RECOVERY AS A GUIDE FOR ENVIRONMENTAL ENHANCEMENT IN GROUP HOMES FOR PEOPLE WITH A MENTAL ILLNESS: A SOCIAL-ECOLOGICAL APPROACH

By

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Abstract

Background: As the paradigm underlying mental health care slowly shifts from an approach primarily institutional and medical in its orientation toward one more community-based and recovery-oriented, housing needs have come to the forefront. Many people with persistent mental illness accept group home living situations that do not necessarily meet their needs, and do not align with the recovery vision. Research focused on recovery for residents of group homes is all but absent in the literature.

Purpose: The purpose of this study was to identify the challenges and opportunities for enabling group homes to increase their capacity to serve as an environment that integrates the recovery vision.

Method: Using ethnographic methods, this case study examined the cultural milieu of a group home, how recovery is understood within the setting, and the impact of policies and practices on enacting the recovery vision. By converging multiple strategies for data collection (participant observation, key informant interviews, and document analysis), a multi-level perspective was achieved. The use of the social-ecological model, with its attention to multiple levels of influence, emerged as a highly relevant perspective, without which the recovery vision cannot be realized.

Findings: The culture within the home revealed a comfortable atmosphere, basic needs being met, access to planned and unplanned activity, and caring relationships with staff, which contribute to a place attachment that could be difficult to loosen. There is a lack of awareness of recovery-enabling practice at multiple levels, which emerged as a key challenge to its implementation. Although some policies at the government level support self-sufficiency as an important objective, others make progress towards this ideal
difficult, if not impossible, such as those related to funding. The focus on enhancing well-being in the day-to-day setting subsumes the growth goals associated with recovery.

**Conclusion:** Integrating the recovery vision within group home could benefit from confronting well-established approaches, embracing advocacy roles, and addressing mechanisms for change at multiple levels. Only then will people with mental illness living in group homes reap the benefits of social justice, social inclusion and full citizenship that come with recovery.
Acknowledgements

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Table of Contents

Abstract ................................................................................................................................. ii
Acknowledgements .............................................................................................................. iv
Chapter 1 Introduction ......................................................................................................... 1
  Shifting housing paradigms: Deinstitutionalization and community integration ............. 1
  Housing and mental illness ......................................................................................... 4
  Community-based housing models ........................................................................... 6
  Toward recovery-oriented services ........................................................................... 12
  Knowledge translation ............................................................................................... 18
  This thesis ................................................................................................................... 20
Chapter 2 From where I sit: Reflexivity statement and theoretical perspective ............... 23
  Examining reflexivity ................................................................................................. 23
  Reflexivity statement ............................................................................................... 28
  Influence of researcher’s assumptions ...................................................................... 28
  Impact of researcher’s expectations .......................................................................... 29
  Examining researcher’s behaviour and emotions ...................................................... 30
  Probing unconscious responses ................................................................................ 31
  Theoretical perspective: The social-ecological approach to recovery ....................... 32
Chapter 3 ............................................................................................................................. 37
The relationship between housing and recovery: A Scoping Review of the literature ...... 37
  Method ......................................................................................................................... 37
  Findings ....................................................................................................................... 39
  Recovery and the Major Approaches to Housing ......................................................... 41
    Treatment first approaches ................................................................................... 42
    Housing first/supported housing approaches ....................................................... 50
    Hybrid approach ................................................................................................... 56
  Recovery in the housing literature ............................................................................ 57
  Housing: An enabler of recovery ............................................................................. 64
    Housing stability .................................................................................................... 64
    Housing versus a home ......................................................................................... 66
    A home as a foundation for recovery .................................................................. 68
  Housing-related barriers .......................................................................................... 69
    Social exclusion ..................................................................................................... 69
<table>
<thead>
<tr>
<th>Chapter 6 Discussion</th>
<th>Chapter 5 Findings</th>
<th>Chapter 4 Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of findings</td>
<td>The current cultural milieu</td>
<td>Purpose</td>
</tr>
<tr>
<td>How recovery is understood</td>
<td>The house</td>
<td>Research design</td>
</tr>
<tr>
<td>Influence of policies and practices on enacting the recovery vision</td>
<td>The neighbourhood</td>
<td>Case selection</td>
</tr>
<tr>
<td>Deposing the dominant cultural narrative</td>
<td>The residents</td>
<td>Definition of the case</td>
</tr>
<tr>
<td></td>
<td>The staff</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Issues of funding</td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>Housing or a mental health program?</td>
<td>Enhancing trustworthiness</td>
</tr>
<tr>
<td></td>
<td>General approach/program</td>
<td>Ethical issues</td>
</tr>
<tr>
<td></td>
<td>The custodial nature of the home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enacting case plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How recovery is understood in relationship to this group home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influence of policies and practices on enacting the recovery vision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chapter 6 Discussion</td>
<td></td>
</tr>
<tr>
<td>Sub-standard living conditions</td>
<td>Chapter 5 Findings</td>
<td>Chapter 4 Methodology</td>
</tr>
<tr>
<td>Lack of choice</td>
<td>The current cultural milieu</td>
<td>Purpose</td>
</tr>
<tr>
<td>Discussion</td>
<td>The house</td>
<td>Research design</td>
</tr>
<tr>
<td>Limitations</td>
<td>The neighbourhood</td>
<td>Case selection</td>
</tr>
<tr>
<td>Conclusions</td>
<td>The residents</td>
<td>Definition of the case</td>
</tr>
<tr>
<td></td>
<td>The staff</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Issues of funding</td>
<td>Data analysis</td>
</tr>
<tr>
<td></td>
<td>Housing or a mental health program?</td>
<td>Enhancing trustworthiness</td>
</tr>
<tr>
<td></td>
<td>General approach/program</td>
<td>Ethical issues</td>
</tr>
<tr>
<td></td>
<td>The custodial nature of the home</td>
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<tr>
<td></td>
<td>Enacting case plans</td>
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<td></td>
<td>Routine</td>
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<td></td>
<td>How recovery is understood in relationship to this group home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influence of policies and practices on enacting the recovery vision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chapter 6 Discussion</td>
<td></td>
</tr>
</tbody>
</table>
Mixed messages: Toward recovery, or not? ................................................................. 157
Addressing the multi-level lack of awareness of recovery ........................................ 162
Implications for practice/mechanisms for change .................................................... 169
Limitations ................................................................................................................... 171
For further study .......................................................................................................... 171
Bibliography ................................................................................................................ 173
Appendix A Papers Included in Scoping Review ....................................................... 186
Appendix B Observation Guide .................................................................................... 197
Appendix C Document Analysis Guide ...................................................................... 198
Appendix D Interview Guides ..................................................................................... 199
Appendix E Consent forms ......................................................................................... 205
Appendix F Ethics approval ......................................................................................... 219
List of Tables

Table 3.1: Method/type of paper.................................................................40
Table 3.2: Disciplines of lead researcher completing the research.........................41
Table 3.3: Geographical locations of research..................................................41
Table 3.4: Linking housing and recovery: Exemplar quotes..................................59
Table 4.1: Key informant interviews................................................................90
Table 4.2: Documents included in document review..............................................91
Table 5.1: Organizationally- and individually-derived approaches to enacting case plans.................................................................119
Table 5.2: Recovery perspectives.......................................................................135
Table 5.3: Mission, vision and values of the group home......................................141
Table 6.1: Challenges and opportunities for integrating recovery...........................151
Table 6.2: Service standards..............................................................................168
Table 6.3: Multi-level mechanisms for change toward recovery............................169
Chapter 1

Introduction

Shifting housing paradigms: Deinstitutionalization and community integration

Deinstitutionalization, the process of repatriating individuals with a persistent mental illness from institutions back to the community that started in the 1960’s, created a widespread need for housing options. Faced with limited income and resources, under-developed daily living skills, few social supports, fluctuating symptoms, and stigma (Kyle & Dunn, 2008), and families and communities unprepared or unwilling to accommodate their needs, many displaced people with a mental illness ended up in congregated living situations in inner-city ghettos with few supports (Walker & Seasons, 2002). Complex housing issues that accompany them into the community are now addressed by a wide range of housing programs and services. Although a range of housing models has emerged, choices are not consistently available. The need is great, and accessing appropriate, sustainable housing remains problematic. Lacking options, many people with persistent mental illness accept group home living situations that don’t necessarily meet their needs (Edge & Wilton, 2009). The policies associated with deinstitutionalization continue, with more psychiatric bed closures reported each year (Sealy & Whitehead, 2004). New Brunswick alone has seen a considerable shift, with institutional facilities of over 20 beds reducing beds from 1,115 in 1984/5 to 708 in 2009/10, while at the same time, beds in group home facilities that have 19 or fewer beds
have more than doubled, from 757 in 1984/5 to 1,690 in 2009/10 (Statcan, 2012). Despite this shift, there has been little supporting evidence tracking outcomes for those involved.

In the wake of deinstitutionalization, the paradigm underlying mental health care has been shifting, albeit slowly, from an approach primarily institutional and medical in its orientation toward one more community-based and, more recently, recovery-oriented. In Canada, with the release of the government-commissioned “Kirby Report,” Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada (Kirby & Keon, 2006), recovery was identified as a guiding principle for mental health reform. Indicative of political will to act on the report, the Mental Health Commission of Canada (MHCC) was established in 2007. Recovery is now acknowledged as one of the strategic priorities by the MHCC in Canada’s new mental health strategy, Changing Directions, Changing Lives (MHCC, 2012b). The MHCC suggests that recovery involves building on individual, family, cultural and community strengths, and defines it as

…a process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being [and enabled to] enjoy a meaningful life in their community while striving to achieve their full potential. (Kirby, Howlett, & Chodos, 2009, p. 122)

This federally-supported philosophy is being embraced through a variety of provincial government initiatives, including New Brunswick, where its newly-released mental health care strategy, The Action Plan for Mental Health in New Brunswick 2011-18 commits to shift to a recovery-based model of practice (Dube, 2011).
Based on the underlying principles of hope, empowerment, choice and responsibility, the recovery-oriented approach to the development, provision, and evaluation of mental health services is gaining increased national and international attention (Mulvale & Bartram, 2009). This shift away from institutional care is widely regarded to be an improvement in mental health care, but, with the ongoing emphasis on individual-level treatment, and little attention to building on community strengths, it has fallen short in enabling people with mental illness to enjoy full community integration and well-being in their communities.

Recovery is not a treatment to be imposed on people, but rather involves the creation of an environment where recovery can occur. Aligning with recovery, Ridgway and Zipple (1990) clarified multiple aspects of the desired shift, which remain relevant today. They highlighted that with respect to housing specifically, there was a need for

… shifting toward homes, not residential treatment settings; choices, not placement; normal roles, not client roles; client control, not staff control; physical and social integration, not segregated and congregate grouping by disability; in vivo learning in permanent settings, not preparatory learning in transitional settings; individualized flexible services and supports, not standardized levels of service; most facilitative, not least restrictive environments; and long-term supports and interdependence, not independence. (n.p)

Furthermore, issues such as stigma and discrimination cannot be ignored if people with mental illness are to integrate not just physically, but socially and psychologically into their communities (Cohen, Pathak, Ramirez, & Vahia, 2009). Thus, increasingly guided by the vision of recovery, mental health services are recognizing the need to broaden beyond individual approaches to include attention to issues of social justice, social
inclusion and full citizenship for individuals with mental illness (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009; Piat & Sabetti, 2012).

**Housing and mental illness**

Lying at the interface between the person and the community, Browne and Hemsley assert that no component of a community mental health system is more important than decent, affordable housing (2010a, 2010b). It has been described as “a necessary health service” (Sylvestre, et al., 2007, p. 91) and the single most important service required by people with mental illness to live independently in the community (O'Malley & Croucher, 2005). Having a home is a most intimate component of one’s being, and as Sylvestre and colleagues describe, “a relatively unique aspect of the health care system in that it significantly touches domains that are associated with privacy, emotional attachment, and personal control” (2007, p. 92). One’s housing can also be seen as a marker of status, with moving to a higher level of supervision seen as a setback, and moving to more independent settings seen as progress (Dorvil, Morin, Beaulieu, & Robert, 2005).

While many of the millions of Canadians with mental illness do live and work in the community without special attention to their housing needs, thousands are inappropriately housed (MHCC, 2011), and struggle to improve the situation. Often lacking choices, many reside with parents, a circumstance which can be stressful for both parties, particularly if relationships are conflicted or parents perceive the burden to be overwhelming (Bradshaw, Armour, & Roseborough, 2007; Chesters, Fletcher, & Jones,
Some people are able to access suitable housing with appropriate supports, but many sit on waiting lists, remain stuck in hospitals, or end up in boarding houses, shelters, on the street, or in jail. Often living in conditions influenced by poverty, as many as 520,700 people with mental illness are inadequately housed in Canada, and approximately one out of five of them is homeless, accounting for 30%-50% of the overall homeless population (MHCC, 2011). Inadequate housing and homelessness have a highly detrimental effect on both physical and mental health, and limit forward movement toward recovery.

As appropriate housing gains attention as a social determinant of health (Raphael, 2009), there is an increasing need to learn about how access to housing resources influences health and well-being, and contributes to recovery (Piat, Ricard, & Lesage, 2006). Housing for people with a mental illness is a complex issue – one that goes far beyond “bricks and mortar” or “a roof over your head.” Peace and Kell (2001) describe how housing difficulties and mental illness are mutually reinforcing, with housing difficulties exacerbating mental health issues, and deteriorating mental health leading to unsatisfactory housing as a result of unemployment, poverty, discrimination, disruption of education, hospitalization, substance abuse or deteriorating physical health.

While functional capacity may intuitively seem to be a key predictor of placement or housing choice, for many, availability of housing and supports, and environmental impacts such as stigma, discrimination, and poverty are more prominent issues which limit options. Thus, inadequate housing emerges as a consequence of social exclusion
(Arthurson, Worland, & Cameron, 2007). For those with a mental illness, obtaining decent and suitable housing has been described as “nothing less than the starting point in their conquest of full citizenship” (Dorvil, et al., 2005, p. 498), linking it to the ideals of recovery.

**Community-based housing models**

The literature describes the various approaches to housing for people with mental illness, highlighting that housing and related services go hand in hand. These approaches have evolved in response to deinstitutionalization, and, more recently, to reflect the recovery movement (Leff et al., 2009). Several authors offer classifications of existing housing approaches. For example, Parkinson, Nelson and Horgan (1999) described three approaches commonly used in Canada: custodial, supportive, and supported housing. Dorvil and colleagues acknowledged these three, but added a fourth approach, autonomous one-room housing (Dorvil, et al., 2005). Using different terms to describe similar approaches, American authors, Leff and colleagues, discussed residential care and treatment, residential continuum, permanent supported housing and non-model housing (Leff, et al., 2009). While different terms are used within the field, (in fact, by 1987, over 160 residential-related terms had already been identified (Ridgway & Carling, 1987)), they generally describe a range of approaches which may form a continuum that people with mental illness traverse, known as transitional housing, or each type of housing may be an end-point in itself. The inconsistent usage of terms and diversity in nomenclature makes comparison within the literature difficult (Arthurson, et al., 2007).
Generally speaking, custodial or residential approaches to housing do not necessarily expect residents to move out. They are often provided in group settings with mandatory supervision. Supportive housing, also commonly associated with group home living, ideally offers a continuum of care that varies in amount of support provided. It is intended to be more focused on skill development and assumes that the individual will progress in a linear fashion, moving on to less supportive housing facilities as functional level increases. This approach is also called transitional housing. Staff members are expected to play an active role in rehabilitation (Dorvil, et al., 2005), which may include counselling and skills training. Although custodial housing and supportive housing are described as distinct entities by some authors, there is much overlap in the way these two group-living housing models are enacted.

Independent living in an apartment of the individual’s own choosing, with or without others, with flexible supports provided on an “as needed” basis directed by the resident is known as supported housing. Supported housing is an emerging approach, and preliminary outcome studies indicate that this housing model improves health, empowerment, resident stability, community integration, and independent living, and leads to reduced symptoms and decreased hospitalization (Parkinson, et al., 1999). Rog (2004) added that although supported housing does most closely align with consumer preferences, sample sizes are very small, housing types and services are inconsistently defined and there is a reluctance to follow a randomized process if it means withholding a housing placement that is available. However, more recent studies, such as the current At
Home/Chez Soi Canadian housing research demonstration project, are using large sample sizes and implementing a randomized process (MHCC, 2011). Preliminary outcomes indicate positive results particularly with regard to housing stability (MHCC, 2012a). Other recent studies have explored such areas as critical characteristics of supported housing (Kirsh, Gewurtz, & Bakewell, 2011), features that contribute to housing preference (Forchuk, Nelson, & Hall, 2006), and battling what is known as the “not in my back yard” (nimby) phenomenon (community opposition based on negative attitudes and fear of impacts such as physical harm, disruption of peace and tranquility, and lower property values) (deWolf, 2009; Piat, 2000). Autonomous or non-model housing refers to housing with little or no associated services specific to the housing, which can be viewed either positively, in that residents are independent and require few support services, or negatively, in that they are fending for themselves in often inadequate circumstances with services unavailable or unfamiliar to them.

With little research to support the idea that one must transition through multiple levels of housing to prepare for more independent living, there remains a lack of consensus as to whether supported housing should be the final step of a continuum, or whether it functions best as an alternative to the transitional approach. As Rog (2004) concluded, more research is needed to clarify which aspects of housing make the most difference, and for whom.

In 1993, Carling suggested that supported housing was replacing residential treatment facilities such as group homes. In 1999, Parkinson, Nelson and Horgan
reported that the literature offered little recent outcome research on custodial-type group homes, suggesting that “while such facilities are still numerous, they have generally fallen out of favour with mental health professionals and consumer/survivors” (p. 155). Progress in this direction has been slow, and the situation persists. While group homes remain numerous in Canada and abroad, there is little research to support their effectiveness in promoting self-sufficiency. Many people with mental illness live in such homes, where 24-hour supervision is provided by poorly-paid staff, and residents have little privacy, responsibility or choice (Edge & Wilton, 2009). Edge and Wilton (2009) compared the housing experience of current group home residents with a similar study from 1986, and found that little had changed. A “containment” philosophy persists, with a lack of attention to rehabilitation or recovery. With little training in mental health rehabilitation, staff place little emphasis on skills training or resource development. Their role becomes one of supervision, rather than one of support and enablement. This type of supervision has been described as “invasive and inconsistent with ‘normal’ living” (Forchuk, Nelson, & Hall, 2006, p. 49). Basic needs such as food and shelter are provided, medications are commonly monitored, and there are rules to be followed, but few expectations are placed on their residents, thus perpetuating a dependent “patient” role (Arthurson, et al., 2007, p. 968). Forchuk and colleagues found that many people in such congregate settings live in cramped conditions described as deplorable, have limited access to food, and are at times treated like children (Forchuk, Ward-Griffin, Csiernik, & Turner, 2006). Other research indicates that custodial group living situations can be
problematic due to the restrictive rules and fear for personal safety and of sexual abuse, particularly for women (Forchuk, Nelson, et al., 2006).

These environments can perpetuate a passivity where residents wait, passing time with abandoned hopes of getting better and moving on. Pat Capponi, a Canadian consumer advocate, chronicled her previous experiences in custodial housing. She described watching rush-hour traffic go by, “…remembering when I too had somewhere to go, something to do…the whole day ahead of me, and absolutely nothing to do…we’d play cards or just be bored together” (Capponi, 1992, p. 69), highlighting the lack of attention to meaningful activity. With limited co-ordination with outside services, and a focus on deficits and dysfunction, a vicious cycle of learned helplessness can be established whereby residents stop using the skills they do have, increasing dependency and perpetuating incompetence (Repper & Perkins, 2003).

Although congregate environments are thought to be poorly suited to recovery and rehabilitation (Edge & Wilton, 2009), and some authors suggest eliminating them, they do garner some support in the literature. It has been suggested that they provide several benefits including: ready access to someone to talk to in a setting free of judgment; a social network that can assist with loneliness; opportunities to reciprocate when others are in distress; and, a general sense of safety, well-being, and belonging (Dorvil, et al., 2005; Piat, et al., 2006). Henwood (2011) suggests that some people may prefer shared living situations, and do better in more structured environments such as those provided in congregate environments. Furthermore, the expectation that people will
transition through the various housing types may marginalize those who need or want longer-term accommodations with higher levels of support, and those for whom other options are not readily available (O'Malley & Croucher, 2005; Piat et al., 2008).

Positive reflections on group homes are sometimes derived from measures of satisfaction, which, as Edge and Wilton (2009) found, may reflect a positive environment, but satisfaction may also be conveyed due to fear of possible repercussions of expressing dissatisfaction, or may reflect diminished expectations. There are mixed views on whether or not this type of housing should continue to exist, given what is now known about recovery, and people’s preferences and capacity for living more independently (Browne & Hemsley, 2010a; Forchuk, Nelson, et al., 2006; Tsai, Bond, Salyers, Godfrey, & Davis, 2010).

It is clear that housing approaches are varied but not consistently defined. There is much diversity in the ways that housing supports are provided, and outcomes are not well documented. Bringing consumer voices to the forefront has been identified as a goal of the limited research on group homes (Boydell & Everett, 1992; Piat, et al., 2006). Methods have included a variety of surveys and interviews, but there is little research that has involved time spent within group home settings. Expectations of the various stakeholders and mechanisms for change are unclear.

Decisions regarding health care services and supports generally are made at macro (institutional, community and political systems), meso (practice) and micro (individual) levels (Restall & Ripat, 2008), and the structure for accountability and
communication is not always clearly defined. Many settings perpetuate the status quo, which does not seem to require the same rigorous scrutiny as does introducing something new. As Drake and colleagues (2001) suggested, existing practices often rely on such things as tradition, convenience, and provider preference which offer no particular assurance of improving client outcomes. As a result, many people receive services, including those related to housing, that have not been adequately evaluated, and which may be neither effective nor appropriate (Gotham, 2004). Without a clear vision for the future, this situation is likely to persist.

**Toward recovery-oriented services**

Although a paradigm shift toward recovery has been underway for over 20 years, Piat and colleagues (2008) suggest that in Canada, mental health services are just in the early stages of adopting the recovery philosophy and there are ongoing challenges associated with moving the agenda forward. With many definitions and a lack of tangible processes associated with recovery, there is a need for recovery to be better developed as a meaningful, measurable construct if it is to have widespread applicability (Wilkniss & Zipple, 2009). As Jacobson and Greenly (2001) noted,

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated—and how—are often not well understood either by the consumers who are expected to recover or by the professionals and policy makers who are expected to help them. (p. 282)

Many aspects of recovery remain poorly understood. Thus, applying the recovery vision to specific aspects of mental health care, such as housing, is challenging.
Evolving from the interaction between the unique attributes of the person, and the opportunities in the environment (Perese, 2007), recovery itself is what the person with mental illness does. Davidson and colleagues have clarified the tasks of recovery to include renewing hope and commitment, redefining self, incorporating illness into life as a whole, involvement in meaningful activities, overcoming stigma, assuming control, becoming empowered, exercising citizenship, managing symptoms, and finding support, (Davidson, O’Connell, Tondora, Lawless, & Evans, 2005). Focused on the goals of the individual, recovery-oriented services are geared to support that effort (Davidson & White, 2007). Facilitating recovery is not accomplished by imposing or prescribing specific treatments, but rather involves the creation of conditions and environments where recovery can occur, involving an active shift in the way services are provided.

Although some progress has been made and policies, systems-level guidelines and competency frameworks for recovery-oriented services and supports continue to emerge (Davidson, et al., 2009; Farkas, Gagne, Anthony, & Chamberlin, 2005; Russinova, Rogers, Ellison, & Lyass, 2011; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005), their dissemination is limited and inconsistent. Recovery-oriented services are not widely available and have not been evaluated (Cobigo & Stuart, 2010). Leaderships is lacking as to if, when, where and how specific recovery-based strategies should be applied (Piat, Sabetti, & Bloom, 2010). Furthermore, a degree of caution is needed to progress in this direction, because, as Campbell, Stickley and Bonney (2008) suggest, there is a risk of adopting the language of recovery with the best of intentions, without integrating the
underlying values of recovery. Without what Anthony (2004) calls fundamental “people first” values of self-determination, freedom, opportunity and choice (p. 105), recovery can become the next thing done to people with mental illness, rather than a fundamental shift in perspective.

One of the most significant contributors to the confusion is the range of definitions used to describe recovery that have emerged from philosophical discussions, grounded theory studies based on lived experience, and practice experience (Onken, Craig, Ridgway, Ralph, & Cook, 2007). They generally fall in to one of two categories: recovery as a process, (what Davidson and his colleagues refer to as “being in recovery”), or recovery as an outcome, (“recovery from” mental illness, equated with cure) (Davidson, et al., 2009, p. 10). While recovery as an outcome (clinical recovery) may be the ultimate goal for people with mental illness, Davidson and his colleagues discuss studies suggesting that only 25% to 65% of people with a serious mental illness will achieve partial to full recovery defined by significant amelioration of symptoms and daily functioning within a normal range (Davidson, O'Connell, et al., 2005). Recovery as a process (or personal recovery), on the other hand, is non-linear, acknowledges ongoing symptoms and does not assume a return to pre-illness functioning, but focuses on building meaningful lives in spite of ongoing challenges. It is recovery as a process that is to guide mental health services, acknowledging that symptoms may persist.

Jacobson and Greenley (2001) offered hope, healing, empowerment, and connections as key conditions of the recovery process, and expanded, highlighting
attention to both the internal conditions of the individual (attitudes and experiences) and the external conditions or environment (circumstances, events, policies, and practices). These internal and external conditions have a reciprocal effect, and, together, contribute to recovery. It is this explicit attention to not only the individual but also the environment that sets recovery apart from approaches that, based on the medical model, situate the illness within the individual.

The medical model of mental health services and supports commonly assumes that there is a biological explanation for the illness, focusing on impairment and personal features as sources of disablement, which, once addressed, should return the person to health, assumptions which do not necessarily hold up in the case of mental illness (Slade, 2009). There is a growing base of knowledge to suggest that people with mental illness are actually more disabled by the social implications of their illness than the symptoms themselves (Davis, 2006). As Onken and colleagues (2007) suggested, people with mental illness must recover from disabling symptoms as well as face the many stigmatizing barriers, such as poverty and social exclusion, erected by society. McColl and Bickenbach (1998) clarified that from the perspective of the social model of disability, people are disabled by barriers of oppression, discrimination and social exclusion within their environments, a view that emerged in the 1970’s and 1980’s and guided the collective actions of the disability movement (Oliver, 2004). As Pat Deegan, a consumer of mental health services and early advocate for recovery proclaimed, “we must also recover from the effects of poverty and second class citizenship. We must learn
to raise our consciousness and find our collective pride in order to overcome internalized stigma” (Deegan, 1996, p. 96), reflecting a perspective far beyond individual impairment. Stigma, whether experienced as ignorance, discrimination, or prejudice, can contribute significantly to feelings of inadequacy and exclusion. Nikelly (2001) confirmed that the role of social and environmental factors in both causing and controlling some aspects of mental illness have been greatly underestimated. He suggested that interventions should be shifted from the individual to focus on collective efforts focused on the elimination of unemployment, poverty, economic inequality and social alienation, all of which could have a significant impact on housing conditions.

The biopsychosocial model, now widely associated with mental health care and aligning closely with recovery, was an attempt to acknowledge the psychological and social components of mental illness. Yet, as Slade (2009) observed, the three components of the biopsychosocial model do not garner equal value, with primacy clearly given to the biological, and emphasis remaining on the individual. The vast majority of mental health services are derived from the medical model, focused primarily on symptom reduction, and the prevention of relapse and re-hospitalization (Drake, et al., 2001), while the social determinants of health struggle to find their place in the health care landscape.

With its focus on rules, staff control, and the perpetuation of dependency, custodial-type housing itself has been described as “the medical model delivered within the community” (Arthurson, et al., 2007, p. 968). People with a mental illness have a
right to access effective interventions, and want to see meaningful outcomes that relate to improved quality of life, but marketing for treatments like pharmacotherapy far exceed those interventions focused on empowering individuals to live with meaning and dignity in the community, skewing their perceived value (Drake, Skinner, & Goldman, 2008). Thus, in the absence of powerful, organized stakeholder groups and a clear agenda for broadening the perspective to a biopsychosocial approach, moving recovery into mainstream practice has been limited. Furthermore, tensions in practice accompany the shift toward recovery-oriented practice (Krupa & Clark, 2009). For example, historically, society has restricted the ability of people with mental illness to make certain decisions about their lives, including where they live and with whom (Courtney & Browne, 2005). Service providers, such as case managers, come from a professional culture where they feel a responsibility to minimize risk, so sharing power and allowing risk-taking may be challenging for them (Piat, et al., 2008). Alternatively, Frese, Stanley, Kress, and Vogel-Scibilia (2001) argued that when people with serious mental illness are impaired in decision-making, expecting them to take a greater role in doing so is “tantamount to abandonment” (p. 1464). Thus, balancing risk, opportunity, and responsibility becomes a tension to be worked out in recovery-oriented services and supports, including housing.

Because recovery occurs within the context of complex relationships, working from a recovery perspective involves a fundamental shift from professionals as experts offering interventions to navigating a way of being in a relationship (Repper & Perkins, 2003). In validating recovery competencies, Russinova and colleagues found elements of
the relationship to be central to recovery: expressing respect; trust, understanding and care; listening without judgment; and, believing in the person’s potential to recover (Russinova, et al., 2011). Mental health service providers need to learn to implement services traditionally described as caregiving in ways that empower people to build meaningful and satisfying lives. Swain, French and Cameron (2003) further consider traditional caregiving, suggesting that “the cozy image of care as synonymous with love can serve to mask the control that operates in many relationships where one person is substantially dependent on another” (p. 142), a perspective which must be considered in the shift toward recovery-oriented services. Townsend (1998) invoked and revised an old proverb, stating, “you can care for people for a day. But if you educate people to become involved, you have helped them to care for themselves and others for a lifetime” (p. 3). This, she argues, involves a process of empowerment, not only at the individual but also at the collective level. When people are educated to take actions that enhance thoughts and feelings of power, it can develop the basis for collective action, which in turn has greater potential to bring about social change toward inclusiveness. Thus, moving forward, this broader perspective will be essential in both the development and evaluation of relevant services and supports.

Knowledge translation

The mental health field has much to gain from the practice of knowledge translation – a change process that enables the application of research to health services and supports (Graham et al., 2006). There is a considerable lag between discoveries made
through research and changes to front-line practice, needlessly delaying the benefits that could be conferred to those the research is about. Defined as “a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products and strengthen the healthcare system” (Straus, Tetroe, & Graham, 2009, p. 4), knowledge translation embraces planned action theories with a focus on bridging the gap between what is known and what is done in practice. In mental health, this gap has been described as “enormous” (Drake, et al., 2008, p. 1385), and efforts at knowledge translation have been frustrated by a lack of leadership, limited partnerships between knowledge producers and knowledge users, and the emergence of a wide range of knowledge products that are not sensitive to the varying contexts in which the knowledge is to be applied, resulting in inconsistent applications across the country. Furthermore, mental health practitioners are not well versed in enacting advocacy-type roles that could lead to policy-level influences on social change (Restall, Cooper, & Kaufert, 2011).

Although the recovery vision has gained national and international attention as a guide for mental health services, and is embraced in Canada (Piat & Sabetti, 2012), it has been difficult to translate the vision into a consistent approach to service delivery. Specifically, it has not necessarily filtered down to all front-line services, and support services on the periphery of formalized care, such as those for housing, are even more disadvantaged. Passive dissemination of research – simply making it available – is ineffective; it may increase awareness, but has little if any effect on eliciting change
Thus, mental health services and supports such as those provided in group homes may be aware of recovery, but are left wondering how they might align their services with this vision.

**This thesis**

Group homes, and, more importantly, their residents, stand to gain from forming partnerships that could enable them to integrate recovery-focused approaches. Identifying challenges and opportunities for change toward recovery requires a better understanding of the connection between recovery and housing, and in particular, the group home experience. This includes the complex interaction between the people who need housing, features of the housing itself, the nature of the services and supports provided, the influences of the environment in which it is embedded, and, the impact of policies and practices on past, present and future approaches to housing. As Davidson and colleagues expressed, to embrace recovery, there is a need to cultivate welcoming environments and eliminate stigmatizing attitudes, policies and practices, highlighting the need “to determine which of the elements of current practice are helpful and needed as opposed to those that are lingering legacies of our institutional past” (Davidson, et al., 2009, p. 72).

Given that recovery is “contextually embedded and influenced by a host of factors at multiple levels of a person’s psychological and social experience” (Wright & Kloos, 2007, p. 79), there is a need to identify barriers and opportunities at a variety of ecological levels (Sylvestre, Ollenberg, & Trainor, 2009). A social-ecological framework considers the interactional dimension between the individual and the various aspects of
the environment, acknowledging that recovery can be impeded or facilitated through their dynamic interaction (Onken, et al., 2007). With its claim that social-ecological theory can advance research and programs that promote adaptive functioning, recovery, and participation in the community for people living with persistent mental illness, highlighting that individual factors and environment are inextricably linked (Kloos & Shah, 2009), a social-ecological lens will be used to guide this study.

The purpose of this study is to explore the challenges and opportunities for enabling the group home setting to increase its capacity to serve as an environment that integrates the recovery vision. This thesis is organized as follows: Chapter 1 provides background information, highlighting the persistence of custodial housing, the incongruence with recovery-oriented services and the lack of mechanisms for change. Chapter 2 is a reflexivity statement that integrates personal perspectives with the theoretical framework (social-ecological theory) that guides the study. Chapter 3 provides a scoping review of the literature addressing the question: How does the scholarly literature describe the relationship between recovery and housing for people with mental illness? Chapter 4 describes the methodology, which is a case study using ethnographic methods. Chapter 5 provides the findings, answering the sub-questions: What is the current cultural milieu of a group home for people with mental illness? How is recovery understood in relationship to this group home? How do policies and practices impact the capacity of the group home to enact the recovery vision? Chapter 6 is a discussion integrating the information from previous chapters, in response to the overall question:
What are the challenges and opportunities for enabling a group home to increase its capacity to serve as an environment that integrates the recovery vision? It also offers final conclusions.
Chapter 2

From where I sit: Reflexivity statement and theoretical perspective

Examining reflexivity

Defined as the process of reflecting critically on yourself as a researcher, writing a reflexivity statement is considered an important component of rigor or credibility in qualitative research (Merriam, 2009). As Finlay (1998) argues, reflexively exploring subjectivity can function as a resource, the absence of which may undermine the research. Meant to clarify assumptions, biases, experiences and theoretical orientation applied to the research study, as well as the researcher’s relationship with the study setting, the reflexivity statement clarifies the researcher’s perspective, acknowledging that as one becomes part of the social world of the study, there may be intentional or unintentional influences on the findings (Jootun, McGhee, & Marland, 2009). As Jootun and colleagues elaborated, one’s position is that of either an outsider (unfamiliar with the area under study), an insider (part of the existing setting), or a hybrid of the two (familiar with the practice area, but not part of the actual setting). Making the relationship explicit contributes to the credibility of the research. In the following reflexivity statement, I have placed myself in the hybrid role, familiar with mental health settings in general, and, as it turned out, familiar with some of the residents from past work-related experiences, and familiar with board members and some neighbours, but unfamiliar with the actual setting (the specific group home) under study.
With over fifteen years of experience as an occupational therapist practicing in the field of mental health, I have had the opportunity to build relationships with hundreds of people with mental illness. With much of it taking place in an acute-care hospital setting, people are seen at their worst, typically in times of crisis. Such crises, especially if not their first, often become turning points in the lives of those experiencing them, which may result in a scenario whereby they are unable to return to their previous living situations. With limited resources, their options are few. It has become increasingly evident to me that as mental health professionals (and I will count myself among them), we have treated the process of addressing housing issues as another mundane task to be checked off of a list. Recent experiences have affected me in a way that woke me up to the fact that housing is a meaningful and intimate aspect of one’s being, not an interchangeable entity like a pair of shoes.

In one case, a young man was brought to the hospital from the group home where he had lived for over a year, as he was experiencing symptoms of early psychosis. Also having mild developmental delay, he had fit in nicely in the group home and described how, for the first time in his life, he had friends, a part-time job, and an active social life where he was not made fun of. Movie night, bowling outings, and special events at restaurants were new to him when he went there, and he relished the new opportunities. He had even learned to take the bus to work independently, an accomplishment that made him proud. The psychosis was soon under control with a small dose of medication, but when it came time for discharge, the group home operator decided he could not return.
The incident prompting the admission had frightened the owner, and she felt she could not risk exposing the other residents to him again. Her home was not set up to deal with mental illness, she said. With his parents unable to have him back either, suddenly, he became a “placement issue.” It seemed like we treated him as a storage problem – where would we put him? His response was heartbreaking. He pleaded and cried, “I just want to go back with my friends,” but to no avail. That door was closed. Visibly upset by the situation, I was told by co-workers not to worry, we would find him another spot.

Another spot! It did not sit well with me. He was finally discharged to another home, no choice, no consideration of his needs or wants, just discharged. “Placed” we call it – a passive process of shuffling pawns, storing them where we think they fit.

In another situation, a gentleman with bipolar disorder was hospitalized when his elderly mother felt she could no longer handle him at home. After a short stay, during which he stabilized quickly, assessors filled out paperwork and deemed him to need group home placement, even though he voiced a strong preference for either returning home, or getting a place of his own. He loved music and had a room set up at home where he could listen to CDs whenever he wanted to, which was helpful when he couldn’t sleep, he said. Feeling rejected by his mother, and lacking the resources to pursue the option of independent living on his own, he reluctantly went to the group home. It was located in a nearby community, one unfamiliar to him, where he would be sharing a bedroom with a man he did not know, unsure if the setting would permit him to listen to his music, particularly late at night. He was told he was “lucky” as group home
openings in that area don’t come available all that often. Moving to the home meant he no longer had access to his mother’s car which he relied on to attend church and participate in the choir, an activity he had enjoyed for many years. Not to worry, he was told. There was a church just up the road from the group home. He could walk. Two weeks later he was brought back to the hospital by the group home operators, in a manner not unlike the way a teacher would walk a naughty child to the principal’s office. They were unwilling to have him back as he was “unmanageable” they said, not following the rules. Upon further questioning, they revealed his violations. Among them, he had been found in the kitchen at 9 pm helping himself to a bowl of cereal, a privilege he had apparently relinquished when he walked through the front door.

Shortly after, just days before packing up and moving to Ontario to undertake my PhD studies, I was greeted at the front door of my New Brunswick home by a frantic woman waving a petition in her hand. “You’ve got to sign this,” she said. “They’re planning to put in a group home around the corner, for people that are mentally ill.” Apparently, “not in my back yard” remains alive and well. Funny, I thought. For years there had been a house on that site known to be that of a drug dealer, but no petition had been circulated to address that issue. Down the street, an old warehouse was turned into a beer bottle exchange. Again, no petition. “We really need everyone’s support. We’re taking it to City Hall next week.” This was the most (and only) community spirit I’ve seen in this neighbourhood since moving in over 20 years ago. “I won’t be able to sign it,” I said. “I work in mental health.” I wish now I had said more, but that alone was
enough to garner a look of disgust. This must be what they mean when they say “stigma by association” I thought. A few weeks later, I was exploring the quilt fabric shops in my new Ontario community. Recognizing that I was a new customer, the owner struck up a conversation. I shared that I was a student in the Rehabilitation Science program at Queen’s. “Oh,” she said, “so you get people to do exercise and things?” “Well, actually,” I replied, sensing her confusion with physiotherapy, “my work is in mental health.” “Oooh,” she snickered, “well, you wouldn’t be getting THEM to do exercise.” It seems that stigma there too is alive and well!

These experiences speak for themselves. Taken together, they form a problematic that has sensitized me to be aware that housing is very complex, influenced by so much more than the individual. For example, conversing with the lady with the petition led me to think of what it must be like to move to a neighbourhood, knowing a petition had been circulated to block “you” – the stereotypical “you” that is, not you personally. People with a mental illness do not see their housing situation as an interchangeable entity. I realized that housing options may have very little to do with individual features or personal competency. There is so much more at play. There is a strong sense of attachment that goes along with having a home, whether to the physical aspects, the social bonds, or the access to meaningful occupations. Having a choice is also important. It is from this reflective stance that I approached the present study.
Reflexivity statement

Finlay (1998) offers a four-part framework useful for guiding a systematic reflexivity process which will be used here to guide reflection on researcher assumptions, expectations, behaviour and emotions, and unconscious responses. With personal and methodological reflexivity not easily separated (Finlay), the two are combined below.

Influence of researcher’s assumptions

Early in the research process, it became evident that my assumptions about group homes, based on past experience, would provide the lens through which all observations would be viewed. The situations outlined above are but a few of the many group home-related experiences that comprise the lens. I have twice been told by group home employees (from two different group homes) that residents could not wash their own laundry for fear of them breaking the knobs. I have heard stories of residents being required to sell their vehicles, give up their homes and their jobs, give up their pets, and generally give up their autonomy. At the same time, I heard about group homes being a “life saver,” as one client who lived a dangerous lifestyle on the street said “I would be dead if it wasn’t for them.” Thus, colouring my assumptions was the fact that some people access group homes when their lives are taking a downturn, while others do so as a first step of an upswing. In the middle, they meet. I assumed I would see people on both trajectories, and wondered if their experiences and perspectives would differ.

Knowledge that an extensive array of paperwork is completed prior to admitting a resident to a group home led me to believe that various living situations were
considered, and residents were well matched to the selected housing. The group home at the centre of this study enjoys a good reputation as one that helps residents to build on skills, so I was particularly interested to learn about how the staff went about facilitating each person to build on skills. In occupational therapy, we talk about “enabling occupation.” It seemed like in addition to providing a place to stay, the role of group homes was to enable occupation – enable participation in personal care, social and leisure activities, community events, and even work – but with no occupational therapists involved in the process, I wondered what this would look like.

Knowing that the group home frequently incorporated students and volunteers into their routines, my assumption was that I would not seem out of place there. Residents and staff alike were told that I was doing research, but also that I would be a volunteer. My familiarity with some of the residents and other participants from my role as an occupational therapist at the local hospital eased the transition.

**Impact of researcher’s expectations**

As I prepared to go to the group home, one which I had visited just once before, I was acutely aware that I would have a critical eye. With a mixture of positive and negative reports colouring my perspective, I realized that choosing to do a case study of just one home would have limitations, but at the same time, the up-close and personal interactions afforded by participant observation could be invaluable. I expected to be able to maintain an emotional distance in my role of researcher, while at the same time developing a rapport with residents and staff alike in my role of volunteer.
Regarding record-keeping, I started the study expecting to see records chronicling the progress and outcome for each resident. I felt it would be a valuable source of information, knowing how residents were progressing toward their goals, and knowing if residents left the group home with an enhanced skill set to take up residency in a more independent setting, or if they left under stressful circumstances, perhaps in rebellion to rules such as curfews and sobriety.

**Examining researcher’s behaviour and emotions**

As I began to spend time observing within the home, it became increasingly difficult to remove my “occupational therapist” hat. Of particular note were instances in which staff implemented a “do for” approach. I felt almost compelled (but not quite) to intervene, but chose rather to step back and firmly place the researcher hat back in place. As one staff member told me early in the research, “our job is to work ourselves out of a job”, meaning that residents would become independent and not need them. That might be the underlying philosophy, but actions speak louder than words, and actions soon demonstrated that that was not an imminent risk. While some residents were actively involved, for others, much time is spent in bed, with personal goals buried in tucked-away files. So much lost potential, I thought. With such limited expectations, where is the press to move forward?

Engaging in the group home as a volunteer allowed much time to be spent with the residents, whether within the home, or on community outings. By becoming part of the routine, residents and staff alike seemed to quickly adjust to my presence, a feature
that likely contributed to the formation of relationships that upon completion of the research were sadly missed.

**Probing unconscious responses**

While some of the emotional response was clearly linked to the day’s events, or something specific shared by a resident, it wasn’t until much later that thoughts about how individuals are situated in a bigger picture revealed the limited opportunities people in such homes have for advancement toward meaningful goals. Regardless of how many checkmarks one gets on one’s teeth brushing chart, virtually no one is out there fighting for them to get an apartment or a job or a car or a dog. I found it unsettling to reflect on how much of the actions of mental health care revolve around what we think is best, with little attention to what is really important to those involved. Benevolence may be great. It is what we know how to do. Help people. But as I reflect on what this help looks like, and to what end, I can recognize an underlying feeling that we all need to take a step back and tackle the bigger issues of stigma, discrimination and social exclusion that keep a tight parameter on the realm of possibility for people with mental illness. In my own neighbourhood, where that protested group home is now nicely situated on a well-groomed property and the residents actually smile and wave when you walk by, I feel like we need to recant that petition, and circulate a giant “welcome” card. Welcome to the neighbourhood!
**Theoretical perspective: The social-ecological approach to recovery**

These reflections confirm that success in community integration is a multi-level process for which individual-level interventions will not suffice. As a recovery vision guides forward movement in mental health care, both the positive and negative implications of the environment at all levels must be considered as individuals are supported to claim full citizenship, and actually be treated like everyone else in their communities. By providing a person-in-context paradigm, a social-ecological perspective holds promise as a theoretical guide (Kloos & Shah, 2009; Wright & Kloos, 2007), and has been selected, to sensitize the research to issues of transaction between the individual and the environment.

The nature – nurture dichotomy acknowledges that the two components are inseparable, both making major contributions to human development. In mental illness, the same could be said, although the relative contributions of each are the subject of much debate. For example, beliefs regarding the schizophrenogenic mother (nurture) gave way to biological causes of schizophrenia (nature), which persist today as evidenced by the pervasiveness of pharmacotherapy. While current mental health care places a strong focus on individual treatment such as medications and behaviour management, assuming for the most part that mental illness arises from within, Nikelly (2001) asserts that the supportive and curative aspects of the environment have been greatly neglected in mental health care. Beyond individual and family interventions, attention to social and economic barriers across layers of the environment is required in support of recovery.
(Davidson, Rakfeldt, & Strauss, 2010). With the recovery paradigm gaining momentum as the guide for mental health services, focusing increased attention to participation, community integration and social inclusion, limiting beliefs regarding nature will have to make room for the full potential of nurture to be explored.

Nurture is conveyed largely through interaction with the multiple levels of the environment. Considering the influence of social, institutional and cultural contexts, social-ecological theory views the organism within his or her environments as a multi-level system of nested structures (Stokols, 1996), comprised of the ontosystem (the individual), microsystem (family, friends), mesosystem (community), and macrosystem (society), and the dynamic synergy reflected by the continuous interaction among them (Scaffa, Reitz, & Pizzi, 2010). Social-ecological theory advances the idea that physical and social environments are multi-dimensional and inextricably linked. With their cumulative effect on physical, emotional and social well-being (Stokols, 1996), adaptive outcomes such as self-esteem and personal development, or dysfunctional reactions, including elements of mental illness can result (Moos, 1974). Defined as “the study of the impacts on human beings of physical and social environments [with a] primary concern with the assessment and optimization of human milieux” (Moos, 1974, p. 20), social ecology embraces an applied values orientation, manifest in its use of practical techniques to apply research-derived information in a manner that respects the values of the group under study. Furthermore, its focus is to increase the quality of the human environment in support of effective human functioning and engaging stakeholders in
decision-making regarding change, giving them increased control over their environments (Kloos & Shaw, 2009), thus aligning with the recovery vision.

Distinguishing features of social-ecological theory applied to health research include:

i) examination of the interaction between physical and social environments

ii) a focus on the individual’s experience within the environment

iii) an emphasis on human adjustment, human growth and promotion of adaptive functioning

iv) explicit attention to the environmental impact on adjustment, adaptation and coping

v) consideration of how the environment acts as an active stressor, a limiting force, a social selector, releaser of capacities, or as an active positive force, and,

vi) having an explicit values orientation focused on improving the practical situation of those involved by organizing the environment to maximize individual functioning, increasing control people have over their environments and, challenging policy makers and planners to improve environments (Moos, 1976, as cited in Kloos & Shah, 2009).

Social-ecological research aims to improve the health and practical situations of the research targets, paying specific attention to the ways in which the environment might be
organized to meet their needs and maximize adaptive functioning (Kloos & Shah, 2009), thus promoting an enhanced person-environment fit (McLaren & Hawe, 2005).

In their study of housing for people with mental illness, Kloos and Shaw (2009) found social-ecological theory to be well suited for research promoting adaptive functioning, health, and recovery in community settings. By shifting their view from one of examining individual risk factors, to consideration of the broader environmental influences at play in community integration, a social-ecological approach allowed a more comprehensive approach to examining barriers and protective or health promoting factors. Their model, the Social Ecology of Housing Environments, considers the interplay between the physical environments of the home and the neighbourhood in which it is situated, the social environment of the housing and the neighbourhood, and the interpersonal relationships associated with the housing. The physical environment encompasses the actual quality or condition of the dwelling, but also considers available resources such as access to stores and transportation, all of which can contribute to housing stability. Social environment in this model considers perceptions of belonging, tolerance, acceptance, or discrimination, as well as perceptions of safety and security, prevalence of crime, and property destruction or victimization occurring within the neighbourhood, all of which comprise the social climate. The interpersonal relationships include those with co-residents, landlords and neighbours, which contributed to perceptions of stress or comfort within the housing. This model provides the opportunity
to examine the relationship and interconnections between the three components, and their impact on the individual within the context of the housing.

In 1792, Dr. Philippe Pinel’s classic example of removing chains and shackles from patients at a Paris asylum revealed that the social and treatment environment could have a significant impact on the recovery from mental illness (Moos, 1974). Patients stopped being violent and demonstrated significant improvement when they were treated differently and were free to move around. Within a social-ecological paradigm, the impact of all levels of environment, and the extent of possibility for recovery continue to be explored within mental health care. As environments such as group homes embrace a recovery vision, a merging of attention to include not only individual-level treatment of the illness, but full consideration of the capacity of the environment to promote meaningful participation, social integration and full citizenship for people with mental illness within the community is required if the recovery vision is to be realized.

Offering a guide of where to look for environmental influences and interrelationships, appropriate research approaches, and guidance on how to use the findings, social-ecological theory provides an appropriate framework (Kloos & Shah, 2009). As Kloos and Shah suggest, research based on this framework can contribute to the empirical base focused on designing interventions that reduce exposure to risk and promote adaptive functioning, recovery, and participation in community life for people with mental illness.
Chapter 3

The relationship between housing and recovery: A Scoping Review of the literature

As public policy and an increasing body of literature identify housing as a critical element of recovery, a better understanding of the relationship between the two is critical. Separate bodies of literature related to recovery and housing have evolved, but only recently have the two begun to converge in a meaningful way. With its focus on building a life in the community, social inclusion, and full citizenship, clearly recovery is closely linked to housing, but there is an ongoing debate regarding the extent and specific ways in which housing actually contributes to recovery (Kirsh, Gewurtz, & Bakewell, 2011). Thus, a scoping review of the literature has been used here to examine how the literature describes the relationship between housing and recovery.

Method

The scoping review has emerged as a means of mapping the breadth of literature on broad topics that use a range of study designs, increasingly popular for reviewing health research (Anderson, Allen, Peckham, & Goodwin, 2008; Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010). With its “aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available…especially where an area is complex or has not been reviewed comprehensively before” (Mays, Roberts, & Popay, 2001, p. 194), it is selected here as an appropriate method. The scoping review provides a mechanism for examining the extent, range, and nature of research on a given topic, for summarizing research and for
identifying gaps in the existing literature. Arksey and O’Malley (2005) have proposed a methodological framework aimed at providing a consistent approach to scoping reviews, which includes identifying an appropriate question, identifying and selecting relevant studies, charting the data, and collating, summarizing and reporting the results. Effectively used elsewhere as a means of reviewing literature related to housing and mental illness (O’Malley & Croucher, 2005), Arksey and O’Malley’s iterative 5-stage process served as a guide for this scoping review.

Facing the challenge of balancing comprehensiveness with precision (Anderson, et al., 2008), an appropriate question serves as a precursor to building the search strategy. This scoping review was guided by the question: How does the scholarly literature describe the relationship between recovery and housing for people with mental illness? To identify relevant studies, the terms housing or residence or home or living situation or living arrangements were combined with mental illness or mental disorder and recovery (not limited by dates, to allow an emergent perspective) were used to search the following databases: CINAHL, MEDLINE, PubMed, PsycINFO, EMBASE, and ProQuest Sociology. Hand searching of bibliographies expanded the range of the search. Given the everyday nature of some of the search terms, a large number of references emerged in each database, many of which were irrelevant to this review. The abstracts from promising titles were reviewed, and relevant papers were obtained and read. Papers that offered a significant focus on the relationship between housing and recovery were included. Those that did not actually use the term “recovery” in a significant way in their
discussion of housing were excluded. Thus, once the inclusion and exclusion criteria were applied, a total of 27 papers and 6 theses, 33 items in total, were selected.

To chart the data, a data charting form was created using headings suggested by Arksey and O’Malley (2005), which included authors, year of publication, study population, purpose of the study, method, and key findings. Geographic location and discipline of the lead researcher were also recorded. The author’s definition or interpretation of recovery, and any key quotes were documented, in addition to key points which specifically linked housing and recovery. Once all information was charted, a conventional qualitative content analysis approach was used to identify key concepts (Hsieh & Shannon, 2005), which were then collated, and summarized below.

**Findings**

Inadequate housing or homelessness confounded by poverty and stigma has been described as a key barrier to recovery while appropriate housing has been described as “a potent catalyst for recovery” (MHCC, 2011, p. 3). Clearly, housing and recovery are linked. However, the findings of the scoping review revealed a dearth of research explicitly linking the concepts of recovery and housing, a range of research methods and report styles, varying definitions and components of the construct of “recovery”, and inconsistent usage of housing terminology. For example, it was not easy to distinguish custodial housing from supportive housing, as both are commonly provided in supervised group settings. Also, while some literature clearly differentiates between supportive housing and supported housing, these distinctions are not universally reflected; thus, in
some cases, the two terms are used interchangeably. The most common approach to studying the relationship between recovery and housing was to use qualitative approaches, particularly using key informant interviews. There was strong emphasis on consumers as respondents (21/33 papers), which Kyle and Dunn (2008) suggest is beneficial for capturing the richness and uniqueness of individuals’ lived experience (see Table 3.1 for methods used).

**Table 3.1: Method/Type of Paper**

<table>
<thead>
<tr>
<th>Method/type of paper</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative – interviews</td>
<td>11</td>
</tr>
<tr>
<td>Other (Theoretical/conceptual/discussion/literature review/speech/policy paper/editorial)</td>
<td>8</td>
</tr>
<tr>
<td>Mixed methods</td>
<td>5</td>
</tr>
<tr>
<td>Quantitative approach</td>
<td>4</td>
</tr>
<tr>
<td>Qualitative – focus groups</td>
<td>3</td>
</tr>
<tr>
<td>Case study</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total number of papers</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

The papers emanate from a variety of disciplines (see Table 3.2), with the greater number from psychology and nursing, and from a variety of geographical locations, primarily Canada and the United States (as indicated in Table 3.3). The selected literature was published in years ranging from 1990 to 2011, with 23 (70%) of the papers emerging within the last five year period.
The housing and recovery literature explores the major approaches to housing, the concept of recovery in general, and addresses aspects of housing that can generally be viewed as enablers of recovery, or as barriers to recovery.

**Recovery and the Major Approaches to Housing**

The two main overarching approaches to housing described within the housing and recovery literature can be described in general as *housing first* and *treatment first*. The Pathways to Housing agency in New York formally introduced Housing First as a specific approach to homelessness for people with mental illness, which is further
developing as an evidence-based best practice with a recovery perspective for people with mental illness (Henwood, 2011; Kirsh, et al., 2011; Padgett, 2007). The housing first philosophy aligns most closely with supported housing models. Treatment first approaches are less well-defined, particularly with respect to recovery, and appear as a catch-all of a variety of housing models in the literature, but align most closely with transitional housing. The literature reflects people with mental illness having a strong preference for having a place of their own or with partners of their own choosing, in a community setting of their own choice (Chesters, et al., 2005; Davidson et al., 2005), but commonly service providers new to recovery perspectives identify more restrictive settings as appropriate for their clients, limiting choice and risk-taking (Piat, et al., 2008). Thus, a range of housing models exists, with some approaches aligning better with recovery than others. The process of making a match between resident and housing is not clearly defined.

**Treatment first approaches.**

Emerging in the post-deinstitutionalization era, treatment first approaches are reflected in custodial and supportive housing, which are not clearly distinguished in the literature. They are sometimes called board and care homes, foster homes, or group homes which typically offer high to medium levels of supervision (Kavanagh & Lavelle, 2008; Piat. et al., 2008; Piat, et al., 2011). Such homes are predicated on the belief that opportunities and structure for learning and practicing daily living skills and social interaction in a contained setting will gradually prepare an individual for increasingly
independent settings, thus the belief that they are transitional. Lacking an explicitly defined service philosophy or program theory, Hopper (as cited in Henwood, 2011) pointed out that treatment first is not an official approach. It “appears on no budget document, is the designated subject of no regulatory agency. It is simply what has evolved — by hook, crook, and convenience — in the wake of the postwar dismantling of state hospital systems” (p. 10). Treatment first did not develop as a designed intervention, but emerged as a default measure to accommodate a variety of displaced people with mental illnesses, particularly those with co-occurring substance abuse issues. Nevertheless, such housing persists to this day in an over-abundance for a variety of reasons, not the least of which is lack of feasible options for their residents (Edge & Wilton, 2009).

Treatment first approaches are typically meant to offer a continuum of care that diminishes as skills and abilities improve. In these settings, the supervision is somewhat invasive, often on-site around the clock, with ongoing tenancy associated with program compliance. While there are few empirical studies that illustrate the impact of such housing on enhancing ability to function (Kloos & Shah, 2009), an assumption remains that with this approach, the individual will progress in a somewhat linear fashion toward increasingly independent living situations as certain arbitrary and poorly defined functional milestones are achieved to the satisfaction of care providers who function both as gatekeepers and guides to those seeking permanent housing (Henwood, 2011). However, as Posey discusses, housing provided in such settings may be popular, but the
popularity is with the providers. In many cases, they are operated on a for-profit basis, in which as much as 90% of allocated money is kept by the home operator, leaving little spending money for the resident. These situations can perpetuate dependence, and a way of life Posey called “existing, not living” (1990, n.p.).

In settings that are meant to be transitional, individuals must “climb a ladder of program requirements” (Padgett, 2007, p. 1925) to prove they are ready for increasing levels of independence. For example, as Henwood (2011) found, the clients must demonstrate housing readiness, indicated by compliance with such things as medication and sobriety, with lack of compliance equated with lack of readiness for housing. This comment, by a treatment first service provider encapsulated this perspective: “I let them know, this is what we need to do, and if you’re not ready for that, I can’t help you. This is what you have to do in order to get your apartment” (Henwood, 2011, p. 128). Other studies have found that people would prefer not to move along a continuum, finding it unsettling when they have to relocate (see for example Browne, et al., 2008). Those who do ascend the ladder may be faced by a lack of availability of individual units and the absence of requisite funds for rent subsidy and appropriate supports, leaving few choices available when it comes time for transitioning (Weddle, 2002). Thus, for those who would like to move, the coveted “prize” of one’s own place may exist as a false promise, perpetuating one’s stay indefinitely in housing that he or she has outgrown. This is problematic, because it has been found that people kept in restrictive settings over time show increasingly pessimistic attitudes towards their eventual life beyond, perceiving
themselves as powerless, thus giving up on their own recovery (Pejlert, Asplund, & Norberg, 1999).

Krazier and Baker-Smith (as cited in Weddle, 2002) examined the relationship between group home residents and recovery, and argued that rigid routines and lack of flexibility may inadvertently teach skills required for congregate living rather than preparing residents for independent living, thus actually limiting their potential for transitioning to more independent settings. Data also suggest that, due to availability, as many as one half of all those accessing housing supports are placed in supervised congregate settings, when of those living in such settings (with 24-hour supervision), as few as 14% actually require that level of support. The rest could most likely live independently with either daily or weekly support (Sylvestre, et al., 2007). A growing base of evidence suggests that, with focused support, many such residents could – and would prefer to – reside in living situations that promote recovery by offering more privacy, autonomy, self-sufficiency and community connections.

Pejlert and colleagues (1999) followed clients who were moved from an institutional setting to a group home setting to promote recovery, based on the belief that with interpersonal relations, participation, responsibility and freedom of choice as central features, each individual has an inherent capacity for positive change. While the clients struggled to take on their new responsibilities, the move fostered hope for the future, and evidence of increased competence and self-confidence emerged, as noted one and two years following the move. As Henwood (2011) highlights, in treatment first type housing,
there is benefit in removing the person from a previously detrimental environment, such as homelessness or from the company of substance abusers. Then, by providing a supportive, sober-living group environment, they can learn specific skills that could support recovery. However, in the absence of opportunities to exert increasing autonomy, the process of recovery could be stalled.

Weddle (2002) identified a range of positive and negative aspects of group home living that either contribute to, or hinder recovery. Positive aspects that contributed to recovery included: learning about their illness; learning about chores/responsibility; increased quality of life based on a sense of belonging and support; having a safe haven from temptation to use drugs and alcohol; and, feeling less pressure from family’s high expectations. Having a positive relationship with the home operator and practical assistance with meals, as well as cleanliness, medications, and emotional support were also found to be positive aspects of group home living. In addition to the concern that residents were being taught skills required for group living rather than preparing them for independent living, hindering aspects included: conflict with other residents; restrictions such as curfews, limited phone time, and limited quality of and access to food; decreased independence as a result of the group home operator doing more than needed (e.g. cooking, laundry); undesirable locations, lack of privacy; and being treated poorly (e.g. theft by co-residents, or poor treatment by staff, including physical abuse, inattentiveness, emotional abuse, and financial exploitation). Weddle concluded that while living situations such as group homes are left out of discussions of recovery, they hold potential,
much of which could be realized by shifting the perspectives of staff to become more collaborative, respecting client choice.

In one of few outcome studies of transitional housing, Kavanagh and Lavelle (2008) completed a retrospective analysis of participants who had transitioned out of what they called high-support rehabilitation and recovery housing that had offered interventions including assessment of individual needs, pharmacological interventions, behavioural interventions, compliance programs, family interventions and vocational rehabilitation. The retrospective analysis indicated that 50% of participants did transition out of the high-support rehabilitation and recovery housing, but half of them actually transitioned to more restrictive settings. Those who had previously lived independently did better than those who had been institutionalized for long periods. This stands in contrast to the conclusion by Kloos and Shah (2009) who found that previous housing tenure, diagnosis and case manager rating of function did not predict residential transitions.

Carers (not professional caregivers, but typically family members), have expressed agreement that appropriate housing was a critical element of recovery (Browne & Hemsley, 2010b). The carers felt that with recovery taking time, housing should address safety and vulnerability issues, such as needing protection from themselves, a balance between choice and compulsory treatment, and protection from drugs and alcohol. The carers suggested the need for full-time staff to monitor individuals while they built confidence, highlighting their belief that women in particular need extra
protection. Their view of recovery-promoting housing was a setting that provided privacy and constructive things to do, supported clients to regain daily living skills, and offered gradual reintegration to the community, which supports the transitional perspective.

Tsai and colleagues (2010) report on one of few studies where some of the participants, who had both mental illness and substance abuse disorders, credit the higher level of supervision provided in transitional housing as instrumental to their recovery. In addition, Padgett found that participants reluctantly accepted custodial care, viewing it as stable whereas their illness was unstable (2007). Likewise, Weddle (2002) found that residents felt they were not ready for independent living, and wanted to solidify progress and gains before moving on. A Quebec study of consumer preferences indicated that almost one third of their participants actually preferred custodial group home living suggesting that, while other explanations are possible, such as lack of awareness regarding options or fear of living alone after lengthy tenure in a group setting, the housing may, in itself, have merits (Piat, et al., 2008). Pejlert and colleagues, (1999) confirmed that options for group home residents are often unclear, but residents do contemplate where they might go in the future. Some residents voiced the desire for an “ordinary life” at some time in the future (p. 667), implying the group setting was not ordinary, although four of the six residents suggested that they would consider future group living with some of their fellow residents, citing the kindness of others as the feature they liked most.
Treatment first approaches remain as an over-used mode of housing, (Edge & Wilton, 2009; Sylvestre et al., 2007) often accepted by default rather than by choice, in which, in the absence of more suitable and available options, many residents are under-housed (Kavanagh & Lavelle, 2008). While this approach represents preliminary efforts toward community integration, with rigidly enforced daily routines and staff values subsuming those of the residents, they run the risk of simply relocating institutionalization to the community (Borg et al., 2005; Posey, 1990). Posey suggests that if housing based on this approach is to be useful, tenancy should be time-limited with a clear program oriented toward independent or semi-independent living.

Overall, the literature offers very little support for treatment first methods from a recovery perspective. Although it may be preferred to homelessness, and some have identified appreciation of the support and sense of belonging, treatment first housing is often mentioned in contrast to more autonomous living situations which better support recovery. People commonly accept it not by choice, but due to the lack of perceived options. There is little research to support the effectiveness in enabling residents to develop what is assumed to be the appropriate skill set for transitioning residents to increasingly independent housing (Padgett, 2007; Weddle, 2002). Nevertheless, programs and policies continue to favor transitional types of housing over more permanent options for people with mental illness in the “mistaken belief that such persons are not capable of stable, independent living in the community” (Padgett, 2007, p. 1934). Weddle (2002) suggests that such settings have the potential to promote recovery, recommending a
strengths assessment, and timely accommodation of changing needs, especially given the growing evidence to support that even people with serious mental illnesses, histories of homelessness, substance abuse, and other psychosocial and health problems are able to live independently and to maintain their housing when appropriate individualized support is provided (Sylvestre, et al., 2007). Sylvestre and colleagues (2007) conclude that there is a need to reform custodial housing so that it reflects the standards expected of other types of supported housing, such as abiding by the Tenant Protection Act, providing privacy, offering increased control over living spaces, and by providing rehabilitation and access to community supports. Finding a balance between the need for skill development and the need for identifying and securing appropriate supports as the means for increasing independent living remains a challenge for residents and support workers alike.

**Housing first/supported housing approaches.**

As mentioned, the Pathways to Housing agency in New York formally introduced *Housing First* as a specific approach to homelessness for people with mental illness. Because the housing first philosophy aligns most closely with supported housing models, the two terms are often used somewhat synonymously in the literature. In this approach, housing is viewed as a basic right necessary for successful community integration, not something to be earned (Henwood, 2011; Sylvestre, et al., 2007). The progressive levels are by-passed, and the individual is supported to obtain rent-subsidized housing with individualized, flexible, ongoing support reflective of priorities directed by the resident
Such housing commonly involves a rent-subsidized unit, where residents are expected to contribute 30% of their income to housing which, as Kirsh and colleagues (2011) found, enabled participants to secure a decent apartment with money left over to support other aspects of recovery. Utilizing a harm-reduction philosophy, it is often paired with Assertive Community Treatment (ACT) teams which offer a range of open-ended supports and services in the community that are not directly linked to the housing, and are meant to provide a strengths-based or capabilities-enhancing environment (Henwood, 2011).

Based on underlying values of empowerment and community integration, accepting services is encouraged, but not mandated for residents of supported housing, reflective of a difference between supervision, which is not optional in the homes in which it is provided, versus supports, which are chosen by the recipient. In its ideal, residents of supported housing are free to choose the type, sequence and intensity of the services they would prefer (Henwood, 2011), selected “not from a list of limited options but from a complete scan of the community and their skills and interests” (Parkinson & Nelson, 2003 p. 12). This diversification promotes community integration by enabling access to formal and informal supports beyond the housing situation, increasing access to valued resources such as self-advocacy skills to help obtain resources for education, employment, housing, activities and information regarding rights (Parkinson & Nelson, 2003).
Supported housing can offer the choice of clustered apartments in which several units in one building are designated for mental health consumers, or as scattered apartments with individual units located in various buildings (Kirsh, et al., 2011). Each approach carries an array of advantages and disadvantages. Scattered apartments promote community integration, allow residents to have a fresh start, and enable them to keep their history of mental illness private. Furthermore, it offers flexibility for people who would prefer to live in diverse settings such as in small towns or in rural areas (Sylvestre, et al., 2007).

Some care providers and residents prefer the clustered approach instead, which may have an increased risk for stigma, but the tradeoff is a sense of community with others with similar issues, thus preventing isolation, a common complaint of residents of scatter-site units. In clustered settings, residents indicate they value the opportunity for reciprocity by showing compassion and empathy to each other (Kirsh, et al., 2011), but the literature does not offer consensus on whether or not consumers prefer to live in proximity to others with mental illness. As Whitley, Harris and Drake (2008) found, there is an ongoing tension between residents’ desire for social connections and sense of community with fellow consumers, and their conflicting desire for privacy and independence. As Whitley and colleagues found, residents of “recovery housing” did prefer to live in a building with fellow consumers, as did some participants in a study of housing preferences by Tsai and colleagues (2010). However, in spite of the initial preference, Whitley and colleagues (2008) described how a spirit of mutual support and
trust gave way to fear and insecurity when some in their midst relapsed into substance abuse. Co-residents felt it placed them at risk by causing them to fear the person under the influence, fear the disreputable individuals that might accompany that person to the building, and fear for their own safety, as well as their own potential for relapse in the face of temptation. Inherent with the housing first and harm reduction approach, on-site supervision is not provided, and ongoing tenancy is not related to abstinence. Thus, such situations are left to be dealt with by the residents themselves who may be more vulnerable due to past experiences. However, situations such as these are reminiscent of regular community housing, and provide opportunities for negotiation and gaining control over one’s environment, which Murphy (2008) suggested was important to recovery.

Housing first type approaches are based on the belief that obtaining the housing itself is a key component to moving forward with recovery and community integration. (MHCC, 2011; Parkinson & Nelson, 2003). Consumers who discuss their recovery experiences in the housing and recovery literature are most commonly associated with housing first or supported housing programs (Kirsh, et al., 2011; Parkinson & Nelson, 2003). Parkinson and Nelson (2003) found that prior to participation in a supported housing program, participants had frequent hospitalizations, and felt needy, dependent and powerlessness in areas of decision-making, resources, time, family relations, addictions, friendships, jobs and housing security. They credited supported housing as a turning point, enabling recovery of their mental health, sense of power and control,
development of new skills, improved relationships, movement toward employment and
more active involvement in the community, drawing particular attention to the
philosophical shift of support workers, from a “doing for” perspective to a “doing with”
perspective (p. 12).

Chesters, Fletcher, and Jones (2005) highlighted that in addition to having a place
to live and supports to live there, social engagements are essential to recovery. As Kirsh
and colleagues (2011) found, required skills such as budgeting or accessing food banks
are taught as needed once the person is in the housing. Once basic needs were met,
service providers looked ahead to next steps in recovery, identifying such needs as social
networks, recreation and work or volunteering.

Inherent with the recovery-oriented focus of supported housing, residents are
expected to take responsibility for their own decisions, which may not always align with
those of his or her service providers. Henwood (2011) specifically targeted the service
providers to discuss fidelity with Housing First ideologies. One participant revealed that
although he embraced the philosophical underpinnings of the Housing First model, there
were at times significant challenges associated with the harm reduction approach:

…the most tragic ones are when you move someone into an apartment, and it
becomes a drug den…I don’t see the value in people who are using drugs to the
point where their neighbors are afraid to walk up the stairs, and people are busting
into other apartments. I don’t see the value in keeping the person housed.
(Henwood, 2011, p. 126)

This perspective confirms that upholding the rights of one individual in his or her
recovery journey may at the same time be a hindrance to another. Furthermore, it can be
difficult for care providers to support personal choice and decisions that will clearly result in negative outcomes for a consumer, including eviction, relapse, strained social relationships, or encounters with the criminal justice system. However, dealing with the repercussions of one’s own decisions is something Deegan (1992, as cited in Henwood, 2011) has called a cornerstone of recovery.

While viewed as more autonomous, supported housing, or housing first approaches do not represent fully independent living, despite their alignment with recovery. Housing tenancy is not tied to compliance with program requirements, and the housing is seen as permanent, but with its dependence on rent subsidy and other formal supports such as ACT teams, such programs are costly and clearly subject to political whim. Financial supports such as rent subsidy reduced stress, allowing limited funds to be diverted to other areas of recovery (Kirsh, et al., 2011); nevertheless, housing resources were viewed as vulnerable and dependent on wellness and financial stability (Browne, et al., 2008). For example, participants in an Australian study discussed concerns about the security of tenure, which in that cultural milieu was based on home ownership (Chesters, et al., 2005). They felt vulnerable living in a subsidized unit in a building that belonged to someone else, fearing it could be taken away. In an American study, some consumers in supported housing viewed the subsidies as charity, and it affected their sense of self-worth. For example, one Housing First participant represented this view, saying, “I wanted like, to pay for my own apartment… do it on my own… it’s mostly like a charity case or something in my eyes, you know. I wish I could just get a
job and pay for my own things and yeah, be my own person” (Padgett, 2007, p. 1932).

Thus, although tenure was not tied to compliance, the lack of economic security impacted residents’ perceptions of independence.

Henwood (2011) concluded that housing first approaches more closely align with a recovery orientation than do treatment first approaches, a difference that he attributes to systems-level influences that embrace consumer choice, separation of housing and services, having a stated recovery orientation, and having a focus on community integration. For those who do obtain supported housing, there are ongoing needs to sustain the housing, and it is but a starting point for recovery. However, although the literature offers increasing support for housing first or supported housing as a part of recovery-oriented services, rent subsidies and support services such as ACT teams are not universally available, waiting lists are long and the supply remains inadequate for meeting the demand, (Sylvestre, et al., 2007) leaving many to seek alternative routes in their quest toward recovery.

**Hybrid approach.**

There are also configurations of housing in the housing and recovery literature that appear as hybrids of the two approaches. For example, the Fairweather Mental Health Housing Model offers an alternative wherein much of the support is offered in congregate settings by peers, and residential services are linked with employment opportunities with the goals of providing productive personal, interpersonal and
community-based living. (Haertl, 2007). Thus, there is increasing awareness that traditionally custodial models can be shifted to reflect recovery-oriented practices.

Recovery in the housing literature

The literature linking housing and recovery acknowledges recovery as both a process and an outcome (Kirsh, et al., 2011; Perese, 2007; Piat, Sabetti, Fleury, Boyer, & Lesage, 2011), but with its references to housing as a foundation for recovery (Kirsh, et al., 2011), a springboard to recovery (Borg, et al., 2005), a catalyst for recovery (MHCC, 2011), or a base from which recovery can be launched (Browne, Hemsley, & St. John, 2008), it appears to have a distinct leaning toward recovery as a process that can be influenced by various aspects of housing. Recovery is conceptualized as a complex construct, incorporating not only factors related to individual growth, but also contextual factors and both positive and negative influences contributed by the environment (Parkinson & Nelson, 2003). Thus, the housing literature indicates, one must recover “from symptoms, from the stigma of the illness, from the effects of treatment, from the lack of opportunities, and from the destructive aspects of their illness” (Browne, Hemsley, & St. John, 2008, p. 407). As such, recovery involves working on relationships, establishing meaningful social roles, reclaiming self-identity, and becoming a fully integrated member of the community (Ahern & Fisher, 2001, as cited in Perese, 2007).

Countering previously held views of mental illness as having an irreversible, continuously deteriorating course (Borg & Kristiansen, 2004), recovery offers hope of a meaningful life, often constructed around ongoing symptoms. Reflective of this belief,
several housing studies (for example, Parkinson & Nelson, 2003; Piat, et al., 2011) cite Anthony’s widely accepted definition of recovery, which describe it as

… a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (1993, p. 19)

Likewise, other authors offer definitions of recovery acknowledging the ongoing presence of symptoms, such as “people with a mental illness can lead reasonable lives within the limitations imposed by their illness” (Kirby, 2008, p. 6) and “a transformational process leading to a more fulfilling, satisfying, contributing life despite the presence of symptoms” (Piat, et al., 2011, p. 50). While these definitions provide an overall sense of the recovery construct, they fall short in making explicit connections to housing. Several papers offered no actual definition of recovery, but used the term in a vague or general way, as if the meaning were already understood (see for example Borg, et al., 2005; deWolf, 2009; Kloos & Shah, 2009). Those who made connections between recovery and housing did so making links between housing and specific elements of recovery such as community integration, or the various ways that housing provided a secure base from which recovery could be launched (see for example Browne, et al., 2008; Haertl, 2007; Kirkpatrick & Byrne, 2009).

Several features of recovery derive from access to appropriate housing. In the housing and recovery literature, these include: a sense of meaning and purpose (Borg, et al., 2005), empowerment (Haertl, 2007; Parkinson & Nelson, 2003), hope for the future
(Borg, et al., 2005), social and reciprocal connections (Browne, et al., 2008; Parkinson & Nelson, 2003), personal choice, control and self-determination (Borg, et al., 2005; Kirsh, et al., 2011; Padgett, 2007), taking responsibility, (Haertl, 2007; Kirsh, et al., 2011; Pejlert, et al., 1999), managing illness (Browne & Hemsley, 2010a; Kirsh, et al., 2011), personal growth and development (Borg, et al., 2005; Kirsh, et al., 2011), community integration (Borg, et al., 2005; deWolf, 2009), citizenship (Borg, et al., 2005; Posey, 1990), social justice (deWolf, 2009), and participation (Browne, et al., 2008; Parkinson & Nelson, 2003), clearly establishing the multifaceted nature of the construct. Some examples, drawn from the housing and recovery literature, clarify these linkages (see Table 3.4).

**Table 3.4: Linking Housing and Recovery: Exemplar Quotes**

<table>
<thead>
<tr>
<th>Features of recovery</th>
<th>Exemplar quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning and purpose</td>
<td>“Having a home affords a sense of order, identity, connectedness, warmth, haven, and physical protection, which, in turn, provide the means to pattern existence in meaningful ways through...cherished routines or interactions with people one cares about.” (Borg, et al., 2005, p. 243)</td>
</tr>
</tbody>
</table>
| Empowerment | “I’m not told what to do and how to do it…I’m writing the play.” (Parkinson & Nelson, 2003, p. 7)  
“Persons in the program lived together, worked together, and learned the skills necessary to function in a peer supported environment empowering them to function and make decisions relatively autonomous from staff.” (Haertl, 2007, p. 151) |
| Hope for the future | “…dreams of home occasionally invoked other aspirations, like having a partner and children…living in a nice neighbourhood…caring for a cat” (Borg, et al., 2005, p. 251). |
| Social and reciprocal relationships | “…relationships with children had improved due to several factors (i.e., confidence, better mental health, better apartment, cooking skills, communication).” (Parkinson & Nelson, 2003, p. 9)  
“Quality housing offers a secure base that helps consumers establish friendships, develop social networks…” (Browne, et al., 2008, p. 406) |
| Personal choice, control, self-determination | “…felt like a normal environment, punctuated by everyday life experiences such as watching television, drinking coffee, decorating, having friends around, or even enjoying one’s solitude” (Borg, et al., 2005, p. 248)  
“Supported housing offered residents the freedom to live independently, to do chores, and to organize their daily routines around their personal priorities…. residents were in control of their living space and, by extension, their lives.” (Kirsh, et al., 2011, p. 21)  
“Having one’s own apartment offered both ‘freedom from’ and ‘freedom to’ opportunities.” (Padgett, 2007, p. 1930) |
| Responsibility | “…having their own place…motivated them to take care of themselves…eat better…exercise more.” (Kirsh, et al., 2011, p. 21)  
“Clients seem to be more motivated by each other than by staff expectations. This is the first place people have been given a voice and responsibility.” (Haertl, 2007, p. 153) |
<table>
<thead>
<tr>
<th>Managing illness</th>
<th>“They all care for their personal hygiene, cleaning of their rooms, and their own laundry, even if this is not without problems: ‘It is tough, but you know you have to look fresh’.” (Pejlert, et al., 1999, p. 666)</th>
</tr>
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<td></td>
<td>“Housing works best if it is stable, so consumers can set down roots, develop networks of supportive friends and family to help them stay well, and help them after they have been ill and in hospital.” (Browne &amp; Hemsley, 2010a, p. 582)</td>
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<td></td>
<td>“Residents described the relief they experienced in having a place of their own. Many felt that their stress levels were reduced because they had private space to unwind and reflect at the end of the day.” (Kirsh, et al., 2011, p. 21)</td>
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<tr>
<td>Personal growth and development</td>
<td>“…a cozy place that reflected her interests and hobbies...felt simultaneously inspiring and comforting” (Borg, et al., 2005, p. 247)</td>
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<td></td>
<td>“…being able to pursue goals for employment and education as they became settled into supported housing” (Kirsh, et al., 2011, p. 21)</td>
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| Community integration | “…many tenants are more than tolerated in their neighbourhoods…many are active contributors to strengthening their neighbourhoods.” (deWolf, 2009, p. 70)  
“…feeling freer to go out for a walk, to work, to attend services at the local church, or simply to meet somewhere with friends…having a home felt like a direct connection to the outside world” (Borg, et al., 2005, p. 250) |
| Citizenship | “Forcing persons who have experienced mental illness to live with families does not promote family unity, but may in fact act as a deterrent in allowing those persons to take their rightful place in society” (Posey, 1990, n.p.)  
“…having a home may be critical for maintaining a sense of personal and life continuity while living among ‘normal’ others in the community.’(Borg, et al., 2005, p. 253) |
<p>| Social justice | “It gives me hope that I can live in normal neighbourhoods – that I don’t have to stay in shelters in not very nice parts of the city - and that people will treat me like anyone else.” (deWolf, 2009, p. 70) |</p>
<table>
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<tr>
<th>Participation</th>
<th>“…each person had become more involved in the community for recreation, volunteering, employment, education, or shopping” (Parkinson &amp; Nelson, 2003, p. 9)</th>
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<td>“Housing is central to building a future. It offers a secure base; when that base is established, friendships, social networks, and meaningful activities can develop” (Browne, et al., 2008, p. 407)</td>
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While recovery is clearly linked to housing, the literature more specifically explores the ways in which aspects of housing are enabling of recovery, and the ways in which they can be barriers.

**Housing: An enabler of recovery**

Three elements emerge from the literature that are particularly salient to the ways in which housing enables recovery: the importance of housing stability, recognizing that housing and a home are not one and the same, and the capacity of housing to provide a foundation for recovery.

**Housing stability.**

Housing stability, “the ongoing ability of individuals to access, over the course of their lives, housing that promotes their optimal health and quality of life”(Sylvestre, et al., 2009, p. 200), is more than maintaining particular housing for a period of time. It
involves having the resources that enable one to remain in housing, or to relocate in response to individual wants and needs. Sylvestre and colleagues have recently added to the recovery-oriented housing theory base with a model of housing stability, suggesting that as a social determinant of health with links to social integration and citizenship, housing stability is “implicated in the process of recovery” (2009, p. 197). The model of housing stability sees housing as a dynamic interaction between the individual, including his/her needs, abilities and preferences; the housing itself, including the structure, the housemates and the neighbours; and, the supports, including formal and informal supports, and broader system influences such as the program, agency, or government which can impact income, access to supports, programming, and treatment. The environment in which the housing is situated is also considered, with change at any level increasing or decreasing stability by affecting the fit between the individual and the housing.

Housing stability is compromised by housing affordability and poverty which often result in dependence on family, available government supports, and sub-standard housing situations. Moving at twice the rate of the general population, relatively few people with serious mental illness live in decent, stable housing. Known as “chronic residential mobility,” such transience has a negative influence on one’s capacity for developing social connections and integrating into the community (Newman, as cited in Kloos & Shah, 2009, p. 317). Recovery is difficult when people are unable to access stable community housing and participate in reciprocal and supportive relationships.
(Chesters, et al., 2005). With a lack of supportive, meaningful relationships, loneliness becomes prevalent, with support workers and other consumers providing the bulk of social connections, somewhat reminiscent of institutional living. Thus, living situations that promote the development of a healthy interdependence with opportunities to give back through interpersonal relationships emerge as an important part of recovery (Piat, et al., 2011), and are increasingly made possible with housing stability. Attention to appropriate housing that goes beyond community maintenance, supporting community participation and resulting in lasting improvements in residential stability, is paramount (Kirsh, Gewurtz, & Bakewell, 2011).

**Housing versus a home.**

The literature clarifies that having a place to live, or housing, is not the same as having a home. Posey aptly confirmed that “when we begin to focus on homes, and not just housing, we have taken a major step toward recovery and reintegration into society” (Posey, 1990, n.p.). In addition to providing shelter and privacy (Kirkpatrick, 2005), having a home provides a sense of order, identity, connectedness, warmth, and haven, as well as physical protection (Borg, et al., 2005), and is not run by institutional-like rules or strict treatment regimens (Sylvestre, et al., 2007). According to the recent report on Canadian housing needs for people with mental illnesses, *Turning the Key*, elements such as affordability, access to the right supports, security of tenure, being in a desirable location, and feeling safe form the basis of a home (MHCC, 2011).
Interestingly, when residents of custodial housing gained access to more independent settings with support to develop life skills, interpersonal skills, access to social and community events, and advocacy skills, the emerging stories of recovery focused more on valuing the recovery of a home than on features of mental health. A home provided a place to have a sense of control and make connections, which contributed to the development of social supports and reconnection with family (Kirkpatrick, 2005), difficult when one is in more transient situations.

While much of the discussion in the literature on housing and recovery relates to external features such as opportunities to build relationships and participate in activities, there are also important intrapersonal recovery-oriented aspects that result from having a home. For example, Kirsh and colleagues (2011) found that, for participants in supported housing, home emerged as a place of comfort that provided a sense of relief, and a place for reflection and healing. One of their participants described the suppression and hopelessness felt in a previous rooming house, and how obtaining his own apartment shifted his outlook to one far more positive. Davidson and colleagues (2005) described how having their own space could enable residents to “unwind and chill out...recharge...batteries...calm down” (p. 188), highlighting the need for peace and quiet in a safe, private, and secure space which could allow for retreat, respite, and renewal. The desire for a place to unwind and retreat, “…to have a free zone, to spend time with yourself,” (Davidson, et al., 2005, p. 188), or to have a private space to reflect on the day (Kirsh, et al., 2011), makes an interesting distinction between privacy and
isolation or loneliness, the key being choice. Likewise, Borg and colleagues differentiated between social and private lives, and found the privacy afforded by their own place enabled residents to better face everyday challenges (2005). They attributed having a home to having a place to attain peace of mind or relief, to relax, be oneself, and appreciate the basic security.

A home as a foundation for recovery.

With its foundational role, appropriate housing is seen as an integral component of recovery-focused services, without which access to other opportunities, supports and resources such as supportive relationships and meaningful activities would be limited (Browne & Hemsley, 2010a; Browne, et al., 2008; Chesters, et al., 2005; Sylvestre, et al., 2007). As Kirsh and colleagues (2011) confirmed, people need a place to have pride in and to build a life around, which sets the stage or forms the foundation from which other aspects of recovery can be pursued (Borg, et al., 2005; MHCC, 2011).

With a home as a stage for everyday activities, simple freedoms like arranging furniture, getting up when you want to and having a place to pursue hobbies, try out new things, exercise creativity and talents, and to consider the possibility of having the companionship of partners, children, and pets have been identified as contributors to recovery (Borg, et al., 2005). Appropriate housing can provide a sense of relief, reduce stress level, and provide a space to process the day, motivating residents to take care of themselves. With the freedom to organize their day around their own priorities, and as
they became more settled, residents were able to pursue other important recovery goals such as employment and education. (Kirsh, et al., 2011).

The housing itself can be seen as a resource that enables the balance between socializing and privacy (Kirkpatrick, 2005), positioning people in the world in such a way that they can take advantage of the social capital provided by the surroundings. Kloos and Shaw (2009) suggested that neighbourhoods could facilitate personal growth and recovery by being tolerant of people with mental illness, supporting community integration, and by providing resources that enable people to meet their needs, such as access to stores and public transportation. Furthermore, they suggest, such an environment could actually be viewed as an active positive force by imposing demands that challenge individuals, but in a manner that facilitates personal and social growth. In this sense, environmental press could have a positive impact by increasing expectations, in which case, “…environments can act as ‘releasers’ of individual capacities” (Kloos & Shah, 2009. P. 319).

**Housing-related barriers**

Social exclusion, sub-standard living conditions and lack of choice have emerged as key barriers to recovery.

**Social exclusion.**

As Kirsh and colleagues (2011) discussed, stigma, discrimination and poverty reduce access to quality housing, and their impact is not erased when housing is obtained. Stigma, as indicated by the “not in my back yard” (nimby) phenomenon, persists as some
Communities and neighbourhoods are less than welcoming when they are aware that housing for people with mental illness is coming to their area. Stigma has been described as a roadblock to recovery and a barrier itself, creating “walls of exclusion” that can prevent community integration (Perese, 2007, p. 286). Although building on community strengths has been identified as part of the recovery process, it receives little attention in the literature. Addressing stigma has been described among the greatest challenges for support workers to address (Chester, et al., 2005).

Physically moving somewhere is a first step toward community integration, but achieving a sense of belonging may not be so easy. Community integration involves the person having the interest and means to integrate, and community acceptance. The former has garnered considerably more attention than the latter. Wright and Kloos (2007) found that perception of the neighbourhood is more predictive of well-being than the perceived physical quality of the dwelling and distal socioeconomic factors. People with better housing conditions in welcoming and tolerant neighbourhoods reported less psychological distress than those in poor, less welcoming conditions, suggesting that neighbourhood response actually plays a role in supporting recovery (Kloos & Shah, 2009). According to McGregor (2008, as cited in Kloos & Shaw, 2009), this can be attributed to the perceptions that supportive neighbours are seen as important social supports.

A Canadian-based participatory study by deWolf (2009) brings forward a unique perspective relating to the way people with mental illness can have a positive impact and
contribute to the quality of the community. She suggests that as individuals in supported housing situations begin to live more confidently, they can strengthen local communities. Tenants in the supported housing engaged in beneficial neighbourhood activities such as gardening, pet networks, and informal neighbourhood watches, which provided important opportunities for reciprocal relationships and giving back, important to recovery. Crime rates and property values were not negatively affected, which is often feared. Participants made a key distinction regarding community integration, differentiating it from tolerance. As one participant aptly stated, “It is not just that people learn to tolerate us – it’s that we are good for neighbourhoods!” (deWolf, 2009, p. 70). Weddle (2002) shared this perspective, suggesting that passive tolerance was not enough, but active communication amongst neighbours was important. Vigilant for discrimination and stigma, service providers are increasingly realizing the need to combat the nimby phenomenon, and promote efforts toward social inclusion, but clearly need to take it a step further if full community integration and citizenship are to be realized (Kirsh, et al., 2011).

**Sub-standard living conditions.**

As the *Turning the Key* report summed up, for optimal outcomes in support of recovery, appropriate housing for people with mental illness must be of good quality, as well as affordable, with supports that fit and that work for the individual (MHCC, 2011), implying that housing that is of poor quality, unaffordable, or lacking appropriate supports could be barriers to recovery. Achieving a good fit, they suggest, will be reliant on coordinated planning and investment, consideration of the needs of specific localized
populations, provision of appropriate supports and the establishment of service standards for providing housing and related supports. By allowing the deterioration of existing housing options and perpetuating unsafe and unsanitary housing conditions, both health and quality of life are compromised, and more barriers to recovery are put in place (MHCC, 2011).

Sub-standard living conditions and homelessness, perpetuated by poverty and unemployment are described as significant barriers to recovery (Borg, et al., 2005). Browne and Hemsley (2010a) discussed how poor quality housing was a risk factor for mental health problems, and suggested that without quality affordable housing, other supports are jeopardized, and homelessness risk is increased. Identified as the “antithesis of recovery” (Kirkpatrick & Byrne, 2009, p. 69), homelessness has emerged as a key target for intervention in Canada, with $110 million earmarked for homelessness research (Kirby, 2008). Under the auspices of the Mental Health Commission of Canada, this research, the At Home/Chez Soi demonstration project, is currently under way in five Canadian cities, with preliminary results now reported (MHCC, 2012a). Kirby (2008) asserts that getting people off the streets is a first step in the recovery process, but, as indicated in the housing and recovery literature, availability of appropriate housing and supports is limited. Given this significant shortage, it has been recommended that, in support of recovery, as many as 100,000 units be created in Canada over the next 10-year period (MHCC, 2011), and clearly the requisite supports will be needed for them to fill
the housing void. Without action on these recommendations, the status quo is perpetuated, and movement toward recovery stalled.

Marginal accommodation, associated with increased exposure to violence, alcohol, drug use, violence and stress, low incomes and poor access to stable affordable housing, perpetuates social isolation (Chesters, et al., 2005). Poor quality neighbourhoods can act as active stressors and contribute to increased residential transitions (Kloos & Shah, 2009). As Whitley, Harris, and Drake (2008) found, environments that conveyed safety and security, such as having control over the front door and who came in and out, had the greatest influence on the experience of recovery. This security was jeopardized, resulting in fear, anger and frustration, when some residents altered the environment, for example by violating expectations for drug abstinence and sobriety. Kirsh and colleagues (2011) confirmed the demoralizing negative effect of drug and crime-ridden neighbourhoods on safety, and found that to promote hope for the future, consumers wanted subsidies to live in regular buildings that were clean and safe, with proximity to amenities, as well as family, friends, mental health programs and doctors.

**Lack of choice.**

The theoretical underpinning of recovery-oriented housing acknowledges the predominant role of the person with mental illness in day to day lifestyle decisions (Chesters, et al., 2005), because as Browne and Hemsley concluded, “even well-meaning and well-resourced housing initiatives can fall short of meeting consumers’ recovery goals when they do not incorporate the expressed needs of consumers” (2010a, p. 1).
When choice in housing is limited, such as having to live in an area without access to public transportation when one does not own a car, so too is access to other opportunities that contribute to recovery (Perese, 2007; Posey, 1990).

The literature suggests that “for housing to be ‘good quality’ it needs to support recovery” (Browne, et al., 2008, p. 407). Aligning with recovery, features associated with quality have been described as: living alone or with others of one’s own choosing; access to appropriate supports; chosen by consumers; neighbourhoods likely to assimilate and support consumers; limited numbers of others with mental illness; appearance consistent with the neighbourhood; manageable levels of stress; not time-limited to enhance stability; and enhanced opportunities for control over environment (Hogan & Carling, 1992, as cited in Chesters, Fletcher, & Jones, 2005). Kirsh and colleagues (2011) expanded the list, adding: flexibility and choice; safe accessible neighbourhoods; good fit between person and neighbourhood; and supports for finances, work, school, crisis support, independent living skills; and education for landlords, suggesting that service providers act as liaisons between residents and landlords. Thus, like housing stability, quality is a function of the interaction between personal needs and preferences, the associated services or supports, and the housing itself, including the environment in which it is situated (Sylvestre, et al., 2009).

There are conflicting views as to whether or not services should be tied to the housing, or totally separate, as some approaches do have services tied directly to the housing, while others do not. Murphy (2008) concluded that empowerment and a shift in
the locus of control, cornerstones of recovery, require the “unbundling of housing from mental health support” (p. 153), to enable residents the choice of whether to receive services or not, and for the decision to be separate from ongoing tenancy. Weddle (2002) highlighted the problems innate when the roles of tenant-landlord are blurred with those of consumer-care provider, and suggests that coercing clients into unwanted or unneeded treatments based on care provider preference, and tying tenancy to compliance actually minimizes recovery. Browne and Hemsley (2010a) present the opposing view, concluding that to be responsive to recovery needs, housing and mental health services should be coordinated so that if the person becomes unwell, and neglects or destroys resources, when they begin to recover again, there will not be the added burden of rebuilding housing and social networks. Likewise, Chesters and colleagues (2005) offered support for close co-operation between housing and disability support services. Thus, while the preferred relationship to the housing situation is unclear there is consistency in consumers wanting client-centred services over which they have some control and choice.

Discussion

In 2001, Newman concluded that research on housing and mental illness was under-theorised, employed inconsistent and inadequate measurements, and most studies had weak designs (Newman, 2001). Fast forward over 10 years, and while designs remain heavily focused on qualitative approaches, considered weak on the evidence-based practice continuum, some progress has been made regarding measurement and theory.
Though not tied specifically to recovery, Kloos and Shah (2009) have added to existing measurement tools, such as the Community Oriented Program Environment Scale (COPES), with the development of the Housing Environment Survey (HES), considered an important advancement in the field due to its focus on the impact of both positive and negative elements of the environment. Furthermore, while theory on housing and mental illness remains limited (Kloos & Shah, 2009), there are increasing efforts to advance the theoretical foundation of housing knowledge and practice. Sylvestre and colleagues’ (2009) Model of Housing Stability reinforces the understanding of the complexity of housing as a dynamic relationship between the person, the housing and the supports, embedded within the environment, which may be helpful in understanding the tumultuous housing experience of people with mental illness that Forchuk and colleagues have likened to a tornado (Forchuk, Ward-Griffin, et al., 2006). Kloos and Shah (2009) introduced a framework, the Social Ecology of Housing Environments, based on social-ecological theory, highlighting the interplay between social environments, physical environments, and interpersonal experiences. In addition, there are increasing efforts to tie the housing literature to the recovery literature, but the convergence remains in the early stages.

Although heavily based on qualitative studies using idiosyncratic definitions of recovery, taken together, the literature linking housing and recovery reaches consensus on several points. Recovery values include self-determination and personal choice, and while there are exceptions, most consumers by and large prefer living in their own unit.
with partners of their own choosing over housing styles that are considered custodial or transitional. They prefer self-directed supports rather than ongoing supervision. Such housing has positive impacts on its residents, including extended community tenure and reduced hospitalization. With its role as a launching pad or secure base, it is credited with jump-starting movement toward other recovery goals. However, the majority of consumers do not live in the type of housing that they would prefer (see for example Nelson, Hall, & Forchuk, 2003; Perese, 2007; Piat, et al., 2008). Thus, there is a significant mismatch in Canada and abroad, in which people live in custodial or supportive housing situations or with family, not due to their functional requirements or preferences, but often due to limited finances, service provider preference, or lack available options and requisite supports (Sylvestre, et al., 2007; Tsai, et al., 2010). Mental health workers themselves have been accused of perpetuating stigma (Krupa, 2008), underestimating the capacity of consumers to make decisions in their own best interests, or painting bleak pictures of their potential for recovery (Borg & Kristiansen, 2004). Furthermore, there is little research clarifying the impact on consumers when housing choices are restricted, and they are constrained to take whatever housing is available (Sylvestre, et al., 2009).

The Turning the Key study concluded that there is adequate knowledge regarding what works in regards to supporting recovery as it relates to housing (primarily making reference to supported housing), but it is not sufficiently implemented (MHCC, 2011), and may not be appropriate for everyone. Such approaches emerged as a means of
dealing with homelessness. While clearly this is laudable, there is an implication that people “hit bottom” before their housing needs come to the forefront. The recovery literature speaks of people “regaining a life” (Browne, et al., 2008, p. 407) or “the development of new meaning and purpose in one's life” (W. Anthony, 1993, p. 19), but less about the role housing could play earlier in the process. As Davidson and colleagues (2005) highlight, life is not what happens after treatment. Increased attention to housing and recovery needs earlier on may hold potential for people to maintain daily living skills and valued relationships, thus preventing the need for the long road back.

The recovery and housing literature is heavily weighted toward studies of Housing First or supported housing, so much so that a message is conveyed that without this type of housing, one’s chances for recovery are significantly curtailed. In fact, this scoping review echoes the findings of Weddle (2002), which were corroborated by Flynn (2004): “perhaps most notable is that the sub-group of psychiatric group home residents with severe and persistent mental illnesses is virtually unmentioned in the recovery literature” (Weddle, 2002, p. 3). Custodial environments are not the preferred choice of most people with mental illness (Forchuk, Nelson, et al., 2006; Piat, et al., 2008), and are thought to be poorly suited to recovery and rehabilitation (Edge & Wilton, 2009), but their residents, who may be there due to a lack of alternatives, should not be exempted from opportunities for recovery. Mausbach et al. (2008) compared functional capacity of those living within custodial group homes with those residing alone or with a family member, and found little difference in capacity. They found that those not living in group
homes were more active participants in their communities, including work, volunteer work, and going to school, which may be due to increased opportunity and expectation. Ware and colleagues have developed a theory of capacity building for social integration which suggests that individuals with psychiatric disabilities have pre-existing capacities, and through exposure to occasions for growth, competency can be affirmed (Ware, Hopper, Tugenberg, & Dickey, 2008). Aspirations and a sense of positive possibility can arise, fueling engagement in further opportunities for growth. Success breeds success. Rebeiro (2001) expanded on the importance of having an affirming social environment and creating just-right challenges, based on client strengths, and client-driven needs. These conditions may lend themselves well to a recovery focus in housing environments where residents could explore and expand on strengths in a non-threatening environment, one which offers support and encouragement - an affirming environment, an environment that expects participation and creates the opportunity to discover talents, thus contributing to empowerment.

Although exact numbers are unknown, custodial housing remains in widespread use across the country, not just as a remnant of the early days of deinstitutionalization, but as an ongoing housing option (Dorvil, Morin, Beaulieu, & Robert, 2005). Thus, as O’Malley and Croucher (2005) suggest, a “…more pressing concern is the fate of those for whom the shift to independent living is not likely to happen in the short term” (p. 839). If independent living arrangements such as supported housing are the only housing model acknowledged as benchmarks of recovery, group home residents may already be
aware of their exclusion as beneficiaries of a recovery perspective. As Weddle (2002) points out, “it is possible that group home residents are already receiving an implicit message concerning their place (or lack thereof) in the recovery movement during this exciting period of new directions in mental health care” (p. 2). Deegan (2000, as cited in Weddle, 2002) suggested that group homes often reflect poor living conditions, which she suggests may be experienced as “microaggression” (p. 2); the lack of current research “may be further construed as a microaggression on behalf of mental health researchers, insinuating that individuals participating in this form of treatment are somehow less worthy of quality, effective, empirically informed care” (Weddle, 2002, p. 3). In fairness, front-line providers such as those operating or employed by group homes have a poorly-defined and seldom-evaluated skill set, and more often implement rather than contribute to major policy decisions; thus, it is more of a systems issue, rather than one likely to be addressed by front-line providers. Furthermore, given the “enormous” gap in moving knowledge to action (Drake, Skinner, & Goldman, 2008, p. 1385), in which it is known to take up to two decades to integrate research into clinical settings (Agency for Healthcare Research and Quality, 2001), group home operators and their residents may lack awareness of the shift toward the recovery paradigm, remaining more focused on community maintenance, symptom reduction and skill development rather than increasing participation in day-to-day life (Davidson, et al., 2010). However, as Anthony (2002) highlights, community maintenance is not enough: “It is yesterday’s goal. The goal for the future is community participation; that is, can we help people who are
maintained in the community function in the community more successfully and with greater satisfaction?” (p. 305). Clearly, as potential knowledge users, their roles as key stakeholders in knowledge translation have been undervalued, and their own efficacy in promoting recovery remains unexplored.

While the ideal that we should “recognize housing as a basic human right fundamental to recovery” (Sylvestre, et al., 2007, p. 88) is virtually unchallenged in the literature, the idea that housing first approaches will provide the solution is not so universal. Some of the knowledge gaps related to housing first/supported housing may be filled by the current randomized control trial, the At Home/Chez Soi research demonstration project, but its emphasis is on homelessness. There remains a lack of consensus as to whether supported housing is in fact the final step of a continuum, or whether it is an alternative to the supportive approaches. As Rog (2004) concluded, more research is needed to clarify what aspects of housing make the most difference, and for whom. Sustainability in housing first approaches is dependent on access to the finances for rent subsidies and requisite support persons, which are not universally available, nor guaranteed into the future. Furthermore, authors such as Shaheen and Rio (2007) suggest that while housing first approaches may have merit, they may be insufficient to prevent future displacement if they lack attention to employment, which can provide a more sustainable source of income support. Mental health care retains a strong focus on individual treatment, even though the environment has been increasingly implicated in both creating and controlling aspects of mental illness (Nikelly, 2001), but individual
treatment will be thwarted without parallel attention to both positive and negative environmental factors.

As Sylvestre and colleagues concluded, “unfortunately, we seem to routinely accept that the community mental health system in general, and the dedicated system of housing in particular, will be inadequate” (Sylvestre, et al., 2007, p. 91). Edge and Wilton (2009) found efforts for changing group homes to be frustrated by funding cuts, lack of adequate political will and vested interests of facility owners in for-profit settings, but questioned how group homes could be “reengineered” to integrate the principles of recovery (p. 137). However, for people with mental illness, “recovery delayed is recovery denied” (Davidson, et al., 2010, p. 184). The recovery-promoting potential of the custodial group home is yet to be explored and documented in the recovery literature (Weddle, 2002), but with the appropriate vision and commitment to recovery, systems change is possible (Kirkpatrick, 2005). Resigned to the fact that systems-level transformation is unlikely to revamp such housing in the immediate future, Sylvestre and colleagues suggest developing “recommendations that could proceed expeditiously” (Sylvestre, et al., 2007, p. 92), integrating consumer preference and a recovery vision.

Limitations

Much of the housing literature uses terms related to recovery, while not explicitly using the term recovery (e.g. quality of life, community integration, empowerment, and independence). Thus, a body of literature connecting these elements to housing has not been reviewed here, unless it appears in articles explicitly discussing recovery.
Conclusions

Clearly, housing and recovery are connected at multiple levels, some of which are yet to be clearly articulated in the literature. Housing options poorly suited to recovery and rehabilitation, such as custodial settings, persist and their capacity to promote recovery remains unexplored. As individual approaches to mental health care, guided by the medical model, prevail, important opportunities for understanding contextual issues and addressing multiple levels of influence on recovery for people with mental illness are lost.

As the recovery paradigm continues to unfold, it is incumbent upon mental health researchers to eradicate exclusionary behavior that only serves to perpetuate the daunting stigma faced by these residents, and draw their recovery needs into the current discourse. As a precursor to change, it is invaluable to have a better understanding of the current situation. With few studies offering contemporary views regarding the group home experience, a closer examination is warranted. In order to advance in this direction, a comprehensive understanding of how this housing context could address housing issues and promote recovery is required.
Chapter 4
Methodology

Purpose

In response to the overall question, “What are the challenges and opportunities for enabling group homes to increase their capacity to serve as an environment that integrates the recovery vision?” the purpose of this case study was to study one group home in depth, to:

1. Explore the current cultural milieu of a group home for people with mental illness.
2. Determine how recovery is understood in relationship to the group home.
3. Consider the influence of policies and practices on enacting the recovery vision within the group home.
4. Identify mechanisms for change that could increase the capacity of group homes to serve as an environment that integrates the recovery vision

Research design

Guided by a social-ecological paradigm which considers the person in context (Wright & Kloos, 2007), an instrumental case-study has been selected as the best means to explore in detail the group home experience and its capacity to serve as an environment to promote recovery. This approach involves studying the complexity of a particular case to gain a general understanding of a phenomenon, the results of which may shed light beyond the bounds of the case itself (Stake, 1995). Furthermore, it
provides the means for an in-depth understanding of a real-life contemporary phenomenon, in this case, the experience of recovery for people with mental illness living in a group home. With multiple stakeholders shaping and being shaped by the environment, the case study provides the opportunity to explore multiple viewpoints as well as the context of the issues (Yin, 2009). As a method of discovery, the case study allows for an in-depth understanding of the phenomenon, resulting in a detailed description which can be used to influence policy, practice and future research (Merriam, 2009).

Ethnographic techniques were used in this study as they provide a lens on culture, appropriate for the study of social settings and situations, and lend themselves well to case study research which does not in itself dictate specific research methods (Merriam, 2009). Wolcott (1994) agrees that ethnographic techniques are freely available to researchers who wish to approach their study in a descriptive manner. Ethnography is most closely associated with the study of culture, including the beliefs, values and attitudes that structure the behaviour of a group of people (Merriam, 2009). D’Andrade (1992) elaborated, suggesting that culture is something shared (behaviourally enacted, physically possessed, or internally thought) by a significant number of people in a social group, is recognized by others, and has the potential to be passed on to new members. In the case of the group home, social interactions are behaviourally enacted, with roles of relevant players economically and/or socially defined. Situated in an unremarkable neighbourhood, the home itself is physically owned and occupied as a home for its
residents and as a workplace for staff members. The various stakeholders hold their own views, whether stereotypical or idiosyncratic, about the group home and the roles and responsibilities of each stakeholder. The home is recognized and funded by the provincial government (Department of Social Development) as a group home for individuals with mental illnesses, and acknowledged as such by residents, staff, neighbours and others in the community. As such, it meets all of the criteria of a culture as specified by D’Andrade.

Case selection

Criteria for selection of the case included choosing a group home that: a) offered 24-hour on-site care, b) housed residents with a mental illness, and, c) was amenable to the involvement of a researcher. The home that was selected was thought by the researcher to be typical or representative of others like it, because the entry criteria were the same as other homes that provided the same level of care. Through collaborative mental health related committee work and participation in educational workshops related to recovery, a relationship with the executive director of this particular home was formed. The executive director indicated an interest in opening the home to this study, due to an interest in examining the ways in which recovery could be implemented. The willingness was confirmed by the board of directors. Considerations around time and access narrowed the choice, because, as Stake suggests, “we need to pick cases which are easy to get to and hospitable to our inquiry, perhaps for which a prospective informant can be identified and with actors (the people studied) willing to comment” (1995, p. 4). The
selected case met all criteria; with its accessibility to the researcher, the current study was undertaken in conjunction with a group home for individuals with mental illness in a mid-size city in New Brunswick, Canada.

**Definition of the case**

A case study must begin with the delimitation of the case itself – what will and will not be studied (Merriam, 2009). In this situation, the case consisted of the people, the house, and the related services, and the environment in which they are embedded, because as Wright and Kloos (2007) suggest, to apply an ecological paradigm to the study of housing and mental illness, individual and environmental variables and the interaction between the two must be considered together. In this case, the people included current residents of the home, the staff of the home (including the executive director, managers, and front-line staff), neighbours, family members, case managers with Mental Health Services, and a representative from the board of directors. The house included the physical house itself, as well as the structures governing the house, such as house rules, policies, standards and job descriptions. The services include the routine activities and functions of the house, and those provided by family, staff, management, case manager/outside mental health care providers, board members and the funding source. The physical and social environments are inextricable and were considered across the multiple levels of the microsystem (co-residents, staff, family, friends), mesosystem (community), and macrosystem (society) (Scaffa, et al., 2010).
Data collection

Culture generates behavior which can be observed through first-hand participation in day-to-day activities, and better understood through more in-depth engagement with some of the individuals, known as cultural informants (McCurdy, Spradley, & Shandy, 2005). From a social-ecological perspective, multiple methods are required to adequately assess interactions between physical environment, social environment and interpersonal experiences (Kloos & Shah, 2009). With culture conveyed over time by the places, events, routines and patterns that structure daily living (McLaren & Hawe, 2005), ethnographic methods were well suited to the enquiry. Thus, consistent with ethnographic techniques, data collection included participant observation (documented by a fieldwork diary – see Appendix B for observation guide), document analysis (see Appendix C for document analysis guide), and informal as well as recorded semi-structured key-informant interviews (see Appendix D for interview guides, and Appendix E for consent forms).

Following ethics approval through Queen’s University (REH-469-10 – see Appendix F), data collection was completed primarily during the summer and fall of 2010, with some ongoing clarification and member checking continuing throughout 2012. To begin, an overall consent was obtained from the executive director with whom the project was initiated, as well as the house manager. This consent included permission to spend time in the home and engage in participant observation in the role of volunteer, to engage residents and staff in informal conversation/interviews, as well as permission to
approach the residents and staff members to request private, recorded interviews. All staff and residents were made aware that my presence was related to a research project, and they were free to voice objections to the executive director, and to participate, or decline to participate in recorded interviews. No staff member or resident voiced objection to my presence in the home for participant observation or informal interviews. A further informed consent was obtained for each person participating in recorded private interviews. While no staff members refused, following two requests per person spaced out over a few weeks, three of the eight residents chose not to participate, citing concerns regarding the interviews being recorded. Their views were incorporated through informal interactions and participant observation, following which, notes were recorded. Those outside the home were recruited by being approached directly, particularly those who were known personally, or through a snowball approach whereby they were referred by another participant. Written informed consent was obtained prior to the completion of all formal interviews. Initial interviews lasted an average of 1 to 1.5 hours. While participants outside of the house were interviewed only once, all participants within the house (staff, management and residents) were interviewed either formally (recorded) or informally (with notes taken) on more than one occasion. See Table 4.1 for a summary of interview participants.
Table 4.1: Key Informant Interviews

<table>
<thead>
<tr>
<th>Participant category</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>5</td>
</tr>
<tr>
<td>Executive directors</td>
<td>2</td>
</tr>
<tr>
<td>Managers</td>
<td>3</td>
</tr>
<tr>
<td>Staff members</td>
<td>12</td>
</tr>
<tr>
<td>Case managers</td>
<td>4</td>
</tr>
<tr>
<td>Board member</td>
<td>1</td>
</tr>
<tr>
<td>Family member</td>
<td>1</td>
</tr>
<tr>
<td>Neighbour</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of key informant interviews</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

The documents included in the analysis were obtained from the public domain or provided by the management and staff. See Table 4.2 for a listing of documents included in the document review.
Table 4.2: *Documents Included in Document Review*

<table>
<thead>
<tr>
<th>Title of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards and procedures for adult residential facilities (DSD, 2006, 2009)</td>
</tr>
<tr>
<td>Organizational chart</td>
</tr>
<tr>
<td>Mission statement; Vision; Values</td>
</tr>
<tr>
<td>Job descriptions (Human Services Counsellor; House Manager; Executive Director)</td>
</tr>
<tr>
<td>Case plans</td>
</tr>
<tr>
<td>Policies and Procedures</td>
</tr>
<tr>
<td>House rules and expectations</td>
</tr>
<tr>
<td>Activity schedule</td>
</tr>
<tr>
<td>Collective agreement (2009)</td>
</tr>
</tbody>
</table>

Involving over 100 hours of participant observation (which continued until no new observations were emerging), engagement with the facility took place over a 6-month period, providing exposure to different seasons. Initially, observation periods were done almost daily, ranging from 1-7 hours per day, for an average of 4 hours per day for the first month. Once repeated observations had been made throughout the various hours of the day (for example, several evenings, to include the evening meal and the bedtime routine, or several mornings, to include the change of shift and the morning routine), and all of days of the week (noting that the routine is different on weekends), observation periods became shorter and more infrequent, and were sometimes targeted at specific
events or activities, such as the Friday night outing or a special meal. Termination of observation occurred by gradual disengagement from the home.

Participation in a volunteer role was suggested by the executive director as a means of avoiding the discomfort that might have resulted (for staff, residents, and the researcher) from a strict “observer” role. Preliminary sessions were focused on building rapport with residents and staff, which was achieved relatively quickly by engaging them in conversation, joining in on meals, playing games with the residents, and taking part in outings. The volunteer role, modeled on the role played by other volunteers, allowed interaction with groups and individuals within and outside of the home, and observation of the daily routine at various hours of the day and night. By coming at the same time each day, routines could be observed, and similarities and discrepancies noted. For example, several people told me that residents were required to assist with the preparation of the evening meal, but observation of multiple evening meal preparations revealed an inconsistent approach to resident assistance. Coming at varying times of the day, and on different days of the week allowed observation of the interactions of all of the different staff members with all residents, and participation in a range of activities. For example, every Friday night, an off-site activity such as playing pool or going bowling is planned by the staff. By shadowing the staff member responsible, observations regarding how such activities are planned and carried out were made possible, exposing the researcher to data that would have been unlikely to arise in an interview. Joining the group for meals at
the table, playing games, attending staff meetings, and sometimes just sitting in the living room watching television all provided key opportunities for observation.

While the volunteer role for participant observation provided a comfortable vantage point, it is acknowledged that it also altered the social dynamic of the setting. Residents and staff members alike quickly adjusted to my presence, and while one resident in particular interpreted our conversations to contain too many questions, most seemed comfortable sharing personal information quite early in the research. A strict observer role would be almost impossible in this setting, would have limited access to valuable data, and may have caused residents to retreat to their rooms. Thus, the volunteer role provided a suitable compromise. They could choose to interact, or not interact, but did not appear intimidated by my presence.

Data analysis

Data analysis was completed using ethnographic techniques, to provide a socio-cultural interpretation of the data, exploring as many variables as possible and portraying their interactions (Merriam, 2009). Congruent with ecological approaches, the analysis included consideration of the interaction and interdependence of the participants within the context of the setting, and the resulting behaviours (McLaren & Hawe, 2005). Such an analysis allowed the opportunity to rethink the phenomenon being studied and gain insight as to how and why things are the way they are, suggesting possibilities for change (Stake, 1995). As Merriam (2009) highlights, such a study may reveal discrepancies or dissonance between what people think they are doing, say they are doing, appear to be
doing and are actually doing. The job of the analysis was to integrate and condense data from the multiple data sources, and confront discrepancies.

As it is virtually impossible to enter a fieldwork site with no preconceived notions, “sensitizing concepts” can be used, not to thwart the inductive process, but rather to provide a preliminary framework for the organization of data (Patton, 2002, p. 279). Merriam (2009) suggested that ethnographic analysis sometimes uses pre-existing category schemes as a starting point. Consistent with a social-ecological perspective, such a strategy was used here, using the Model of Housing Stability’s broad categories of the person – housing – service within the environment framework developed by Sylvestre et al. (2009). This framework represents background knowledge that guided which questions to ask and which incidents to attend to - a helpful strategy for new researchers (Miles & Huberman, 1994).

Guided by the overall research questions and study purpose, the analysis began during the data collection phase of the study, and focused on describing and analyzing the pattern of relationships (Miles & Huberman, 1994). As suggested by Merriam (2009), memos of reflections, emerging themes, and ideas to pursue in subsequent data collection were noted within the fieldwork diary, which also served to document observations recorded following each participant observation session. Recorded interviews were transcribed verbatim and data from informal interviews, observations and document analysis were transformed into a narrative format. Thus, narrative data from these data sources (fieldwork diary, interview notes and transcripts, and document summaries)
comprised the data set for the study. While the categories of the Model of Housing Stability (person – housing – service within the environment) were used as sensitizing concepts, attention was taken not to allow those categories to constrain the analysis.

Next, the narrative data were read repeatedly to enhance familiarity with the overall data set, followed by line-by-line coding at which time notes were made relating to emerging themes. For example, statements such as “we prompt with hygiene” and “teaching them the good and socially acceptable skills” revealed house values (hygiene, socially acceptable behavior) and methods of interaction (prompting, teaching). The “structural levels of analysis” approach (which includes item, pattern and constituents as the levels of abstraction) (LeCompte & Schensul, 1999. p. 68) was implemented. In the “item” level of analysis, the data were sorted and items that were alike in some way were clustered, providing a beneficial next step. As additional approaches of interacting were noted, it was evident that although some were used to move the individual forward while others focused on enhancing or maintaining current relationships, they were expected to be derived from each individual’s case plan. Next, the “pattern” level seeks to arrange the clustered data into patterns. The various approaches to intervention were analyzed, revealing both organizationally-derived and individually-derived approaches to intervention, which formulated part of the “general approach/program.” Finally, as a result of arranging the various patterns, the “constitutive” level illustrates the whole picture. The “general approach/program” emerged as one element that informed the overall culture of the group home.
The final product includes a detailed description of the case in response to the research questions. Given the descriptive nature, the findings are presented using an “unsequenced structure” in which the topics are presented in no particular order (Yin, 2009, p. 164), but inform a response to the study questions.

Enhancing trustworthiness

Trustworthiness was enhanced by triangulation of sources and methods, by member checking, and through frequent interaction with the thesis supervisor and input from the advisory committee. As suggested by Elliott, Fischer, and Rennie, (1999), 7 guidelines for evaluating qualitative research have been addressed to enhance trustworthiness:

1. Owning one’s perspective: This study acknowledges that the observations and interpretations are my own, and are seen through the eyes of an occupational therapist. A reflexivity exercise (see Chapter 2) further highlights assumptions and the potential for bias, and situates the researcher relative to the study.

2. Situating the sample: Housing both male and female residents, the unit of analysis for this study is one well-established not-for-profit group home in the downtown area of a mid-sized city in New Brunswick, Canada.

3. Grounding in examples: Many examples and verbatim comments are shared, both in the methods section and in the findings to illustrate analytical processes.

4. Providing credibility checks: Triangulation of data sources and methods of data collection, including participant observation, formal and informal interviews with multiple key informants, as well as document analysis informed the study.

96
Analysis of data was completed in collaboration with the thesis supervisor.

Member checking, also known as “respondent validation” whereby feedback on emerging findings is sought from some of the respondents (Merriam, 2009, p. 217) was completed during data collection by providing transcripts of interviews for confirmation, and by individually engaging all participants in informal discussions of emerging themes. The results were used to guide further questioning in subsequent interviews and observations. Following analysis, a framework of key themes was presented for review by a small focus group of two participants, who endorsed the findings.

5. Coherence: The findings are presented in a narrative format, with multiple examples to clarify each finding.

6. Accomplishing general versus specific research tasks: While the case study methodology provides the opportunity to provide an in-depth exploration of the study target, like other forms of qualitative research, it is not known for generalizability of the findings. However, many advancements in human and natural sciences have been made based on single cases (Merriam, 2009). Thus, while some of the findings in this study are idiosyncratic to the setting, with its attention to multi-level influences, applicability beyond the setting itself must be considered. The concept of transferability has been proposed as the means of extrapolating qualitative findings, suggesting that “the degree of transferability is a direct function of the similarity between the two contexts” (Patton, 2002, p. 97).
The thick description, characteristic of the case study report, informs “logical, thoughtful, case-derived and problem-oriented” extrapolation of relevant information (Patton, 2002, p. 584), thus contributing to transferability.

7. Resonating with readers: The current study is intended to expand awareness of a subject that has received little attention in the literature in recent years. It is in many ways a multi-level “call to action,” acknowledging the ripple effect that can occur with change at any level, whether raising expectations, or enhancing opportunities. With increased awareness comes the opportunity to “either advocate consciously with others for justice, or comply with occupational injustices through silence and inaction” (Townsend & Wilcock, 2004, p. 83).

With the intent of resonating with readers, the choice is clear.

**Ethical issues**

As Miles and Huberman (1994) cautioned, a variety of ethical issues were worthy of further consideration:

1. Informed consent: The executive director and the house manager provided consent for participant observation to occur, having gained a general consensus from staff and residents prior to my arrival. There was a risk that some individuals in the home would withdraw their consent to being observed. At one point, one gentleman voiced to a staff member that he did oppose my presence, saying I asked too many questions which made him uncomfortable. The staff member was able to provide strategies to both of us, telling him that there was no pressure or expectation for him to talk with me, and
suggesting that I not approach him, other than to be cordial within the home. These strategies were effective in enabling me to build a relationship with the man over time, and he was soon comfortable with my presence, later requesting an interview.

2. Confidentiality: This case-study involves one home only. As such, it has been difficult to protect its identity, and the identity of key informants. I have been careful when documenting sensitive issues, and have chosen to refer to all residents as “he” and all staff members as “she” (representative of the dominant gender of each group), to protect confidentiality. Furthermore, in the findings section, although attention has been taken to provide comments from all participants (as confirmed by the advisory committee of this study), specific quotations will be attributed to “resident” or “staff/management” (which will include front-line staff, managers, executive directors and board members) to further protect identification of participants.

3. Legal dilemmas: While there was the potential to become aware of illegal activity (e.g. drug use), no such incidents occurred.

Strategies suggested by Miles and Huberman (1994) were helpful for dealing with potential ethical issues. These included anticipating possible issues, and contracting or creating preliminary agreements with the stakeholders before entering the field. They also suggest using a third party as a mediator. The executive director agreed to serve in such a role, but her services were not needed. In this study, the ethical issues discussed above were discussed with the manager of the home, and a preliminary agreement was developed addressing each of the potential issues, as well as other concerns which could
have arisen. Regular checking and renegotiation (Miles & Huberman, 1994) was incorporated, particularly as it related to the gentleman who was at one point unhappy with my presence. One other unforeseen ethical issue that arose was the misunderstanding of one resident that I would be able to implement all of the suggestions that were given to me. He was hopeful for a new, more modern spacious home, one in which he would not have to share a bedroom. A staff member with whom he was close was able to dispel this belief, but I confirmed that his concerns would be noted.
Chapter 5

Findings

This chapter provides the findings, organized according to the sub-questions:

What is the current cultural milieu of a group home for people with mental illness? How is recovery understood in relationship to the group home? How do policies and practices impact the capacity of the group home to enact the recovery vision? Direct quotations from study participants are provided in italics.

The current cultural milieu

The house

Located on a small downtown side street, with the exception of a winding ramp up to the front door, and frequent smokers on the doorstep, the house is indistinguishable from its neighbours. While showing its age (probably 50+ years), the house itself is a fairly well-kept one and one-half storey home with a well-groomed lawn and simple landscaping. It has a room built on to one side, which, once inside, reveals itself as a sparsely-furnished, clean but dated family room with two old sofas, a television, and window ledges covered in plants. The back exit through the family room opens on to a patio containing a barbeque, an array of lawn chairs, and some badminton racquets. The long, narrow back yard is shaded by several large trees, under which two additional seating areas have been assembled next to a small garden on one side and a storage shed on the other. Closer to the house is a patio table surrounded by chairs, with a large
overflowing ash tray as a centrepiece, around which staff and residents alike congregate regularly to smoke.

Back inside, the kitchen emerges as the hub of the home. The counters and cupboards have seen fairly recent updating, and a large harvest table fills the centre of the room, with seating for at least ten people. A well-used dishwasher hums next to the sink, signaling the end of another communal meal, further evidenced by a couple of residents and a staff member lingering at the table over coffee and the day’s newspaper. A message board next to the telephone displays a monthly activity schedule, and a roster of “chores” is stuck to the refrigerator beside the weekly menu. On to the living room, a large sofa and two chairs point toward an old-style television, flanked by some other aging electronic equipment. In the window, a newly-acquired air conditioner brings relief to the stifling hot day. A few games, crafts and magazines are noticed on the coffee table. Some hand-made crafts on the mantle, a couple of pictures on the wall, and a fully-functioning fish tank round out the décor. Down the hall, which houses a locked food cabinet, a small and dated bathroom separates two bedrooms, each one occupied by one of the two main-floor residents. While it is clear that the bedrooms are private, a glimpse into each reveals two very different personalities, one neatly organized, and one in disarray. Both were freshly painted I am told, and both contain a bed, television set, dresser, desk, and several books and magazines. The remainder of the residents are housed either upstairs or downstairs. Downstairs, next door to an area of the house which is otherwise used for administrative purposes, (with two offices, a staff bathroom, and a utility room
containing a washer and dryer, a freezer and some storage units), two residents share a sparsely-decorated bedroom containing two beds, two dressers, some disheveled clothing, and a large CD player with several CDs. Upstairs, two residents have their own bedrooms, while the other two, totaling eight residents, share the remaining bedroom.

The neighbourhood

With its ready access to downtown amenities, and its prime location on a bus route, residents can avail themselves of a wide range of opportunities, such as work, school, mental health services, shopping, and recreational activities. The quiet neighbourhood is conducive to walking and cycling. The residents and staff enjoy a friendly rapport with neighbours. For example, one evening, when I was sitting on the front step with one of the residents, a woman walked by on the other side of the street. She smiled and waved and yelled “hello (resident)”. He yelled back “hello, (neighbour), do you want to go on a date?” She answered, laughing, “(resident), I didn’t know you were that kind of guy.” He was laughing, and told me she was a neighbor, and described how she and the other neighbours in the area were friendly. Another neighbour confirmed the cordial relationship, describing how, other than contending with numerous cars that are sometimes parked outside, she had no concerns moving in next to the group home. They made great neighbours. However, she said that although she and other neighbours might go back and forth to each other’s homes for barbeques or similar get-togethers, it would not occur to her to invite the group home residents over to such events. Likewise, she would not expect to be invited over for any reason. “We more or less keep to
ourselves and so do they,” she said, highlighting that while they are described as good neighbours, they are different in a sense from other neighbours.

The residents are aware of the stigma that might be attached to such a home, even if they are not experiencing it directly within this neighbourhood. As one resident discussed,

...the terms they call it here, like special care home or group home, there is attitudes toward those words... negative to the public. They don't know what it is like. You really don't know what any thing’s like until you go to the place, but people will judge things right off the hop. (resident)

In spite of this knowledge, the residents generally seem happy and content living in this neighbourhood and in this group home, describing it as a peaceful place to live.

The residents

The residents, a mix of males and females, all of whom have a mental illness, range in age, with one half of them under forty years of age and the other half over fifty. Half of the residents have either part-time jobs or attend educational programs. The tenure of current residents ranged from approximately 2 years to 10 years, with an average of 4.5 years.

While residents seem quite settled now, there is consensus that when they first move in, “they are usually not in a very good place” (staff/management). As a family member described, her son went to live in the group home after landing in the hospital following a period of significant turmoil. It would have been too stressful to have him return home, but it was important to her that he be content with his living situation. When he went to live there, she said “there was relief. I was optimistic. I was very glad to have
him there, well, because I knew he was safe.” Likewise for others, although at an earlier point in their lives, residents had jobs and closer family connections, it is generally by virtue of not doing well that they came to live in this group home. A typical scenario of residents arriving at the group home was described as: “they haven’t been taking their meds, they haven’t been eating properly, they have been using drugs and alcohol, they have been leading unhealthy lives” (staff/management). Coming from turmoil, the group home offers them some stability and much-needed nurturing and support. A resident described the contrast to his previous living situation: “The best thing about living here is that you get good care. You get all the meals that you need and your medication is paid for. You feel your well-being and your health is maintained” (resident). Others agreed that it is a good place to live, you are well cared for, and loved like family, and the environment is beneficial to your mental health. It is described as a respectful environment where fighting and bad language are not tolerated. There are a lot of activities to participate in, and with staffing around the clock, there is always someone to talk to.

Although some spoke of moving on to more independent settings, such a move did not seem imminent for any of the current residents. Residents were vague regarding indicators of readiness for moving out, when they might move out and where they might go, citing such locations as “Toronto” or “out to the country” as next steps. As one resident said, “…I hope I can eventually move there. It is sort of my plan” (resident), highlighting that it was a distant goal, but not one in the forefront of each day.
Even though the residents are physically integrated into the community it is more difficult for them to integrate socially. Although there are a few situations in which residents engage with friends or family nearby and participate in activities outside of the group home, relationships and activities are primarily anchored within the home. The prevalent resident interaction is with staff, and, to a lesser degree, with other residents. Residents particularly appreciate having 1:1 time with staff to talk things through and relieve stress, but given the staffing ratio (often 1 staff to 8 residents), this is seldom possible. Family connections vary, with some residents having regular contact, while others have little to no involvement, even on special occasions such as birthdays and Christmas. As a result, staff place added emphasis on making such occasions special, sometimes giving their own time and money to do so. On occasion, family members contribute to the social milieu by developing relationships with multiple residents and including them in their family outings. For example, “sometimes, maybe one of them, their parents are taking them out to the camp to go fishing. A lot of the other clients will go with them, and things like that which is really nice to see” (staff/management). Family members were more likely to take residents out, whether for meals, errands, or overnight visits, but did not spend much time within the group home. Having a relationship with a partner was considered problematic, as residents did not feel free to invite people over without the approval of all of the other residents. Even having a friend or family member over was not easy, as there is little privacy or space to entertain, and doing so would compromise the privacy of other residents. Furthermore, the household budget does not
allow for hosting others for meals or snacks. Thus, residents found they could visit at the homes of others, but could not readily reciprocate.

**The staff**

The staffing for the home includes an executive director, who oversees this home and a number of other housing-related services in the area, an on-site manager, and a number of front-line staff. Periodically, volunteers and students, such as nursing students completing community-based practicums, are also present. As a not-for-profit agency, they are governed by a volunteer board of directors that functions at arm’s length, and receive their funding through the provincial Department of Social Development on a per-diem basis, meaning they receive a certain amount of money per person, and only when the space is filled. As a not-for-profit agency, this home is different from the many for-profit privately-owned group homes in the province, held to a higher standard with regard to staffing. Unlike privately-owned homes operated by people with little or no training, the front-line staff are expected to have a one-year program in Human Services Counselling, or equivalent. Provision is made within the governing documents for casual staff who must only be sixteen years of age, (nineteen if they are to be alone with clients), and have high-school graduation (DSD, 2009). In this home, it is common for staff to have the Human Services Counsellor course, or a Bachelor’s degree in psychology. Of note, neither educational program contains information specific to recovery, which may explain why few have heard of it. As one staff member admitted, revealing the prevalent caregiver approach, “…we are not trained in mental health. We are trained in care, and
in day-to-day living, but we are not trained to help them recover” (staff/management). Much of the training does occur on-the-job, with more seasoned employees passing along key information to the newer staff.

The staff at all levels of the group home are very low-paid (although recent unionization has given them optimism for pay equity with similarly-educated groups). For example, according to the 2009 collective agreement, prevailing at the time of the study, facility support workers started working for the minimum wage of $9.15, and received small annual increases for three subsequent years up to a maximum wage of $10.50. The manager’s starting wage was $11.01, with incremental increases up to $12.95. The low wages meant that many of the staff held down more than one job so they could make ends meet, often requiring them to finish their shift at the group home, and go directly to another job. Others were constantly seeking higher-paid opportunities, seeing time at the group home as a transitional opportunity to gain experience. This frequently-heard comment encapsulates the situation: “We work here not for the money, but at a certain point the money plays its part and that’s what I would say would be the major point in why we have constant turnover” (staff/management). The constant turnover was confirmed, with many staffing changes occurring during my six months of participant observation. This turnover greatly influenced residents, with some experiencing exacerbations of depression and anxiety in the face of losing valued relationships.

The staff members of the group home have a critical impact on the social environment within the home, and have clearly built close bonds with the residents.
There is variation in how they perceive and enact their roles, which impacts their interactions. Promoting independence, enforcing rules, insulating residents from the outside world, and providing a comfortable place to live represent common views.

Whether by sharing a prayer or a dirty joke, staff described how they value using their own personalities to build relationships with the individual residents. At times interacting with the collective, and at other times with individuals or small sub-groups, some staff members employ a more authoritarian approach while others present themselves more as a “buddy” to the residents. As paid employees in an informal work setting which is also someone’s home, the relationship of staff to residents becomes an awkward aspect of the environment where both parties continuously struggle to navigate their roles.

**Issues of funding**

With regard to finances, the pervasive mentality within the group home is that they are on a very tight budget. Although the group home receives roughly $2,300.00 per person per month, the budget has to be stretched to cover staffing as well as all of the expenses associated with home ownership and to provide food for the residents, with little left over for such things as recreational activities for residents, or educational opportunities for staff. This theme was reflected in the following comment:

> ...honestly I think funding is our biggest problem. We do the best with what we have, which is not a lot, and our manager and our executive director pull their hair out trying to work with the tiny bit of money that the government gives them. It is hard to get qualified staff when you can't afford to pay them.

(staff/management)
Furthermore, when resident spaces are empty, funds are cut. However, if individuals are assessed to need a higher level of care, funds are increased to allow for added supervision. Thus, issues of funding may be seen as conflict of interest as they relate to resident transitions.

Residents are entitled to a very small amount of money, known as a “comfort and clothing allowance,” roughly $135 per month at the time of the study. With the expectation that all personal care and toiletry items, as well as clothing, transportation, and any other personal requirements be funded from this meager sum, little is left for recreation, let alone long term saving, limiting the opportunity for eventually moving to a more independent setting. In an effort to make it last throughout the month, staff often act as gatekeepers of the money, with residents requesting funds as needed.

Some of the residents are able to work to supplement their income, but are limited in the amount they can make before other benefits are affected. Much confusion surrounds this issue, with numerous versions presented regarding how much money could be made and kept by the resident, and where additional money might go. Residents who do obtain employment commonly do so through specialized programming which is not normally full-time or long-term, and supports for such employment are limited for those living in group homes. For example, discussing a particular employment support program, staff were not optimistic a specific resident would qualify due to his residency within the group home:

_We were surprised that he was approved, because the emphasis is on hoping that they will become more independent and be able to work independently, and I_
think the feeling is, or the idea is that if you are living in a special care home, that sort of would indicate that perhaps you are not able to be that independent, so would you really be able to work independently, so we were surprised when he was approved, and when he found out he was not going to be able to keep all of the money he was discouraged. (case manager)

Not being able to keep the money he earned due to the funding arrangement implied by residing in the group home interfered significantly with this resident’s plan to save up and move out on his own. With the short-term nature of the employment program, uncertainty regarding future opportunities, and vulnerability to government cuts for support services, such a plan was not viable, perpetuating his stay at the group home based on finances, not necessarily functional ability. Furthermore, although approximately $2,300.00 is allocated to cover his expenses at the group home, if he was to move out on his own, his entitlement would drop to roughly $600.00 per month, a challenging sum on which to survive. Acutely aware of this reality, staff are reluctant to encourage residents to move on.

Staff members are also aware of the impact of the finances on the day-to-day running of the home, and the related challenges of providing a normal life for the residents:

I mean a normal life is not sitting in the house all day because you don’t have the money to go for an ice cream. That is not normal life. Normal life is not always having to wear clothing from the Salvation Army because that is all you can afford, or socks that are full of holes because you have to wait until your next cheque comes so that you can get new personal items. It just always seems to be about the money. This is the first year we’ve had air-conditioners. Do you know what kind of summers we have suffered through, these guys have suffered up in those upstairs rooms, from heat because we couldn’t afford air conditioners? (staff/management)
Groceries are also affected, with powdered milk replacing actual milk, food sometimes having to be rationed and locked up, and specialty items such as ice cream and other desserts eliminated from the grocery list. To address these financial issues while ensuring nutrition of residents, staff members have become quite resourceful in teaching frugal grocery shopping to the residents, as well as preparing homemade soups and stews and engaging the residents in baking.

Funding issues affect residents not only within the home, but also with accessing activities in the community. With limited disposable income, they are in constant search of low-cost leisure activities. From a recovery perspective, connecting with natural supports such as friends and family would be encouraged, but there are at times financial disincentives for residents planning activities on their own. For example,

…if they go and decide to do a movie themselves, which they do, then that can come out of their own money, but if we at the house here plan an outing for everyone to go then that comes out of the house budget…but if they decide to go out on their own, like... if some of the clients decide 'I want to go and play pool Wednesday night' then that would be something they would pay for on their own. (staff/management)

An activity must appeal to several of the residents if it is to be one paid for by the group home, limiting the range of possibilities. With limited resources, residents also commonly access low-cost activities organized by mental health services. Thus, it is clear that influence of finances in this setting can play significant role in recovery, by limiting opportunities in both the present and the future.
Housing or a mental health program?

This group home for individuals with mental illness is an environment where the boundaries of one’s home are blurred by the mandate to provide treatment: “We are not just a housing facility. If you are just looking for room and board we are not the place for you” (staff/management). While, for the most part, the residents are free to come and go, there are restrictions and there is an expectation that they will adhere to prescribed treatments and work toward mutually-established goals. Differing views amongst staff are evident in the perceptions of how much freedom residents of this group home have. One sees it as “they do not have to do nothing…freedom, independence. You can do whatever you want” (staff/management). Another views it differently, saying, “they don’t have all the freedom in the world. They still have like their stuff governed. They’ve got like charts and stuff up everywhere” (staff/management). With its balance between mandatory requirements, such as adhering to one’s medication regime, and the freedom to come and go, the daily routine in the group home speaks to the fact that it is seen as both a home and a mental health program where balancing freedom and expectations characterize the day-to-day experience.

The staff members become closely involved with each person, discussing personal matters such as hygiene habits, but are ever-mindful of the fact that their interactions take place within a home setting. “Here, we are in their home, right, this is where they live. We want them to feel comfortable but at the same time we want to motivate them to want that and to feel the benefits of say, good hygiene, and you know,
‘oh, don’t you feel better?’” (staff/management). This balancing act becomes a key challenge for all involved.

Referred to as “a family environment” (staff/management), “quite family oriented” (staff/management), and “like a nuclear family” (resident), staff and residents share the perspective that it is a home-like setting and that the social environment is in many ways reminiscent of family life. It is in a way the casual nature of the interactions that make it feel like a home setting, and distinguish it from a more institutional setting: “we have supper with them, we watch movies, we go and do stuff, we joke around. It is a very good home atmosphere” (staff/management). In an effort to maintain a welcoming environment, no uniforms are worn, and no credentials hang on the walls. As one staff member highlighted, drawing attention to the nature of the relationship:

You become much more a part of their lives in this setting. A lot of our clients see us as an extension of their family, because like... a lot of them have been there a long time and you really get to know them. It is really easy to become very attached because you are spending eight hours a day five days a week, 40 hours a week. (staff/management)

One resident expressed appreciation for the opportunity to be in a family-like setting where it was safe enough to exhibit your weaknesses without fear of ridicule, a situation that had characterized his life prior to moving in. The semblance of family is most notable in the mealtime rituals, where the residents and staff share responsibilities (albeit inconsistently) and gather around the large harvest table, particularly for lunch and supper. With some of the residents coming and going throughout the day, meal times provide a regular check-in opportunity:
...we make a lunch and we all sit down and normally at that time we try to catch up with people and see what people are doing because we have some people who like I said work in the morning or work in the afternoon and we have a couple, well we have one resident that is going to [school], so we always catch up on his courses, and there is another resident here with grown children and we like to see how that is progressing. It is normally like a family time. (staff/management)

Although there is agreement that it is a family-like homey setting, there is an undercurrent that something about it distinguishes it from home and family. It is “kind of a family” (staff/management), not an actual family. Staff are aware of the power differential: “We say we are trying to create a home. It is an artificial home...we have a lot of control over them and that gets all mucky” (staff/management). Ranging considerably in age, some staff members are seen as mother figures, while others are seen as friends. The residents are aware of the complicated nature of the relationships, and try to navigate accordingly. For example, one said, “you might slip and think of them as your friend...it almost feels like it is your friend, but it is not exactly the same” (resident), confirming the sense that a distinction is made. It is this distinction that creates challenges in the long term, because, although the relationships seem close, they are connected to the organization and are unlikely to continue beyond the period of residency. Thus, although close bonds are formed, they do not form part of a support network that can be relied upon into the future.

The group home is their home, but at the same time it is a shared space and there are responsibilities that come with communal living that may not exist in independent living. For example, housekeeping chores are assigned to each person, and the completion of chores has implications for the whole group. Thus, structures are put in
place to ensure they get done. It becomes a balancing act of making people feel at home, while respecting the needs of the group. “We are very conscious that we are in their home, this is their home, and they need to feel at home, but at the same time, just because they don’t feel like doing chores for a week doesn’t mean they don’t need to get done” (staff/management). Furthermore, in a small home such as this one, with many shared spaces, there is little privacy, and disagreements are inevitable. Staff members sometimes see the need to shift roles and deal with the various circumstances that come up, as “some clients are sharing bedrooms and it is difficult. We act as mediators and go-betweens and assist, and try to maintain it as a family home... It is not a facility, it is but it isn’t. We only pull that hard ball out when we need to” (staff/management). “It is but it isn’t a facility” highlights the complexity of understanding the culture of such a home, and the challenges faced by the staff members who are primarily responsible for much of the face-to-face interaction that goes on there. Thus, although it may be “like home to the staff and the residents” (staff/management), there are distinct differences that reveal its identity as a mental health program.

General approach/program

While at the administrative level, there is growing awareness and interest in the recovery vision as indicated by their recent participation in community-based education regarding recovery, there is actually little indication of any particular approach or program theory guiding programming. Rather, there are some overarching, but vaguely defined aims that guide what goes on within the home, loosely geared toward promoting
the independence of the residents, and providing a peaceful and stable environment. At its inception, the home was considered transitional, with the expectation that two years would be the maximum tenancy. For a variety of reasons, including lack of sufficient progress toward independence, and lack of feasible options for the residents, the policy was changed to the current situation, whereby tenancy is unlimited. Furthermore, no records are kept regarding the outcomes for those who have left the group home. Thus, it is unknown how many departures have been positive, how many have been negative, and what the key contributing factors might have been.

**The custodial nature of the home**

Several features reflect underlying beliefs, and reveal the home’s custodial nature:

- Although they can leave the home unattended, residents cannot be left unattended within the home. One or more staff members must always be present within the group home, communicating that something about this group of adults that renders them unable to be left alone, which may perpetuate a sense of dependence.

- Medications are kept under lock and key in the office. Each morning, and periodically throughout the day, residents are roused by staff and summoned to the office to be supervised taking their medication. They are not permitted to refuse the medication, having committed to the regimen upon admission to the home as indicated by a signed agreement. Failure to comply could jeopardize the placement.
• The “comfort and clothing allowance,” is kept under lock and key, and doled out in increments throughout the month. Residents must approach staff to request money, providing a rationale for the desired amount.

• Tobacco for three of the residents is portioned out and provided according to a schedule, to ensure the supply lasts throughout the month.

• Some foods (primarily snacks and treats) are kept under lock and key to ensure they last throughout the month, and to limit excess consumption by certain residents. Access is monitored by staff.

• Sharp objects such as butcher knives and shaving implements are kept under lock and key.

• A curfew of 11 p.m. is implemented (with occasional exceptions made). Residents are expected to notify staff of their whereabouts, particularly in the evening.

These longstanding policies inadvertently send the message that the residents can’t be trusted alone, can’t manage their own medications, can’t manage their own money, and so on, conveying a “risk management” stance which contradicts the stated aim of promoting independence.
Enacting case plans

Primarily anchored by what is known as the “case plan,” interventions with each resident are somewhat informal. Case plans are intended to be annually-reviewed documentation of individualized, collaboratively developed goals created with the resident, the house manager and the case manager through Mental Health Services. Staff members are expected to interpret the individual case plans, create opportunities and interact with the residents as individuals and as a collective to move the identified goals forward. As indicated in Table 5.1, some approaches to enacting case plans arise from the policies and procedures of the organization, while others are idiosyncratic, arising from staff perception of what is beneficial in each situation. The individually-derived approaches can be described as therapeutic ways of interacting within a relationship, and ways of moving residents forward.

Table 5.1: Organizationally- and Individually-Derived Approaches to Enacting Case Plans

<table>
<thead>
<tr>
<th>Approaches</th>
<th>Examples</th>
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<td>Organizationally-derived approaches</td>
<td>“When somebody comes here they sign a resident agreement, and that resident agreement indicates that they are committed to their case plan, and they develop a case plan in collaboration with their case manager and the manager here, that they are working towards goals and objectives that have been established via the case plan and the staff work with them to try to assist them with attaining those goals and objectives.”</td>
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| Developing individualized case plans | “We make up case plans that are kind of like yearly goals for them. It is done with their help. It is their goals, it is what they want to do, and it is done with their case managers and our staff works to help them achieve and succeed with those goals...we make goals that are attainable....”

“so they actually have their own case plans... I am not involved in making them at all but we all have to follow them, like we can’t go against the case plan” |

| Creating tracking charts to monitor progress on specific goals | “the manager has set up charts so you can track who showered and when...A lot of them are men and they do smell in the summer. It can get really gross. We have had problems in the past with it too, just trying to get people to shower... it takes a lot of effort to monitor.” |

| Planning outings to encourage increased activity level | “some of the outings, we organize...we are planning a movie night...walks and bike rides...go for ice cream, go to the park” |

| Expecting participation in meal preparation and daily chores | “We get them to help make supper and stuff...other than that they have all got their chores that they do, that we kind of encourage them to do. There is a list up there that says who is to do supper prep and who is to do cleanup”

“You have a chore. You can choose to do it or you can choose not to. If you do it you have a clean place. If you choose not to, somebody else has to do it, and you are losing the ability to learn that skill, and you are not picking up your weight, because there are certain expectations” |

| Individually-derived approaches | **Therapeutic ways of interacting in a relationship** |

| Building a relationship/rapport with each individual | “getting to know them like I said, the most important is to know the client...it is building that rapport”

“if you do not have a rapport with the residents, then you are sunk. What are you going to be able to do for them if you can't talk to them, if you can't find an individualized way to relate to them, each resident” |
| Negotiating the relationship | “I look at them say, as not a friend but as an acquaintance who I know”
|                            | “I hope I befriend them, you know, more than anything, because like I said if you don't do that... I think it is easier to talk to a person when you are a friend than it is when you're holding yourself as staff”
|                            | “some of them sort of call me mother ... so that is kind of cute”
| Impromptu counsellor to address arising issues | “If some need to stay up later, talk, then there is always that opportunity”
|                            | “If you have a problem, we will listen”
| Individualizing approach in interpersonal interactions | “knowing the individual, we do have some guidelines in approaching certain things and part of that is knowing that for instance so and so is very resistant to being directly told to do something, but responds well to sarcasm and joking around, so it’s not necessarily a guideline...so instead of saying ‘go take out the garbage’ it is like, ‘oh, it stinks in here, would you mind taking that out while I do this’”
| Not being authoritative | “we try as much as possible to not take the overtly authoritative approach at all, that is not our goal”
| Therapeutic use of self in personal interactions | “If everyone is collected in the kitchen, staff, you try and be upbeat, talk and try to bring up the room level, make everybody feel good, so it brushes off on the residents, because if everyone just sits and it is quiet, and no one is really saying anything, I mean, that is good as well I guess, but you try, as staff, to get people feeling good about their general day.”
| Showing an interest in each individual to enhance motivation | “show an interest, and that gets them talking, and just by showing that interest it shows, it gives them an avenue to be passionate about something, and I find that works the most. You say a couple of questions and just let them go and you get to learn so much about them. Then they have an avenue to talk it out, and the more they get to talk about it and the more they get to do it I find is motivating for them because it is something that they truly enjoy.”
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<th>Ways of moving residents forward</th>
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<td>Encouragement to set a higher personal standard in spite of their illness</td>
<td>“she (the manager) encourages them to be active, to live their life and not spend their whole life in bed, and I find the staff here is really good at encouraging them to better themselves, and not become a victim of their illness, because it is not who you are, it is just something you deal with.”</td>
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<td>Prompting to follow through on commitments</td>
<td>“We are just here to prompt...if they feel like for blood work they want to take the bus up and do it themselves, we would make sure they knew when the bus was and we would encourage that”</td>
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<td>Encouraging increased activity level</td>
<td>“I always encourage them and the coworkers would also encourage them, encourage the people to get out once a day”</td>
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<td>Promoting social integration</td>
<td>“I think it is helping them to integrate into the community is one of them”</td>
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| Educating with regard to specific knowledge and skills | “life skills...maintaining hygiene, maintaining proper diets, getting a good night’s sleep, the value of exercise...how to cook, how to clean...also social skills”  
“He doesn't know how to sort his clothes properly or puts in too much, teach him how to do laundry” |
| Modeling health behaviours | “So I explained my caloric intake, because I was getting older, I did not need as many calories, and the weight was staying with me so I was trying to be a little healthier and just not eat as much, and it sort of gave them something to think about, instead of me ranting and raving about 'you need so many vegetables a day’ they could see what I was doing and then they could ask...it does not feel like you are being smacked over the head with a book” |
| Acting as a mediator to resolve interpersonal conflict | “some clients are sharing bedrooms and it is difficult. We act as mediators and go betweens and assist, and try to maintain it as a family home” |
| Monitoring individual situations | “(Resident) is going through a difficult time right now so we are all supposed to be monitoring, getting the phone, monitoring his calls for him...screening them I guess, so that kind of direction.”  
“make sure they are eating properly, keep an eye on the folks who need a little more individualized attention around their diet” |
| Focusing on strengths to promote personal growth | “You know when you go to see a physician, you deal with what is wrong, whereas here we deal with also what is right, so we get to encourage them and see them grow in a different way” |
| Providing opportunities to build independence in daily activities | “letting them get their own snacks, letting them make a fried egg, getting them to say call a taxi and I think at first they are quite fearful, but then when they can do it gives them pride, or calling in their meds to the med shop, or taking the bus by themselves” |
| Behaviour modification | “We try with their case plan to modify their behaviors. I think if everyone had more of an understanding of behavior modification, we could do better, but we do the best with what we have” |
| Positive reinforcement for success in accomplishing daily activities | “it is a lot of positive reinforcement is mostly what we do, like ‘oh, great, I see you did your laundry. I know you have normally struggled with that, and I just wanted to say that is great. If you need any assistance, you know where to find me’. Do you know what I mean, it is a lot of building them up so that they have the confidence to do it and once they have the confidence, it just kind of carries them through” |
| Instilling a sense of potential without undue pressure | “I try not to put a whole lot of pressure on them because they are still adults and they are going to make their own decisions in the end, but I try a least to put the idea and see if like ‘Oh, yea, maybe I can do that’, you know what I mean” |
| Allowing protected risk-taking | “letting them take risks while at the same time obviously protecting them... but I think sometimes the risks are stunted, or they are not allowed to take risks that other people take” |
| Expanding range of interests by exposing to own personal interests | “we have a very diverse staff so it might just be that we have a staff member that is really good at gardening and that might pique their interest, so they can do that with that staff, or we do a lot of painting and stuff so that again, it is really great to have a lot of different personalities...our individual personalities also lead to discovery because what we like to do and what we might just do on habit might be brand new for a client and it might pique their interest.” “knit and crochet and we have worked on sewing projects...cross-stitch...quilting... I try to include them in things that I know how to do” |
| Motivate to succeed with new roles | “try and motivate them to do, like some of them have difficulty going to, if they go to work, they are sometimes a little slower getting up in the mornings, or they don’t feel like it and you just try to kind of motivate them to get there, get their jobs done” |
| Encouraging participation to build on interests | “As we get to know the person, their skills and their interests, for example one of our clients has a high level of interest in plants and gardening, so we have a garden. We encourage his assistance. We encourage all kinds of participation in that. We start seedlings on the window ledge and I encourage this individual to research on the internet what does this plant need? Those kinds of things, so there is recognizing the person’s interests and expanding their abilities” |
| Linking to community resources to access activities and explore interests | “We have activities that we encourage them to join say in the community such as the REACH (Clubhouse-type program with social/leisure component). They have cooking classes so that might have been where they discovered that hey cooking, or there is a computer class, ‘well I’ve never really been proficient, so maybe I’ll give that a go’, and they have woodworking and just to find out what they are interested in” |
| Bribing to encourage compliance with expectations | “You end up bribing them with their own money” |
| “I believe they get money every week, and it is tied into how well they are doing with their hygiene just as an incentive” |
| Providing a positive environment for mental health residents | “This is an amazing place...I think it is the ultimate spot for a mental health resident. They have all kinds of freedom to make their own choices. They have a very comfortable living situation. They have support from the staff and from the other residents. There is a great deal of, as much is possible there is lots of social integration” |

Thus, while not intentionally deriving the approach from recovery, there is a sense that client choice is to be respected, personal strengths and interests are to be built upon, and attention to increasing activity level and promoting social inclusion is considered. However, focused attention to identified goals of each individual seems to take a back seat to the collective, with an overall goal of increasing quality of life by providing a pleasant living environment within the home.

While these processes hold potential to advance the resident in his or her recovery, there are challenges associated with enacting the case plans which are limiting.
Staff and management alike speak of the case plan as the ultimate documentation of what each resident is working on, but a closer analysis reveals that the reality is not always a match with the intention. While it is clear from the residents that “you are supposed to have a case plan and follow your case plan” (resident), based on observation, review of documents, and information revealed in interviews, it became evident that, due to a range of challenges, case plans are not always used to their full potential in support of recovery. These included:

- Resident involvement in setting the goals is limited, with residents only vaguely aware of their goals (for example, “to be a better person” and “I hope it goes good” were verbally identified by residents as their current goals, but these statements are vague and do not align with their documented goals)

- Many goals seem to be reflective of what staff want for the resident, not necessarily what residents want for themselves (for example, room cleaning and hygiene goals)

- Many of the goals are relevant to successful group home living, with little focus on independent living beyond the group home (for example, “good behavior” or “will complete assigned weekly chore”)

- The minimum staffing ratio of 1 staff to 8 residents limits the capacity of staff to work on specific goals with individuals, especially outside of the home
Although they are aware of the existence and location of case plans, few staff members are familiar with each resident’s current goals, and as a result focus on generic goals such as encouraging participation in outings, or making sure each person has a “good day”

More focused on the “here and now” of the home itself, part-time and casual staff do not feel the same obligation to work on individual goals as full-time staff (for example, one part-time staff member describes herself as a weekly “treat” for the residents)

Some staff see the case plans as the “rules” that govern the person, rather than their goals, losing sight of the capacity of the goals to move the resident forward in support of recovery (for example, “staff to be consistent re: tobacco”)

Many of the goals are vaguely articulated, or not articulated as goals (for example, “encourage to eat properly” is reflective of what staff intend to do, not a goal)

Many of the goals reflect a “maintenance” orientation (for example, “Independent living: maintain current pattern”)

The roles of the case manager, the facility manager and the staff in creating case plans and monitoring progress are unclear, and inconsistent across residents
• The timeframe of reviewing the case plans on an annual basis distances them from the day-to-day realities of the home, and from their capacity to motivate residents. Furthermore, evidence of consistent annual reviews and documentation of progress is lacking.

Staff and residents alike agreed that the process could be improved. For example, a staff member mentioned “We don’t really discuss personal goals...I mean when I say personal, I mean like say asking (resident) what would he want to aspire to, and then putting it into a plan. We don’t really talk about that” (staff/management). Implied this was a new idea, suggestions such as...

...reviewing their goals and encouraging them to have hopes and dreams. Something like that might be a good thing to start here... I am not always clear on what some of the goals are... I am not trying to criticize it because, but I think that is an area that we need to, could improve on here and have them more involved (staff/management)

offer strategies that might shift the approach to one more in keeping with recovery than the current orientation that is more accurately described as being focused on maintenance.

Because individualized involvement is challenging, and at times prohibitive based on the staffing pattern, adjusting to competing needs has resulted in the situation where a more generic approach is used and individual needs are subsumed:

It is normally...generalized throughout the whole house. Depending on if there is a particular client that needs help with a particular thing, then you would involve yourself a little bit more, but as a whole you try to promote the same skills especially around the house and stuff, how to clean and how to start the dishwasher and how to make coffee, how to make meals and stuff like that. (staff/management)
Engagement in household tasks might be implemented, “depending on their capabilities...so I mean depending on their ability” (staff/management), but there are no defined processes to suggest how client strengths or capabilities are assessed, nor how improvements are documented. In some cases, staff use language such as “letting them” (“letting them get their own snacks, letting them make a fried egg”), and “getting them to” (“constantly try and get them to like brush teeth and shower and to change their clothes” or “getting them to make positive food choices”) as their approach to engaging residents in a range of activities, implying both a power differential (in the case of “letting”) and sense of pressure (in the case of “getting them to”).

A commonly-used strategy in the home is prompting, but concerns have been raised around the ways in which it is enacted. For example, one case manager wondered if her client finds there to be too much prompting. The client had particularly complained about the regular practice of staff announcing that it was medication time. This practice was observed, as noted in the observation log: “At 9 pm, (staff) loudly said ‘pills’ and left the kitchen. (4 residents) got up from the table and followed her out of the kitchen, and went downstairs to the office. Shortly after, (another resident, whose bedroom is upstairs) came through the kitchen looking very disheveled, and headed down to the office as well. All re-emerged in the kitchen shortly after.” The case manager clarified, her client was “not wanting someone to call to him ‘medications are ready’. He preferred if someone would come to get him” highlighting his preference for a more dignified and private
means of prompting to be used. Interestingly, he did not suggest managing his medications on his own.

In general, risk-taking is not supported within the group home, with issues of liability sometime over-ruling decisions staff members or residents might like to make. This example conveys how concern for safety and liability may limit access to meaningful occupations important for recovery:

I wanted to take them kayaking...take someone... to volunteer at the SPCA but the board said no, it was a liability, but I felt like the board members, a lot of them don’t know the clients that well and don’t know what they are capable of and what they aren’t and I think it is frustrating...With the kayaking, it would be ‘what if they drowned?’ and I don’t know what it was specifically at the SPCA, I think, ‘what if they got bitten by a cat or a dog or something’... obviously you wouldn’t want to get bitten by a dog, but at the end of the day it is not going to really traumatize them that much. (staff/management)

Thus, while case plans are credited with dictating the approach, they are somewhat limited in capturing residents’ actual goals. Risk aversion, attention to the collective, and smooth running of the home can subsume attention to individual goals.

Routine

Each day starts with a change of shift whereby the night staff member briefs the incoming day staff on relevant issues, and documentation is reviewed. The breakfast and lunch routines seem to vary depending on the day of the week and the staff member responsible. For example, through the week when some residents have to get ready for work, the staff member on duty commonly prompts them to attend to their personal care, and prepares something for breakfast:
At breakfast and lunch what we would try to do is... have it ready so that they can grab it because a lot of them get up and go, but I might make the oatmeal and whoever is up I might ask to set the table or to get out cutlery so it is kind of a group effort...we are here to promote independence. (staff/management)

Likewise for lunch, some staff members make lunches for the residents to take to work, while others make their own. Interestingly, “we try to have it ready so that they can grab it” is described in the same passage as “we are here to promote independence,” thus indicating an approach reminiscent of backward chaining where successfully getting off to work might start with staff placing a lot of structure around the process, and gradually pulling back, raising expectations for independence. It is not clear, however, if and when they pull back and allow the consequences to be realized. At other times, coaxing and prompting are used to encourage residents to prepare their own breakfast from supplies that are made available:

You try to convince them, if they have not eaten, and they don’t feel good, which for some of them can just be a bad day, but you try and get them to go and eat food... mostly just cereal or small things. Coffee is a huge one around here. They have coffee, cereal, Eggo’s, toast or bread, stuff like that. (staff/management)

Thus, different staff members take different approaches toward the same overall intent of promoting independence.

The routine changes on the weekend, and is seen as something of a treat that residents and staff members alike look forward to. On Friday nights and Saturday mornings, an extra staff member is commonly scheduled, making group outings possible. Friday night often involves an outing to play pool or go bowling, while on Saturdays, the day starts out with a trip to the farmer’s market to buy special ingredients like bacon and
fresh fruit, around which a brunch is later crafted. One resident in particular looks forward to the weekly brunches as a chance to try out new recipes. There is a camaraderie evident in the kitchen as the residents gather to sample the week’s specialties, and socialize with staff members who are not commonly seen throughout the week. Saturday night is also a special time, baking night. The staff member responsible described how she has shifted her approach to one of skill development, rather than just providing home-made treats to the residents:

Tonight is our typical Saturday baking night, and we do not have everything that they decided to make so a couple of the residents will go off and buy the supplies and when they come back we will do the baking together. They do decide and help, and typically now, before I just used to bake even if they did not want to help, but now if they don’t, no baking gets done, so they have learned from that, because the baking is supposed to be one of their programming activities, and something to help, because they are not supposed to live here forever. So it is to teach them that they can, and they do, they help me do the measuring and then I double check, so that they know that they can, when they move out, they can do this baking themselves. (staff/management)

The rule of thumb with regard to helping in the kitchen is that there is a revolving schedule for helping with the supper meal preparation and helping with cleanup. However, one staff member called it a “semi-schedule” and another said that although “there is usually a resident assigned to each night…that doesn’t always work itself out.” Illustrative of a lack of consistency in the way each staff member handles these resident responsibilities, comments such as “we usually do all the meal prep anyways, like we will dish out the plates, the portions on the plates and people will be sitting there, and we will give it to them” (staff/management) and “the staff generally do it themselves. We try to encourage them [the residents] the whole time, but we generally do it…if they don’t want
to do it, I don’t push it because I don’t want them to get upset about it”

(staff/management) indicate that responsibilities are taken lightly, limited expectations are placed on residents, and there are few, if any, consequences of not completing assigned tasks. Thus the enactment of enabling participation in the daily routine as a means of enhancing independent living skills, particularly as it relates to meal preparation, appears to vary considerably from one staff member to the next, with most staff members stepping in before the natural consequences are realized.

There is also a schedule of chores with each resident assigned to a chore (such as mopping hallway floors or taking out the garbage) which is expected to be done daily. Beyond the chore schedule, each person is assigned a laundry day, and they are expected to clean their room on that same day. There is also an expectation that residents help out with general cleanliness, yard work, and grocery shopping, all in an effort to facilitate the development of independent living skills and smooth running of the household. There is a sense that several of the residents need prompting to engage in a healthy hygiene routine: “you have to constantly try and get them to like brush teeth and shower and to change their clothes. Not all of them but a good half of them” (staff/management). Reminders and transportation for appointments are often provided.

In between meals, residents are free, for the most part, to come and go as they wish. Those who are not working or at school spend much of the day within the house, commonly in their rooms. Staff members encourage each person to get out of the house at least once per day, even if it is for a walk around the block. Some residents are
encouraged to arrange get-togethers with friends and family not associated with mental health, while others are encouraged not to, for fear (based on past experiences) they would be taken advantage of, or exposed to, and tempted to partake in, drugs and/or alcohol.

Participation in activities offered through the Community Mental Health Centre REACH program (such as bingo, classes including crafts, computer skills and cooking, or outings of various types) is encouraged, and 2-3 residents regularly participate. Art classes, sports, music festivals and library-based events are just some of the community-based activities that a few of the residents find for themselves, and engage in regularly. Several activities are made available within the house, such as cards/games, gardening, baking, and knitting. Some staff members are more active than others in engaging the residents in activities. As one staff member said, “If they are watching TV or if they are relaxing, I try to get them into board games, just so they are not bored. I think boredom, it is not a good thing” (staff/management), highlighting that in addition to skill development, relief of boredom is another function of engaging the residents in a range of activities. Sometimes specific activities are planned in the community, such as bowling, pool, or going to the indoor walking track, in which case the event is paid for with “house money,” transportation is provided and residents are accompanied to the activity by a staff member. At other times, the staff members interact in a more casual or informal manner, watching television, playing cards, or going outside to smoke together.
It is expected that staff co-ordinate resident meetings to address concerns and discuss suggestions from the clients relevant to social and recreational programming, daily routines, menu planning, and the day-to-day running of the house. Although they were discussed, no such meetings occurred during the course of data collection for this study.

**How recovery is understood in relationship to this group home**

Administration at the group home revealed general support for embracing the recovery vision, or “*that elusive recovery model*” (staff/management) as it came to be known throughout the study. However, this view was tainted by a skepticism arising from a lack of understanding of contemporary interpretations of recovery, and fear that the promise of recovery (when equated with cure) could set residents up for disappointment. Participants in the study shared their varied perspectives highlighting a number of barriers to recovery within this group home setting, and brought forward ideas for moving the recovery agenda forward.

Participants had a wide range of knowledge, or lack thereof, about recovery, but generally acknowledged its idiosyncratic nature. Several staff members admitted to being confused by the term as it relates to mental health, or having no knowledge at all of the recovery vision, having not been exposed to information that would convey current trends in mental health care. This lack of awareness is not unexpected given the absence of attention to recovery in the curriculums that informed staff education, the lack of the use of recovery language in the standards documents that govern their services, and the
extremely limited budget and low expectation for continuing education. While participants conveyed a wide range of definitions and understandings of recovery, when a definition was provided, there was consensus that incorporating recovery into the functioning of the group home would be possible.

Recovery equated with cure was a common view, shared by residents and staff alike. From this perspective, recovery was either seen as unattainable, or was seen as purveying false hope, neither of which connoted a positive outcome for residents. Remaining participants offered definitions that aligned more closely with the recovery vision, highlighting attention to moving forward in a meaningful way in the face of ongoing symptoms. See Table 5.2 for a sample of quotes featuring these perspectives.

Table 5.2: Recovery Perspectives

<table>
<thead>
<tr>
<th>Recovery knowledge</th>
<th>Sample quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No knowledge/exposure</td>
<td>“I have never been introduced to that... Is it really the right term for mental health patients?” (staff/management)</td>
</tr>
<tr>
<td></td>
<td>“Recovery is, the word itself confuses me” (staff/management)</td>
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<tr>
<td></td>
<td>“I was afraid you were going to ask me more about recovery and I don't know all of that, in the literature what it says, that recovery involves these certain factors and I don't even know that as a clinician and I probably should” (case manager)</td>
</tr>
</tbody>
</table>

135
<table>
<thead>
<tr>
<th>Equated with cure</th>
<th>“I think they get to a place where they are better but not where they are recovered... I have not seen anybody recover” (staff/management)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“When I read the word recovery, when we got that calendar...some course on recovery or something, I can’t exactly even remember how it was worded, but it shocked me... to me I thought if a client reads that, they are going to think, ‘oh, wicked, sign me up. So does that mean there is an end to this? There is a specific thing I can do or take, whatever. This is it. I am going to be no mental illness any more’... that’s what I initially thought” (staff/management)</td>
</tr>
<tr>
<td></td>
<td>“Recovery? I could not say I am fully recovered, because I feel with [my illnesses], I think I will always have them” (resident)</td>
</tr>
<tr>
<td>Aligning with recovery vision</td>
<td>“I just feel like it is getting back on your feet and just learning to deal with it I guess, learning how to overcome it in an independent setting, because I find that you are not truly recovered until you are able to do things for yourself again, but balancing that with the fact that you have still got the disease I guess, if that makes sense” (staff/management)</td>
</tr>
<tr>
<td></td>
<td>“It is an improvement in their quality of life, that it is better than it was. It doesn’t mean they don’t have problems. That goes along with the illness...but they do their best with the resources they have” (family member)</td>
</tr>
<tr>
<td></td>
<td>“I think for me recovery means being able to regain or develop the ability to live within the community to the best of your abilities, so that may be different levels for different people” (staff/management)</td>
</tr>
<tr>
<td></td>
<td>“Recovery is a process of living, and learning to live, just acceptance and making good choices that you can live a healthy life and learn how to adapt and cope and buffer” (staff/management)</td>
</tr>
</tbody>
</table>
As a caveat to many of the definitions and descriptions of recovery, participants offered opinions about who could and who could not recover, and the extent to which they believed recovery to be possible. A widely-held belief that for some, recovery is not possible, was conveyed by this illustrative comment: “Some residents, our residents here are generally long-term and their health issues are pretty much with them... for the duration of their lives. Schizophrenia is something that, do you ever really recover from that?” (staff/management). Older people, those who had been diagnosed for longer periods, and those whose illness was considered more severe were considered to be less likely to experience recovery, while those newly diagnosed were thought to “have a good shot at making something out of their lives” (staff/management), which participants equated with recovery. These findings are significant because people who describe lived experience of recovery commonly cite the importance of having a support person who believes in them and believes that recovery is possible. These pre-conceived views may subtly convey the belief that recovery is not possible for some residents, and may limit collaboration toward resident-identified goals, especially if the goals are not considered to be “realistic.” Furthermore, the discrimination that may accompany age could serve to exclude a significant portion of residents from opportunities for recovery.

These attitudes and beliefs, and a general limited awareness of recovery are compounded by conflicting processes, limited resources and a lack of specific recovery-based knowledge and skills, which collectively emerged as barriers to recovery in the group home. While there is general agreement that the overall intent of the home is to
promote self-sufficiency or independence, the processes in place are not always enacted toward these ends. Staff members get caught up in the day to day running of the congregate setting, and the focus on providing basic needs subsumes the bigger picture for each resident. While unintended, a sense of “doing for” rather than “doing with” can prevail. As a staff member commented, demonstrating an awareness that current processes were not necessarily aligned with the recovery vision,

…we can’t afford to give them what they really deserve…case plans that will help toward their recovery instead of just aiding them in living day to day, which is what we do right now. We make sure they are clean and they have a roof over their head and they are fed proper meals, healthy meals… (staff/management)

thus, blaming the lack of recovery focus in part on inadequate resources and insufficient education. This experience of having needs met and feeling cared for in the group setting is experienced as positive by most of the residents, and in the absence of other housing options, becomes a comfortable home, albeit one where residents might be limited in opportunities to flourish.

While knowledge of the recovery vision was limited, ideas for moving it forward within the group home were presented. There was agreement that staff and residents alike could benefit from education about recovery – what it is and how it might look in a setting like this group home. Thus, they agreed, “if we had training, we could help more in their recovery” (staff/management). The Wellness and Recovery Action Plan (WRAP), a well-known tool used in recovery-oriented services, was proposed as a means of enhancing current goal-setting within the home. Improvements to the documentation and
communication systems were also suggested, primarily as a means of moving resident goals to the forefront.

Staff members identified that recovery-oriented services could not be offered in isolation within the home. They would have to be part of a constellation of services surrounding the resident, using a team approach to integrate formal and informal resources including medical professionals and family members, each having a role to play in promoting recovery. Connections and timely access to community-based agencies and services were also discussed as both a resource and a barrier, as was aptly conveyed in this comment:

...so it is not necessarily just for their recovery and their own path. It unfortunately hinges on a lot of things coming into play at certain time and if you don’t have those supports or you don’t have the ability to reach out at those critical times, I mean, encouragement goes down quite easily, so if you don’t keep that momentum, there is only so far our momentum can carry them... ‘Oh, great, you want to work, but now we have to find you a job so let’s contact these agencies’ and then they make us wait for 6 months. ..It’s really hard, ‘yay, you are at that point, we got a job for you’ and ‘whatever, I like watching tv’, crap, how do you get them to maintain that level?’” (staff/management)

Likewise, a lack of more independent housing options was identified. Thus, there is a sense that in the absence of appropriate readily-available community-based resources and supports, which are outside the control of residents and the group home, it is difficult to consolidate progress and disappointing setbacks to recovery can occur.

**Influence of policies and practices on enacting the recovery vision**

The policies and practices that are enacted within the group home play a key role in establishing the environment. The group home is tasked by the Department of Social
Development “to work with clients in achieving self-reliance, [and] an improved quality of life” (DSD, 2009, n.p.). It is expected to provide services based on the assessed needs of each individual in an effective and efficient manner, but there is little direction as to whether that means to prepare them to live elsewhere, or to be more self-sufficient within the current setting. Practices such as the development of case plans are enacted in an inconsistent manner, and the resultant goals are not necessarily consistent with enhancing self-sufficiency, focused rather on successful group home living. Furthermore, with low-paid staff and recent policy changes actually lowering the educational requirements for working in such homes (DSD, 2006, 2009), a lack of clear indication of the required skill set, and little funding for continuing education, staff are not exposed to contemporary approaches, and thus enact a caregiver role with which they are comfortable. With case managers placing significant attention on getting their clients into group homes, and little on enabling them to get out, compounded by a perceived lack of options beyond the group home and financial disincentives associated with working, residents are destined to be there for a long time.

The group home is required to develop a mission statement complete with guiding principles, as well as goals and objectives, and policies and procedures relevant to the mission statement. A review of the mission statement provided by the group home (see Table 5.3) reveals values that are congruent with recovery, and a vision for being progressive, but the mission currently lacks specific commitment to the recovery vision.
The Department of Social Development itself does not use the language of recovery, so any resulting congruity is coincidental rather than intentional.

**Table 5.3: Mission, Vision and Values of the Group Home**

<table>
<thead>
<tr>
<th>Mission Statement</th>
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<tbody>
<tr>
<td>Our mission is to provide quality non-profit housing services and associated programs to persons with severe and persistent mental illness.</td>
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</table>

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be recognized and respected as a progressive organization dedicated to the care and betterment of persons with severe and persistent mental illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalization</td>
</tr>
<tr>
<td>Independent Living</td>
</tr>
<tr>
<td>Development of Positive Life Skills</td>
</tr>
<tr>
<td>Autonomous Life Style</td>
</tr>
<tr>
<td>Mutual Respect</td>
</tr>
<tr>
<td>Collaborative Partnership</td>
</tr>
<tr>
<td>The Right to Self Determination</td>
</tr>
<tr>
<td>Confidentiality</td>
</tr>
<tr>
<td>Quality Programming and Services</td>
</tr>
<tr>
<td>Facilitating Access to Community Resources</td>
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<tr>
<td>Education of the Public</td>
</tr>
<tr>
<td>Advocacy</td>
</tr>
</tbody>
</table>
In the absence of clear direction, at the front-line level, there are multiple examples of staff enacting practices that reflect a well-intended “do for” approach, even though their stated goal is “to work ourselves out of a job” (staff/management) by promoting independence. With recovery involving not doing things for people that they are capable of doing for themselves, “do for” actions may rob residents of opportunities to build and practice skills needed for independent living.

Consider the following observations:

Bowling night: Two staff members are scheduled, to enable one to leave the home with the group, and one to stay back. “I hope everyone is going bowling,” was met with blank stares. From the time she came on at 4pm until we left for bowling at 6:15, staff approached each resident and tried to talk them into going bowling. When it was time to go, four of eight residents had agreed. The staff member phoned the taxi. When the taxi arrived, the staff member got in the front seat, and the residents got in the back. The staff member told the taxi driver where we were going. The staff member paid the taxi driver. We entered the bowling alley. The staff member approached the counter, arranged for the bowling, and paid for the group. We all got our shoes, and proceeded to the bowling area. The staff member did not participate in the bowling. When we were done, the process was reversed, with staff again calling the taxi, sitting in the front seat, directing the taxi, and exchanging the money.

“Missed opportunity” I wrote in the observation log, and although it was the first, it was not to be the last. While perhaps fulfilling the directive to “facilitate access to community resources,” everything about it reinforced the idea that there is a level of incompetence or dependency that comes with being a resident of this group home, albeit unintended. Other examples, such as:

...sometimes they just don’t want to come down and do another load, so sometimes ... I will say ‘just leave it, I will, when one is finished I will put the other one in and stick it in the dryer’ and that way they don’t get frustrated (staff/management)
...a bit of a problem is that sometimes the meal that is being set up needs to be prepared before, so you come in and it may of already been started, so then it is hard to get somebody, like...(resident), he doesn’t get home until after four so you can’t really wait for him, and he will come in and he will say ‘I am ready to help’ but you have passed the stage where there is anything for him to help with other than setting up the table....Yes, and I tend to be somebody who...I am going to get in and I’m going to get it ready and the difficulty is allowing them to be a part of it (staff/management)

If we all go out together, like if we go to Tim Horton's then they each get a medium coffee, or they each get the same thing kind of. It is not like ‘here, you have five bucks.’ It is paid for all together... normally it is like you [staff] have a $20 and you go and take everybody out, and pay for it or whatever (staff/management)

...they have different residents that are supposed to come and help...like if they are just not feeling it or if they are asleep, which is sometimes the case, then they don’t have to (staff/management)

exemplify that staff value smooth running of the house, facilitated by the “do for” approach, which is clearly not their stated intention. In the absence of reflection on the implications of their actions, there are many missed opportunities to enact values of recovery by developing positive life skills and progressing toward self-sufficiency each day.

A further review of values reveals the importance of advocacy. During the study, the Executive Director paid a visit to the Minister of Social Development for the purposes of advocacy, but the advocacy was aimed at increasing funding to enable the group home to abide by upcoming policy changes regarding wages. While management and board members have advocated in the past for funding to enhance housing options, their success has been limited. Other examples, including staff advocating for a resident to obtain employment, and a case manger advocating for a resident to obtain a rent subsidy
indicate that advocacy can be a valuable tool in creating important recovery-oriented opportunities in the future, but remains underutilized at many levels.
Chapter 6
Discussion

As recovery increasingly takes its place as the guiding vision for mental health care, much consideration is needed to clarify the mechanisms for change in related services and supports. Housing in particular holds considerable potential to influence recovery outcomes for people with mental illness. Supported housing continues to gain credibility as a recovery-oriented approach to housing, but the many other types of housing, including group homes, have been left behind as targets of recovery-enabling practice and research, despite their abundance. The purpose of this case-study was to explore and describe the challenges and opportunities for integrating a recovery vision in group homes for individuals with mental illness.

This research offers a scoping review of the housing and recovery literature, highlighting that, in spite of their close connection, convergence recovery as it relates to housing is in the early stages. The review confirmed that the capacity for group homes to serve as an environment that promotes recovery has not been explored, and identifies both positive and negative aspects of housing that may influence recovery. Having a home, not just housing, serves a foundational role and contributes to recovery, with stability being the key. Negative influences that come from social exclusion, sub-standard living conditions, and lack of choice emerged as housing-related barriers to recovery. The scoping review confirmed that group homes have been neglected in discussions about recovery.
With few studies offering a current perspective of day-to-day life in group homes for people with mental illness, the opportunity to engage in participant observation within such a home afforded a vantage point novel to the current literature. Using ethnographic methods, this work examined the cultural milieu of a group home, how recovery is understood within the setting, and the impact of policies and practices on enacting the recovery vision.

Understanding culture, a key feature of ethnography, includes examining the beliefs, values and attitudes that structure the behaviour of a group of people (Merriam, 2009). The data collection methods used in this ethnographic case study (participant observation, interviews and document analysis), provided an ideal lens on the culture within a group home. With culture conveyed over time by the places, events, routines and patterns that structure daily living (McLaren & Hawe, 2005), ethnographic methods were well suited to this enquiry.

By converging the multiple strategies for data collection, a multi-level perspective was achieved, revealing possible mechanisms for integrating the recovery vision within group home settings. The use of the social-ecological model, with its attention to multiple levels of influence, emerged as a highly relevant perspective without which the recovery vision cannot be realized. Individual approaches, which dominate today’s mental health care, are simply insufficient to enable recovery.
Summary of findings

The cultural milieu

With a focus on culture, the results of this study revealed a situation in which a diverse group of people with a mental illness come together in a collective setting, and become the recipients of caregiving under the guise of promoting their independence. Structures within the home, such as case plans and daily chores, promise to provide a skill set congruent with increased independence, but the intent can be confounded by well-meaning staff conveying a spirit of benevolence, often wanting to help residents by “doing for” them, whether consciously or unconsciously. Seeing residents as emotionally fragile, the “doing for” approach allows staff to sidestep interactions that are feared to be confrontational, inadvertently reinforcing a perception of emotional vulnerability and limiting opportunities for skill development and self-efficacy. Furthermore, custodial markers such as not leaving residents home alone, locking up food, sharps, money, and medications, and having curfews reveal underlying beliefs, and may cause individual narratives to conflate to the lowest common denominator, one not congruent with independence.

The comfortable atmosphere, basic needs being met, access to planned and unplanned activity, and caring relationships with staff contribute to a place attachment that could be difficult to loosen. Much of the culture within the home is defined by relationships, particularly those with staff, but also with other residents. Although the staff to resident ratio does not allow a lot of 1:1 interaction, there are obvious caring
relationships formed between the two. The around-the-clock availability sets residents up to expect immediate attention to emotional upsets or arising issues. With barriers such as lack of privacy and limited resources impacting the cultivation of naturally-occurring relationships, the environment reinforces the strengthening of bonds within the home and limits opportunities to build relationships that could serve as long-term supports in a life beyond the group home.

With elements of both custodial and supportive housing at play, the approach offered within the group home of the current study cannot be clearly identified as either. This creates an ambiguity which has a significant impact on the way services are offered, and the way they are experienced by residents. Since its inception, the home has seen a policy shift with the maximum two-year tenancy being replaced with the current unlimited tenancy, significantly reducing the environmental press once felt to avail oneself of opportunities to build skills and seek more independent alternatives. Making the change was intended to be responsive to client needs, with a general underlying belief that residents would not live there long-term. However, the result is a situation in which there are now no clearly-defined processes to move residents forward. Furthermore, with few people “graduating” from the setting, there is little press for more independent settings to be created, either from within or outside of the group home setting.

The residents themselves have limited opportunity to engage in goal setting, few role models such as peer supports, and little press to move forward, reinforcing an orientation towards ongoing maintenance of the current situation, and precluding a focus
on the future. With management enacting a risk-averse approach to resident safety, staff enacting the caregiver role, and few outside supports advocating for change, the status quo is maintained.

**How recovery is understood**

Although a recovery vision is the guiding paradigm for all mental health services, for the most part, group homes have been left out of relevant discussions. This circumstance was confirmed by this study where group home residents and those in their surrounding infrastructure had little specific knowledge of the movement. An unclear understanding of the mandate for shifting toward recovery-oriented services, lack of recovery language in supporting documents, and a wide range of perspectives on what recovery in mental illness actually means explain the multi-level confusion regarding the implementation of the recovery vision within the group home.

Much of the confusion arises from the lack of understanding about what recovery-oriented services might look like, even though, at all levels, it is confirmed that working toward recovery is an important goal of mental health services. Residents and staff members alike, including those at the managerial level, had little exposure to contemporary perspectives, and while agreeing in principle that adopting a recovery focus was a good idea, their perspectives of recovery mirrored those of the broader mental health system where clinical recovery and personal recovery remain at odds. Thus, lack of awareness of recovery-enabling practice and no clear mandate emerged as key challenges to its implementation.
Influence of policy and practice on enacting the recovery vision

Some policies at the government level suggest that attention to the development of self-sufficiency is an important objective (DSD, 2009). Others make progress towards this ideal difficult, if not impossible, such as those related to funding issues. This includes the funding structure dictating reduced eligibility for support if residents choose to leave the group home, which limits housing options. Furthermore, while the role of advocacy is valued, it is not enacted adequately to make a difference. Staff members are not trained in the methods of advocacy, and with limited attention to recovery, are not aware of advocacy targets that could enhance opportunities and enable residents to become more independent.

Workers trained in caregiving fill the front-line roles, while those knowledgeable in recovery-enabling practice are all but absent in the lives of these group home residents. With limited knowledge and resources, the focus on enhancing well-being in the day-to-day setting subsumes the growth goals associated with recovery. Practices are conveyed from one staff member to the next, and there is little structure in place for reflection or evaluation. Thus, practices such as the common practice of “doing for” are often perceived by the caregivers as helpful, and, in the absence of feedback, are likely to continue. With few records kept regarding the success or failure of the group home in terms of enhancing self-sufficiency, and goals not particularly relevant to this aim, it is difficult for them to build on strengths, or to correct areas of weakness. The lack of clarity on whether the group home is meant to provide transitional or permanent housing
further confounds the intent of interactions within the home. Furthermore, although this group home is situated within a structure that also offers a more independent supported housing option, there are few units available, and none of the residents identified an aspiration to move there.

A review of the findings indicates a variety of challenges and opportunities for integrating the recovery vision (see Table 6.1).

**Table 6.1: Challenges and Opportunities for Integrating Recovery**

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant cultural narrative – proximal and distal</td>
<td>Multi-level narrative shift</td>
</tr>
<tr>
<td>• Custodial mentality</td>
<td>• “Raising the bar”</td>
</tr>
<tr>
<td>• Discrimination</td>
<td>• Empowerment</td>
</tr>
<tr>
<td>• Stigma, including self-stigma</td>
<td>• Pain-avoidance versus growth goals</td>
</tr>
<tr>
<td></td>
<td>• Shifting role from caregiver to recovery coach</td>
</tr>
<tr>
<td></td>
<td>• Community-level awareness</td>
</tr>
<tr>
<td>Lack of awareness of recovery</td>
<td>Increased awareness of recovery</td>
</tr>
<tr>
<td>• Micro-level</td>
<td>• Micro-level</td>
</tr>
<tr>
<td>-lack of knowledge</td>
<td>• Meso-level</td>
</tr>
<tr>
<td>-lack of exposure to peer role models</td>
<td>• Macro-level</td>
</tr>
<tr>
<td>• Meso-level</td>
<td></td>
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<tr>
<td>-insulated environment</td>
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<td>-lack of recovery language</td>
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151
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<thead>
<tr>
<th>Systems-level role conflict</th>
<th>Systems-level transformation</th>
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<tr>
<td>• Transitional versus custodial</td>
<td>• Adopting recovery-oriented structures and practices</td>
</tr>
<tr>
<td>• Caregiver role</td>
<td>• Targeting upstream funding issues</td>
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<td>• Absence of strong advocacy force</td>
<td>• Getting on the “housing first” radar</td>
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<td>• Partnering for change</td>
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<td>• Issues of knowledge translation</td>
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**Deposing the dominant cultural narrative**

Falling victim to the dominant cultural narrative, defined as “socially constructed stories about disadvantaged people, often of the victim-blaming variety that help members of the dominant groups to rationalize their role in contributing to and perpetuating the oppression of disadvantaged people” (Nelson & Prilleltensky, 2010, p. 46), people with a mental illness are undermined in their recovery efforts toward meaningful participation, social integration and full citizenship within the community. Often communicated as stereotypes, such overlearned stories, can have a negative influence on how people with mental illness come to see themselves and their potential (Rappaport, 2000). Known as self-stigma, this negative influence can result in “depression, demoralization, poorer illness management, social avoidance, and [can] obstruct the pursuit and achievement of recovery goals” (Lucksted et al., 2011, p. 51).

For group home residents, this influence is evident at proximal and distal levels, where policies and practices reveal limiting beliefs about recovery and the capacity of residents to become more autonomous. For example, at a more distal level, government policies related to funding regarding housing, support programs or income entitlements
have a clear impact on the quality, type and availability of housing one might access (Sylvestre, et al., 2009). Qualifying for specific housing types reveals beliefs about need and capacity. At a more proximal level, reflected in the day-to-day interactions within the home itself, there are numerous indicators that reveal the underlying cultural narrative of the setting, and the implications of its custodial nature. In between, social attitudes and stigma reflect the narrative. As Lynam and Cowley (2007) discuss, such marginalization, characterized by being overlooked or excluded based on stereotypical images, can constrain capacity building and participation which are key features of recovery.

Based on the cultural narrative in such settings and with limited staffing, individual needs can be subsumed into stereotypical assumptions about the needs of the group (Pyke & Lowe, 1996). The assumption that the level of structure and supervision provided is that which is required, the lack of individual-level jurisdiction, a focus on compliance, and the provision of collective activity suggest limited capacity for realizing capabilities and enacting self-determination. There is limited attention to supporting residents to move to more independent settings whether from within the house or from more distal support services. Furthermore, with little structure for advocacy, few feasible options existing in the community, and social and economic disincentives accompanying a move, the cultural narrative is further reinforced, and emerges as a key challenge to implementing the recovery vision in group homes.

Acknowledging the dominant cultural narrative as a challenge to implementing the recovery vision in group homes opens the door for opportunities to be identified. In
In order to redress the situation, there is a need to locate barriers at a variety of ecological levels (Sylvestre, et al., 2009), noting that change at one level will have a ripple effect to other levels. For the residents themselves, accepting the dominant cultural narrative results in self-stigma, reflected by “setting the bar low” when it comes to personal aspiration, reinforced when few expectations are placed on them. Breaking the downward spiral of powerlessness and dependence involves confronting the status quo and enhancing readiness for change (Parkinson & Nelson, 2003). While the group home may serve to provide defense against discrimination by enabling residents to be part of an accepting collective, allowing them to stay indefinitely, meeting their basic needs, and minimizing responsibility may in fact limit their progress toward recovery. Moving beyond pain-avoidance goals, ensuring a focus on growth goals (Nelson, Hall, & Walsh-Bowers, 1998) creates the opportunity to confront constraining narratives, requiring a shift in caregiver role from one supervisory in nature to one more supportive (Topor et al., 2006).

Thus, it becomes somewhat of a “what comes first, the chicken or the egg” situation. Forchuk and her colleagues noted an ongoing shift in social environment as indicated by staff role changes in response to the recovery of people who experienced psychosis, “to keep in synchrony with the evolving needs of the clients” (Forchuk, Jewell, Tweedell, & Steinnagel, 2003, p. 276). Townsend (1998) suggested a pro-active shift, not waiting for people to initiate change, evidenced by extending invitations and the creation of opportunities to enable discovery of talents as a means of empowerment.
Doing so conveys belief in the person’s capacity for growth and change, a central value in recovery (Newbury & Strong, 2009). Rebeiro and Cook (1999) discussed the role of opportunity in enhancing participation. Rebeiro (2001) expanded on the importance of having an affirming social environment and creating just-right challenges, based on client strengths, and client-driven needs. These conditions may lend themselves well to housing environments where residents could explore and expand on strengths in a non-threatening environment, one which challenges the dominant narrative by offering support and encouragement. An affirming environment that expects participation and creates the opportunities to discover talents contributes to empowerment. As New Brunswick consumer advocates, LeBlanc and St. Amand highlighted, to expand the range of possibilities, “what we need is not more psychiatry…but rather more teachers who can enthuse us to imagine and consider innovative ways to health such as expanding our thought processes, leading us to an awareness of our capacities” (2008, p. 11).

Furthermore, Krupa (2008) supports enabling meaningful connections at the community level, suggesting that “public demonstrations of occupational participation can contradict negative stereotypes, balance inequities in social status, reduce social distancing, and reverse social disadvantage” (p. 201), thus confronting stigma.

Although the group home in this study experienced little neighbourhood opposition at its inception, actions in support of the “not in my backyard” phenomenon are common when housing for people with mental illness is discussed, typically out of fear for the negative impact on the “social fabric” of the community (Piat, 2000, p. 8).
The existence of stigma is reflective of the dominant cultural narrative, which, by contributing to loneliness, distress and discrimination, is a harmful barrier to the recovery of people with mental illness (Hocking, 2003). There is growing evidence, confirmed in this study, to suggest that fears related to the “not in my back yard” phenomenon are often unwarranted once such housing is established (deWolf, 2009; Wahl, 1993; Walker & Seasons, 2002). Positive benefits can result from positive neighbourhood relations. Thus, significant opportunity exists to shift the dominant narrative and pre-empt the negative impact by promoting community tolerance (Kloos & Shah, 2009). Cobigo and Stuart (2010) acknowledge that policy-level responses are required, highlighting that approaches such as legislation, community supports, anti-stigma and anti-discrimination initiatives, and better monitoring and evaluation of existing practices may serve as valuable tools to promote social inclusion, necessary for recovery. Expanding from supporting individuals in their efforts to cope with unjust social conditions to collaboration toward social change allows a multi-level response, and shifts the focus to the influences of social exclusion (Nelson & Prilleltensky, 2010). Methods such as addressing widespread misunderstandings and improving the mental health literacy of the general public, and opposing the constant reinforcement of stigma within the media are offered as possible actions (Hocking, 2003). It is only by shifting the dominant cultural narrative that recovery, characterized by meaningful participation, social integration and full citizenship will be realized. Recovery-enabling practice within housing such as group homes can have a positive impact on this shift.
Mixed messages: Toward recovery, or not?

Saegert and Evans (2003) discuss how the unequal distribution of economic and social capital contributes to the sorting of those with similar resources into socially-produced housing niches, with institutional practices playing a critical role in either perpetuating the cycle of inequality or supporting change. People with mental illness clearly fall into sub-optimal housing niches, but what remains unclear is whether people with mental illness are “sorted” into group homes due to their potential for recovery, or their perceived lack of potential for recovery. Without a clear differentiation, valuable resources are at risk of being directed toward the wrong targets, and potential for recovery diminished. The varied perspectives shed light on the different ways the group home experience can be viewed, drawing attention to the ways in which systems-level role confusion can send mixed messages and limit recovery potential.

From the emic or insider’s perspective, the staff members are described as pleasant and friendly, the residents are happy, and the neighbourhood is peaceful. The day-to-day running of the home is smooth on most days. Three wholesome meals a day are provided, there is a consistent medication regime, and expectations of residents are not daunting. The group is taken out into the community on a regular basis for various activities, holidays and birthdays are made special, and residents can generally come and go as they please. Although there is little money available for discretionary spending, the basics are covered by the government assistance most residents receive. The family-like casual atmosphere is comfortable, caring staff are readily available to play games or lend
an ear, whether at 2 a.m. or 2 p.m., and the general aim is to promote independence. “The ultimate spot for a mental health resident” (staff/management)?

Shift lenses to the etic or outsiders perspective, and a different view emerges. In the growing field of community psychology, Nelson and Prilleltensky (2010) highlight the importance of increasing awareness of oppressiveness as a first step toward empowerment, central to recovery, by making the invisible visible. Recall that the setting is described as “an artificial home” (staff/management) in which the living situation is “kind of a family” (staff/management), or you “might slip and think of them as your friend” (resident). The staff members are not friends, nor are they family. There is clearly a power differential in which paid people come into the home of residents with mental illness, and shape their environment guided by systems-level standards.

They are paid to act friendly, but they will not be spending time with residents on their days off (although, occasionally staff members do blur the boundary). If a resident moves out, or the staff member moves on, the relationship will be over. The staff has little training in mental health or in rehabilitation, and little familiarity with contemporary perspectives of recovery. Although they will try to help residents to reach their individual goals, particularly if they find them to be “realistic,” most of the staff, especially those who are part-time or casual, will be more focused on making sure the home runs smoothly on a day-to-day basis. Residents have little access to money, and what they do have is kept locked up in a drawer, awaiting a convincing request. Likewise, medication is locked away, awaiting mandatory withdrawals supervised by staff. There is little
expectation for residents to work, because if they are deemed unable live independently, a pre-requisite for the funding they receive, how could they be expected to work independently? If they do work, they will not likely be able to keep all of the money due to limitations imposed by the Department of Social Development, the funding source. Most work opportunities obtained through supporting agencies will be part-time and short-lived. It will be almost impossible for residents to save up first and last month’s rent, a damage deposit, purchase a car, or plan for further education, thus making future long-term planning difficult. Asset development programs focused on the enhancement of economic security may be beneficial in this regard (Burke-Miller et al., 2010). Without such programs and without a job, residents will have access to very little money, and very few decent options for housing and supports. With a job, expenses such as medications are likely to become their own responsibility, and will claim a considerable portion of the income, leaving little for day-to-day living. Government allocations of money significantly diminish if one does relocate from a group home to an independent setting. Because they are not homeless, they are not seen as a high priority for rent-supplemented “housing first” types of programs. In fact, much effort is expended by case managers and other supports, including family, to aid residents to gain entry to a group home, but because supports often perceive people with mental illness to require a more restrictive environment than they may actually need (Holley, Hodges, & Jeffers, 1998), less attention is placed on assisting them to move out. Examining housing preferences, Piat and colleagues found that service providers were more conservative in housing
preferences for clients, opting in favor of those with more structure and supervision, while clients favoured more autonomous housing (Piat, et al., 2008). Service providers, such as case managers, come from a professional culture where they have historically had a key role in making housing decisions on behalf of their clients, and have been trained to minimize risk, so making the shift to “allow” risk-taking may be challenging for them. The impact of power structures within the institutional environment is clear. Mental health service providers prefer housing choices over which they can exercise some control, and are less comfortable with choices outside of their control, thus introducing a conflict of interest wherein they may be less likely to support risk-taking and, inadvertently, independence.

With their cordial relationships, residents are thought of as good neighbours. However, they do not have personal or individual relationships with the neighbours, and are not invited to neighbourhood get-togethers, so they are not seen quite like other neighbours. The residents are seen more as a collective, rather than individuals, which may in fact have a negative impact on individual community integration. A group of eight, along with requisite staff members, is unlikely to garner many invitations. Other options for enhancing reciprocal social interaction, such as dating, or cultivating friendships, are also difficult, as residents have little privacy within the home, few dollars to spend, and a curfew if they go out. As a result, most social connections are with those within the home where they can enjoy pleasant interactions and attend community outings with co-residents and staff. Thus, while intending to build on self-efficacy within
the group home setting, with limited opportunity to regulate social interaction, limited
control and access to privacy and space, and lack of jurisdiction over the household
environment, feelings of low self-efficacy may result (Evans, Wells, & Moch, 2003).

Residents are supposed to help with meals and household chores, but there are
few consequences of not doing so. For example, being in bed at 4 p.m. will suffice as a
reason not to take part in supper preparation. In an effort to be helpful, staff will do things
for the residents, such as cooking and plating food, advancing laundry, calling the taxi
and paying the money on outings, and portioning out tobacco so they do not run out.
Reducing expectations, doing things for people that they are capable of doing themselves,
and generally focusing on getting along and being liked by the residents may enhance
resident satisfaction with the living situation, but, as Norquist highlighted, “one doesn’t
want to win a popularity contest at the expense of quality of care and improvement in
clinical and functional status” (2009, p. 867). Thus, although there is support for the idea
of residents becoming “independent,” whether within the home, or in terms of moving to
a more independent setting, the ideal is poorly defined, and structures associated with the
house can encourage a dependence that appears difficult to overcome.

There is little talk of residents moving out, few viable options await them, and
there are few advocates taking up the cause, thus deepening the entrenchment within the
home. Furthermore, as McLaren and Hawe discuss, it is unclear how ecological
transitions are expected to occur, and whether the key determining features relate to
individual skill set or systemic factors such as finances and support services (2005),
illustrating, from an ecological perspective, the need to consider the interaction between individual and environmental variables (Wright & Kloos, 2007). While likely unintended, there is a mixed message of promoting independence and place attachment at the same time, perhaps thwarting its own best intentions. Thus, there is dissonance between what people think they are doing and are actually doing, revealing contradictions of which they are seemingly unaware. A review of policies and practices garnered little evidence of a strong commitment to contemporary understandings of recovery, and exposed challenges and opportunities for moving forward guided by the recovery vision.

**Addressing the multi-level lack of awareness of recovery**

As Davidson and colleagues remind us, there is a need to separate out “lingering legacies of our institutional past” from practices that can confront stigma and cultivate recovery (Davidson, et al., 2009, p. 72). With custodial group homes guilty of bearing lingering legacies of our institutional past, they are prime targets for reflection on the ways in which stigma can be targeted, and recovery cultivated. However, lacking a clear sense of direction, and without conscious knowledge of what that entails, change toward recovery can be slow and complex.

Acknowledging the fact that group home residents are virtually ignored in the recovery literature, Weddle (2002) suggested that the recovery promoting potential of group homes has not been explored, and confronts the assumption that recovery necessitates independent living, highlighting the risks inherent in excluding group home residents from the recovery discourse. Some researchers, as well as some government
policies, have suggested that custodial housing be phased out in favour of other options (Parkinson, et al., 1999; Piat, et al., 2006), while others consider the possibility of “reengineering” them to integrate principles of recovery (Edge & Wilton, 2009, p. 137). Action in support of alternatives has been slow, and there may always be a sub-group of individuals, for example consumers with complex needs, long histories of institutionalization, and/or concurrent disorders, who access or prefer this type of support (Piat, et al., 2006; Sylvestre, et al., 2007). They need not be excluded from opportunities for recovery.

With Canada’s new Mental Health Strategy suggesting a future where “mental health service providers…work with planners, funders, and users of the system to examine what changes are required in the way that they work in order to create a system…better integrated around people’s needs and fosters recovery” (MHCC, 2012b, p. 12), a significant shift in the way services are offered is required. A recent consultation process in New Brunswick addressed the challenges associated with mental health systems-level change. In outlining a recovery-oriented plan for the future, the consultants concluded:

…people want us to do more than tinker with the status quo; they want a transformed system. Transformation is based on seeing the world in a different way, with traditional relationships and ways of “doing business” replaced by new ways of connecting and working cooperatively. The starting place will not be the mechanics of the system, but rather what people need for recovery and good mental health. (McKee, 2009, p. 5)

Thus, responding to federal-level initiatives, New Brunswick, like other provinces, has placed an emphasis on system transformation which confronts traditional approaches and
embraces recovery as the guiding vision. The resulting action plan identifies the importance of enhancing knowledge at multiple levels, acknowledging that even at government and health-care provider levels, knowledge about mental illness and recovery is limited (Dube, 2011). With the mandate for rolling out recovery-oriented services falling to the provinces (Piat, et al., 2010), this is somewhat concerning.

Davidson and colleagues have clarified the tasks of recovery to include renewing hope and commitment, redefining self, incorporating illness into life as a whole, involvement in meaningful activities, overcoming stigma, assuming control, becoming empowered and exercising citizenship, managing symptoms, and finding support (Davidson, O’Connell, et al., 2005), all of which are possible whether one remains in a group home, or not. However, in order for group homes to increase their capacity to serve as an environment that integrates the recovery vision, a significant shift in organizational structure and processes will be required. For example, Townsend (1998) suggests that if there is to be a transition from a caregiving perspective which perpetuates dependence, to a collaboration that can enable people to become active participants in their own lives, hallmarks of recovery, processes must include inviting participation at higher levels. This might include establishing an environment that expects full participation, increasing resident roles in organizing and not just participating, and promoting an atmosphere of helping the self and each other. With a shared focus on empowerment and self-efficacy (White, 2011), aligning recovery-oriented mental health services with Chronic Disease Management and implementing self-management strategies has been suggested (Mulvale
& Bartram, 2009). As Wallcraft (2005) clarifies, “being more in control of one’s own life and managing one’s own mental health is the key to regaining self-respect and self-esteem [and is a] major plank of recovery” (p. 209). In both self-management and recovery, the person is viewed as an active agent and untapped resource rather than a passive recipient of services. Medical interventions remain, but maintaining or increasing participation in meaningful roles and activities gains prominence.

This shift represents a perspective new to mental health care providers, particularly those affiliated with custodial care which continues to be influenced by the dominant cultural narrative that focuses on individual responses to the negative aspects of mental illness rather than creating environments that enable the strengths and potential of the individual to be realized. Because recovery occurs within the context of complex relationships (Campbell, et al., 2008), working from a recovery perspective involves a fundamental shift from professionals as experts offering interventions to navigating a way of being in a relationship (Repper & Perkins, 2003).

Knowing where to start is a significant challenge in this situation. Davidson and colleagues advised that to promote recovery, “any interventions or assistance mental health practitioners seek to provide should then be framed in terms of their utility in promoting the person’s own agenda” (Davidson, et al., 2009, p. 31). Moving forward from a recovery perspective, with people directing their own recovery journeys, will demand the reallocation of power in relationships where the agenda is no longer dictated by the professionals (Borg, et al., 2005). Rather, with a shifting view, from clients being
seen as dependent and needing to be taken care of, to dynamic individuals interacting within their environments in pursuit of recovery (MHCC, 2011), services will need to be presented in ways that are empowering to consumers, supporting them to build meaningful and satisfying lives (Browne & Hemsley, 2010a). Furthermore, it will “require new ways of seeing and using the local environment as a resource and opportunity to support a client’s emerging, or re-emerging, sense of self” (Borg, et al., 2005, p. 254). This involves consideration of the multiple levels of impact on residential success (Haertl, 2007), thus acknowledging the contextual factors that have to date been undervalued.

Role models and resources speaking to the specific context of group home are scarce. Residents are not familiar with recovery, and as a result, have little likelihood of banding together as their own advocates. While some resources are emerging, such as the collaborative effort of the Canadian Psychiatric Association and the Schizophrenia Society of Canada who have published, and offer workshops entitled *Schizophrenia: The Journey To Recovery* (CPA & SSC, 2007), dissemination remains limited.

Staff members within the home maintain the custodial culture, shouldering responsibility for resident safety, at the expense of promoting risk-taking. Furthermore, as Piat highlights, “many providers have not ‘bought into’ the recovery vision and are using recovery language to describe the status quo” (2010, p. 175). Associated mental health professionals outside of the home, such as case managers and doctors, many of whom themselves have limited knowledge of recovery, see few options for their clients outside
of group homes, and have little influence on the day-to-day interactions within the home. At the management level, a mandate for integrating the recovery vision has not been communicated from any official source, and such a mandate is not clearly reflected in the standards documents. Thus, although they are becoming increasing aware of recovery, there is little press to move forward with change.

Defined as “efforts that strive to shift the underlying infrastructure within a community or targeted context to support a desired outcome, including shifting existing policies and practices, resource allocations, relational structures, community norms and values, and skills and attitudes,” (Foster-Fishman & Behrens, 2007, p. 192), systems change encompasses a social-ecological perspective with sufficient scope to address relevant factors at proximal and distal levels. However, as Piat and colleagues noted, Canadian decision-makers do not necessarily see their role in providing leadership for such system-transformation, leaving the implementation of recovery to providers, but if providers lack the mandate and the requisite competencies, change is unlikely (Piat, et al., 2010). Thus, as Piat and colleagues note, decision-makers are urged to “play a more responsible and active role in the transformation process” (2010, p. 175).

Compatible with evidence-based practices and reflective of recovery-based values, Farkas and colleagues have identified key components that can be used to guide recovery-oriented services (Farkas, et al., 2005). These include being guided by the values of person orientation, person involvement, self-determination/choice, and growth potential, and a mission, policies and procedures, record-keeping, quality assurance,
physical setting, and network, as well as staff selection, training and supervision reflective of the values.

Davidson and colleagues have also advanced the field with what they call a “beginning roadmap” by developing recovery-oriented service standards that can be applied in practice (Davidson, et al., 2009, p. 89), (see Table 6.2).

**Table 6.2: Service Standards**

<table>
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<tr>
<th>Domains</th>
<th>Indicators</th>
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<tr>
<td>Primacy of participation</td>
<td>Participation of clients and family members at multiple levels of service delivery</td>
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<tr>
<td>Promoting access and engagement</td>
<td>Multiple points of access to services; timely access</td>
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<tr>
<td>Ensuring continuity of care</td>
<td>Continuity of access to healing relationships across time and agencies</td>
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<tr>
<td>Employing strengths-based assessment</td>
<td>Seeing clients as experts on their own recovery; strengths-based assessment as central focus</td>
</tr>
<tr>
<td>Offering individualized recovery planning</td>
<td>Planning based on client goals, hopes, assets, interests</td>
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<tr>
<td>Functioning as a recovery guide</td>
<td>Practical assistance offered in community contexts</td>
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<tr>
<td>Community mapping, development and inclusion</td>
<td>Awareness of opportunities, resources and potential barriers in the community</td>
</tr>
<tr>
<td>Identifying and addressing barriers to recovery</td>
<td>Awareness of stigma and discrimination</td>
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(Davidson, et al., 2009; Davidson, Tondora, O'Connell, Kirk Jr., & Rockholz, 2007)

These documents, and other emerging competency guidelines, offer preliminary guidance for systems transformation guided by the recovery vision, the implementation of which could be instrumental in moving group homes toward a recovery vision.
Implications for practice/mechanisms for change

The social-ecological perspective that guided this study suggests that integrating the recovery vision within group homes will require addressing mechanisms for change at multiple levels. Although given their interdependence, changing one part will have a ripple effect on the others (Peirson, Boydell, Ferguson, & Ferris, 2011), but, given their synergy, a more effective approach will involve targeting all levels. Relevant to moving forward toward a recovery vision, acknowledging that wide-reaching system transformation is not imminent, the development of “recommendations that could proceed expeditiously” (Sylvestre, et al., 2007, p. 92) is more prudent. Thus, converging the data sources, the following mechanisms for change are recommended. See Table 6.3 for multi-level mechanisms for change.

Table 6.3: Multi-Level Mechanisms for Change Toward Recovery

<table>
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<tr>
<th>Level</th>
<th>Mechanisms for change</th>
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<tr>
<td>Individual/resident</td>
<td>• Increase individual awareness of recovery through exposure to education (for example, Psychosocial Rehabilitation) and peer role models (requiring resource allocation and policy change)</td>
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<td>• Accept increasing responsibility for recovery</td>
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<td>• Embrace growth goals in addition to pain-avoidance goals</td>
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<td></td>
<td>• Build support networks beyond the group home</td>
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</table>
| Staff | - Increase individual awareness of recovery through exposure to education and peer role models (requiring resource allocation and policy change)  
- Create opportunities and provide invitations to share power  
- Function as a recovery guide or coach, facilitating progress on goals identified by the residents.  
- Shift from a “do for” perspective to a “do with” perspective |
| Management/organization | - Increase awareness of recovery at an individual and systems level  
- Seek leadership resources and models to facilitate  
- Embrace the mandate to implement the recovery vision  
- Raise clear expectations and support to staff with respect to recovery  
- Adopt recovery-oriented structures and policies (including mission, policies, procedures)  
- Enact an advocacy role  
- Seek partnerships for change |
| Community | - Promote housing as a mechanism for positive interactions between the community and people with mental illness  
- Address stigma and discrimination through community education  
- Promote inclusive neighbourhoods |
| Government | - Convey a clear mandate to implement the recovery vision in all housing initiatives, including those relevant to group homes  
- Incorporate the language of recovery in all relevant documents  
- Engage in knowledge translation strategies that bring the interests of all stakeholders together  
- Allocate money to invest in affordable housing and requisite services |
Knowledge transfer activities arising from this research will aim to raise awareness of the benefits of a social-ecological approach to address housing issues, and in particular, issues related to recovery and group homes, through written manuscripts and verbal presentations to multiple stakeholder groups.

Limitations

As a case study, this study is limited by the fact that data were collected relevant to one group home only. As a not-for-profit home, this group home has some contextual variables which differ from the many other for-profit group homes that operate in the province, perhaps limiting applicability of the findings.

For further study

Many topics emerge for further study. In general, more research is needed to clarify the relationship between specific elements of housing, and the recovery process. It would be beneficial to replicate this study in other group homes, both for-profit and not-for-profit, and engage in cross-case analysis to determine commonalities and to determine whether or not the findings transfer to other settings. More research is needed to clarify how the recovery process applies to different age groups; older adults in particular have not been clearly addressed in existing research. Future research from a knowledge translation perspective would also be recommended to enable the application of recovery-oriented practices to group home settings. In this regard, participatory action research could be particularly relevant to ensure that recovery values are integrated. Further research regarding the government-level policies, financial policies in particular, that
influence housing and recovery-oriented practice is also warranted.

**Conclusion**

Knowing better implies the need for doing better. With recovery reflective of civil rights, it is not a passing trend. People living in group homes have been forgotten long enough. They are not exempt from recovery, and much can be done “expeditiously” to launch them on a recovery journey, but, as this study confirmed, there is a widespread lack of knowledge about recovery at multiple levels, creating significant barriers to its implementation. Continuing to address issues at the individual level, which has been common practice in mental health care for many years, is insufficient to promote recovery. Armed with the knowledge that a social-ecological perspective aligns with recovery, mental health care providers, whether in front-line services, or in related peripheral services such as housing, can confront well-established approaches and embrace advocacy roles that draw attention to the multi-level influences on mental health. This will support people with mental illness to reap the benefits of social justice, social inclusion and full citizenship that come with recovery.
Bibliography


178


<table>
<thead>
<tr>
<th>Title, authors</th>
<th>Type of paper/study, location, purpose, method</th>
<th>Key findings</th>
</tr>
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</table>
| What makes a house a home? The role of material resources in recovery from severe mental illness (Borg, et al., 2005) | **Type of paper/study:** Qualitative – key informant interviews  
**Location:** Norway  
**Purpose:** To determine role of material resources, particularly having a home, in recovery | • Material resources  
- material meanings  
- immaterial meanings  
• Having a home  
- a place for growth and development  
- a place of control  
- a place to long for and dream about |
| Consumer participation in housing: Reflecting on consumer preferences (Browne & Hemsley, 2010a) | **Type of paper/study:** Literature review  
**Location:** Australia  
**Purpose:** To examine consumer participation in housing | • Consumer participation in housing is not common  
• Importance of appropriate housing to recovery cannot be underestimated  
• Housing initiatives must incorporate expressed needs of consumers (small units and drop-in support) |
| Housing and living with a mental illness: Exploring carers’ views (Browne & Hemsley, 2010b) | **Type of paper/study:** Qualitative, focus groups  
**Location:** Australia  
**Purpose:** To determine carers’ (not paid caregivers) views on the recovery needs re: housing of their loved ones | • Safety and vulnerability  
• Stigma and the consequences of living with a mental illness |
| Consumer perspectives on recovery: A focus on housing following discharge from hospital. (Browne, et al., 2008) | **Type of paper/study:** Qualitative, focus groups  
**Location:** Australian  
**Purpose:** To investigate recovery needs specific to housing | • Money/finance  
• What having a mental illness can mean  
• Recovery  
• Housing |
<table>
<thead>
<tr>
<th>Title</th>
<th>Type of paper/study:</th>
<th>Location</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness recovery and place</td>
<td>Qualitative, interviews</td>
<td>Australia</td>
<td>• The importance of a place to base recovery</td>
</tr>
<tr>
<td>(Chesters, et al., 2005)</td>
<td></td>
<td></td>
<td>• Loneliness and lack of supportive meaningful relationships</td>
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<td></td>
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<td></td>
<td>• Moving on from housing and support</td>
</tr>
<tr>
<td>Processes of recovery in serious mental illness: Findings from a multinational study</td>
<td>Qualitative interviews (phenomenology)</td>
<td>Multinational: Italy, Norway, Sweden, U.S.</td>
<td>• How the person deals with his or her problems</td>
</tr>
<tr>
<td>(Davidson, Borg, et al., 2005)</td>
<td></td>
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<td>• The roles of material resources</td>
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<td>• Roles of formal and informal health systems</td>
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<td>• The roles of significant others</td>
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<td>• The roles of social and cultural factors</td>
</tr>
<tr>
<td>The creation of “We Are Neighbours”: Participatory research and recovery</td>
<td>Community-based participatory research - interviews</td>
<td>Canada</td>
<td>• Empowerment</td>
</tr>
<tr>
<td>(deWolf, 2009)</td>
<td></td>
<td></td>
<td>• Hopeful findings</td>
</tr>
<tr>
<td>“Reengineering” residential care facilities: A case study of Hamilton, Ontario.</td>
<td>Mixed method</td>
<td>Canada</td>
<td>• Concerns raised regarding housing were similar to those raised 20 years previously</td>
</tr>
<tr>
<td>(Edge &amp; Wilton, 2009)</td>
<td></td>
<td></td>
<td>• Lack of privacy, overcrowding, harassment by staff and co-residents, and security raised as issues</td>
</tr>
<tr>
<td>Title</td>
<td>Type of paper/study</td>
<td>Purpose</td>
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</tbody>
</table>
| Reliability and validity of the Recovery Assessment Scale for consumers with severe mental illness living in group home settings (Flinn, 2004) | Type of paper/study: Quantitative (thesis)  
Location: U.S.  
Purpose: Validating Recovery Assessment Tool | • Construct validity of recovery was supported  
• Positive significant relationships between recovery and readiness to change and between recovery and performance in daily activities were found |
| The Fairweather mental health housing model—A peer supportive environment: Implications for psychiatric rehabilitation (Haertl, 2007) | Type of paper/study: Theoretical/conceptual paper, based on a case example  
Location: U.S.  
Purpose: To describe the alignment of the Fairweather mental health housing model with recovery | • Basic tenets of peer support, empowerment, community, and productive work align with recovery |
| Understanding program models to address homelessness and serious mental illness: A qualitative inquiry of service providers (Henwood, 2011) | Type of paper/study: Case study and grounded theory (thesis)  
Location: U.S.  
Purpose: To examine front-line providers’ experiences of delivering Housing First services | Housing First providers more closely align with a recovery orientation than do Treatment First providers  
**Housing First providers:**  
• Platform for recovery  
• Leveling the playing field  
• Value-oriented ‘top down philosophy’  
**Treatment First providers:**  
• Making the sale  
• Coping with the revolving door  
• Use of discretionary power |
<table>
<thead>
<tr>
<th>Title</th>
<th>Type of paper/study:</th>
<th>Location</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| The impact of a rehabilitation and recovery service on patient groups residing in high support community residences (Kavanagh & Lavelle, 2008) | Review of case notes and staff interviews  
**Location:** Ireland  
**Purpose:** To describe the impact of a rehabilitation and recovery service on outcomes of patient groups residing in high support community residences | Ireland | • Positive outcomes were achieved with rehabilitation interventions, but there remained a cohort of patients whose needs could not be met in this setting |
| The homeless and mental illness: Solving the challenge (Kirby, 2008) | Report/speech  
**Location:** Canada  
**Purpose:** To discuss the plan for the mental health strategy to be based on idea of recovery; To announce funding for homelessness research | Canada  | • Homelessness seen as a barrier to recovery  
• $110 million promised for homeless research |
| Moving on from homelessness: A narrative inquiry (Kirkpatrick, 2005) | Narrative inquiry; participant observation and interviews (thesis)  
**Location:** Canada  
**Purpose:** To explore the experience of "moving on" from homelessness for individuals with a major mental illness, after they obtained permanent housing with supports as part of the Province of Ontario Homelessness Strategy | Canada  | • Being on the move while homeless meant a continued and repetitive search for basic needs, food and a place to sleep  
• A place of their own and supports to assist them were critical in moving on |
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of paper/study</th>
<th>Location</th>
<th>Purpose</th>
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</table>
| A narrative inquiry: Moving on from homelessness for individuals with a major mental illness (Kirkpatrick & Byrne, 2009) | Type of paper/study: Metaphorical narrative inquiry space (3 dimensional – place or series of places, temporal, including past, present and future, and interaction, including personal and social) - included participant observation, document review and interviews | Canada   | - On the move  
- Moving on  
- The door  
- Getting the message out                                                                 |
| Critical characteristics of supported housing: Resident and service provider perspectives (Kirsh, et al., 2011) | Type of paper/study: qualitative interviews of residents and service providers of supported housing | Canada   | - Supported housing as a foundation for recovery  
- Guiding values  
- Key supports  
- Importance of neighbourhood and community context                                                                 |
| A social-ecological approach to investigating relationships between housing and adaptive functioning for persons with serious mental illness (Kloos & Shah, 2009) | Type of paper/study: Theoretical/conceptual paper, describing the evolution of social-ecological methods for studying housing and recovery | U.S.     | - Housing and neighbourhood risk factors  
- Relevance of social ecology for mental health – housing research  
- Developing a framework to study the social ecology of housing environments  
- Investigating a social ecology of housing environments                                                                 |
<table>
<thead>
<tr>
<th>Title</th>
<th>Type of paper/study</th>
<th>The national study concluded the need for:</th>
</tr>
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</table>
| Turning The Key<br>(MHCC, 2011)                                      | Policy paper<br><strong>Location:</strong> Canada<br><strong>Purpose:</strong> To document the housing and community support needs of people with mental illness in Canada; to support planning and policy work in housing and related supports | - Affordable housing  
- Quality housing  
- Housing and supports that work  
- Housing and supports that fit |
| Residential placement and well-being among persons recovering from serious mental illness<br>(Murphy, 2008) | Cross-sectional relational design and employed a consumer survey (thesis)<br><strong>Location:</strong> U.S.<br><strong>Purpose:</strong> To examine those aspects of community based residential treatment that relate to stability, recovery, and well-being for people with severe and persistent mental illness | - With the exception of education level, quality of life for respondents living in group homes was very similar to their counterparts receiving supported housing  
- Independent functioning ability was significantly higher for respondents receiving supported housing services in eight areas, including cooking, shopping, housekeeping, personal finances, use of medications, active use of services, pursuit of recovery goals, and ability to find and use health care  
- Group home residents were significantly more likely to have substance abuse problems than respondents receiving supported housing, and were more likely to have problems that could put them or others at risk. |
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of paper/study:</th>
<th>Location:</th>
<th>Purpose:</th>
</tr>
</thead>
</table>
| There's no place like (a) home: Ontological security among persons with serious mental illness (Padgett, 2007) | Qualitative, descriptive study using interviews, grounded theory analysis | U.S. | • Control and self-determination  
• Routines of daily life: The simple things  
• Privacy and freedom from supervision  
• Identity construction and repair  
• The “what’s next” of having a home  
• Staying in transitional housing |
| Consumer/survivor stories of empowerment and recovery in the context of supported housing (Parkinson & Nelson, 2003) | Narrative approach, qualitative interviews | Canada | • Empowerment  
• Community integration  
• Access to valued resources |
| Towards recovery: Living in a home-like setting after the move from a hospital ward (Pejler, et al., 1999) | Qualitative interviews | Sweden | • Experiences of life at the villa  
-Being capable  
-Having relationship problems  
-Needing other people  
• Experiences of caring relationships  
-Being in a state of dependence  
-The good care provider  
-The care provider with hyper control  
-The absent care provider  
• Experiences of disease/illness  
-Dealing with illness related problems  
-Living with fatigue  
-Suffering from “inner experiences,” vulnerability |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Type of paper/study</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Stigma, poverty, and victimization:</td>
<td><strong>Discussion paper</strong></td>
<td>• Stigma</td>
</tr>
<tr>
<td>Roadblocks to recovery for individuals with severe mental illness</td>
<td><strong>Location:</strong> U.S.</td>
<td>• Poverty</td>
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<td><strong>Purpose:</strong> To describe the adverse effects of stigma, poverty, and victimization; to provide information that will enable psychiatric nurses to build advocacy skills; to identify strategies to reduce stigma, and help patients cope with poverty and reduce victimization</td>
<td>• Poverty and unmet needs</td>
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<tr>
<td></td>
<td></td>
<td>- Need for basic survival supplies</td>
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<td>- Need for self-identity</td>
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<td>- Need for persons, groups and roles</td>
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<td>- Need for money</td>
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<td></td>
<td>• Victimization</td>
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<td>- Victimization by violent behavior of others</td>
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<td>- Victimization by neglect or omission of care</td>
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<td>- Victimization by exploitation</td>
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<td>- Victimization by care providers</td>
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<td><strong>Housing for persons with serious mental illness:</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Consumer and service provider preferences</strong></td>
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<tr>
<td></td>
<td><strong>Type of paper/study:</strong></td>
<td><strong>Quantitative - questionnaires</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Location:</strong> Canada</td>
<td><strong>Purpose:</strong> To evaluate housing preferences of consumers, and compare them with those of their case managers</td>
</tr>
<tr>
<td></td>
<td><strong>Purpose:</strong> To evaluate housing preferences of consumers, and compare them with those of their case managers</td>
<td><strong>• 44% of respondents preferred to live in their own apartments while 11% of their case managers preferred this option</strong></td>
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<td><strong>• 1/3 of consumers lived in their preferred type of housing, while 55% of case managers believed their clients lived where they preferred</strong></td>
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<td><strong>• Almost 1/3 of residents preferred foster homes/ group homes</strong></td>
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<td><strong>• Most consumers would prefer to live in housing offering more autonomy</strong></td>
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<td></td>
<td></td>
<td><strong>• case managers were more conservative in their preferences, preferring housing that offers more structure and clinical involvement</strong></td>
</tr>
<tr>
<td>Title</td>
<td>Type of paper/study:</td>
<td>Location</td>
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</tbody>
</table>
| “Who believes most in me and in my recovery”: The importance of families for persons with serious mental illness living in structured community housing | Qualitative interviews | Canada   | To determine the role of family for people living in structured residential care | - My family believes most in my recovery  
- My family shows that they believe in me  
- affection and sense of belonging  
- emotional and practical support  
- stay actively involved in my life |
| A home, not housing                                                  | Editorial             | U.S.     | Introduction to special issue on housing                               | - No component of community mental health is more important than decent affordable housing  
- Living with family is not recovery-oriented, but often based on lack of choice  
- Supported and normalized housing more effective  
- Need to focus on homes, not houses |
| Strengthening Ontario's system of housing for people with serious mental illness | Discussion paper     | Canada   | To discuss strategies to improve Ontario’s housing system for people with mental illness | - Values underlying housing programs  
- Evidence of effective housing practices  
- Current status of the system  
- International practices for monitoring community mental health systems |
| A model of housing stability for people with serious mental illness   | Qualitative           | Canada   | To add to the housing theory base by clarifying a definition and developing a model of housing stability | - Definition  
- Model of Housing Stability |
<table>
<thead>
<tr>
<th>Study Title</th>
<th>Type of paper/study:</th>
<th>Purpose</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing preferences and choices among adults with mental illness and substance use disorders (Tsai, et al., 2010)</td>
<td>A qualitative study; semi-structured interview (was a follow-up to a larger study in which surveys were completed)</td>
<td>To determine factors and barriers to desired housing (population had dual diagnosis)</td>
<td>U.S.</td>
<td>Likes and dislikes about current housing; Housing choice and options; External factors in housing choice; Barriers to housing; Housing preference; Housing preference change</td>
</tr>
<tr>
<td>Negotiating the boundaries of mental health and illness: A study of recovery in permanent supportive housing (Watson, 2011)</td>
<td>Case study and grounded theory (thesis)</td>
<td>To study the recovery process for formerly chronically homeless individuals with dually diagnosed serious and persistent mental illness (SPMI) and substance use disorder in Housing First program</td>
<td>U.S.</td>
<td>From structural chaos to a model of consumer choice; Recovery in consumer-centred programming; Program implementation and recovery; Calmer on the surface</td>
</tr>
<tr>
<td>Mental health recovery of psychiatric group home residents (Weddle, 2002)</td>
<td>Qualitative interviews and focus groups (thesis)</td>
<td>To explore recovery from the perspective of group home residents (what aspects helped or hindered)</td>
<td>U.S.</td>
<td>Precipitant of group home entrance; Impact of the transition; Getting back on one's feet; Self-reflection and decided outcome</td>
</tr>
</tbody>
</table>
| Safety and security in small-scale recovery housing for people with severe mental illness: An inner-city case study  
(Whitley, Harris, & Drake, 2008) | **Type of paper/study:** Qualitative - focus groups and participant observation over 2-year period  
**Location:** U.S.  
**Purpose:** To identify and understand factors influencing adjustment and stability in recovery housing | - Safety  
- Security |
| --- | --- | --- |
| Housing environment and mental health outcomes: A levels of analysis perspective  
(Wright & Kloos, 2007) | **Type of paper/study:** Quantitative  
**Location:** U.S.  
**Purpose:** To explore the effects of perceived housing environment on selected well-being outcomes of a seriously mentally ill population in supported housing programs | - Neighbourhood variables are the most influential predictors for understanding variance in well-being  
- Apartment level variables also contribute to explaining variance of well-being outcomes |
## Appendix B
### Observation Guide

<table>
<thead>
<tr>
<th>Physical environment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Location (external)</td>
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<tr>
<td>• Space (internal)</td>
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<table>
<thead>
<tr>
<th>Human/social environment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Who is present in the home?</td>
</tr>
<tr>
<td>• Interactions (within the home): positive and negative interactions, or lack of interaction (resident – resident, resident – staff, staff – staff, other)</td>
</tr>
</tbody>
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<tr>
<th>Activities:</th>
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</thead>
<tbody>
<tr>
<td>• Nature of interactions between people (residents, staff) and physical structures of house</td>
</tr>
<tr>
<td>• Individual?</td>
</tr>
<tr>
<td>• Collaborative?</td>
</tr>
</tbody>
</table>
## Document Analysis Guide

<table>
<thead>
<tr>
<th><strong>Document analysis guide</strong></th>
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</thead>
<tbody>
<tr>
<td>Name of document:</td>
</tr>
<tr>
<td>History of document (Merriam, 1998)</td>
</tr>
<tr>
<td>- purpose of its creation</td>
</tr>
<tr>
<td>- author</td>
</tr>
<tr>
<td>- intended audience</td>
</tr>
<tr>
<td>- what sources of information does it draw on?</td>
</tr>
<tr>
<td><strong>Frequency/process of revision</strong></td>
</tr>
<tr>
<td><strong>Content analysis of document – relevance to the research question</strong></td>
</tr>
<tr>
<td><strong>Use of the document – availability, distribution, means of communication</strong></td>
</tr>
</tbody>
</table>
Appendix D
Interview Guides

Interview Guide: Manager

1. Can you tell me about how things work here at this special care home?
   - What is it like to work here? How is it organized?
   - training/ experience you have to work here?
   - how does it compare to other places you have worked? Good things? Challenges?

2. What is your role in deciding what is done at this special care home?
   - Interactions? (direct, indirect), Communication? – giving and receiving, formal/informal
   - how decisions are made? – who is involved? Rules, policies etc.

3. Can you tell me what your daily routine looks like on an average day?
   - on a good day?
   - on a bad day?

4. What are your expectations when a client is funded/approved for placement in this special care home? E.g. length of stay, treatment
   - how do you ensure that your expectations are met?

5. What do you look for when choosing staff for the home? What makes for a good fit? A poor fit?

6. What makes it possible for the residents to build on their skills and abilities?

7. How do you/the staff show the residents you are hopeful about their future?
   - are there goals for each resident? For the home in general? Coordination of outside services?

8. What does recovery mean to you? (offer definition for response)
   - How does this home support the recovery of the residents?

9. How could things be different in this house to better support the residents on their recovery journey?
   - What are the challenges/barriers? Opportunities?
Interview Guide: Current Staff

1. What is it like to work in this special care home?
   - training experience you have to work here?
   - how does it compare to other places you have worked?

2. Can you tell me what your daily routine looks like on an average day?
   - on a good day?
   - on a bad day?

3. How do you make it possible for the residents to build on their skills and abilities?

4. How do you show the residents you are hopeful about their future?
   - are there goals for each resident? For the home in general?

5. What supports are in place to guide your interactions with the residents?

6. What does recovery mean to you? (offer definition for response)
   - do you think this home supports the recovery of the residents? How?

7. How could things be different in this house to better support the residents on their recovery journey?
Interview Guide: Current Residents

1. What is it like to live in this special care home?
   -best thing about living here? Worst thing?
   -how does it compare to where you were living before?
   -how long do you plan to continue living here?
   -where would you like to live if you do move from here? What stops you?

2. Can you tell me what your daily routine looks like on an average day?
   -on a good day?
   -on a bad day?

3. How does living here allow you to build on your skills and abilities?
   -what are your responsibilities?

4. Who are the people in your life who support/help you?

5. Can you tell me about your hopes for the future?
   -how does the staff show you that they are hopeful about your future?

6. What does recovery mean to you? (offer definition for response)

7. As you continue on your recovery journey, what is most important to you?

8. How could things be different in this house to better support you on that journey?
Interview Guide: Family member / Friend

1. How do you feel about your family member / friend living in this special care home?
   -best thing about living there? Worst thing?
   -how does it compare to where he/she was living before?
   -how long does he/she plan to continue living here?
   -where might he/she live if they moved from there? What stops them?

2. Can you tell me what their daily routine looks like on an average day?
   -on a good day?
   -on a bad day?

3. How does living there allow them to build on their skills and abilities?
   -what are your responsibilities?

4. Who are the people in your life who support/help them?

5. Are you hopeful about their future?
   -how does the staff show them that they are hopeful about their future?

6. What does recovery mean to you? (offer definition for response)

7. As they continue on their recovery journey, what do you think will be most important?

8. How could things be different in this house to better support them on that journey?
Interview Guide: Mental Health Service Providers (not employed at the house, e.g. case manager)

1. What is it like to work with this special care home?
   - training experience you have to work here?
   - how does it compare to other places where your clients live?

2. Can you tell me what your client’s daily routine looks like on an average day?
   - on a good day?
   - on a bad day?

3. How do they make it possible for the residents to build on their skills and abilities?

4. How do you show the residents you are hopeful about their future? How does the staff at the house show the residents they are hopeful about their future?
   - are there goals for each resident? Who decides? How are these communicated?
   - for the home in general?

5. What guidelines are in place to guide your interactions with the residents? With the staff?

6. What does recovery mean to you? (offer definition for response)
   - do you think this home supports the recovery of the residents? How?

7. How could things be different in this house to better support the residents on their recovery journey?
Interview Guide: Board of Directors

1. What are your expectations when a client is funded for placement in this special care home?
   - how do you ensure that your expectations are met?

2. What is your role in deciding what is done at this special care home?
   - interactions?
   - how decisions are made? – who is involved?

3. What does recovery mean to you? (offer definition for response)

4. How do you ensure that the services in the home are recovery-oriented?

5. What could be done to make this special care homes more recovery oriented?
   - what are the challenges/barriers? Opportunities?
Appendix E
Consent forms

Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form: Special Care Home Manager

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people with mental illness who live in special care homes. Since you are the manager of this special care home, your consent to undertake the study is essential. I will review the details of this consent form with you, and answer any questions you may have before beginning the study.

Description of Procedures
If you agree that this special care home can participate, I will be asking you and all of the residents and staff, as well as some former residents and staff, family members and friends of current residents, and representatives from the Board of Directors, Mental Health Services, Department of Health, and Department of Social Development to participate in a private interview that will take about one hour. If each person will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. I will also be spending some time in the group home in the role of volunteer so that I can observe what goes on. At a future time, I may ask you and/or them a few questions to clarify what has been observed or said in the interviews, to make sure I have understood.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While this home may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery for people with mental illness.

Confidentiality
All information collected during this study will be kept confidential. The final results may be used in presentations and publications, but opinions will be combined and the name of the home or the names of individual participants will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.
Voluntary Participation
It is completely up to you if you would like the home to participate in this study. If you say yes now but have concerns once the study is in progress, I would be happy to address them with you.

Participant Statement and Signature Section
I have read and understand the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form giving consent for the study to proceed. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or
Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.
If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree that:

_____ Cathy White can undertake this case-study research within the special care home at which I am the manager

_____ the residents and staff can be approached to take part in an audio-recorded interview,

_____ Cathy White may spend time in the home in the role of volunteer for the purpose of observing what goes on within the home

____________________  _______________  __________________
Signature of Participant  Printed Name of Participant  Date

____________________  _______________  __________________
Signature of Witness    Printed Name of Witness   Date

Statement of Investigator
I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________  __________________
Signature of Principal Investigator  Date
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form
Current Staff

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you work in this special care home, your opinions will be really valuable to the study. I will review the details of this consent form with you, and answer any questions you may have.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood. I will also be spending some time in the special care home, and would like to observe what goes on.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect your employment at the special care home. If you do participate, you can decide to answer or skip any of the questions I have for you.
Participant Statement and Signature Section
I have read and understand the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview, and

_____ to be observed within the special care home

______________________________________________
Signature of Participant                        Printed Name of Participant                        Date

______________________________________________
Signature of Witness                            Printed Name of Witness                          Date

Statement of Investigator
I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

______________________________________________
Signature of Principal Investigator

Date
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form
Current Resident

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you live in this special care home, your opinions will be really valuable to the study. I will review the details of this consent form with you, and answer any questions you may have.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood. I will also be spending some time in the group home to observe what goes on.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect your housing or any of the care you receive. If you do participate, you can decide to answer or skip any of the questions I have for you.
Participant Statement and Signature Section

I have read and understand the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:

Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview

__________________________________________
Signature of Participant  Printed Name of Participant  Date

__________________________________________
Signature of Witness  Printed Name of Witness  Date

Statement of Investigator

I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

__________________________________________  Date
Signature of Principal Investigator
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form
Family member/friend

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you have a family member or friend who lives in this special care home, your opinions will be really valuable to the study. I will review the details of this consent form with you, and answer any questions you may have.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect any of the care your family member/friend receives at the special care home. If you do participate, you can decide to answer or skip any of the questions I have for you.
Participant Statement and Signature Section
I have read and understood the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview

____________________     ______________________     ______________________
Signature of Participant     Printed Name of Participant     Date

____________________     ______________________     ______________________
Signature of Witness     Printed Name of Witness     Date

Statement of Investigator
I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________     ______________________
Signature of Principal Investigator     Date
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form
Mental Health Service Providers

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you work with residents who live in this special care home, your opinions will be really valuable to the study. I will review the details of this consent form with you, and answer any questions you may have.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect your relationship with the special care home. If you do participate, you can decide to answer or skip any of the questions I have for you.
Participant Statement and Signature Section
I have read and understood the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview

____________________  ______________________  ______________
Signature of Participant   Printed Name of Participant   Date

____________________  ______________________  ______________
Signature of Witness   Printed Name of Witness   Date

Statement of Investigator
I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________  ______________________
Signature of Principal Investigator   Date
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form
Board of Directors

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you are involved with what goes on in this special care home, your opinions will be really valuable to the study.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect your relationship with the special care home. If you do participate, you can decide to answer or skip any of the questions I have for you.
Participant Statement and Signature Section
I have read and understood the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview

____________________  ______________________  __________________
Signature of Participant  Printed Name of Participant  Date

____________________  ______________________  __________________
Signature of Witness  Printed Name of Witness  Date

Statement of Investigator
I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________  ______________________
Signature of Principal Investigator  Date
Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study

Information/Consent Form

Others

You are being invited to participate in a research study being conducted by Cathy White, as part of her doctoral studies at Queen’s University.

Background Information
The study is about how to promote recovery for people who live in special care homes. Since you are (associated with) special care homes (in some way), your opinions will be really valuable to the study. I will review the details of this consent form with you, and answer any questions you may have.

Description of Procedures
If you agree to take part, you will be asked to participate in a private interview that will take about one hour. If you will allow it, the interview will be audio-recorded. Otherwise, I will take detailed notes. At a future time, I may ask you a few questions to clarify what you have said in the interview, to make sure I have understood.

Risks/Benefits
There are no known risks involved if you take part in the study, or if you decide not to. While you may not benefit directly from this study, results from this study will contribute to the understanding of how to develop housing as an environment that supports recovery.

Confidentiality
All information collected during this study will be kept confidential. Your opinions will be combined with the opinions of others, and your name will not be used in any reports or presentations about the study. All information collected will be labeled with a pseudonym and kept in a locked file cabinet, and only my supervisor and research team will be able to see it.

Voluntary Participation
It is completely up to you if you would like to participate in this study, and if you say yes now, but change your mind later, that is fine too. Your decision will not affect your relationship with the special care home. If you do participate, you can decide to answer or skip any of the questions I have for you.
**Participant Statement and Signature Section**

I have read and understood the consent form for this study. I am familiar with the purpose and procedures of this study. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions I can contact:

Catherine White at (506) 999-0093 or

Doctoral supervisor Dr. Terry Krupa at (613) 533-6236.

If I have questions regarding my rights as a research participant I can contact:
Dr. Albert Clark, Chair, Research Ethics Board at (613) 533-6081.

By signing this form, I am indicating that I agree:

_____ to take part in an audio-recorded interview

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<th>Signature of Witness</th>
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**Statement of Investigator**

I have carefully explained to the participant the nature of the above research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

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<th>Signature of Principal Investigator</th>
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Appendix F  Ethics Approval

QUEEN’S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

April 14, 2010

Ms. Catherine White
School of Rehabilitation Therapy
Louise D. Acton Building
Queen’s University

Dear Ms. White,

Study Title: Enabling Recovery in a Special Care Home for Individuals with Mental Illness: A Case Study
Co-Investigators: Dr. Terry Krupa

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent forms for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair’s signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

➢ Reporting of Amendments: If there are any changes to your study (e.g., consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval. (see http://www.queensu.ca/vpr/reb.htm).

➢ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➢ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➢ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair’s signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

Chair, Research Ethics Board

Date

Study Code: REH-469-10

➢ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete