed at the outset of this document, there is no literature or current framework regarding the integration of spirituality into assertive community mental health outreach teams. Until now, no study has ever been conducted to explore how the faith-based approach of the clergy impacts clients of multidisciplinary outreach teams.

The strengths of the ACMO model, and more specifically Bill's role as the outreach minister within the team, can serve as solutions for current critiques of ACT. Clients and researchers alike have reported that ACT interventions are coercive (McGrew, et al.,

2002), paternalistic (Gomory, 1999), and result in creating a state of dependency and powerlessness within the client (Gomory, 2005; Watts & Priebe, 2002). The very foundation of the ACT model is based on the objective to keep people out of the hospital and reduce healthcare costs (Diamond, 1996).

Conversely, according to the team's program manager and based on observations and interviews with staff, ACMO is based on the notions of consumer empowerment and recovery. Clients of ACMO are active participants in treatment and goal planning. Medication, hospitalization, and employment are never forced on clients. Outreach staff assists clients in developing options, but full power is given to clients in determining which options, if any, are incorporated into their treatment plans. Additionally, the management of this outreach program firmly believes that the best approach to working with clients is to acknowledge the mind, body, spirit connection to wellness and quality of life.

Despite the assets of the ACMO team, in my view there is always room for improvement. The ACMO approach could be strengthened by future research investigating sources of structurally determined conflict between professionals on the team and by exploring potential negative impacts of this outreach approach for clients. By acknowledging any limitations of the ACMO team, staff and management can positively shape and improve program functioning.

Emerging paradigms of consumer empowerment and recovery advocate for choice, control, community integration, and eliminating power imbalances between health professionals and clients (Nelson, et al., 2001b; Trainor, et al., 2004). Also, current research demonstrates the value of informal sources of support, such as religious

communities and clergy, in promoting recovery from mental illness (Trainor, et al., 2004).

It is clear from the findings of this study that the ACMO team, along with Bill's outreach ministry, facilitates the process of personal empowerment and recovery for their clients. Among all participant groups themes of respect for cultural and faith differences, value for all human beings, and accessibility were prevalent. Diverse beliefs and perspectives are valued by outreach staff. A sense of community is present among clients, which promotes integration into the larger community. The theme of pastoral care and spiritual support demonstrates that the team recognizes the importance of informal sources of support. Finally, Bill's role of companionship, listening, and presence enables him to give up his power as the expert and allow clients to have some control in their journey of recovery.

Limitations

As with any qualitative study, causality regarding impacts for clients and any outcomes as a result of Bill's role cannot be determined. Generalizations are not possible outside of this particular urban community and specific mental health outreach team. This study regarding Bill's role as an outreach minister is context-specific. The findings are limited to a particular client-group that worked with a team of unique individuals interacting in a specific environment (a Southern Ontario urban community with its own social issues and programs). Furthermore, many of the findings related to Bill's role have to do with individual personality characteristics that he possesses, which other ministers with similar theological training may not necessarily enjoy. Although this exploratory project occurred within a particular environment and utilized strictly qualitative methods

(which limits the extent that results can be discussed in relation to other situations) these findings are important to communicate to other municipalities that employ multidisciplinary mental health outreach teams. The extent to which the unique aspects of Bill's role are generalizable beyond the individual "Bill McKinnon" is examined further in my discussion of the implications and directions for future research.

With regards to focus groups, Patton (2002) recommends that participants not know each other because there are complicated dynamics when they have prior established relationships. In the current study most of the participants were acquainted with each other. A few of them were friends. Most were regular clients of the two church's outreach programs. Another specific limitation with focus groups is that this interview method limits the amount of time each person can speak. Participants who are less assertive may withhold valuable information.

Due to the temporal constraints of this research project the amount of time I was able to spend engaged in field observations was moderate. If I had been able to observe Bill interact with similar clients over time I may have achieved a deeper understanding of Bill's role and greater insight into the impacts of this role for clients.

Despite my best effort and planning, I was unable to meet with consumer members of the CAB prior to beginning the study. I believe this project would be more meaningful and insightful, if consumers had been consulted during the planning stage. Participant-researchers could have made critical suggestions regarding the phrasing and inclusion of certain questions in the focus-group interview-guide. With the assistance of a consumer, I might have been able to recruit individual clients of Bill's to participate in a focus group, rather than recruiting all client participants from the church outreach programs. Finally,

having a consumer board-member co-facilitate the focus groups may have yielded greater participation from clients and different responses.

Action, Implications, and Future Research

Community action. Throughout the course of the research process I took on a praxis-explicator role (Elias, 1994). This is a role in which the community psychologist works within settings to understand and assist in conceptualizing change processes, while also reflecting on action processes that are part of the setting, reflecting on theory, and generating products that share knowledge. In order to fulfill this role I initially planned on engaging all participants in a participatory feedback session and incorporating the community's recommendations into an organizational-development action-plan. However, due to the challenges associated with contacting participants from the consumer group and arranging for them to attend this session, along with setting up meetings with professional service providers and outreach team members who have busy schedules, I was unable to hold this action planning meeting within the time constraints of this project.

Future research will involve returning to the research participants with my interpretations as presented in my thesis document, and inviting their feedback. In preparation for this feedback session I will present a summary of the findings, implications, and preliminary recommendations, and develop some questions in order to facilitate a group discussion around these issues. At this time I will share the findings with all participants. I will identify and invite all relevant stakeholders to assist with the development of an action plan. I will later invite a select group of stakeholders to participate on a taskforce, whose goal will be to follow through with implementing the

action plan. I will communicate the results from the work of the action planning committee using multiple formats depending on who the target audience is.

The first stage of the action plan will be to develop a logic model that can potentially serve as a framework for developing a holistic model of care that integrates faith and spirituality into mental health outreach. Although these research findings are based on a case-study that is context-specific, the role of a clergyperson within a mental health outreach team appears to be positive and contributes to the multidisciplinary mix. The third-level findings of convergence across all data-sets will serve as a foundation for this model. I have identified three major themes within this foundation that serve as critical implications for community practice. This holistic model of care will be based on spiritual, relational, and moral characteristics of an outreach minister's role. Spiritual components of the foundation involve pastoral care and spiritual support, and companionship, listening, and presence. Relational aspects include accessibility issues, a friendly and welcoming atmosphere, and fostering a community of support among clients. Finally, the moral or value-based facets of the model's foundation involve a value for all human beings, respect for cultural and faith differences, an ecumenical ethos, and a virtuous moral code. From my present research experience and personal reflections, I believe that all of these spiritual, relational, and moral characteristics must be present for an individual to be successful in his/her role as an outreach minister on a multidisciplinary mental health team. To integrate spirituality into mental health treatment programs it may not be necessary to specifically employ a clergyperson as part of the team. Other methods of incorporating religion and faith into treatment programs will be explored as well.

Following the development of this holistic model of care it would be necessary to test the model using a quasi-experimental design. Using both qualitative and quantitative methods, a program evaluation could be conducted in the form of a pilot study on the effectiveness of the model, along with a needs/assets assessment of the overall community. This model could initially be tested in Hamilton, and then in another similar urban setting such as Toronto. If the model is found to be effective, these findings could then be communicated to other municipalities across Canada. Of course adapting a model based on a specific community case study in southern Ontario would have to be implemented with caution and some advance preparation. Prior to implementing the new outreach program model in other settings, a community needs/resources assessment would be necessary along with some significant planning among relevant stakeholders and key informants in that specific community.

Practice and policy implications. An extrapolation refers to a modest speculation on the potential application of findings to other situations under similar, but not identical conditions (Patton, 2002). Due to the qualitative nature of this exploratory project, the findings cannot be generalized to other communities. However, I can extrapolate the findings by reflecting on lessons learned and potential applications for future research. Like any form of socially constructed knowledge, the insight gained regarding Bill's role as an outreach minister is localized, occurring within a specific social, political, community, and temporal context. However, naturalistic generalization can be found by recognizing the similarities of issues in and out of context (Patton, 2002). Many of the social issues that mental health consumer/survivors and people living in poverty face in Hamilton occur in other large cities across Canada. Poverty, homelessness,

stigmatization, violence, and addictions are prevalent in virtually any urban area. The needs identified by consumers (i.e., trust, respect, acceptance, right to privacy, lived experience) to aid in the process of recovery are likely the same in other communities. I also expect that many of the barriers and challenges to outreach are experienced by staff in other multidisciplinary outreach teams. Another similarity between Hamilton and other large urban communities is that the current mental health care system across Canada is fairly homogenous in its lack of any integration of religion or spirituality.

Although the City of Hamilton is unique in many ways, it is easy to observe the commonality it shares with other Canadian urban settings. For example, many urban municipalities lack affordable housing, and share problems of crime, pollution, poverty, and homelessness. Therefore, it is necessary to determine what conclusions drawn from this study are transferable to other settings. Practically speaking, some of the valuable aspects of this service include Bill's ability to perform spiritual ceremonies, and his religious affiliation with a local church which allows him to connect with a wider group of clients and utilize the church's resources. These practical features of Bill's role would be valuable to assertive mental health outreach teams in any community. Another consideration regarding transferability of findings is that the success of Hamilton's outreach team and the observed effectiveness of Bill's role demonstrate the potential for linking secular and faith-based supports. Collaboration among secular and faith-based organizations can increase knowledge and understanding of client issues and promote holistic care. Increased communication between religious and secular organizations is therefore critical for engaging in reciprocal learning opportunities and for developing collaborative interventions. A more holistic model of care is necessary to meet

consumer/survivors' needs and promote recovery from mental illness. People living on the streets and experiencing mental health issues have spiritual needs, along with their physical, mental, and practical ones. Based on the literature concerning personal empowerment and recovery for consumer/survivors (Carpenter, 2002; Trainor, et al., 2004) and from the findings of the current study, it is clear that hope, faith, and spirituality is critical to facilitate consumers' recovery from mental illness. Any framework that is developed based on the findings of this case study would have to be flexible and adaptable so that it could be effectively applied to other settings.

The current funding model in Canada is a biomedical-based capitalist system. This type of system readily funds health programs that are based in the traditional medical model and are driven by a capitalist economy, which values money and wealth over individual health and well-being. This funding structure forces consumer/survivors to function within a system that is not working for them. Other forms of treatment are more effective and generally preferred by clients, as voiced by the participants in my study. Alternative and holistic approaches to mental health treatment require greater funding because these are highly valued and desired by program consumers across North America. Social policy changes within the health care system are required in order to realize a consumer-centred, recovery-focused system with access to personalized care (Kirby, 2005).

Future research. Reflecting on the limitations of the current study, in future research I will aim to involve program consumers as participant-researchers and consultants earlier in the process. I perceive the clients as the primary stakeholders of the outreach program and believe that their voices are the most important with regards to service delivery.

From my experience consumers have a significant amount of insight into relevant issues in their lives, and they have interesting ideas to improve the effectiveness and impacts of the program.

Secondly, I would return to the third-level findings and, referring to the clusters of codes and convergence across two data sets, I would design additional interview questions based on these issues. Using the unique perspectives gained from each participant group, I would ask the other participant groups who did not refer to these issues whether they observe or experience these particular aspects of Bill's work.

Some of the findings from this study regarding the moral or relational facets of Bill's role are a result of specific personality characteristics of a certain individual. In future research it would be important to consider what is generalizable beyond the individual "Bill McKinnon." Some of the attributes of the specific individual occupying this position (i.e., Bill) include having a calming manner, being humble, non-anxious, easily approachable, and non-judgmental. These are not simply idiosyncratic characteristics of a specific individual. I strongly suspect that these are traits that a team's program manager or hiring committee would desire for any person occupying an outreach minister's position. It is relevant to this type of work to include such personality characteristics in a job description. It would not be effective to have an outreach minister who is confrontational, egocentric, or dogmatic and judgmental. Of course, the team would not want an exact clone of Bill and may desire a different balance of characteristics. Additionally, as part of the multidisciplinary mix, a team seeking an outreach minister would require someone who has had theological training that involves ecumenical/interfaith collaboration, pastoral care and support, social ethics, and critical

thinking skills. These features of theological education are legitimate parts of the interdisciplinary mix. Without this type of training the team's resources are diminished.

It is important to note that across all participant groups there were no critiques or shortcomings mentioned regarding Bill's role as the outreach minister or impacts for clients. During my individual interview and focus groups with program consumers I explicitly asked whether clients experienced any negative impacts and if there were any negative aspects of Bill's outreach ministry. Client participants only offered positive comments. This lack of critical insight from clients and others involved in the study does not mean that the approach of the outreach minister and the team in general is perfect. In my opinion, there is always room for improvement. Constructive criticism results in recommendations that can improve service delivery and enhance positive outcomes for programs clients. In future research I would aim to develop some type of measure, set of questions, or observation tool to investigate any shortcomings in this mental health outreach program. By extracting any critiques and reflecting on these findings the effectiveness of Bill's role can be improved, and any recommendations can be integrated into the developing holistic model of care.

These research findings are important for the assertive case management outreach team in Hamilton, and personally significant for the individual pastor. This research has the potential to effect change at multiple ecological levels. At the individual level, mental health outreach team members may begin to recognize the significance of spiritual issues and the importance of integrating religious approaches into service delivery. Additionally, mental health professionals participating in this study may place greater value on religion and personal faith. At the relational level, outreach team members may

alter their roles and approaches with individual clients. At the community level, greater grassroots collaboration can be supported, and public education regarding the significance of this research may be presented to the general public. Additionally, self-help could be facilitated among primary stakeholders and these individuals could be linked to various consumer/survivor initiatives in Ontario. At the macro-level, this line of research could influence social policy resulting in increased funding for the program. If stakeholders at the action-planning session agree that the role of a clergyperson within a mental health outreach team is critical and brings about positive impacts for service users, then this information could be communicated to other municipalities across Canada. A model could be created for integrating a clergyperson into mental health outreach teams. Although such a level of organizational development was beyond the scope of this project, future research in this area could significantly influence the structure and approach of mental health outreach teams within Canada and abroad.

Conclusions

Stigmatized and disempowered people in society, such as mental health consumer/survivors and people experiencing homelessness, are exposed to multiple risk factors and often abused or neglected by government, medical, and social service systems. Connecting with an outreach minister who is part of a multidisciplinary ACMO team can benefit marginalized individuals. There are many unique spiritual, relational, and moral roles of an outreach minister as perceived by clergy, professional service providers, and program clients involved in the study. From multiple participant perspectives, these affirmative characteristics include pastoral duties, committed

leadership, a comprehensive social support system, education and learning opportunities, social consciousness, and a capacity for critical thinking.

As the outreach minister, Bill works collaboratively within the framework of a larger team to meet client needs such as trust, respect, acceptance, lived experience, and a right to privacy. The unique roles of the outreach minister occur within the context of client needs and translate into various responses which positively impact program consumers.

From the perspectives of clients and PSPs, there are four major functions of Bill's role: 1) He responds affectively to clients with his excellent human relation skills. 2) He responds instrumentally to clients' practical needs. 3) He responds spiritually by living the Christian values of faith, hope, and charity. 4) He engages in mental health problem-solving by assisting clients to overcome substance-abuse problems. The effectiveness of these responses is impeded due to specific barriers and challenges to outreach work that occur at multiple ecological levels. Some of these barriers include the client not acknowledging having a mental health issue, not being aware of Bill's position as a clergyperson, not attending appointments, along with various external social factors including poverty, discrimination, and conservative social policies of government.

Based on a shared understanding among all participant groups, the most salient aspects of this particular outreach minister's role, which serves as a strong foundation for his work, involve his ecumenical spirit and virtuous moral code. The ecumenical spirit and value of the United Church of Canada overarches and links Bill's roles of respecting cultural and faith differences and his value for all human beings. Furthermore, Bill's virtuous moral code underlies his outreach ministry and serves as a basis for his work, linking his value for humanity and respect for differences. The findings from the current

study indicate that the unique spiritual, relational, and moral characteristics of an outreach minister's role within a multidisciplinary team, potentially entails significant benefits for consumer/survivors experiencing urban poverty. These findings demonstrate the potential to promote greater collaboration and understanding between mental health professionals and faith-based organizations involved in working with people experiencing urban poverty.

Personal Epilogue

Reflecting on the past year and a half that I have been immersed in this research project, I feel excited to continue my education and training as a community psychologist. From my moderate involvement conducting field research, collecting and analyzing data, and reviewing literature in the areas of poverty, homelessness, community mental health, and religion and spirituality, I believe that I have truly found a vocation that can combine my personal values and interests with my academic research and analytical skills. The field of community psychology has provided me with an avenue to work towards my goals of social justice and equality for all people in Canada regardless of age, ethnicity, socioeconomic status, or ability. I am confident that I have found a niche in which I can facilitate social change and strive to transform the status quo for people living in poverty and mental health consumer/survivors.

With regards to educational learning opportunities, my thesis study has enhanced my development as a community researcher. Through this project I gained experience working with multiple stakeholders, negotiating with representatives within the municipal government, and engaging with consumer/survivors in different capacities. I found it stimulating and insightful to interview people from different professional, cultural, and

socioeconomic backgrounds, and reflect on the multiple perspectives that my participants provided me.

Through this study I gained greater experience using qualitative research and analysis methods. I also came to value the use and applicability of qualitative methodologies more than in the past. It would have been impossible to gain this level of understanding and depth of knowledge regarding Bill's role within this ACMO team and the experiences and outcomes for clients if I had been confined to quantitative methods. My first experience with conducting a third-level analysis to observe and interpret overlapping perspectives from multiple stakeholder groups was interesting and insightful. This level of analysis strengthened the results and potential implications of my study, and allowed me to reflect on why certain issues were observed, experienced, and reported more by particular participant groups.

Integrating field observations with qualitative interviewing enhanced my findings and provided me with a rich research experience. The use of my field notebook and reflection journal helped me to relate to my findings and become increasingly emerged in the study. The field observations in conjunction with my reflections of them provided greater context for the verbal data I collected while enhancing my learning experience.

Reviewing my reflection journal, I believe that my detailed field notes and journal entries provided me with greater insight into the work I was doing, which increased my capacity to accurately interpret participant data. My personal reflections and observations made the data more meaningful and improved the quality of my analytical skills. Some of the entries allowed me to personally debrief challenging experiences I had and relieve some anxiety and stress. For example, immediately following my experience with Jane

that I described in the section on community ethics, I felt the need to debrief the strange situation in which I put myself. At the time of occurrence, Bill was on vacation and due to client-confidentiality agreements I could not discuss this situation with anyone else. The use of my journal really helped me to work through my emotions and reflect on what I could have done differently. Writing my feelings down allowed for a crisis to transform into an excellent learning experience.

I also had the opportunity to reflect on how the findings from the study were related to my own faith beliefs and the spiritual perspectives of religious leaders. The following quote from the Dalai Lama, ties into some of my third-level findings based on overlapping perspectives of Bill's role across all participant groups: *"Love, compassion, and tolerance are necessities, not luxuries. Without them, humanity cannot survive"* (His Holiness the Dalai Lama, 1999, p. 3). The categories of pastoral and spiritual support, companionship, listening, and presence, and compassion and empathy from the current study, all overlap with and are driven by the themes of love and compassion. The categories of value for all human beings and respect for cultural and faith differences are also expressions of love and compassion, but these two findings have the added dimension of tolerance as well. The major finding from this study, based on multiple stakeholder perspectives, is the overarching ecumenical ethos of the United Church and Bill's virtuous moral code which underlies his work and serves as a foundation to link his value of humanity with his respect for diversity. I have identified this main finding as a strong basis for a holistic model of care to incorporate spirituality into mental health outreach. I find it very compelling that this congruent finding and identified foundation is

consistent with the Dalai Lama's conviction that the core of all religions is love, compassion, and tolerance.

Immersing myself in this exploratory study to examine the role of an outreach minister and the impacts of this faith-based approach to mental health care for impoverished consumer/survivors has encouraged me to examine my own faith-beliefs. Contemplating my personal faith is something I have not actively engaged in for several years. One night following the completion of my data analysis, I was lying in bed and began reflecting on my personal values and faith beliefs. I became compelled to read an anthology of spiritual writings that I had been given as a gift some time ago, but had not yet had a chance to read. *For the Love of God: Handbook for the Spirit* (Carlson & Shield, 1999) is a collection of essays written by world-renowned spiritual leaders and academics. Three specific chapters really spoke to me and awoke my interest in personal faith and living by one's spiritual beliefs. The aforementioned essay written by the Dalai Lama, another by Mother Teresa, and finally one by Rabbi Harold Kushner, not only were consistent with my own faith beliefs, but significantly overlap with community psychology values.

In her essay entitled *Compassion in Action*, Mother Teresa (1999) asserts that God and compassion are one and the same. She explains that compassion entails sharing what we have with others and understanding human suffering. It is not the amount of generosity and support that we give to others that matters, but how much love we put into doing it. Mother Teresa's belief of faith in action illustrates that people all over the world from every walk of life, have the capacity to love one another and be compassionate to human needs. In closing, she expresses her value of diversity and mirrors the Dalai Lama's

position that all religions share love, compassion, and tolerance by stating that, *"religion is meant to bring us closer to God, not separate us"* (Mother Teresa, 1999, p. 180).

In his paper, Rabbi Kushner (1999) expresses his religious beliefs by explaining his view that God is personal in the sense that he affects every individual in a different way. He explains further that for him, religion begins with community rather than a series of theological propositions. The Rabbi goes on to quote Psalm 146 from the Bible: *"God is the one who sustains the fallen and feeds the hungry and brings justice to the widow and the orphan."* We can find and express our faith by helping the poor, by providing homes to the homeless, and by working for justice. Just as the Dalai Lama and Mother Teresa highlighted commonalities between all religions, Rabbi Kushner observed that what holds most religions together is the sense of community its members share.

These three religious leaders' expressions of their personal faith and relationship with God are consistent with my own faith beliefs, and with the main findings of the current study. These writings also provide me with a framework for how I want to live my life. Furthermore, these spiritual perspectives demonstrate the importance of cultural and faith diversity by linking all of humanity with the common threads of love, tolerance, compassionate action, and the importance of community and human relationships.

Considering the implications of the current study and thinking about the action component in future research has increased my desire to learn about social policy formation. The potential to effect second-order change with regards to issues of poverty and homelessness is strengthened if community activists intervene at the policy level. My long-term goal following the completion of my doctoral dissertation is to use the collective findings from my graduate research to impact social policy changes on issues

of poverty, homelessness, and faith-based outreach.[11] Upon completing this thesis study, I feel rejuvenated and motivated to continue this line of research that integrates my interests and passion for issues of urban poverty, community mental health, and religion and spirituality.

[11] I know I set my goals high, but a wise professor I have once told me to reach for the stars, because at least if you fall short you'll hit the moon.

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Appendix A: Summary Document and Invitation for CAB

The Role of a Clergyperson within an Assertive Case Management Outreach Team

Rachel Fayter, Department of Psychology, Wilfrid Laurier University

Summary of Proposal:

Taking a unique and different approach to outreach in an urban setting, the City of Hamilton, Ontario is the only mental health outreach team in North America to employ an ordained minister.

The current study explores the role of a pastor as part of a multidisciplinary team doing mental health outreach work with people experiencing urban homelessness. Qualitative research methods include a review of service records, field observations (i.e., job shadowing of the outreach pastor), focus groups with program consumers and individual interviews with various service providers and experts in Hamilton. Another focus of the study is to look at the differing experiences of homeless individuals across gender and ethnicity. Program consumers are invited to be active participants in the study serving as consultants, providing data, and also assisting with data analysis. Focus groups and interviews will be recorded and typed for coding. All data will be put together and qualitatively analyzed. Results will be presented and discussed in a feedback session with all involved program stakeholders. The community's recommendations will then be made into an action plan. The findings are expected to promote greater teamwork and understanding between mental health professionals and faith-based organizations involved in working with people experiencing urban poverty.

Research Questions:

1) What role can a clergyperson take with regards to mental health service delivery and what are the unique aspects of this role when compared to other mental health professionals?

2) What are people's experiences of the clergyperson within the outreach team? (Consider differences across gender and race/ethnicity.)

Research Progress to Date:

The following is an overview of the multiple qualitative data collection methods that have been used so far:

- Field Observations/Job Shadowing of Outreach Minister – attended two staff meetings, one workshop, and went on six observation sessions to hospital, Tim Horton's, church drop-in centres, and clients' apartments.

- Facilitated two focus groups at local downtown churches with drop-in centres (13 participants in total)
- One individual interview with a client
- Three key informant interviews (a public health nurse, urban Presbyterian minister, and the Volunteer Coordinator of the Hamilton AIDS Network)
- Individual interview with team's outreach minister
- One interview with outreach team member
- Four additional individual interviews with outreach team members scheduled for week of June 5th -11th.

Next Steps...

The interviews and focus groups are in the process of being transcribed (typed) so that the text can be reviewed and coded for themes. The data obtained from the field observations/job shadowing sessions will be included with the interview data.

In a qualitative study that is looking at a unique role of a professional doing outreach work with clients it is very important that the program clients' voices are heard and understood correctly. In order to gain an understanding of clients' experiences and the impacts of this program on peoples' lives it is necessary to have program consumers and peers involved in the study as much as possible.

I am inviting your feedback on the information I have presented here. I would also like to invite two or three consumer members of the Community Advisory Board to be involved in the qualitative data analysis with myself. The following page in this package provides an overview of your potential role and involvement in this study along with some reasons why you should consider participating and benefits to you and your community.

Invitation for Involvement in Research Study on Role of Minister in Mental Health Outreach Team

Data Interpretation Workshop:

Qualitative data includes the typed words of clients from the focus groups and interview and some written observations that were made during my time with the outreach minister.

Because you all know a lot about the poverty situation in Hamilton, are involved on the Community Advisory Board for the outreach team, and are experts in your own lives and past experiences I need your help to understand and interpret what was said during these discussions I had with program clients.

I am inviting two or three consumer members of the CAB to participate in a half-day (3-4 hours) workshop to help me analyze this data. I will give you a general overview of how to analyze interviews. We will look at the words and conversations of your peers and come to a shared understanding of what was being discussed.

To thank you for your time and help we will be having a pizza lunch and I will give each of the three workshop participant-researchers $20. This workshop will be held at First Pilgrim United Church sometime in late June or early July. Once I hear from people we can set up a time to meet.

Providing your Ideas and Perspectives:

After the interviews and focus groups are coded for themes I will arrange a feedback session in which I will return to the research participants with our understanding of the discussions and invite their feedback. Findings will be shared with all participants and I will invite various stakeholders to assist with the development of an action plan.

If the role of the outreach minister is found to have positive impacts for clients, then an action plan can help to create a model for including clergy into mental health outreach teams in other cities. Recommendations can be made to ensure that this important role is not lost and also to highlight the outreach team's strengths. Your voices can help move the findings of this study into action.

If you would like to give me some feedback on this study or sign up for the data workshop you can contact me by phone, email, or regular mail. If you need help with reaching me you can speak with Valine, Bill the outreach minister, or Rev. Paul Fayter at First Pilgrim. I would appreciate your opinions on the information I have presented here. If you are interested in participating in the action planning or feedback session please let me know. My contact information can be found below. Please let me know if you have any questions.

Why be Involved?

- The voices and opinions of program consumers are central to the success of this project. You will be helping to build a new area of research about a very important program. The findings of this research will be shared with people across North America.
- It is important to hear and take into account the opinions of people who have actually experienced living on the streets, surviving the mental health system, and working with people on the outreach team.
- The results of the study will be more trustworthy and meaningful if you and your peers are actively involved in the research.
- You will have a chance to speak up about issues that are important to you and have your ideas put into an action plan. This action plan is going to be used to guide a future study next year.
- For the 2-3 volunteers who participate in the Data Interpretation Workshop you will gain research skills around analyzing interview data. Volunteers will also share a pizza lunch and be given a $20 honourarium (gift) for your time.

Contact Info:

Researcher Name: Rachel Fayter
School/Program: Wilfrid Laurier University, Community Psychology
Address: Department of Psychology
75 University Avenue West
Waterloo, Ontario
N2L 3C5
Office: (519) 884-0710 ext. 3111
Email: laurierpsychgirl@yahoo.ca

Appendix B: Interview Guide - Individual Interview with Outreach Minister

Research in the area of community mental health and spirituality shows that the work of clergy represents a significant mental health resource for marginalized people who lack access to needed care. Clergy can also serve as an intermediary between disadvantaged communities and mental health professionals. The purpose of this interview is to learn about your role as an outreach minister and gain an understanding about the unique aspects of this role.

Description of MH outreach services:

- Can you give me an idea of what a day engaged in mental health outreach is like for you? What are some of your typical duties? What types of services do you provide?
- How do you approach people on the street? Highlight some of the issues you may encounter.
- What are some of the services offered by the outreach team? What are some of the interventions that are used?
- What role if any does the greater community play? [If none: In what ways could community involvement be beneficial?]

Role of a clergyperson engaged in mental health service delivery?

- What is your role as an ordained clergy engaged in community-based work?
- What is your view of a clergy's role as a mental health worker within the community?

Unique aspects of an outreach minister's role when compared to other mental health professionals:

- What are the unique aspects of your role? What do you offer that other professionals on the team do not? How is your approach different from that of other team members?
- What is your perspective on the issue of collaboration between clergy and traditional mental health professionals?
- How can clergy assist traditional mental health professionals in their work? What can be taught and what can be learned?

Values and Ethics

- What are some of your personal values? How do you incorporate these values into your work?
- How do you incorporate your Christian values and beliefs into your work?

- What are some ethical issues that are relevant to your work? Have you encountered any moral dilemmas or a conflict of ethics in your work?

Cultural and Faith Diversity

- How do you approach and work with culturally diverse individuals and people with different faith perspectives?
- What is the value of a primarily Christian minister working with people from diverse backgrounds? How could other faith perspectives be integrated into this work?
- How could you partner with diverse faith-communities? In what ways could this enhance your faith-based approach? How would these partnerships impact consumers?

Perspective of Mental Health and Wellness

- What is your perspective on mental health? What does mental health mean to you?
- How do you view consumers and their issues? (i.e., How do you view the issue of homelessness and mental illness?) Probe: multiple factors relating to these issues.
- What do you believe is the most effective way to facilitate recovery from mental health issues? What is the best way to assist someone in achieving wellness?
- How much power do clients have in their own treatment and recovery process? What role can they take?

Integrating Religion and Spirituality into Mental Health Treatment

- In your view, what role does religion and spirituality play with regards to mental health treatment?

Is there anything else you would like to add that we have not had an opportunity to discuss? Thanks for participating in this interview. I will get back to you in _____ weeks to review quotes and interpretations of them.

Appendix C: Interview Guide - Individual Interview with Professional Service Providers

Research in the area of assertive community mental health outreach lacks any reference to the integration of spirituality and a faith-based approach to working with consumers in urban settings. The City of Hamilton's outreach team is unique from other similar teams across North America because it is the only one to employ a clergyperson. Clergy can serve as an intermediary between disadvantaged communities and mental health professionals. The purpose of this interview is to learn about your role as a professional mental health outreach worker and gain an understanding about the integration of spirituality into mental health service delivery.

Description of MH outreach services:

- Can you give me an idea of what a day engaged in mental health outreach is like for you? What are some of your typical duties? What types of services do you provide?
- How do you approach people on the street? Highlight some of the issues you may encounter.
- What are some of the services offered by the outreach team? What are some of the interventions that are used?
- What role if any does the greater community play? [If none: In what ways could community involvement be beneficial?]

Role of a clergyperson engaged in mental health service delivery?

- What is your view of a clergy's role as a mental health worker within the community?

Unique aspects of an outreach minister's role when compared to other mental health professionals:

- What is your specific role within the team? How is your approach different from that of the outreach pastor?
- What is your perspective on the issue of collaboration between clergy and traditional mental health professionals?
- How can clergy assist traditional mental health professionals in their work? What can be taught and what can be learned?

Critical Perspective on Outreach Team Members Role:

- Many of the clients that are involved with the outreach team lack social support networks and experience many barriers and challenges. Some may lack certain lifeskills. In your professional opinion do you think it is possible that clients may become dependent upon the support offered by Bill? What about other outreach team members?

- Or does the team encourage independence by helping clients to build skills so that they may not require external support in the future.
- What can be done to ensure that clients do not become dependent on outreach workers?

Values and Ethics

- What are some ethical issues that are relevant to your work? Have you encountered any moral dilemmas or a conflict of ethics in your work?

Perspective of Mental Health and Wellness

- What is your perspective on mental health? What does mental health mean to you?
- How do you view consumers and their issues? (i.e., How do you view the issue of homelessness and mental illness?) Probe: multiple factors relating to these issues.
- What do you believe is the most effective way to facilitate recovery from mental health issues? What is the best way to assist someone in achieving wellness?
- How much power do clients have in their own treatment and recovery process? What role can they take?

Integrating Religion and Spirituality into Mental Health Treatment

- In your view, what role does religion and spirituality play with regards to mental health treatment?

Is there anything else you would like to add that we have not had an opportunity to discuss? Thanks for participating in this interview. I will get back to you in _____ weeks to review quotes and interpretations of them.

Appendix D: Hamilton Outreach Team Stakeholder Groups

- Hamilton urban homeless community
- Mental health consumer/survivors
- Family members of homeless community and consumer/survivors
- Hamilton Public Health Department and Community Services
- Community members
- Psychologists/Psychiatrists
- City of Hamilton government officials
- Social workers/Youth workers
- Local churches and pastors
- Local Aboriginal community
- Outreach team members
- Street Outreach Steering Committee (Representatives from 22 partnering agencies)
- Discharge to Shelters Planning group (21 participants)
- Outreach team Community Advisory Board
- St. Joseph's Healthcare
- Housing Help Centre
- Hamilton AIDS Network
- Sexual Assault Centre
- Hamilton Urban Core Community Health Centre
- Alcohol, Drug, and Gambling Services
- Aboriginal Health Centre
- Youth and Newcomers Program

Appendix E: Interview Guide - Key Informant Interview

Research in the area of community mental health and spirituality shows that the work of clergy represents a significant mental health resource for marginalized people who lack access to needed care. Clergy can also serve as an intermediary between disadvantaged communities and mental health professionals. The purpose of this interview is to learn about your views and experiences regarding the integration of spirituality to mental health service delivery and urban outreach work with the homeless community.

Overview of Urban Homelessness in Hamilton:

- From your professional perspective, please describe the seriousness of the urban homelessness situation in Hamilton.
- What barriers and challenges do people experiencing homelessness face on a daily basis? In your view, what issues are important to the homeless community?
- What steps need to be taken to address the issues of homelessness and mental illness?

Description of MH outreach services:

- What are some of the services offered by your agency? What are some of the interventions that are used?
- What role if any does the greater community play? [If none: In what ways could community involvement be beneficial?]

Role of a clergyperson engaged in mental health service delivery?

- What is your view of a clergy's role as a mental health worker within the community?
- What is the value of a faith-based approach to working with people experiencing urban homelessness?

Unique aspects of an outreach minister's role when compared to other mental health professionals:

- What is your professional role as a service provider?
- What is your perspective on the issue of collaboration between clergy and traditional mental health professionals?
- How can clergy assist traditional mental health professionals in their work? What can be taught and what can be learned?

Values and Ethics

- What are some values and moral guidelines that you believe are central to a faith-based approach to service delivery? How can these be incorporated into one's professional role?
- What are some ethical issues that are relevant to your work? Have you encountered any moral dilemmas or a conflict of ethics in your work?

Cultural and Faith Diversity

- How do you approach and work with culturally diverse individuals and people with different faith perspectives?
- What is the value of a primarily Christian minister working with people from diverse backgrounds? How could other faith perspectives be integrated into this work?
- How could the outreach team partner with diverse faith-communities? In what ways could this enhance the team's faith-based approach? How would these partnerships impact consumers?

Perspective of Mental Health and Wellness

- What is your perspective on mental health? What does mental health mean to you?
- How do you view consumers and their issues? (i.e., How do you view the issue of homelessness and mental illness?) Probe: multiple factors relating to these issues.
- What do you believe is the most effective way to facilitate recovery from mental health issues? What is the best way to assist someone in achieving wellness?

Integrating Religion and Spirituality into Mental Health Treatment

- In your view, what role does religion and spirituality play with regards to mental health treatment?
- What is the importance of integrating spirituality into mental health service delivery?

Is there anything else you would like to add that we have not had an opportunity to discuss? Thanks for participating in this interview. I will get back to you in _____ weeks to review quotes and interpretations of them.

Appendix F: Primary Stakeholder Focus Group Interview Guide

Research in the area of community mental health and religion and spirituality show that millions of North Americans seek the help of a clergyperson when experiencing distress and living with mental health issues. Although pastors can serve as an important mental health resource there is not much information on their work in the community. The purpose of this focus group is to learn about your experiences with the outreach team and what it has been like working with Bill the minister specifically. Personal spiritual beliefs are very individual and diverse. For the purposes of this discussion it is important for us to recognize and value different faith perspectives, including the absence of personal faith.

Individual Quality of Life and Personal Stressors

- What difficult things do you face on a daily basis? Describe some ongoing issues.

General Experiences with Outreach Team

- Please describe some of your experiences with people from the mental health outreach team. (Probe: positive/negative? Which professionals in contact with? Feelings/emotions?)
- What kinds of things were offered to you? What resources are available from the outreach team? What was helpful?
- Have you found the outreach workers helpful? Do you value the team? Do you feel as though they respect you and are truly concerned?
- Describe how you feel about how approachable and easy to talk to the team members are.

Experiences with Outreach Pastor

- What was it like spending time with Bill the outreach minister?
- What kind of person is he?
- Is Bill like the other professionals on the team or is he different? (Probe: how he is unique; describe differences.)
- In what ways does your involvement with Bill help you reach your personal goals?

Role of Power

- How much control do you have in choosing your goals and working towards them? Does the outreach team allow you much choice and power in your treatment plan? When working with Bill do you feel like you have power to make your own decisions?

Personal Faith and Spiritual Beliefs

- Do you have religious faith or spiritual beliefs? If so, how important is this to you? Tell me about your faith.
- In what ways does your personal faith impact your outlook on life?
- Do you participate in a faith community? In what ways?

Perspectives on Value of a Faith-based Approach

- Do you believe that spirituality and faith are important for health and wellness?

- Describe how faith-based organizations can help people who are experiencing homelessness? Are there times where these same organizations can cause harm?
- Is it important to integrate spirituality and a faith-based approach into mental health outreach services? Why or why not?
- In what ways would the team be different if there was no outreach minister?
- According to a study conducted in the late 1990's (Weaver, 1998) people experiencing mental health issues are more likely to seek help from a clergyperson than from psychologists and psychiatrists combined. Why do you think this is true?

Empowerment Impacts

- How has your life changed as a result of working with Bill? How have your interactions with Bill changed the way you feel about yourself?
- Describe any lifestyle or behaviour changes since your contact with the outreach team.

Is there anything you would like to add that we haven't had a chance to talk about yet? Thanks for participating in this focus group. I will get back to you in _____ weeks to go over quotes and my interpretations of them.

Appendix G: INFORMATION LETTER FOR OUTREACH MINISTER

The Role of a Clergyperson within an Assertive Community Outreach Team
Principal Investigator: Rachel Fayter; Thesis Advisor: Dr. Richard Walsh-Bowers

Dear Prospective Participant:

I am inviting you to participate in a research study that I am conducting for my Master's thesis in Community Psychology at Wilfrid Laurier University, under the supervision of Dr. Richard Walsh-Bowers. The purpose of this study is to explore the unique aspects of your role as an outreach minister in comparison to other professionals on the team and to learn about the integration of spirituality and a faith-based approach to mental health services delivery. I will be facilitating a discussion about the topics of urban poverty, community mental health, religion, faith, and spirituality. Individual interviews will be held at First-Pilgrim United Church. The interviews will be tape-recorded so that the discussion can later be transcribed and coded for themes. I will also take notes during the interviews.

Your participation in this study would consist of taking part in a series of two to three individual interviews over a period of two months. The questions you will be asked during these interviews are related to your own professional experiences with the mental health outreach team and more specifically your views regarding the integration of spirituality with mental health outreach. This discussion will be related to issues of people living with mental health issues and experiencing urban homelessness. The principal investigator of this research project will conduct the interview. The interview sessions will be recorded to tape on a voice recorder. Each interview will take under an hour. I have attached a copy of the interview questions that will be asked during the interview.

Along with the interview process your participation also includes allowing the principal investigator to accompany you on your outreach work in the form of job shadowing for the purpose of field observations. There will be four to five field observation sessions lasting approximately one half of a regular workday and will occur at various times over the course of the project. Job shadowing will occur only after informed consent is obtained from the involved clients. Possible contexts for observations may include, but are not limited to hospital accompaniments, meetings with social workers, advocacy meetings with landlords for housing related issues, and visits in coffee shops or hospitals.

Please note that your participation in this research is purely voluntary, and that if you choose not to participate that this will not in any way affect your relationship with the church or your participation in any activities or programs. You are under absolutely no obligation to participate in this research.

The only risk that we anticipate is that the job shadowing process may affect regular interactions with clients. The informed consent process is in place to ensure that clients are aware they are not obligated to participate and their relationship with you will in no way be jeopardized. Please note that we want to make the interview process as comfortable as possible for you. Moreover, you are free to refuse to answer any question without penalty. If you leave the discussion before data collection is completed, your responses will be destroyed and omitted from the transcripts. The results of the research will be presented at a professional psychology conference sometime in the following year and submitted for publication in an academic journal. The final report will be submitted to the Wilfrid Laurier University Department of Psychology

and will remain on file there. Another copy of the final report will be left on file at the City of Hamilton Public Health Department.

You may find the interview session personally beneficial, as you will have an opportunity to share some of your professional experiences and perspectives in your own words. As a participant you will be contributing to a new area of research. There is currently no published research on the role of a minister in a mental health outreach team or the experiences of consumers who have worked with a team that integrates spirituality into mental health services. This research is exploratory, meaning that we are trying to learn more about this topic. Participation from individuals who have a lot of information and knowledge from first-hand experiences is critical to expand this body of knowledge.

We ask that you bring the attached consent form to the initial interview session to indicate that you understand the purpose and conditions of participation in the research and agree to participate. The researcher who conducts the interview can answer any questions you have before you sign it, and will clarify with you that your participation is purely voluntary.

Everything you say during the interviews and field observations will be held in the strictest confidence by the researchers. Your name will not be associated with anything you say and your interview responses will be securely stored in a locked filing cabinet in the principal investigator's home.

Due to the nature of the study it will be necessary to use quotations from participants in the final report of the findings. No quotes will contain information that will jeopardize the anonymity of participants (i.e., quotes will not identify who you are). Participants will be informed if their quotations will be used. If you do not want any quotations to be written into the final report you may inform the researcher of this. The accuracy of quotations will be verified with participants before being added to the final document. You may choose to be identified (not be anonymous) in the research project.

If you wish, we will provide you with a copy of the transcript of your interview, which you can review and return to us with your comments. The transcripts will be seen only by the two researchers (Rachel Fayter and Richard Walsh-Bowers). Please note that the transcriber (Rachel Fayter) will keep all information confidential and your name will not be associated in any way with your responses. Finally, once the interview has been transcribed, the tape with your recorded responses will be erased.

When we have completed a draft of the research report, we will make copies available to you and the other research participants. You can read over this draft and send us your feedback. We will then make modifications to the drafts based on the feedback from you and others who participated in the research. The final drafts of the research report will be available to the sites by August 31, 2006.

If you have questions at any time about the research or the procedures, or you experience adverse effects as a result of participating in this study, you may contact either of us, Rachel Fayter, (519) 884-0710 extension 3111, or Dr. Richard Walsh-Bowers, (519) 884-0710, extension 3630. This project has been reviewed and approved by the Research Ethics Board of Wilfrid Laurier University. If you feel your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

Appendix H: Consent Form for Participants

The Role of a Clergyperson within an Assertive Community Outreach Team

Principal Investigator: Rachel Fayter; Thesis Advisor: Dr. Richard Walsh-Bowers,

Department of Psychology, Wilfrid Laurier University.

I have been informed of the purposes and methods of the above named study and what will be required of me to participate in this study. Furthermore, I understand that:

- ✦ I am free to withdraw my participation at any time and to not answer any questions which I do not wish to answer;
- ✦ the researchers will provide me with the complete transcript of the interview, if I wish, which I can review and return to the researchers with my comments;
- ✦ the transcript of my interview will be stored in a locked cabinet to protect my confidentiality;
- ✦ my name will not be associated with any quotes; Unless I request so;
- ✦ the researchers have promised to provide a final report to the City of Hamilton Department of Public Health, who will share this report with me.

Participant's Signature

_____

Researcher's Signature

_____

I have read and understand the information from the informed consent letter. I agree to participate in the interview for this research.

Yes_____ No_____

I agree to have the interview tape-recorded.

Yes _____ No _____

I agree to allow quotations of things that I say to appear in reports or presentations available to the public, but only in an anonymous form, so that I cannot be identified as the source of these quotes.

Yes_____ No _____

Appendix I: INFORMATION LETTER FOR PROFESSIONAL SERVICE PROVIDER PARTICIPANTS

The Role of a Clergyperson within an Assertive Community Outreach Team
Principal Investigator: Rachel Fayter; Thesis Advisor: Dr. Richard Walsh-Bowers

Dear Prospective Participant:

I am inviting you to participate in a research study that I am conducting for my Master's thesis in Community Psychology at Wilfrid Laurier University, under the supervision of Dr. Richard Walsh-Bowers. The purpose of this study is to explore the unique aspects of the outreach minister's role in comparison to other professionals on the team and to learn about the integration of spirituality and a faith-based approach to mental health services delivery. I will be facilitating a discussion about the topics of urban poverty, community mental health, religion, faith, and spirituality. Individual interviews will be held at your office or another place in Hamilton at your convenience. The interviews will be digitally recorded so that the discussion can later be transcribed and coded for themes. I will also take notes during the interview.

Your participation in this study would consist of taking part in an individual interview, The questions you will be asked during this interview are related to your own professional experiences with the mental health outreach team and more specifically your views regarding the integration of spirituality with mental health outreach This will be related to issues of people living with mental health issues and experiencing urban homelessness. The principal investigator of this research project will conduct the interview. The interview session will be recorded on a digital voice recorder. It will take about one hour. I have attached a copy of the interview questions that will be asked during the interview.

Please note that your participation in this research is purely voluntary, and that if you choose not to participate that this will not in any way affect your relationship with the church or your participation in any activities or programs. You are under absolutely no obligation to participate in this research.

The only risk that we anticipate is that the discussion of personal views regarding religion and spirituality may be uncomfortable for some people. Please note that we want to make the interview process as comfortable as possible for you. Moreover, you are free to refuse to answer any question without penalty. If you leave the discussion before data collection is completed, your responses will be destroyed and omitted from the transcripts. The results of the research will be presented at a professional psychology conference sometime in the following year and submitted for publication in an academic journal. The final report will be submitted to the Wilfrid Laurier University Department of Psychology and will remain on file there. Another copy of the final report will be left on file at the City of Hamilton Public Health Department.

You may find the interview session personally beneficial, as you will have an opportunity to share some of your professional experiences and perspectives in your own words. As a participant you will be contributing to a new area of research. There is currently no published research on the role of a minister in a mental health outreach team or the experiences of consumers who have worked with a team that integrates spirituality into mental health services. This research is exploratory, meaning that we are trying to learn more about this topic. Participation from individuals who have a lot of information and knowledge from first-hand experiences is critical to expand this body of knowledge.

We ask that you bring the attached consent form to the interview session to indicate that you understand the purpose and conditions of participation in the research and agree to participate. The researcher who conducts the interview can answer any questions you have before you sign it, and will clarify with you that your participation is purely voluntary.

Everything you say during the interview will be held in the strictest confidence by the researchers. Your name will not be associated with anything you say and your interview responses will be securely stored in a locked filing cabinet in the principal investigator's home.

Due to the nature of the study it will be necessary to use quotations from participants in the final report of the findings. No quotes will contain information that will jeopardize the anonymity of participants (i.e., quotes will not identify who you are). Participants will be informed if their quotations will be used. If you do not want any quotations to be written into the final report you may inform the researcher of this. The accuracy of quotations will be verified with participants before being added to the final document. You may choose to be identified (not be anonymous) in the research project.

If you wish, we will provide you with a copy of the transcript of your interview, which you can review and return to us with your comments. The transcripts will be seen only by the two researchers (Rachel Fayter and Richard Walsh-Bowers). Please note that the transcriber (Rachel Fayter) will keep all information confidential and your name will not be associated in any way with your responses. Finally, once the interview has been transcribed, the tape with your recorded responses will be erased.

When we have completed a draft of the research report, we will make copies available to you and the other research participants. You can read over this draft and send us your feedback. We will then make modifications to the drafts based on the feedback from you and others who participated in the research. The final drafts of the research report will be available to the sites by August 31, 2006.

If you have questions at any time about the research or the procedures, or you experience adverse effects as a result of participating in this study, you may contact either of us, Rachel Fayter, (519) 884-0710 extension 3111, or Dr. Richard Walsh-Bowers, (519) 884-0710, extension 3630. This project has been reviewed and approved by the Research Ethics Board of Wilfrid Laurier University. If you feel your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

Appendix J: INFORMATION LETTER FOR FOCUS GROUP PARTICIPANTS

The Role of a Clergyperson within an Assertive Community Outreach Team
Principal Investigator: Rachel Fayter; Thesis Advisor: Dr. Richard Walsh-Bowers

Dear Prospective Participant:

I am inviting you to participate in a research study that I am conducting for my Master's thesis in Community Psychology at Wilfrid Laurier University, under the supervision of Dr. Richard Walsh-Bowers. The purpose of this study is to explore the unique aspects of the outreach minister's role in comparison to other professionals on the team and to learn about consumers' experiences with the mental health outreach team. I will be facilitating a discussion about the topics of urban poverty, mental health, religion, faith, and spirituality.
Two focus groups will be held at First-Pilgrim United Church. Overall there will be between ten to sixteen participants. The focus group interviews will be tape-recorded so that the discussion can later be transcribed and coded for themes. I will also take notes during the interview.

Your participation in this study would consist of taking part in a focus group, which will contain between five and eight participants. A focus group is a type of group discussion where people give responses to a set of questions and then discuss these responses together. The questions you will be asked at this focus group are related to your own personal experiences with the mental health outreach team and more specifically with Bill the minister. This will be related to living with mental health issues and experiencing urban homelessness. The principal investigator will facilitate a focus group. The focus group session will be recorded to tape on a voice recorder. Your participation in this study requires consent to have your voice recorded. If you are uncomfortable with this procedure but would still like to be involved we could arrange to speak individually without a recording device. It will take about one to two hours, with breaks if necessary. I have attached a copy of the interview questions that will be asked during the interview. One month following the initial meeting, I will invite participants to attend another session in which the results or findings of the research will be discussed and confirmed by those who were involved. At this time I will show the participants the transcribed (typed) focus group interview and ask for their feedback on the themes of the focus group discussion. This meeting will take less than one hour and will not be tape-recorded.

Please note that your participation in this research is purely voluntary, and that if you choose not to participate that this will not in any way affect your relationship with the church or your participation in any activities or programs. You are under absolutely no obligation to participate in this research.

The only risk that we anticipate is that some of the questions may trigger experiences that caused you distress. For example, you may feel uncomfortable speaking about the daily stressors you face. Please note that we want to make the focus group as comfortable as possible for you. Moreover, you are free to refuse to answer any question without penalty. If you leave the focus group before data collection is completed, your responses will be destroyed and omitted from the transcripts. The results of the research will be presented at a professional psychology conference and submitted for publication in an academic journal. The final report will be submitted to the Wilfrid Laurier University Department of Psychology and will remain on file there. Another copy of the final report will be left on file at the City of Hamilton Public Health Department.

You may find the focus group personally beneficial, as you will have an opportunity to share some of your experiences in your own words. Additionally, participation in a focus group is often enjoyable because of the informal social atmosphere of the interview. People often like having group discussions with similar others, and refreshments will be provided. As a participant you will be contributing to a new area of research. There is currently no published research on the role of a minister in a mental health outreach team or the experiences of consumers who have worked with a team that integrates spirituality into mental health services. This research is exploratory, meaning that we are trying to learn more about this topic. Participation from individuals who have a lot of information and knowledge from first-hand experiences is critical to expand this body of knowledge.

We ask that you bring the attached consent form to the focus group to indicate that you understand the purpose and conditions of participation in the research and agree to participate. The researchers who conduct the focus groups can answer any questions you have before you sign it, and we will clarify with you that your participation is purely voluntary.

Everything you say during the interview will be held in the strictest confidence by the researchers. Your name will not be associated with anything you say and your interview responses will be securely stored in a locked filing cabinet in the principal investigator's home. While we will encourage all focus group participants to keep what is said in the focus groups confidential, we cannot guarantee that other participants will adhere to this request.

Due to the nature of the study it will be necessary to use quotations from participants in the final report of the findings. No quotes will contain information that will jeopardize the anonymity of participants (i.e., quotes will not identify who you are). Participants will be informed if their quotations will be used. If you do not want any quotations to be written into the final report you may inform the researcher of this. If during the discussion you say something aloud that you do not wish to be included in the study you can ask to have your statement immediately erased from the tape. The accuracy of quotations will be verified with participants before being added to the final document. You may choose to be identified (not be anonymous) in the research project.

If you wish, we will provide you with a copy of the transcript of your focus group, which you can review and return to us with your comments. The transcripts will be seen only by the two researchers (Rachel Fayter and Richard Walsh-Bowers) and by a couple of your peers who have been invited to both participate in the discussion and assist with the data analysis. Please note that the transcriber (Rachel Fayter) will keep all information confidential and your name will not be associated in any way with your responses. Finally, once the focus group has been transcribed, the tape with your recorded responses will be erased.

When we have completed a draft of the research report, we will make copies available to you and the other focus group participants. You can read over this draft and send us your feedback. We will then make modifications to the drafts based on the feedback from you and others who participated in the research. The final drafts of the research report will be available by August 31, 2006.

If you have questions at any time about the research or the procedures, or you experience adverse effects as a result of participating in this study, you may contact either of us, Rachel Fayter, (519) 884-0710 extension 3111, or Dr. Richard Walsh-Bowers, (519) 884-0710, extension 3630. This project has been reviewed and approved by the Research Ethics Board of Wilfrid Laurier University. If you feel your rights as a participant in research have been violated

during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

Appendix K: Clergy Interviews - Table of categories from open coding:

Code	Description of Code	Example Quotation
General Outreach Job Duties	General job duties, specific hours, and meeting times common to all team members	*"We take turns working evenings because the program runs from 8:30 in the morning to 9 at night, Monday to Friday, so from 4:30 until 9, one of us covers that each week, so I do every Monday night."*
Overview of Outreach Team	General discussion of the way the team operates.	*"a couple of staff are employed by housing help centres. They do half a day a week on the desk at the housing help."*
Client Diversity	Mention of different client groups, such as the prevalence of male clients or discussion of aboriginal groups.	*"I tend to work with more men than women. There's no sort of intent around that, it's just the way it happens. We get more male clients than female."*
Links with outside agencies	Providing referrals. Relationships with related agencies. Collaboration between team and other organizations	*"One of the best options for short-term housing is the YMCA. I have good rapport with the staff there, so sometimes [we] just negotiate a room for somebody in a rooming house"*
Practical Supports	Assisting clients with obtaining ID, transportations, clothes, completing paperwork, etc.	*"This morning we gave out I don't know how many hundred meal tickets to the Salvation Army. We do that once a month."*
Advocacy	Phone calls and letter writing; Meetings with other agencies and professionals on behalf of a client.	*"I go with people to their appointments with Ontario Disabilities or with program workers when there's a lot of, sort of, mediating and troubleshooting with clients who are having difficulty with their Ontario Works or ODSP."*
Companionship, listening, and presence	Simply being there for the person without any professional agenda. Active listening without offering	*"I can spend six hours sitting with someone in, at the hospital waiting to be assessed."*

	any advice, remaining calm.	
Housing Emergencies	Assisting individuals and families to find housing or temporary shelter when they are o the streets.	*"I remember one time one of the shelters phoned and they had a family show up and they weren't equipped to deal with a family. It was a mother, father and three kids from Newfoundland that just arrived in Hamilton with no place to stay and no money."*
Comprehensive understanding of mental health issues	A general understanding of the clinical signs, symptoms, and impacts of mental health issues along with a deeper understanding of the systemic and sociocultural issues that people with mental health issues face.	*"I certainly share a view of health overall as mental and physical and spiritual and try not to separate them."* *"As far as mental illness is concerned, a bad mistake was made when they decided to release most of the patients that they had in institutions back into the community. This was grossly miscalculated because there weren't enough places in the community for people to go."*
Bereavement issues	Assisting clients to deal with death and dying. Spiritual guidance and counseling for clients who have had someone close to them pass on.	*"She had just had five stillbirths, one after the other and really needed some bereavement work around that."*
Performing spiritual ceremonies	The performance or practice of any type of spiritual or religious ceremony.	*"I did a memorial service at one of the lodging homes on the Mountain...there had been a sudden death of one of the residents."*
Pastoral care/Spiritual support	Offering some type of spiritual support to clients or guidance relate to faith-based issues. Discussion of religious issues and questions. Care, comfort, consolation, and counseling.	*"Usually one of the things that come up for him are some things he's doing which he thinks he's being punished for, that God is angry with him, so it's often the same conversation we have; he just needs to be hearing it again, that God loves him regardless of his*

		illness."
Accessible to everyone	Accessibility of the outreach minister. Making oneself and services accessible to clients. Efforts are made to ensure that religious support and spiritual services are easy to access and people feel safe doing so.	*"We're just a place they can come and knock on the door and they don't always have to have an appointment."* *"Most people seem to be fairly comfortable and safe coming there even though it is a church and they may not have any interest or allegiance to the religious community, but they feel safe coming."*
Accompanying team members/Support for team members	Outreach minister goes on a call or visit with a team member to offer support. Team member refers a client to Bill for spiritual issues. Team member requests some specific spiritual service from Bill.	*"I didn't even know the people who had died but it was my co-workers who, the public health nurses who go to that home regularly, who, asked if I'd be willing to do that, so I did."*
Value for all human beings	Not giving up on someone despite a bleak situation (e.g., serious addictions, relapse). Valuing the inherent worth and dignity of all persons. Conveying this to the client as an expression of hope. Having trust in the person.	*"don't give up on anybody. That's important to me. Treating people with as much dignity as you can, treating people fairly."* *"my approach I suppose, is simply to attempt to treat them as people, know their names, at least their first names and not have any pre-conditions for dealing with them."*
Practicing theological values	Theological values that guide the work of the clergy. Living and practicing the values without necessarily talking about them explicitly.	*"Jesus talking in the temple about, I come to proclaim good news to the poor. Matthew 25 about feeding the sick and visiting people in prison...Those are the ones that I don't think about consciously but they sort of underline what I do."*
Critical reflection on religious influences	The ability of the clergyperson to look critically one one's role and the influence of religious institutions. The understanding that some	*"There are probably an equal number of people who don't trust the religious community for the same reasons – bad experiences."* *"Once in awhile there's*

	clients may have had bad experiences with the church or clergy. Also, the knowledge that some clients may experience religious delusions and traditional MH professionals may be apprehensive about the impacts a clergy can have on a client's mental health.	*someone who doesn't come in because it is a church and it's just going to bring back bad memories for them or somebody's told them something that makes them nervous."*
Critical self-reflection	The ability to look critically at oneself and personally reflect on one's own strengths and shortcomings. Considering one's personal values and looking at how these may come into conflict with one's work	*"I do have some recognition of the privilege I have of being that and of being in the majority, and I guess some sense that if somebody wants to talk to a colleague who's black or aboriginal, I'll try and make that happen."*
Unique challenges for clergy engaged in multidisciplinary collaboration	Some barriers or obstacles that the outreach pastor has to overcome when working with professionals outside of the religious community. Some professionals have negative views about the church and the role of the clergy. Some see no value in a minister's work.	*"it depends on the individual psychiatrist. It also depends on the sort of networking we're able to do."* *"I've had more problems with difficult social workers than I have with the traditional medical community."*
Accepting and tolerant of diverse faith perspectives	Diverse faith perspectives or the absence of faith is not a salient issue for the client/minister relationship. Different religious beliefs and perspectives are valued and respected. The clients are also accepting of the minister having a different faith background.	*"My relationship with any of the clients is sort of irrespective of whether they have a faith perspective or not."* *"Doesn't seem to matter to them at all that I'm not one of them in that way." – referring to clients having different religious practices than himself.*
Sharing power	Minister does not take the role of the expert. Rather than presenting as an expert the pastor acknowledges that clients are experts in their own lives and that things can be learned from them. Relationship built on equality. Allowing clients to	*"Me personally, tend to look at it as I've got something to learn here, from these folks more than they have anything to get from me because we're so ignorant here about other faiths for the most part and I look on that as*

	have control, power, and choice.	*opportunities to learn something for myself." (maybe move to accepting and tolerant code) "When you have literally nothing, at least give them the dignity of making a choice."*
Issues experienced by clients	The types of issues that outreach clients experience. Examples of client issues including MHI's, housing emergencies, poverty, violence, personal crises. Focus of the client population. Specific issues that people face which would result in a referral to the outreach team.	*"The problem involves, as far as street-oriented people are concerned, the inability to stabilize their lives in any lasting way. The difficulty they have is just coping with any kind of organization in their lives and that's because of a number of factors."*
Critical skills for successful mental health outreach	Some skills that are important for outreach workers to possess in order to be successful in their position.	*"it isn't always possible, but not taking things personally when somebody gets upset. You know it's probably not because of something I've done; it's other stuff and I'm the target."*
Virtuous moral code	Ethics and values that are critical to outreach work. Important moral guidelines for working with marginalized and oppressed individuals. Ethics and values at the core of one's work. When an ethical dilemma or challenge arises, the focus is on the best interest of the client.	*"not taking action that I ethically feel I should take because it may have negative consequences for the client at the other end." "The client is always number one...most of us will sort of go that extra mile to uphold that and that's a value I think that, everything that we're doing here is supposed to be focused on the client."*
Ecumenical spirit	Interfaith collaboration. Perceiving a value in partnering with diverse faith communities. Valuing diverse perspectives and incorporating this into outreach work. "Ecumenical Spirit" – desire to promote	*"Many of us, certainly in the United Church, tried for years to do things collaboratively with the other downtown churches...I think the future of collaboration is probably more interfaith than just within the Christian*

	cooperation and better understanding between different religious groups.	*community itself."*
Recognition of systemic issues (looking at issues from multiple levels)	A comprehensive understanding and awareness of social issues from multiple levels of analysis. The realization that systemic factors play a significant role in social problems. Not looking strictly at the individual and blaming the victim. Looking at the "Big Picture" and considering the various factors that play into client issues.	*"with the law, cause a lot of the people in the psych wards in the jails shouldn't be there. I mean they're not criminals but they're not able or willing to address their behaviors which is caused by their illness, so they do something stupid and end up in jail."* *"the closing of the hospitals is a big one."*
Social resources	Meets an individual's basic needs of socializing. A way for clients to meet people and make friends. This can be coded as both a role and an outcome/impact for the client. A recognition of the value of social support and healthy relationships in recovering from mental illness. Part of the work on an outreach minister is to help build healthy relationships with clients and model positive social skills so they can have positive relationships with other and be able to trust.	*"I think the engagement piece that we do with folks, is often the most important thing that we do." It's fine to work on their housing and get people bus tickets and all of that, but if you can have a positive trusting relationship then it's often a good spin off from that, leads to better health."*
Fosters a sense of community	Overall sense of belonging to a larger community with a greater purpose. (More than just interpersonal relationships.) Part of the role of the clergy us to help engage clients with a group of peers in order to facilitate the creation of a sense of community among clients. This is also a client impact. Having a SOC reduces feelings of isolation. A value in community.	*"get them involved in a group, or encourage them to go to drop-ins where they're going to meet some people and not feel so isolated."* *"The creation of small communities in some way, communities of trust, and I think, you almost always have to have an element of faith base in this, in these communities."* *"establishing kind of a*

	Recognition that belonging to a community is important.	*community of trust, safety."*

Appendix L: Professional Service Provider Interviews - Table of Categories from Open Coding

Code:	**Description of Code:**	**Example Quotation:**
Relationship Building	-Part of the role of an outreach minister is to build trusting relationships with clients so that there is some sense of familiarity and clients will be willing to work with Bill. -Engaging people. -Good sense of humour	*"He meets the people on the street in that whole outreach role, engaging people and relationship building..."* *"He has a sense of humour which is all-important when you're dealing with anyone, anywhere. I mean, you have to have that sense of humour."* *"Sometimes it's just about building relationships with the client."* *"That's how I see outreach...that relationship building and then bridging them to the help they need."*
Spiritual Dimension	-There is a clear spiritual dimension to Bill's role as an outreach minister. -He does not necessarily speak specifically about the church or a religion per se, but he does recognize that "street people" have spiritual needs. - Allows clients to guide the process and does not force any discussion of spiritual issues.	*"The beauty of Bill or any clergy on a team, is that it is so ingrained...he's a social worker in his work as well, but he has this extra dimension and I think it's wonderful because for years and years we never recognized...we recognized the mental, the emotional, the physical, the environmental...but we don't look at that spiritual part that is part of all of us as human beings."* *"What is different is that Bill does bring a spiritual dimension to the work..."*
Sense of Hope	-For those clients with personal faith or spiritual beliefs their resulting sense of hope is something very important that they hang on to, even when they have nothing else. - Clients may not have any connection to a church or	*"But they really have this belief in God out there, a higher being...and for some of them that is the only hope in their life, they kind of hang on to that even if they have nothing else."* *"I think homeless people are just like the rest of*

	formal religion, but their sense of hope is linked to their relationship with Bill and their own personal belief in a higher being. -Hope for something more, a better life.	*society. I think we hear it more because people who are homeless have lost so much...I think these people have lost everything, or many of them have lost almost everything, so when you've lost everything there's that one thing you can hang on to, that kind of hope..."*
Spiritual Connection	-Bill is able to connect with clients when other team members are not able to. -Some impoverished people living with MHI's have a clear spiritual dimension to their lives. For some outreach clients, recognizing this dimension is the only way to connect with them. They may not be able to relate to an outreach worker in any way other than to connect on a spiritual level. -Connecting through faith, not a specific religious denomination. -Helping the client to reconnect with their spiritual beliefs and finding ways that are good for them to meet this need.	*"...saw him as a religious, spiritual leader and so just having that on our team is so unique and unlike anything anyone else can bring to the table. And it does mean that we can connect with some of the clients we wouldn't be able to connect with, or as easily."* *"Having a clergyperson on this team, any culture is going to connect with that."* *"They need to find their own way back to their spirituality, whether they find it through drawing and painting, whether they find it through Gestalt, whether they find it through talking as you would with your psychiatric counselor or whether they find it in a form of worship that is not the one they were born with."* *"I think there's a core of our humanness that has a connection to the spiritual."*
Companionship, listening, and presence	-A salient component of Bill's role is his calm approach in working with clients. He has excellent listening skills and a calming presence. -He is fully there for the person in times of need. He	*"Bill has a very nice manner about him...he's a real listener, he has a very calming affect on people."* *"That's one thing I've seen with Bill. He really listens to people. And I mean really listens. He really lets them*

	has a quiet nature which allows him to be present without assuming a traditional professional role with an agenda. -Focus on emotional and spiritual needs.	*speak and backs off about all the things he knows. He just keeps to himself and he just hears the person speak. Not just their words, but everything about them."* *"Actually hearing the person and hearing their experience is beneficial and certainly I think clergy would do that. They would focus more on, on what's going on for you and what are your emotions than what's your diagnosis, cause ultimately who really cares."*
Safety and Trust	- Bill strives to create an environment in which clients feel a sense of safety and security. He has a non-threatening attitude and is not intimidating. - Clients place a certain degree of trust in Bill because of his professional stance and religious affiliation.	*"He's not intimidating in any way, which is huge, so a non-threatening attitude."* *"I've heard clients call him Reverend Bill" and so they see him sort of as a spiritual leader and that maybe allows them greater trust or comfort in their relationship with him."* *"Because of his religious background people have faith in him in a sense, or trust him kind of de facto, which is a good thing for sure, especially for people who are kind of distrustful and haven't had the most success with the whole social services experience."* *"I think the underlying issue for the population in the street and facing the ramifications of that is, one is safety and I think clergy can offer a form of safety that nobody else can."*
Transcendence	-Based on their own personal beliefs and through their relationship with Bill, clients experience a sense of	*"...somebody who says, 'Geez, I have a sense that there's something bigger than me but I don't know*

	transcendence, or searching for something more. They believe there is something greater out there. They look beyond themselves. -Even when as individual may claim to have no religious beliefs, they still have a spiritual dimension and seem to be reaching out to find something more. -Seeking transcendence as a way to get "up and out of myself."	*what it is,' and being given tools and resources to explore that a little bit in a manner that's safe."* *"You meet the odd person that will say, 'I'm an atheist. I don't believe in God. I don't believe in an afterlife of any kind'...yet when they talk there's still this kind of searching for something more. Transcendence. Something greater than what we have here."*
Collaboration	- Bill will seek the help of other team members for their professional expertise. - An important aspect of Bill's role is to collaborate with other professionals and work as part of a team. - Collaboration is seen as being critical for working with marginalized people. They often require multiple and varying types of support. - Because of Bill's professional role as a clergyperson he is able to complement other professional approaches to create a more holistic type of care. The client is cared for mentally, physically, emotionally, and spiritually. -Connecting the secular services to faith-based approaches.	*"So Bill asked me to just because I'm a nurse. He asked for my nursing skills that day."* (referring to an outreach call I went on with A and Bill) *"And Bill is just one other petal on the flower, but the flower would be incomplete without Bill."* *"...good collaboration, rarely goes wrong in my view, I think that's a very traditional Western medical model, benefits from [a] more holistic approach, adding a spiritual component into that."* *"...social services tend to be secular and separated from religion so to be able to facilitate that connection is really important and seeing that first hand..."* *"...requires a multidisciplinary team of clergy, mental health experts...[people with] emergency response training, psychologists and/or psychiatrists who have access to appropriate medication and also to educational resource*

		material to provide to the client."
Reciprocal Learning	-Being on an interdisciplinary team allows for a learning exchange between Bill, and the other team members. They each learn things about their co-workers' profession. -Attempting to teach and learn from other mental health professionals in the community.	*"Obviously clergy can learn from mental health professionals the actual sort of symptoms."* *"I think you gotta realize that, um, nobody knows everything and you need to share."* *"I think that there's a misconception on both sides that clergy sees the mental health profession as being enabling and the mental health professional sees the clergy as being enabling. They see each other as being too soft. And I think they need to learn more about one another in order to dispel that particular myth."* *"Because a clergyperson is on the team, I think the team has grown because they've learned from him. Now, he's learned from them too. That's the whole idea."*
Personal Engagement	- Putting yourself in your work. -Because trust is such a huge issue for "street people", in order for them to build trust, outreach workers must show who they really are to their clients. -Sharing a bit of yourself. -Having clear motivations and understanding of why you are engaged in this type of work.	*"When you're doing outreach... the big issue is trust... if you expect them to spill their guts to you, but you give nothing of yourself. Now, I'm not saying you spill your guts to people, but if you don't share a little bit of yourself and who you are with them, it ain't gonna happen."* *"I think your motivations for doing this kind of work would need to be clearly understood. Because if you're doing this kind of work because you're going to save people, you're in the wrong business. If you're*