

"It's about a restricted living environment": Experiences in supported housing of people  
who use forensic mental health services

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## **Abstract**

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The forensic mental health population is made up of individuals who are living with mental illness and encounter the criminal justice system. Supported housing—which combines housing and mental health support and services—as part of the larger forensic system must manage individuals' risk to ensure public safety, and attend to the rehabilitative needs of forensic mental health populations. Drawing on 'therapeutic surveillance', my study explored experiences in supported housing of people found Not Criminally Responsible on account of Mental Disorder. Photovoice and in-depth interviews were conducted with three individuals living in supported housing. Data were analyzed inductively using thematic analysis and produced three overarching themes, including 'It feels like a normal house', 'Being responsible, being able to live independently', and 'Parts of it are a very restricted living environment'. The results point to the ways in which supported housing was experienced as empowering, and, at times, restrictive and controlling.

April 27, 2018

## Table of Contents

List of Figures .....	
Introduction.....	1
Literature Review.....	5
_____ The legal framework .....	5
_____ The forensic mental health system.....	9
_____ The NCRMD population.....	11
_____ The residential continuum.....	15
_____ Supported housing .....	17
_____ Supported housing and people who access mental health services .....	20
_____ Housing and offenders .....	26
_____ Supported housing and the forensic mental health population .....	27
Theoretical Framework .....	31
_____ Dissemination of social control .....	31
_____ Risk management.....	34
_____ Therapeutic surveillance .....	36
Methods.....	41
Results.....	65
Discussion .....	101
Conclusions .....	110
References .....	111
Appendixes .....	121
_____ Appendix A: Recruitment poster .....	121
_____ Appendix B: Informed consent form .....	122
_____ Appendix C: Training Guide.....	126
_____ Appendix D: Interview Guide.....	128
_____ Appendix E: Description of themes and subthemes .....	130

## **List of Figures**

Figure 1: Residential continuum model

Figure 2: Kitchen

Figure 3: Mop and bucket

Figure 4: Dinner table

Figure 5: Garden

Figure 6: Outside bedroom window

Figure 7: Crib board

Figure 8: “Comfy spot”

Figure 9: Street view

Figure 10: Washer and dryer

Figure 11: Chore sheet

Figure 12: Meal plans

Figure 13: Locked cabinet

Figure 14: Freezer with lock

Figure 15: Possessions shelf

## **Introduction**

The Mental Health Commission of Canada's National Strategy for Mental Health provides a framework for supporting Canadians who struggle with mental health issues (Mental Health Commission of Canada, 2012a). It describes ideals related to services, programs, and community supports, with emphasis placed on reintegration to the community. Access to services, including primary health care, counselling, peer support, employment, and housing are highlighted. These guidelines also apply to forensic mental health populations that are in contact with mental health, legal, and criminal justice systems. Importantly, the strategy asserts that continuity of care (i.e., mental health services) is of the utmost importance for forensic mental health populations returning to life in the community after hospitalization (Mental Health Commission of Canada, 2012a).

The forensic mental health population is made up of individuals who are living with mental illness and encounter the criminal justice system, usually after committing a criminal act. As such, these individuals have unique rehabilitative needs encompassing both mental health recovery and needs related to their offending (Simpson & Penney, 2011). The forensic mental health system in which they receive treatment is made up of both inpatient hospitalized settings and community-based mental health services (Livingston, 2006) and is mandated to ensure public safety while attending to the treatment needs of individuals (Centre for Addiction and Mental Health, n.d.). As a result of deinstitutionalization and criminal justice system trends, the community has increasingly become the setting in which forensic mental health populations are managed and treated (Woodworth, Peace, O'Donnell & Porter, 2003).

One forensic mental health subgroup is people who live with a serious mental illness and have been found ‘Not Criminally Responsible on account of Mental Disorder’ (NCRMD) by a court after committing a criminal act. The basis for the NCRMD finding is that individuals cannot be held criminally responsible for their actions when agency is severely impaired by mental illness. Individuals found NCRMD are released from inpatient settings, often forensic mental health hospitals, through conditional discharge or absolute discharge by a provincial court or review board. There are a variety of conditions that can be attached to a discharge to the community from inpatient forensic settings, however, all conditions function to manage individuals’ risk of reoffending in the community. As a condition of discharge, individuals may be required to live in supervised settings, such as supported housing. Supported housing, as a condition of discharge, must work to manage risk and attend to the rehabilitative needs of forensic mental health populations, such as community reintegration. Supported housing, which combines housing and mental health support and services, has been identified as key in the transition of forensic mental health populations to the community (Salem, Crocker, Charette, Seto, Nicholls & Côté, 2015). Housing services may offer a sense of safety and belonging - as compared to institutional or correctional settings - but, they may also feel like spaces of coercion and control for individuals found NCRMD (Petrila, 2004). Housing services contain elements of surveillance and control tied to managing risk of reoffending, which can negatively affect levels of privacy, independence, and freedom.

While supported housing for people with mental health problems has been researched for quite some time, little is known about experiences in supported housing among those who use forensic mental health services. As someone who works in a

supportive role within a supported housing agency, I became both curious and determined to better understand how the care that I, and others, offer is experienced by those who receive supported housing services under the authority of the forensic mental health system. More specifically, I wanted to look beyond a simple dichotomy of experiences based on ‘likes’ and ‘dislikes’ of supported housing—the normative or non-critical way in which this topic has been addressed. Most literature on supported housing has focused on the aspects of housing considered to be beneficial to mental health recovery, and aspects considered to be undesirable or restrictive. Thus, my qualitative study aimed to enrich our understanding of supported housing as it is perceived and experienced by people found Not Criminally Responsible on account of Mental Disorder (NCRMD) in Nova Scotia using photovoice method and in-depth interviews. Drawing on a theoretical framework of therapeutic surveillance, I explore how forensic mental health service users negotiate therapeutic (care) and risk management (control) aspects of their supported housing environments. I ask: how is supported housing experienced by people who use forensic mental health services?

My thesis begins with an overview of the legal framework in which the NCRMD defence is situated, the forensic mental health system in which the NCRMD population is located, the NCRMD population, and examination of housing trajectories of NCRMD individuals. What follows is a review of the residential continuum and a discussion of *supportive* housing versus *supported* housing. Then, I describe available literature of supported housing and mental health service users, supported housing and offenders, and lastly, supported housing and the forensic mental health population. I have structured my

literature review on supported housing for each of these populations to illustrate an important knowledge gap addressed by my research.

The next section explains the theoretical framework used for this thesis. This includes a review of Stanley Cohen's work on social control, Michel Foucault's ideas about the dissemination of social control, and Nicolas Rose's work on risk management. I also discuss Dawn Moore's conception of 'therapeutic surveillance', which provides the central theoretical framework for my thesis.

After describing the background literature review and theoretical framework for my thesis, I describe the methods used in my qualitative study, including the research design, research procedures, and analysis. Finally, I discuss the three overarching themes and six subthemes that were produced from the data and how the results of my research connect to literature review and my theoretical framework of therapeutic surveillance.

## Literature Review

### The legal framework

In accordance with section 16(1) of the *Criminal Code of Canada*, an accused person can be found NCRMD if, at the time of the crime, they did not appreciate what they were doing, or, if they did not know what they were doing was wrong because of mental disorder. The basis for this is that if an individual's agency was impaired by mental illness at the time of the crime, they cannot be held criminally responsible.

Essentially, a verdict of NCRMD means that the court has ruled that the accused was not criminally liable at the time the offence was committed (Maeder, Yamamoto & Fenwick, 2015). Part XX.1 of the *Criminal Code* provides an alternative to traditional criminal justice sanctions for individuals found NCRMD of "individualized assessment to determine whether the person poses a continuing threat to society coupled with an emphasis on providing opportunities to receive appropriate treatment" (*Winko v. British Columbia*, 1999, p. 626).

Part XX.1 of the *Criminal Code* contends that people found NCRMD are entitled to rehabilitation and care to foster mental health recovery, and that restrictions on the liberty and freedoms of people found NCRMD are imposed to protect society, not to be used as punishment (*Winko v. British Columbia*, 1999, p. 630). Part XX.1 of the *Criminal Code* was enacted in 1991 on the premise that treating mentally ill offenders like other offenders fails to address the interests of either the offenders or the public. If the mentally ill offender is punished and denied treatment, the public is no better protected when the offender is released (*Winko v. British Columbia*, 1999). The outcome is that the NCRMD

individual is provided opportunities for treatment and is subject restrictions on their liberty so as to protect the public.

In Canada, a court may order a person facing criminal charges to undergo an NCRMD assessment, which is usually performed in a forensic mental health hospital (Crocker, Livingston & Leclair, 2017). If a person has been found NCRMD by a court, they will usually be diverted to a provincial or territorial review board and will be evaluated on annual basis to determine the appropriate disposition<sup>1</sup>. The task of the review board is to determine whether there is a significant or real risk to the community if the NCRMD individual is released (*Winko vs. British Columbia*, 1999). A significant threat is defined as:

“A real risk of physical or psychological harm to members of the public that is serious in the sense of going beyond merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature.” (*Winko v. British Columbia*, 1999, p. 627)

Section 672.54 of the *Criminal Code* requires that, when contemplating a disposition, the court or review board must consider the need to protect the public from dangerous person, the mental condition of the accused, community reintegration, and the NCRMD individual's other. After considering the above elements, the court or review board must then make the disposition “that is the least onerous and least restrictive to the accused” (section 672.54, *Criminal Code*, 1985). If the review board is of the opinion that an individual found NCRMD is not a significant threat to the safety of the public, the

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<sup>1</sup> If the offender is designated a ‘high-risk accused’, the disposition must be reviewed every three years (Crocker, Livingston & Leclair, 2017)

individual must be discharged absolutely (section 672.54(a), *Criminal Code*, 1985). If the individual is found to be a significant threat to the safety of the public, the review board may order the NCRMD individual be discharged to the community and subject to conditions, or detained in custody in a hospital.

Recent amendments to Section 672.54 of the *Criminal Code*, introduced by Bill C-54: An Act to amend the Criminal Code and the National Defence Act require courts or review boards to take into account public safety as the paramount consideration before making a disposition (Clause 9 of Bill C-54, Section 672.54, *Criminal Code*). As well, the bill creates a new section, that operationalizes “significant threat to the safety of the public” as: “a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent” (Section 672.5401, *Criminal Code*).

The goal of the review board is to provide a disposition that both protects the public and allows engagement in mental health treatment (Latimer, 2006). An individual can be given one of three dispositions following a hearing of the provincial review board under section 672.54 of the *Criminal Code of Canada*: an absolute discharge, a conditional discharge in which an individual may leave the hospital but with restrictions imposed on their liberty, or a detention in hospital order. Until an NCRMD accused person is given an absolute discharge, he or she will remain under the authority of the provincial review board (Latimer, 2006).

As was revealed by a study examining review board disposition outcomes of people found NCRMD in three Canadian provinces, there are significant variations in the

conditions associated with detention or conditional discharge dispositions in Canada (Crocker, Charette, Seto, Nicholls, Côté & Caulet, 2015). The forbiddance of weapon possession was often mentioned in British Columbia in cases of conditional discharge or detention with conditions (Crocker, Charette et al., 2015, p. 121). Restrictions on contact with victims or their family members were rarely mentioned in Quebec, but were prominent in British Columbia and Quebec (Crocker, Charette et al., 2015).

An earlier study done in 2003, which described characteristics of individuals found NCRMD in British Columbia, demonstrated the conditions were most often attached to detention in custody orders. Most often, NCRMD individuals were under the direction and supervision of the Director, were required to keep the peace and maintain good behaviour, and, were required to reside at the provincial forensic hospital (Livingston, Wilson, Tien & Bond, 2003, p. 412). Other conditions that were attached to conditional discharge dispositions included reporting to a specific forensic mental health or outpatient clinic, abstaining from the use of alcohol or non-prescription drugs, and residing in a supervised setting deemed appropriate by the Director (Livingston, Wilson et al., 2003, p. 412). The findings of these studies describe the nature and types of conditions that review boards use in their dispositions to manage risk. Furthermore, they describe how the liberties of NCR people can be restricted by review boards within the framework of risk management. Importantly, one way in which NCR people's liberties are constrained to manage risk is through restrictions on housing.

## **The forensic mental health system**

The legal framework of a jurisdiction determines the organization of forensic mental health services as well as who will receive the services (Crocker, Livingston & Leclair, 2017). In Canada, forensic mental health services are part of the public health system and are under the responsibility of provinces (or territories). Organization of forensic mental health services in Canada range from a highly centralized, integrated network of forensic mental health services, to dispersed regional services (Crocker, Livingston & Leclair, 2017). However, all provinces have a high-security facility or high-security units dedicated to the forensic mental health population.

The forensic mental health system consists of a range of both inpatient and community services for persons with co-occurring legal and mental health problems (Livingston, 2006). Generally, forensic mental health services function to assess and treat the mental health and criminogenic needs of individuals who are involved with legal and criminal justice systems, including individuals found NCRMD (Crocker, Livingston & Leclair (2017). While the forensic mental health system is mandated to facilitate recovery and community reintegration for people found NCRMD, mitigating the risk for reoffending is paramount in the delivery of care (Woodworth et al., 2003). The dual focus on managing risk (i.e., likelihood that a person will reoffend or cause harm to others), reducing harms, and supporting rehabilitation (i.e., promoting positive health outcomes) (Simpson & Penney, 2011, p. 302). As such, determining the services that forensic mental health service users should receive involves both risk assessment and risk management (Crocker & Côté, 2009).

At every stage, from assessment to release into the community, professionals working in the forensic mental health system must balance the needs and rights of individuals with the safety needs of the public (Centre for Addiction and Mental Health, n.d.). The ability to assess risk has important repercussions on the rights and liberties of individuals found NCRMD as well as the intensity and restrictiveness of the services they receive (Crocker, Nicholls, Côté, Latimer & Seto, 2010). Forensic institutions play a vital role in “containing and mitigating public safety risk, enabling justice-involved people with mental disorders to access therapeutic processes and interventions, and facilitating community reintegration, crime desistance, and personal recovery” (Crocker, Livingston & Leclair, 2017, p. 39). In general, forensic community programs are responsible for providing client treatment plans, medication and symptom management, assessment and management of risk, client supervision, and rehabilitation measure to NCRMD clients in the community (Woodworth, Peace, O’Donnell, Porter, 2003, p. 2). Therefore, almost all aspects of life in the community for forensic mental health service users are impacted by the level of risk they pose, as determined by treatment teams and review boards.

In their work on forensic mental health systems, Crocker, Livingston & Leclair (2017) conceptualize what a tiered model of forensic mental health services would look like. The pyramid model was designed with three clusters of custodial-based services and three clusters of community-based services. Services are grouped logically with comparable levels of intensity and restrictiveness to meet varying mental health needs, based on the problem severity. As you move towards the highest tier, deprivation of liberty and forensic specialization increase, as well as the need for intensive services. As such, the top tier of the pyramid represents high-security, custodial services which serve

the smallest portion of the forensic population with a focus on stabilization (Crocker, Livingston & Leclair, 2017). In the mid-range of the tier, you would find low-security, custodial services which prepare service users for care in the community. The lower half of the pyramid provides a continuum of care in the community that matches a service user's level of treatment needs; the lowest tier would focus on transitioning people to non-forensic mental health systems to provide care. The authors suggest that the evidence-based model described above would be weighted heavily toward institutional services to reflect the "distinct nature of forensic populations and the risk management function" of forensic systems (Crocker, Livingston & Leclair, 2017, p. 40). Arguably, this evidence-based model is conducive to the supported housing model in that both models support care in the community and services that match the needs of service users.

### **The NCRMD population**

The National Trajectory Project of Individuals found Not Criminally Responsible on Account of Mental Disorder in Canada (Crocker, Nicholls, Seto, Charette, Côté & Caulet, 2015) describes the psychosocial and criminological characteristics of people found NCRMD in three Canadian provinces. In regard to sociodemographic characteristics, women represented 15.6% of the sample, NCRMD–accused people were 36.56 years of age (on average), one-half had a high school diploma, and more than three-quarters were single at the time of the index offence (Crocker, Nicholls et al., 2015, p. 108). Almost 75% of the NCRMD–accused people received some form of governmental income support (e.g., welfare, pension, or disability) (Crocker, Nicholls et al., 2015). In regard to mental health characteristics, 94% of NCRMD-accused individuals had a

serious mental illness at the time of their index offence verdict; the most common diagnosis was a psychotic spectrum disorder (Crocker, Nicholls et al., 2015, p. 108). One third of NCRMD accused individuals had a substance use disorder (Crocker, Nicholls et al., 2015). In terms of psychiatric history, 72% of NCRMD-accused people had at least one psychiatric hospitalization prior to their index offence (Crocker, Nicholls et al., 2015, p. 108). In regard to criminological characteristics, offences against the person accounted for 64.9% of index offences, property offences for 16.9%, and other Criminal Code violations for 18.2% – assaults represented one quarter to one-third of all index offences in the 3 provinces (Crocker, Nicholls et al., 2015, p. 109). One half of the sample had been previously convicted or found NCRMD (Crocker, Nicholls et al., 2015).

People found NCRMD may face multiple social obstacles when leaving the hospital and re-entering the community including discrimination and social exclusion (Simpson & Penney, 2011). The stigmatizing effect of having mental illness and a criminal history, as well as being involved in the forensic mental health system and labelled as such, can negatively affect people's access to resources and opportunities, such as employment and education (Livingston, 2016; Batastini, Bolanos & Morgan, 2014) and housing (Salem et al., 2015).

Research identifies that having access to supported housing, which combines affordable housing with mental health support, can facilitate the transition of individuals with mental illness and criminal justice backgrounds returning to the community (Salem et al., 2015). Not only is access to adequate housing a fundamental human right (United Nations, 1974, sect. 25), it also provides people with the opportunity to create a home where they can feel safe and gain a sense of belonging in their community (Piat, Polvere,

Townley, Nelson, Macnaughton, Egalité, & Goering, 2012). For individuals with mental illness, housing is considered an essential part of recovery (Sweeney & Shetty, 2013) and critical for increasing quality of life and community integration (Nelson, Sylvestre, Aubry, George & Trainor, 2006). Conditional discharges often include the condition that a person live in supportive housing to promote community reintegration (Salem, Crocker, Charette, Seto, Nicholls & Côté, 2015).

A recent Canadian study by Salem et al. (2016) described the dispositions and housing trajectories of individuals found NCRMD and the factors that predicted different trajectories. The objective of the study was to describe patterns of dispositions with a focus on housing placements for those who had received a conditional discharge from a review board. This was done to analyze contextual, criminal, and clinical factors that distinguish and predict housing trajectories. Dispositions handed down from the review board and housing status were coded for 934 NCRMD people over a 36-month follow-up period and resulted in four distinct trajectories: detention in hospital, conditional discharge in supportive housing, conditional discharge in independent housing, and absolute discharge to unknown housing. The main finding of this work was that trajectories were most often predicted by clinical factors, rather than risk factors. For example, less restrictive dispositions (e.g., independent housing) were predicted by number of hospitalizations, primary diagnosis of psychotic disorder or mood disorder, or a comorbid personality disorder (Salem et al., 2016, p. 361). More frequent hospitalizations prior to committing an index offense significantly decreased the likelihood of a patient belonging to the absolutely discharged trajectory, and, increased the likelihood of being in the supportive housing trajectory as compared to less restrictive

housing (e.g., independent housing). Lastly, a more severe index offense was found to reduce access to supportive housing regardless of evidence showing that index offense severity is not a reliable risk factor and thus should not be used to determine housing placement (Salem et al., 2016, p. 361). Based on these findings, the authors assert that supportive housing placement does not seem to be used as a risk management strategy, which would incorporate evidence about risk to inform housing decisions (Salem et al., 2016, p. 361).

On a broader level, the findings of the above study point to a knowledge-practice gap in the overall management of the forensic mental health population. The trajectories demonstrate that the clinical factors and severity of index offense most often predicted housing placement. As such, the factors taken into account in the housing placement decisions for NCRMD patients in this sample are inconsistent with factors identified to predict recidivism and rehospitalization in this population (Salem et al., 2016). Similarly, research examining review board disposition outcomes of people found NCRMD in three Canadian provinces found that when controlling for province, a higher number of past offences, psychotic spectrum disorder, and severity of the index offence all decreased the likelihood of receiving a conditional or absolute discharge (Crocker, Charette, Seto, Nicholls, Côté & Caulet, 2015, p. 122). As well, the findings indicate that people found NCRMD are being detained and treated based on “the severity of their index offence, as if sentenced” (Crocker, Charette et al., 2015, p. 125). The findings of these studies are of particular relevance to my research as they provide insight into the factors considered by Canadian provincial review boards in determining dispositions and, thus, housing placement for NCRMD populations. Further, the studies provide an alternative way of

thinking about the management of the forensic mental health population in relation to housing placement.

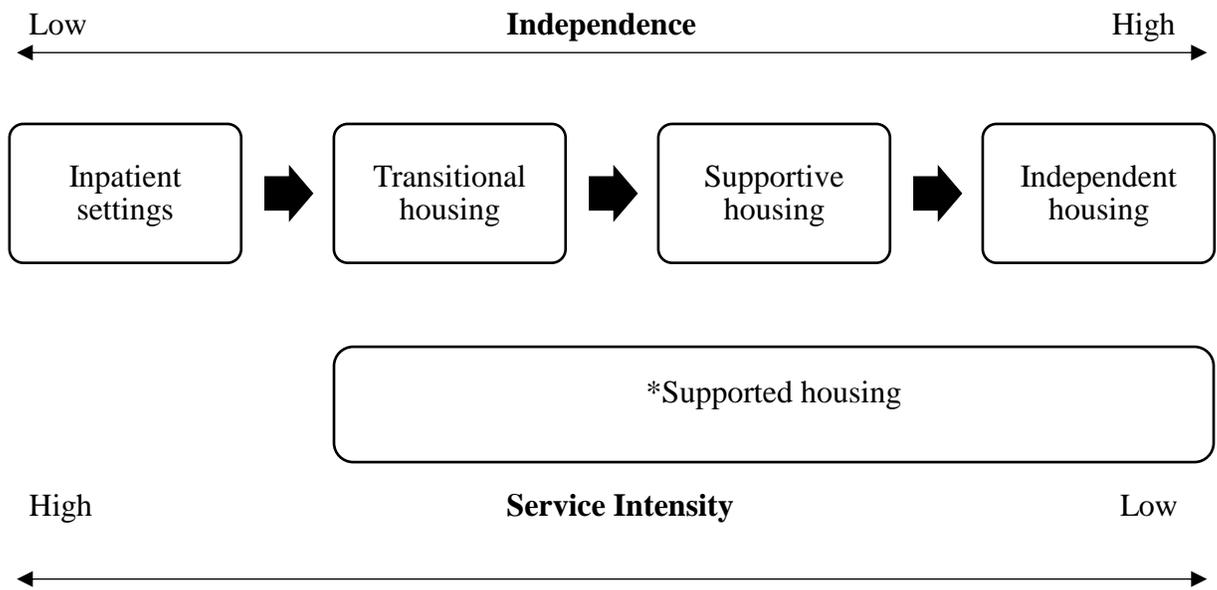
### **The residential continuum**

Deinstitutionalization in mental health care has led to an increase of mental health service users being treated in the community as opposed to treatment in institutions (Woodworth et al., 2003). Although there is now less reliance on institutions to provide care, support is still required to meet the needs of those who struggle with mental health issues. The community has increasingly become the setting in which individuals are assessed and treated (Petrila, 2004), increasing the demand for residential services (Tanzman, 1993). Over time, the mental health system developed a linear, continuum-based model of residential services that provided specialized environments to prepare service users for life in the community (Ridgway & Zipple, 1990).

The residential continuum model (Figure 1) contains several settings that provide different levels of service and supervision, and varying degrees of restrictiveness with the most intensive treatment offered in the most restrictive settings (Ridgway & Zipple, 1990). The more restrictive end of the continuum contains intensive mental health services (e.g., inpatient settings) followed by transitional housing services (e.g., halfway houses) and supportive housing services (e.g., supervised apartments). Within supportive housing, residents live in their own apartment or room and mental health services are provided by in-house staff (Bengtsson-Tops, Ericsson & Ehliasson, 2014). As such, mental health services are attached to or combined with housing—a packaged deal. As quoted in Forenza & Lardier (2017), supportive housing is considered an initiative to help

increase long-term and/or permanent housing for people with mental illness “coupled with support services to help them succeed in their housing” (pp. 33-34). Lastly, supportive housing is associated with providing support in a homelike environment (Bengtsson-Tops, Ericsson, & Ehliasson, 2014). The less restrictive end of the residential continuum contains independent housing without services or supervision. Placement in housing depends on a service user’s programming need: as the person becomes stabilized and the need for services decreases, they move along the continuum towards a less restrictive setting (Ridgway & Zipple, 1990).

**Figure 1.** Residential continuum model



As previously described, many mental health service users were placed, or remained, in the community as a result of deinstitutionalization, increasing the need for community residential services. Residential services provided the solution to the problem of having to accept and integrate people who had previously been detained in psychiatric

institutions. Now, residential services are one of the only forms of supported accommodation available for adults with varying disabilities (Spivakovsky, 2017). However, this model has failed to meet the needs of the mental health population as the full continuum of services is often unavailable in most communities (Ridgway & Zipple, 1990). This impacts the ability to deliver effective care in the community to meet the increasing need for services and has led to a re-examination of the basic concepts of residential services. Overall, this failure has given way to a new emphasis on supported housing as the primary model of community housing (Ridgway & Zipple, 1990, p. 16).

### **Supported housing**

Supported housing is founded on the belief that care in residential housing—as opposed to institutions—is right for people with mental health problems (Ridgway & Zipple, 1990). Supported housing differs from supportive housing in that the latter includes a broad range of residential facilities that usually provide a continuum of supports and have a rehabilitative or skill-development focus (Kirsh, Gewurtz & Bakewell, 2011). As opposed to a moving in a linear fashion along a continuum whereby service users transition to less intensive or more intensive treatment as found in the continuum-based model of residential services, services and supports are provided to service users for as long as they are needed in supported housing (Centre for Addiction and Mental Health, 2011). Although distinctions can be made between the two models, the terms ‘supported’ and ‘supportive’ housing are often used interchangeably when discussing housing services and supports for people who use mental health services.

Receiving housing services in supported housing is not contingent on participation in treatment—services in supported housing are based on the altering support needs, not placement on a continuum with built-in services in each residential site (Gonzalez & Andvig, 2015). As illustrated in Figure 1, the level of intensity and independence offered to service users can vary – based on individual support needs. This allows the service user to relocate and still receive services, or stop receiving services and keep their housing. To summarize, supports and rehabilitative services are made available to individuals to help them stay in their home and participate in their community (Kirsh et al., 2011).

Supported housing is grounded in the values of empowerment and community integration (Kirsh et al., 2011). In supported housing, the role of the service user is shifted from mental health patient to community member receiving services in the community, as opposed to in a formal treatment setting (Ridgway & Zipple, 1990). In the shift from the residential continuum model to a supported housing model, individual choice determines where, with whom, and how the service user will live (Ridgway & Zipple, 1990). Further, the service user is able to make decisions about how to spend their time as well as the type and intensity of services they will receive (Ridgway & Zipple, 1990). As such, supported housing aspires to be a strengths-based approach where tenants are able to exercise considerable choice over their housing (Kirsh et al., 2011). Ridgway & Zipple (1990) describe that the important elements of a supported housing model include:

The development of a permanent home in the community for and with the individual that reflects, to the extent possible, the individual's own ideas concerning an appropriate home; the development of skills associated with normal social roles, and exposure to and participation in the life of the community; the

development and delivery of a personalized set of support services and skills training that occurs in the home and community; and the flexible and, where necessary, continuous delivery of services and support based on the changing needs of the client. (p. 26)

Characteristics of housing models do not always fit neatly into categories of supported housing and supportive housing (Centre for Addiction and Mental Health, 2011). Within supportive housing and other residential models, supports include both housing and services (Centre for Addiction and Mental Health, 2011), and is likely to be organized together, such as clusters of apartments, and are designated for people diagnosed with mental illnesses (Schneider, 2010). Some supported housing services have on-site support. There is overlap between the two models; support may include mental health clinical services or housing support services (i.e., skill-building, finances), or both.

In their review of the literature on supported housing, Tabol, Drebing & Rosenheck (2010) suggest that the key elements of supported housing can be clustered into five broad categories: normal housing, flexible supports, separation of housing and services, choice, and immediate placement (p. 449). In this instance, normal housing refers to affordable housing that is integrated with non-consumers, involves a “normal” tenancy agreement like that of other market renters, and has the potential to be permanent housing. Flexible supports involve individualized support including access to crisis services and other resources in close proximity. Housing and services function separately, and housing is not conditional or based on requirements (i.e., engagement in treatment). Lastly, residents have choice in their housing options and have access to immediate placement into normal housing in the community (Tabol et al., 2010). Thus, supported

housing emphasizes consumer choice and independence, with added participation in ongoing and individualized support (Boydell & Everett, 1992; Ryan & Walker, 2002). This means that, in supported housing, individuals may exercise choice in housing matters (i.e., choice over where one lives and decisions regarding daily life in one's residence) and in relation to professional support they receive (i.e., how much and when) (Nelson et al., 2006, p. 90).

### **Supported housing and people who access mental health services**

Much of the literature on supported housing has focused on describing characteristics or aspects of housing services that service users find valuable or conducive to their recovery. As such, for the most part, supported housing has been described in a normative way; lacking a critical examination. Housing for people with mental health issues has been identified as essential to facilitating community functioning and positive mental health outcomes (Nelson et al., 2006). One important finding from research on supported housing is that such housing can reduce homelessness and hospitalization, and it can improve quality of life for mental health consumers (Nelson et al., 2006). As people with psychiatric diagnoses and mental health issues are the least likely subgroup of the homeless population to gain access to housing, the need to secure and maintain housing is pressing (Schneider, 2010). As a solution to this need, the Housing First program provided housing to 1158 individuals with mental illness in five Canadian cities over two years (Goering, Veldhuizen, Watson, Adair, Kopp, Latimer, Nelson, MacNaughton, Streiner & Aubry, 2014, p. 14). Recipients were given immediate access to permanent housing, individualized treatment, and community support under the mandate of housing

first, followed by wrap-around mental health services. The Housing First National Study evaluated outcomes of the project and found that in one city the affordable housing market remained a problem; participants had limited choices of where they could live, housing was found centrally in environments considered unhelpful to recovery, and some participants went months without being housed (Mental Health Commission, 2012b, p. 3). Service users' limited choice has been revealed elsewhere in the research on supported housing for people with mental health issues (Schneider, 2010; Walker & Seasons, 2002; Kirsh et al., 2011; Gonzalez & Andvig, 2015), reflecting a barrier to the availability and accessibility of supported housing.

In a participatory research project with individuals with schizophrenia, participants took photos to illustrate what they value about their homes. The project highlighted values centering on the home as a sanctuary, privacy, safety and security, spirituality, and community (Schneider, 2010). The group concluded that people diagnosed with schizophrenia need stable housing that “supports their desire for independence and their need for safety, spirituality, and connection to their community” (Schneider, 2010, p. 91). Similarly, in a qualitative study conducted with service users with serious mental illness, Swedish supported housing unit participants talked about having a place to rest, which facilitated freedom from undesirable attention, enabling a sense of privacy and independence (Bengtsson-Tops, Ericsson & Ehliasson, 2014). In a qualitative study exploring supported housing, Kirsh et al. (2011) describe how supported housing offers residents the freedom to live independently in their own place and be more productive. In turn, this reduced stress, provided stability, and motivated them to take care of themselves (Kirsh et al., 2011, p. 21). Residents commented on the importance of

flexibility and choice both in terms of the type of housing they lived in and the amount of support they received from mental health professionals (Kirsh et al., 2011, p. 22).

A meta-synthesis of findings from qualitative studies exploring experiences of tenants with serious mental illness—the majority of whom were living in a Housing First or supported housing models—revealed that positively rated experiences of support were related to being respected, having choices, and meeting a flexible, supportive, and open-minded staff (Gonzalez & Andvig, 2015, p. 984). These elements of housing support were valued highly in relation to mental health recovery and to community reintegration. Both independent living and choice contributed to a sense of control for residents with mental health issues. Tenants also expressed therapeutic and counselling needs which were related to how to life with mental illness, solving the dependence created in the hospital and the “demands of reality when released into the community” (Gonzalez & Andvig, 2015, p. 982).

Literature on supported housing has highlighted the importance of having choice, maintaining a sense of control, and independence for supported housing residents. However, findings from available studies have yielded mixed conclusions when describing service users’ experiences in supported housing. A mixed methods study evaluating a supported housing program for people with psychiatric backgrounds showed that both staff and tenants perceived the housing environment as emphasizing relationships (i.e., involvement and support) and personal growth (i.e., autonomy and personal problem orientation) (Boydell & Everett, 1992). Both groups perceived that these positive characteristics of the housing were more prominent than staff control over tenants. However, in a participatory research project that explored supported housing

(in)stability for individuals with schizophrenia, the researchers identified tensions between elements of care and control as producing complex dilemmas that people with schizophrenia must negotiate (Schneider, 2010). In some cases, limited choice was sometimes viewed as a good thing: “they [service users] resent the requirement that they be compliant, but they sometimes also appreciate the control that accompanies care and they see benefits to themselves being forced into certain actions, such as taking medication” (Schneider, 2010, p. 64). This finding demonstrates the complex ways in which care encompassed aspects of control, prompting service users to comply.

Elsewhere in the literature, loss of control or choice was regarded by residents as an undesirable element of supported housing. In a research project carried out in a supported housing unit for people with serious mental illness, service users talked about being part of a group. This meant being brought together due to a mental illness and congregating in a place and in a system of organized care and support (Bengtsson-Tops et al., 2014). Being part of this group confirmed a sense of needing help and support, which contributed to feelings of “gratefulness and loss of freedom” (Bengtsson-Tops et al., 2014, p. 412). Another theme in this study centered on leading an ‘oppressed life’. Participants highlighted a sense of inequality with regards to asymmetrical relationships experienced in encounters with both staff and users which led to feelings of subordination. This meant adjusting to signs of approval and disapproval from others (Bengtsson-Tops et al, 2014) by altering one’s behaviour or actions. The authors concluded that this supported housing situation generated feelings of “loss and dependency, and created feelings of need” (Bengtsson-Tops et al., 2014).

A qualitative study examining the experiences of supported housing residents in Ontario found four themes: loneliness, making do with socially and structurally inferior housing, a desire for more understanding, and a concern with an individual's sense of integration into a community (Walker & Seasons, 2002). Participants' narratives about loneliness involved a tension between the desire for privacy and a desire for social interactions. The concept of "making do" involves a process of accommodation, or adjusting behaviour, in which residents tolerate deleterious conditions in their living situation while still expressing gratitude (Walker & Seasons, 2002, p. 142). In this instance, making do was related to a number of variables including housing affordability and social and structural conditions of housing (e.g. the physical condition of the housing). Regardless of those variables, participants continued express gratitude and gratefulness for their home. Residents also talked about the desire for more understanding from landlords, other tenants, and the greater community with regards to mental health issues. They suggested that stigma associated with mental illness caused them to feel apart. Lastly, residents spoke against living in housing dedicated to people with serious mental illness. This was connected to a strong desire, overall, to fit in with the larger community in neighborhoods that exhibit diversity (Walker & Seasons, 2002, p. 145).

Residents' experiences in supported housing presented in the literature are complex; they have highlighted elements of housing that are conducive to recovery, as well as a lack of choice and control. Experiences in supported housing have been described as paradoxical contradictions highlighting tensions between care and control (Schneider, 2010; Bengtsson-Tops et al., 2014). This is not unusual in the mental health field as professionals providing services must attend to the agenda of both the service user

and the state. Szasz (1960) suggests that the obligation to ensure protection of the public and the well-being of the service user demonstrates an ethical dilemma with “contradictory functions” (p. 227). Bengtsson-Tops et al. (2014) describe this as a pendulum swinging towards a sense of belonging, security, trust, privacy, independence, relaxation, and well-being, but also towards a sense of neglect, ignorance, dependency, being lost, boredom, and resentment (p. 15). The dilemmas in care for people with schizophrenia in supported housing described by Schneider (2010) involve being limited in what choices were presented to them by service providers, having to present themselves in troubling ways to get services, having to express gratitude for help without asking for desired changes, and being reluctant to ask for help for fear of losing independence (Schneider, 2010, pp. 63-64).

Although housing has been identified as essential to mental health recovery, extant literature on supported housing suggests that mental health service users have limited choices in selecting and securing housing—pointing to a barrier to availability and accessibility of housing options. Nonetheless, supported housing has been described as facilitating privacy, safety, security, independence and as presenting an opportunity to exercise control over housing and community services and supports. Current literature paints the picture of supported housing as an opportunity for mental health service users to recover, choose, and enjoy independence. Another way of viewing supported housing involves identifying elements of social control. Mental health service users reported being presented with limited options at times or forced to make do with inadequate housing. Others expressed feelings of loneliness or having to present themselves in troubling ways to receive services, creating feelings of dependency. Lastly, residents in supported

housing expressed a desire for more community integration as opposed to housing designated people with mental illness.

### **Housing and offenders**

Offenders re-entering the community are often placed in transitional housing, such as halfway houses. Despite this, there is limited research regarding offenders' experiences in supported housing services. Most literature is concerned with outcomes related to recidivism as opposed to offenders' qualitative experiences in housing (Kras, Pleggenkuhle & Huebner, 2016). One qualitative study with sex offenders exploring re-entry and pathways to housing uncovered that one of the most prevalent characterization of the transitional housing facility was that it compared with life in prison (Kras et al., 2016). For participants in the study, a program intended to transition from prison to community was actually no more helpful than being in prison (Kras et al., year, p. 523). If residents had not secured employment in the community, they would be given in-house jobs similar to those in prison. Their pay structure reflected the working conditions of a prison and not a transitional employment opportunity (Kras et al., 2016, p. 524). Further, the sex offender sample were subjected to strip searches and "shakedowns" if staff suspected contraband in the facility (Kras et al., 2016, p. 524). Importantly, participants felt increased stigma due to their sex offender status which was felt throughout their experiences in the transitional facility including looking for housing and employment or through treatment engagement.

Munn & Bruckert (2013) conducted in-depth semi-structured interviews with Canadian men who had been incarcerated for periods of ten years or more and had been

crime-free in the community for at least five years. The men were asked about their experiences preparing for release from prison, about their re-entry, and about the years following their release. The emotional connection to some spaces or places continued from the prison into the community, and a predominant theme in the men's narratives was the impact of place on their post-release experiences (Munn & Bruckert, 2013, p. 128-129). Some of the men found it difficult to transition into a home space because they had developed a sense of 'in-placeness' in a correctional facility: a feeling of being in-place while in a particular location, in the prison or other community correctional facilities (Munn & Bruckert, 2013). One of the ways the men were able to achieve a sense of home in the community was by exercising agency over their residences and belongings: "for men who had spent over a decade in an environment in which material possessions were regulated and restricted, the sensation [of restriction] may be so intense that the ability to purchase a house becomes a particularly significant marker" (Munn & Bruckert, 2013, p. 135). For these men, the ability to own a home and exercise control over a home was particularly meaningful as they had not been able to do so during long periods of incarceration. In this sense, ownership and control of a house and its contents was how some of the men in the study expressed a sense of home. The authors concluded that the majority of the men sought to exercise control over their home spaces in order to achieve a sense of security in their lives.

### **Supported housing and the forensic mental health population**

Research on housing for forensic mental health service users has explored supported housing during the transition from institutional settings to the community. A

qualitative study comparing Irish forensic mental health service users living either in a forensic mental health hospital or in the community uncovered that all participants preferred normal independent living as opposed to shared accommodation with others, mainly because it ensured privacy (Sweeney & Shetty, 2013). Participants still receiving treatment in the forensic mental health hospital hoped their views regarding housing would be considered upon discharge, reflecting the importance of choice in housing decisions for service users. However, only three participants were knowledgeable about the housing options available to them (Sweeney & Shetty, 2013, p. 239). Participants already living in the community gave praise to their housing situation for the level of success they felt they achieved in recovery (Sweeney & Shetty, 2013).

Cherner, Aubry, Ecker, Kerman & Nandlal (2014) present findings from research on the outcomes of the Transitional Rehabilitation Housing Pilot programs in two cities in Ontario. The programs were established to support the transition to the community for individuals found Not Criminally Responsible by a court in Ontario. Participants were supported first through transitional housing and then regular housing. The Transitional Rehabilitation Housing Pilot, involving a partnership between a forensic hospital and community agencies, focused on daily living skills training and community reintegration activities (Cherner et al., 2014). Although this research mainly focused on outcomes related to re-offending and rehospitalization, some data were gathered about the service users' perceptions of the program. Service users frequently talked about independence and having their own space as contributing to improvements in functioning. By living in the community, service users felt they were less controlled by others and could make decisions about how to spend their time (Cherner et al., 2014). Independence also

involved responsibilities, such as taking medications without being supervised, and increased privacy compared to being in the forensic hospital (Cherner et al., 2014).

### **Summary of supported housing literature**

For both mental health service users and offenders, the value in having the opportunity to make choices regarding their housing and, thus, maintain a level of control has been identified in the literature. As forensic mental health service users are at the intersection of the mental health and criminal justice systems, supported housing must provide care to produce positive health-related outcomes while minimizing risk of reoffending. The literature on supported housing suggests that forensic mental health service users place value on being able to make choices about their housing, the opportunity to live independently, freedom, privacy, and flexible support. However, their experiences in supported housing point to a lack of control.

Supported housing is considered necessary in the transition from institutional settings to the community to maintain continuity of care and provide much needed services and supports. Traditionally, literature on supported housing for people who access mental health services, offenders, and the forensic mental health population has mainly focused on aspects of supported housing considered to be valuable to service users or conducive to their mental health recovery. Undesirable elements of supported housing, such as lacking options and privacy, have also been identified. Taken together, the literature provides a normative way in which supported housing can be viewed: as essential for community reintegration and rehabilitation and providing choice and independence not present in institutional settings. However, experiences in supported

housing are quite complex. As supported housing can be a condition of discharge, housing services must engage in risk management and thus impose restrictions on the liberties of NCRMD individuals, if necessary to protect public safety. Thinking in terms of social control and risk management as the objective of the forensic mental health system provides a critical framework that challenges traditional ways of thinking about supported housing and highlights the tensions between elements care and control.

## **Theoretical Framework**

“It is the same set of procedures for punishment that were in effect in the 19<sup>th</sup> century, whereby when someone commits a crime or transgresses in some way, his body will be seized upon; one will exercise total control over him as an individual, place in under surveillance, force his body to labour, prescribe behavioural schemas for him, and prop him up endlessly by mechanisms of control, judgement, rotation, and improvement.” (Foucault, 2009, p. 17)

### **Dissemination of social control**

Cohen (1985) defines social control as “the organized ways in which society responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable in some way or another” (p. 1). Traditionally, the ways in which society responded to people with mental illness, and other ‘problematic’ individuals, was to segregate and confine them (Ridgway & Zipple, 1990). However, since the 1960s, destructuring movements aimed at decreasing the size, scope, and intensity of the system of formal or institutionalized control have resulted in a shift toward deinstitutionalization and a reliance on community alternatives (Cohen, 1985). During this time, thousands of patients were released into the community to various locations as there was not a coherent system of residential services (Ridgway & Zipple, 1990). Many residential services were based on collective care models involving group living arrangements in group homes and residential care facilities (Centre for Addiction and Mental Health, 2011).

As a result of deinstitutionalization, Cohen (1985) argues that new agencies in the community have supplemented, rather than replaced, the original set of control mechanisms resulting in an overall expansion of the system of control. The process of deinstitutionalization has enabled the system of control to expand its scope through the absorption of community alternatives, extending its reach further into the space of the community. Similarly, Foucault (2009) has argued that the mechanisms that were central to the prison during the 19<sup>th</sup> century still operate today, both in the conventional prison and its alternatives. He suggests that the purpose of alternatives to prisons are to ensure, through different kinds of mechanisms, the functions of the prison (Foucault, 2009). More specifically, he argues that alternatives to prisons continue to be centred around labour as the prevention of reoffending, refamilisation (i.e., the idea of the family as the prevention and correction of criminality), and individuals' management of their own punishment (Foucault, 2009, pp. 15-16). Foucault suggests that these are the carceral functions that are still at work in establishments that may not resemble prisons and are labelled as 'alternatives' to the prison, which are "diffused throughout the whole of the social body by these relatively open establishments" (Foucault, 2009, p. 16). Two things occur as a result of this extension of social control: a system that is larger overall and more difficult to define or place boundaries around.

Rose (2000) suggests that the system of control in advanced liberal democracies consists of the development of "dispersed, designed in-control regimes for the continual, silent and largely invisible work of the assessment, management, communication, and control of risk" (p. 321). As a facet of the system of control, surveillance becomes central in the lives of people who come into contact with the criminal justice system as a tool to

manage risk. Rose (2000) suggests there are recurrent switch points to be passed in order to continue to access liberties, allowing for management of conduct through continuous monitoring and constant reshaping of behaviors and actions. Ultimately, the switch points prompt individuals to conform, shaping the overall habitat in which individuals conduct their lives with the goal of minimizing criminal conduct (Rose, 2000). One way this is done is by enmeshing individuals into circuit of inclusion, or exclusion, which enters surveillance into all networks of everyday life in an effort to address issues of security (Rose, 2000).

Within the circuits of inclusion, control operates through continuous monitoring, managing, and reshaping of conduct of populations in order to access goods and thus placing individuals under constant scrutiny (Rose, 2000, p. 326). In this way, control acts as a disciplinary mechanism to survey and shape behaviour of individuals, and to “optimise individual potential and self-advancement” (Spivakovsky, 2017, p. 371). Through these circuits of inclusion, individuals are given the opportunity to make decisions that lead to a self-enhanced, responsible life. In circuits of exclusion, individuals are not only “cast out”, they are subject to strategies of control (Rose, 2000, p. 330). Rose (2000) suggests that there are two possible scenarios for individuals circuit of exclusions: in the first, they take part in strategies which – through a “principle of activity” – are “reattached” to circuits of inclusion (p. 330). The activities may be an employment training program or some sort of intervention or program with the goal of reform. Individuals must conform to the conditions placed on them to find themselves eligible to enter circuits of inclusion, ultimately allowing them to access the benefits of finding themselves in circuits of inclusion. The second scenario deals with individuals

who are considered “anti-citizens”, unable to be reshaped and reaffiliated with circuits of inclusion (Rose, 2000, p. 330). Such individuals are then managed to neutralize the danger they pose as they are considered unable to become responsible for self-management. Individuals who are unable to rejoin circuits of inclusion are managed through the reshaping of physical and social habitats to minimize criminal conduct or, if they cannot be managed in this way, imprisonment is employed (Rose, 2000, pp. 330-331). Within what Rose (2000) calls “the new territory of exclusion,” control agencies such as psychiatrists, doctors, and mental health professionals link up in circuits of surveillance and communication to “minimize the riskiness of the most risky” (p. 333). This is facilitated through multiple points of collecting and sharing information related to risk management.

### **Risk management**

Within the past few decades, there has been a new mindset in criminal justice around risk and prevention. As opposed to thinking about individuals’ status in terms of dangerous (a stable trait in some members of society), thinking in terms of risk involves determining the likelihood an individual will reoffend based on dynamic factors. Rose (2010) asserts that there is a common perception that mental illness carries risk of violence, fuelling the impulse to identify and manage those who are considered threatening both pre-emptively and while individuals are receiving care. Such discourses continue to feed public perceptions of a growing problem of violence and the need to maintain safety and security (Markham, 2017). The question, therefore, becomes how likely it is that an individual will commit further offences. The onus is placed on

assessing and managing risk, and implementing the “rehabilitative functions” of the criminal justice, forensic, and correctional systems (Crocker, Livingston & Leclair, 2017, p. 49).

‘Risk thinking’, or thinking in terms of risk management, recognizes that behaviour is a product of “multiple dynamic factors in a complex situation” (Rose, 2010, p. 86). Determining risk in mental health is complex and involves considering changeable factors. In penal terms, determining risk involves assessing how likely it is that an offender will reoffend, the nature of this reoffending, and, from this, a calculation of how dangerous an offender is to the public (Harrison, 2011, p. 35). Forensic mental health service providers are expected to assess the probability of an individual harming others (or themselves) after discharge by obtaining observational evidence in an environment designed to prevent such events from occurring (Markham, 2017). Szmukler & Rose (2003) suggest that, although risk depends on a number of factors, it tends to become “an objective, calculable, and static measure” attached to an individual (p. 130). Because risk is based on a varying and fluctuating set of factors, continuous monitoring of everyday life is required (Rose, 2010). Thus, surveillance is essential to risk management of an individual or population. In the forensic mental health system, risk is assessed and reassessed in response to the changing status of individuals, placing them on a continuum (i.e., low-, medium-, high-risk). Because it is necessary to know which individuals are considered high-risk in order to channel them through the proper legal and treatment avenues, risk assessment has taken on a new importance (Harrison, 2011, p. 34).

## **Therapeutic surveillance**

Moore (2011) draws on the example of drug treatment courts to theorize the concept of “therapeutic surveillance” (p. 256) which suggests a more complex understanding of what it means to be watched. Drug treatment courts, like supported housing, are considered to be a therapeutic initiative that provides a solution to a social problem (i.e., addictions) (Moore, 2011). Drug treatment courts consist of different components including daily attendance to treatment, urine screening, and court appearances before a judge. Moore (2011) describes drug treatment courts as encompassing an “ethic of care”; the intention to cure the offender of his/her addictions through an alternative to criminal justice system involvement. However, drug treatment courts also use a system of sanctions, such as community service hours or expulsion from the program, and rewards to “keep individuals motivated and overcome their addictions” (Moore, 2011, p. 259). Such sanctions denote an element of control over participants that is used by the court to encourage the desired behaviour—abstinence from drugs.

Moore (2011) suggests that therapeutic surveillance involves “benevolent iterations of power that could be experienced as supportive or repressive or both while not relying on a firm hierarchy of surveillance”—pointing to the varied ways in which drug treatment courts are experienced by its participants (p. 258). Therapeutic surveillance draws on Foucauldian-inspired notions of regulation and governance and suggests that elements of care and control are blended and are, at times, synonymous, as opposed to strictly repressive or negatively-experienced (Moore, 2011, p. 256). Moore (2011) suggests there are four characteristics of therapeutic surveillance that are observable in drug treatment courts: 1) people watching people; 2) many people watch one, 3)

‘personal’—therapeutic surveillance is built on relationships and intimate knowledge of those being watched, and 4) surveillance is presented as benevolent (p. 259). Importantly, Moore (2011) points to the elements of control that are laced within the caring goals of the court, embedded in the power hierarchy that “governs those who come before it” as a criminal justice entity (p. 257). Moore (2011) suggests that we must recognize that benevolence and coercion can be two sides of the same coin.

### **Therapeutic surveillance in supported housing**

Individuals under the authority of the forensic mental health system are increasingly being managed and treated in the community. Community alternatives have not only taken on the role of supporting mental health recovery, but also the role of ensuring the prevention of problematic behaviour and prioritizing social welfare as mandated by the forensic mental health system. This is done through a variety of community alternatives, including supported housing. In supported housing, various modes of surveillance are utilized to ensure that individuals abide by the conditions imposed on them by the forensic system, which ensure the goal of minimizing risk and promoting rehabilitation in a community setting. The end goal of this process is complete community reintegration. Most facets of life are stipulated and monitored, constituting “surveillance over his whole environment” (Foucault, 2009, p. 17). Thus, supported housing may be thought of not as a replacement of an institution, such as a prison, but similar in nature in that they repeat the carceral functions through mechanisms of control, surveillance, normalization, and re-socialization (Foucault, 2009, p. 24).

As the locus of mental health services and supports becomes increasingly deinstitutionalized, the community becomes the new territory for risk management (Rose, 1998). Mental health service users receive services not only within psychiatric facilities, but also through various options in the community, such as housing. Thinking in terms of risk in the forensic mental health system influences the way individuals are treated, or more appropriately, managed. Szmukler & Rose (2003) suggest that risk-thinking may occupy a significant portion of time formerly occupied by the clinical language of mental health diagnosis. Professionals working in community-based mental health services take on more of an administrative role in risk management: identifying potentially risky individuals, performing classification, and placing them on a continuum of low, medium, or high risk. Once classified, treatment is then determined based on the calculated probability of violent or otherwise undesirable behaviour. As such, the focus on therapeutic interventions is shifted to managing risk in the delivery of mental health services. Risk management has come to transform the role of mental health professionals and the nature of their work, but, more importantly, the treatment of individuals in the forensic mental health system (Rose, 1998).

It follows, then, that individuals in supported housing must alter their behaviour or actions to receive services. Schneider (2010) explains: “in order to receive housing services and medical treatment, people must agree to subject themselves to the surveillance and control that accompanies care, and they must express gratitude for that care. In short, they must be compliant” (p. 62). In the context of forensic mental health, individuals found NCRMD must comply to the restrictions placed on their freedoms and liberties – often conditions of discharge – in order to receive services. To summarize, in

order to access points of consumption and liberty, conduct must meet the standards enforced upon populations by the control system. The basis for this is that individuals' agency is considered impaired by mental illness and criminogenic needs, requiring risk management to ensure public safety. In the context of community-based programs such as supported housing, individuals must align themselves to the conditions imposed on them by the legal and forensic mental health systems which function to manage risk.

### **Purpose and research questions**

The overarching goal of this research is to gain a better understanding of supported housing as experienced and perceived by people found NCRMD in Nova Scotia. The study explores how forensic mental health service users negotiate tensions between the therapeutic and risk management functions of supported housing.

## **Methods**

In this chapter, I will discuss the research design, setting and context, procedures, and analysis used in this research project. As well, I have included a section which highlights the challenges I faced in conducting ‘sensitive’ research. Because I am a novice researcher, and because my sample includes a ‘vulnerable’ population, I have also included a discussion of ethical considerations that I contemplated and negotiated in carrying out this research.

### **Research design**

I used the Photovoice method as a way of supporting a small group of research participants to take pictures of their space in a supported housing environment. The photographs were then used as the basis for discussion in qualitative interviews about individuals’ life experiences in supported housing environments. As housing has been identified as an important element of support needed for mental health recovery and risk management, I aimed to highlight both the strengths and issues or concerns from the perspective of the participants. It was important to me to offer space to individuals and develop meaning through sharing and engaging with their experiences in supported housing. The key question guiding this research was: how do service users negotiate tensions between therapeutic and risk management functions of supported housing? In order to answer this question, I asked: how is supported housing experienced by people who use forensic mental health services?

Social constructivism as a worldview involves seeking to understand the world through developing subjective meanings based on individual experiences (Creswell,

2013). Following this line of interpretation, the goal of this research was to explore individual experiences in supported housing of people found NCRMD. The research design of this project is in-depth, qualitative interviews based on photos taken by people found NCRMD who had received a conditional discharge disposition by a review board and were living in supported housing. As the sole researcher on this project, I played an active role in interpreting the realities being presented by participants during analysis.

**Qualitative research.** Qualitative inquiry is about contributing to the in-depth understanding of a case or phenomenon (Sandelowski, 1995, Brown & Lloyd, 2001). It is used to explore an issue to develop a complex and detailed understanding of an issue (Creswell, 2013). To do this, qualitative researchers use purposeful sampling to allow for an in-depth study of information-rich cases (Sandelowski, 1995). Through analysis of cases, qualitative researchers take an active role to develop an understanding of the issue or phenomenon under study. Thus, within qualitative research, knowledge is constructed and subjective.

Within qualitative research, the focus of phenomenology is understanding and capturing the essence of an experience (Creswell, 2013). This is done by studying a number of individuals who share a common experience and analyzing the data by moving from significant statements to meaning units (Creswell, 2013). This study loosely followed a phenomenological approach to qualitative research to explore the common experience of supported housing for forensic mental health service users. My goal in this research was not to develop the essence of this experience, but to explore individual experiences in supported housing to better understand them.

**Photovoice.** Photovoice is a community-based participatory research method that allows people to identify, represent, and enhance their community through photographs. The visual images captured by participants creates evidence and promotes a participatory means of sharing knowledge and participants' expertise of their communities (Wang, Cash & Powers, 2000). Photovoice has three main goals: (a) to enable people to record and reflect their community's strengths and weaknesses, (b) to promote critical dialogue and knowledge about important community issues through group discussion of photographs, and (c) to reach policy makers and people and help mobilize change (Wang, Cash & Powers, 2000). It is a process that "entrusts cameras into the hands of people to enable them to act as recorders, and potential catalysts for change, in their own communities" (Wang & Burris, 1997, p. 369).

This method can be powerful for people who have stigmatized health conditions, such as mental illness, and recognizes that people have expertise and insight into their own communities that professionals may lack (Wang & Burris, 1997). Not only is photovoice used as a means of sharing expertise, but it is a way to communicate needs and assets of communities through visual images which can be very powerful (Wang & Burris, 1997). It can allow others to see the world the way in which the participant sees it using visual means accompanied by rich descriptions (Given et al., 2011). Although images alone can add power and meaning to words, photovoice requires discussion and analysis to establish meaning and relevance (Given, Opryshko, Julien & Smith, 2011). The photovoice research method is highly flexible and can be adapted to varying levels of participation, different groups of participants, and distinct public health issues (Wang & Burris, 1997). Photovoice has widely been adapted to fit the particular needs of research

and photo documentation projects. It produces several types of data, from discussion and interview transcripts to photographic images, enabling data triangulation (Catalani & Minkler, 2010).

I chose photovoice as a research method in this qualitative study because it aims to give voice to participants by being able to share and engage with their lived experiences using photos they have taken. Participants are able to play an active role in determining what they choose to speak about and share through their photos. It also gives participants the opportunity to highlight what they consider strengths and weaknesses in their housing, which is an important part of informing those who provide care. As supported housing is part of the forensic mental health system, giving participants the ability to take photos of where they live provides valuable insight into the complex ways people experience supported housing. Participants were encouraged to share their experiences with, and perceptions of, their housing through their photos, which contextualized and uncovered rich descriptive information that may not have been accessible through interviews alone.

### **Setting and context**

The context in which the research took place was community-based supported housing services for people who experience mental health difficulties. The housing service supported individuals with a broad range of mental illnesses from both forensic and nonforensic mental health populations. The housing itself was provided by the supported housing service and clients received support from the provincial disability programs to fund their placement and care. The housing service provided individual

program plans, medication and symptom management, financial management, risk management and assessments, client supervision, and access to opportunities for education, employment, and recreation. The housing services were situated in residential settings and integrated with 'normal' housing, meaning the housing was not segregated from the rest of the community. Clients participation in treatment was their choice, although the housing service required clients to maintain the medication regime agreed upon by the client and their doctor. The housing service was then kept accountable for clients medication through monitoring and documentation-related policies.

The interviews were conducted in supported housing service settings and ranged from nineteen minutes to almost two hours (one hour, fifty-two minutes). I informed all participants that I was a graduate student in the Master of Arts Criminology program at Saint Mary's University and that I was conducting the research as part of my thesis, information which seemed to yield a positive reaction from participants. Looking back, I feel as though the participants felt positively about contributing to project as it would help me to earn my degree. The semi-structured design of the interview allowed for a conversational interview, queued and dictated by the photos taken by participants using the photovoice method. However, impromptu and open-ended questions allowed me to probe further into the details provided by the participants. The participants decided how few or many photos to take of their supported housing. The number of photos taken by the participants ranged from eight, to all twenty-eight photos allowed by the disposable camera. Some participants took photos of the environment around their supported housing. At the beginning of the interview, participants were asked to sort their photos from most important to least important during which time one participant decided not to

speak about some of the photos she had taken. Participants were given \$20 honorarium as a token of gratitude for spending their time and sharing their experiences.

## **Procedures**

**Recruitment.** This research involved a purposeful sampling method, a technique used for the identification and selection of information-rich cases for the effective use of limited resources (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015). I used my knowledge gained from experience working in a housing agency to identify and select individuals to participate in the study, given they fulfilled the inclusion criteria.

Participant recruitment for this project occurred through a variety of ways. For instance, recruitment advertisements containing a description of the research and my contact information (e.g., phone number and email address) were sent to housing service providers and housing programs who were asked to share the information with people who may be eligible to participate. Information about the study was sent to a pool of participants identified for a previous study who had consented to being contacted in the future for research purposes. As the forensic mental health service user population in Halifax, N.S., is quite small, having the ability to recontact those who had previously participated in research was valuable. Lastly, I held a short presentation at a housing location to provide information about the study and outline participation. I was able to facilitate the presentation with the permission of the executive director of the housing service as well as with cooperation of the housing staff. Having the opportunity to go to the housing location and present the opportunity to participate in research was advantageous because it allowed me to verbally describe the research and outline

participation as well as answer any questions from potential participants, on the spot. As well, it eliminated the need for a potential participant to take the time and effort to contact me. The presentation took place after a meal time when most of the residents were present. Interested individuals were given my contact information (e.g., phone number and email).

Interested individuals were invited to contact me by phone or email to further discuss participation or were screened for eligibility on the spot. First, I described the purpose of the study and what was being asked of participants (i.e., taking of photos, in-person interview). Participants were then informed of the small honorarium they would be provided after the interview was complete. After the participant confirmed interest in participating, they were asked to consent to the use of their information to determine eligibility for participation in the study. Consenting participants were then asked to provide their name, gender, age, address and contact information, length of time spent in supported housing, number of times they were found NCRMD (including dates), and the decision of the Nova Scotia Review Board in their most recent review board hearing. This information was then used to determine eligibility to participate. Those who were deemed eligible to participate were invited to schedule the photovoice training at a convenient time. Throughout this process, I maintained and updated a contact log to store confidential information for each participant. As well, participant information gained from the eligibility screening was kept on a secure spreadsheet.

**Participants.** A small group of forensic mental health service users were asked to share their insight and experiences with supported housing in Halifax, Nova Scotia. Arguably, NCRMD people living in supported housing is a hard-to-reach population due

to the small population size and because of the private and confidential nature of supported housing for people found NCRMD. The housing service in which I recruited participants is mandated to protect the privacy of the individuals who utilize the housing service. As a result, individuals could not be identified and referred to the study by staff or mental health service providers; they had to self-refer to participate. As well, generating interest in participation in the study was difficult. I experienced a level of frustration in recruiting participants, due to the difficulty of recruiting from a hard-to-reach, small population. As well, I felt that most participants were interested in participating to receive the small honorarium being offered. Once a participant became interested, it was difficult to secure participation due to the time commitment associated with photovoice training, taking of photos, and completing the interview.

Sample size in qualitative research should be one that “permits case-oriented analysis that is a hallmark of all qualitative inquiry” and that results in “a richly textured understanding of experience” (Sandelowski, 1995, p. 183). Morse (2000) asserts that the scope of the study, the nature of the topic, and the quality of the data collected should be considered in determining sample size. Similarly, Sandelowski (1995) suggests that decisions about sample size in qualitative research are related to the intended purpose of sampling (e.g., information rich cases) and the intended qualitative product (e.g., phenomenology). The intended outcome of my research was to describe and capture forensic mental health service users’ experiences in supported housing.

There were a number of pragmatic factors affecting sample size for this project. This research is part of a Master of Arts in Criminology thesis requirement, which introduces time constraints that must be considered as the program is intended to be

completed within a set timeframe. As well, my project is unfunded, meaning that I had limited access to resources in carrying out this research. Thus, providing compensation (outside of a small token of appreciation) to participants was not possible which may have factored into the number of people who were willing to give their time. Therefore, what was feasible for this project was a small sample of participants gathered using purposeful sampling based on the below criteria and convenience methods (i.e., accessing a pool of participants who have already been identified).

All participants were required to meet the following inclusion criteria to take part in this research: (a) nineteen years of age or older, (b) able to read and communicate in English, (c) previous NCRMD adjudication by a court, (d) previous or current forensic mental health service involvement, and (e) living in a supported housing residential service in Halifax, Nova Scotia, and the surrounding area.

Three participants were recruited for this study. The population size of NCRMD people in supported housing in Halifax is thought to be around 10 (J. Livingston, personal communication, November 8, 2017). As such, my sample represents thirty percent of the population. Participants included both men and women with ages ranging from early-30s. Their index offences involved violence against others and they were all diagnosed with psychotic disorders. Participants had spent a few months to couple of years in supported housing.

**Data collection.** Data collection took place in two parts: the photovoice training and the qualitative interview. All photovoice trainings were held at the supported housing location where the participant lived. Upon meeting participants in person for the first time, I introduced myself and the study and reviewed what is being asked of the

participant (i.e., the amount of time being requested, taking the photos). If the participant agreed, I then gained written informed consent (see Appendix A).

As the photovoice method requires photos to be taken solely by the participant, a training ranging from ten to fifteen minutes then took place. A modified photovoice training guide was used during these sessions (Palibroda, Krieg, Murdock & Havelock, 2009). The photovoice training (see Appendix B) included a description of how the camera worked, the ethics of taking photos, how to take photos safely, an overview of the instructions for taking the photos, ownership of the photos taken, and information related to the number of photos to take.

First, I showed participants how to use the disposable camera to take photos and the mechanics of using the camera including the flash function. In each case, the participant was unfamiliar with how to use the camera, so this element of the training was crucial. Participants were then informed on how to protect their anonymity, their housing, and neighboring residents while taking photos by not taking photos of identifying things (i.e., other photos, street signs), or photos of other people. During this discussion, it became obvious that most participants intended to take photos of staff and were unaware that they were not able to do so. I interpreted this as the participants' considering the staff to be part of their supported housing as well as participants' acknowledging the impact the staff had on their experience in supported housing.

Participants were instructed how to take photos safely without compromising their health (i.e., taking photos while driving). I asked participants to take photos of their home spaces or things in their home spaces. I informed them that the purpose of taking the photos was to use them as prompts during their individual interview. Participants were

asked to take as many photos as the disposable camera will allow (approximately twenty-seven). I explained that, during their interview, they will be asked to talk about the most important photos to them. In all cases, the participants did not require further explanation or assistance in taking their photos, although I was ready to provide support if necessary. Lastly, participants were informed that they will be given copies of the photos to enable dual ownership, if they wished.

Following the photovoice training, the participant was given their disposable camera and a simple written background information guide. Participants were given time to ask questions. I explained that they would be given a week to take photos, after which I would communicate with them by phone or email to find a suitable time to retrieve the camera and develop the film. As well, I explained that, upon retrieving the camera, we would then schedule a time to carry out the in-person, individual interview approximately two weeks after the camera was given.

The qualitative interviews took place with the purpose of describing the meaning of the photos taken. I was quite anxious prior to each interview and struggled with the responsibility of providing a comfortable and trusting space for participants to share their experiences. I also hoped that I would be able to maintain my role as the researcher and keep hold of the direction of the interview, with the goal of gleaning a rich account of participants' experiences. The interviews were in-depth and followed a semi-structured design. I met each participant at a time and location that were prearranged. Interviews took place in a private room at the housing locations in which the participants lived, often an office or recreational space. All interviews were carried out by me and focused on gaining an understanding of each participant's experience in supported housing. An

interview guide was used during each interview, containing five to seven open-ended, general questions that were asked in relation to each photo taken (see Appendix C). I also took notes that pointed to interesting parts of the participants' experiences, poignant quotes, and pieces of information that related to my theoretical framework. These notes were used during the interview to recall points for further clarification and during the analysis. All interviews were audio-recorded and transcribed by me on an ongoing basis throughout the data collection process. To transcribe the interviews, I used ExpressScribe transcription software and Microsoft Word. The audio recording was transcribed verbatim without fillers (i.e., ums, ahs).

As previously mentioned, the level of importance of each photo as decided by the participant directed the interview. First, I asked the participants to place the photos in order from most important to least important. Then I labelled each photo with a number, starting with number one, to represent the order in which we would talk about each one. The number on each photo corresponded with the interview guide I used to ask questions about the photos. Some participants chose not to speak about all the photos they had taken either because of the quality of the images (i.e., blurry, unfocused) or because they had forgotten why they had taken them. In most cases, the quality of the photos was poor, but still stimulated conversation about participants' experiences. I found that the participants were noticeable proud of the photos they had taken that turned out nicely.

After each interview, I recorded my thoughts and experienced with conducting the research in analytic memos. This information was then used to formulate my experiences with the challenges of doing sensitive research.

## **Analysis**

I performed a thematic analysis of the interview data. I chose not to analyze the photos because of concerns about revealing the identity of the participants, and my main interest was in what the participants were say, not how they took the pictures. Excluding the photographs from the analysis is common in photovoice research (Catalini & Minkler, 2010). In qualitative research, analysis of the data begins when the study is first conceived as the choices that are made during this time influence the types of findings which will be produced. My role in the analysis was to organize, condense, and interpret the data, and, eventually, formulate themes that would provide insight in response to my research objectives. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data in qualitative research (Braun & Clarke, 2006, p. 79). Thematic analysis is used to identify various aspects of the research data in relation to the research objective, thus, making sense of the data through the production of themes. As opposed to a deductive analysis, whereby themes are predetermined, I performed an inductive analysis of the data collected in this study—an analysis driven by the data, not a pre-existing coding framework (Braun & Clarke, 2006). I moved back and forth between the transcriptions and the codes I created to further interpret the content, providing for an in-depth and comprehensive analysis. As the purpose of this research was to explore elements of therapeutic surveillance in supported housing, I was sensitive to information pertaining to surveillance and control within participants' views on their housing.

The steps taken to perform the analysis of the data were based on steps provided by Braun and Clarke (2006). I began by familiarizing myself with the data: I transcribed

the data, read, and re-read the data, and noted initial codes and ideas. While transcribing, I referred to notes taken during the interview recalling interesting pieces of the data as they related to either my theoretical framework (therapeutic surveillance) or were deemed important by the participant or myself. At this point, I felt that the data was mostly descriptive in nature but that there were some interesting pieces that related to my theoretical framework. It became obvious to me that information from the first interview influenced how I thought about the second and third interview. The participant from the first interview was very thoughtful and articulate, and the participant was able to eloquently describe his experiences. As a result, throughout the data collection process, I referred back to information from the first interview to prompt participants and to probe for detail from participants' experiences. The interview transcriptions were then transferred into NVivo analysis software.

Using notes produced in the previous step, I generated the initial codes for analysis and created a codebook with clear and concise definitions for each code. The purpose of the codebook was to define the parameters for each code as well as to describe how they were to be applied during the coding process. The codes were used to group together the descriptive information from the interviews in a way that would allow me to create themes based on the groupings. The codes and the definitions were entered into NVivo analysis software. Then, I carefully coded pertinent pieces of the data in a systematic fashion, collating data relevant to each code at the manifest (i.e., descriptive) level using the codebook I developed. The codes were then reorganized based on the number of references (i.e., quotes) in each.

To search for themes, I examined and reorganized the data in each code, looking for ways to condense the codes into themes, and then draw out subthemes in an effort to better understand the data and make sense of it. As previously mentioned, most of the information gleaned from the interviews was descriptive in nature. This made it difficult to go beyond describing participants' experiences and relate them to my theoretical framework. Once I had collated codes into potential themes, I gathered all data relevant to each potential theme, using quotes from participant interviews and photos taken by participants using the photovoice method. I then checked to see if the themes made sense by comparing them with the pieces of data I had initially coded. Defining and naming themes involved reworking and analysing to refine the specifics of each theme, and the overall analysis, to generate clear definitions and names for each theme, with supporting quotes (see Appendix E). I selected compelling pieces of data for final analysis, relating back to the research question and literature to produce the write-up.

**Achieving qualitative standards for research.** As photovoice is a participatory research method. Participants are involved fully in taking pictures, selecting photographs for discussion, contextualizing, codifying photos, disseminating the findings, and conducting project evaluation (Catalani & Minkler, 2010). Some studies use collaborative analysis that involves researchers and participants working together to analyse and interpret the data. Due to pragmatic reasons (i.e., time constraints, lack of funding) collaboration during analysis was not possible. However, a review on literature on photovoice suggests that projects at the low end of the participatory spectrum can still succeed in gathering in-depth information from hard-to-reach groups, such as those living in supported housing (Catalani & Minkler, 2010).

Credibility, transferability, and dependability are criteria used to evaluate the trustworthiness, or quality, of qualitative inquiry (Cho & Lee, 2014). As quoted in Cope (2014), credibility refers to the truth of the data or the participant views and their interpretation and representation by the researcher (p. 89). During analysis, I kept analytic memos to document my thought-processes and to track the decisions being made at each step of the research process. This was done to in an effort to be transparent about my interpretations of the data and justify the decisions made in the analytic process. Memos were also used to maintain reflexivity which is important as they keep track of how my experiences and bias influences my interpretation of the data. Further, I maintained a codebook which provides the operational definitions used to code the data as a means of keeping detailed records of the research procedure, in an effort to enhance dependability. I have included quotes from the participants in this write-up to describe how the findings were derived as an effort to increase credibility of my interpretation of the data.

Triangulation is the process of using multiple sources to draw conclusions (Cope, 2014), and is used to increase credibility. With methods triangulation, the researcher uses more than one method of data collection in an attempt to gain “an articulate, comprehensive view of the phenomenon” (Cope, 2014, p. 90). Triangulation of sources enhances the completeness of the data (Brown & Lloyd, 2001) and leads to more diverse constructions of realities (Golafshani, 2003). In this project, I have used multiple streams of data (i.e., photos and in-depth interviews) to contribute to a richer understanding of supported housing for people found NCRMD. It is not my intention to produce ‘truths’ about the supported housing experience. Specific to the photovoice method, the photos

taken by participants have not be analyzed, but have been included to support the analysis and showcase the participants experiences.

Transferability refers to producing findings that are “context-relevant” to allow for comparisons to be made (Guba, 1981). Thus, to facilitate transferability, a detailed background to establish the context of the study and a detailed description of the phenomenon are necessary. As such, a description of the NCRMD population, the forensic mental health system, the setting and context of the study, and supported housing for forensic mental health service users has been provided.

As a rule of thumb in qualitative analysis, theoretical saturation is sought to ensure that enough data has been collected so that no new information or themes will emerge from further data collection. Thus, qualitative researchers make decisions about further data collection based on levels of theoretical saturation. Sandelowski (1995) suggests that fitting the sampling strategy to the purpose of and method chosen for a study and appraising available resources is one way to achieve theoretical saturation. The small sample size achieved in this research was mostly based on pragmatic reasons, such as limited resources and time constraints. However, it is likely that if more people were interviewed, new knowledge would be uncovered which negatively impacts the theoretical saturation for this study.

Brown & Lloyd (2001) suggest that reflexivity must be considered in qualitative research, meaning researchers must consider the effect they have on a study in terms of pre-existing theoretical positions and how their presence affects the research process. Reflexivity refers to the awareness that the researcher’s values, background, and previous experience can affect the research process (Cope, 2014, p. 90). My role in the research

process was to interpret the data, abstracting beyond the codes and themes and deriving larger meanings of the data. I used analytic memos to ensure reflection on this process and to further make myself aware of my role and influence on the research process. Analytic memos were also used to document and describe my thought processes in making sense of the data, including my emotional reactions to the data and the experience of carrying out the research.

In an effort to further thrust myself into the research process and ensure meaningful reflexivity, I incorporated themes from Dickson-Swift, James, Kippen & Liamputtong's (2007) piece on the challenges of doing sensitive research into my analytic memos. Dickson-Swift et al. (2007) found that qualitative researchers can face a number of challenges while undertaking sensitive research including: rapport development, use of researcher self-disclosure, listening to untold stories, feelings of guilt and vulnerability, leaving the research relationship, and researcher exhaustion. I noted pertinent and feelings, thoughts, or experiences that were relevant to these themes in my analytic memo throughout the data collection process.

### **Challenges of doing sensitive research**

**Rapport development.** In their study, Dickson-Swift et al. (2007) found that some participants in their study felt that the act of listening to a participant's story often validated the experiences of the participants by giving them the time and space to talk about that. In my own study, it seemed that at times, validation or reassurance was necessary to encourage the participants to continue to share information, or enhance participant disclosure. One participant often sought approval to continue divulging

information on a particular line of thought, seemingly requiring assurance that he was answering my questions “properly, in terms of offering the right information, as well as approval to move onto the next photo” (Analytic memo #1). I felt as though I was not being encouraging or responsive enough when the participant shared his experience with me. This compelled me to reassure the participant that he was in control of what information he offered in response to the questions I was asking. As well, I felt the need to periodically remind the participant that he controlled the pace at which we moved through the interview.

Participants in Dickson-Swift et al.’s (2007) study reported staying with the participant for a period of time after the completion of the interview—having a cup of tea or taking a walk. Similarly, in my study, I spent some time after the interview chatting with one participant in particular while still in the research setting. We talked about not only the interview, but other areas of the participant’s life such as his housing and employment, in more general terms. Dickson-Swift et al. (2007) reflected on the impact of such civilities, writing: “while these courtesies are important for rapport maintenance, they may also create an expectation that the research relationship becomes more like a friendship” (p. 332). Although I did not feel that spending an extra few minutes with the participant meant a promise of friendship, in those moments, it changed the dynamic of the relationship from researcher and participant, to two people catching up. The reason for this may be that I inquired about the participants affairs with housing and employment to offer space for him to comment on any changes that had taken place since the eligibility screening, and his overall feelings towards such circumstances. Because I was

giving the participant the space to speak about his experiences in housing, I almost felt obligated to give the same space to share about other somewhat related areas of his life.

**Leaving the research relationship.** In every instance, at the end of the interview exchange, there seemed to be a lingering awkwardness surrounding the next steps in the research process, aside from offering the participants the opportunity to take part in opportunities to increase the validity of the findings. I looked at this awkwardness in two ways: the first; that my role as the researcher—ultimately, the leader of the ebb and flow of the interaction—subconsciously awarded me some authority over the entire process, including when it was okay to leave. My perception of this experience might also stem from my insecurities related to having such ill-given authority or power. Although I was prepared, I still felt as though we were similarly positioned—I did not feel as though I was in a position of authority. The second way I looked at this had to do with my feeling that the research relationship, and our contact, had not ended with data collection: “some researchers felt that need to follow up the interview with a phone call or some other contact that reflected to the participants the importance of their participation in the project” (Dickson-Swift et al., 2007, p. 340). I felt the need to reach out to the participants to further express my gratitude for their participation in the project.

As well, I felt the need to continue the research relationship to benefit the participants, in some way. I needed to suggest or offer future contact or else I would be leaving the research relationship unequal: with my arms full without the participant gaining in the way that I had. At the end of the interview, one participant stayed seated in the interview room after I had finishing explaining the next steps and gathering my research materials. Even after I thanked him, he stayed seated. I interpreted this as the

participant waiting for confirmation that the interview was over, and he was free to leave. This led me to offer my contact information again in the case of questions or concerns. Looking back, this brings to mind how support housing service users may not always feel in control of their time.

### **Ethical considerations**

**Ethics approval and permissions.** Any research involving the use of human subjects either directly or indirectly, must receive ethics approval (Meadows, 2003). Before initiating my research, I sought and received research ethics approval from Saint Mary's University Research Ethics Board (reference SMU REB File Number 17-157). As well, I gained permission from the housing programs in which the participants live to ensure cooperation and encouragement to conduct this research.

Throughout the research ethics application process, I was asked to clarify information related to the amount of compensation I was offering for participation in the research. Among other things, concerns were raised about whether the amount was considered to be coercive, given that some participants may be in 'vulnerable circumstances'. I was asked to consider whether or not inclusion in my research would exacerbate their vulnerability, and if I anticipated that some participants may be in 'doubly' vulnerable circumstances due to their economic or social situations. There were also questions raised about my plans if an illicit photo was taken by a participant. Lastly, I was asked to reflect on the potential risks to myself as participants may have committed serious crimes, although deemed NCRMD through the court system.

I knew that some of the concerns were helpful in bringing to light some important issues that needed further reflection (e.g., exacerbating vulnerabilities) to aid in mitigating potential risks to participants. However, taken together, I felt that the concerns were rooted in preconceived notions about the forensic mental health population. For example, I was asked to explain what I would do if an illicit photo was taken. Although this is a possibility, I felt that this question may have been asked based on the research population in question, described as having been through the court system and deemed NCRMD for potentially serious crimes. These thoughts were realized when I was asked to repeat the ways in which I would mitigate risks to myself. In contrast, the population was also described as vulnerable, perhaps even ‘doubly’ vulnerable due to their economic and social situations. I interpreted this seemingly paradoxical conception of potential participants as both vulnerable with the potential to be exploited by the research, as well as potentially risky. I found it difficult to subscribe to the way in which the population was being described through the ethics process in responding to the concerns being raised.

**Confidentiality.** Given the small number of supported housing options in Halifax, I had concerns about ensuring confidentiality of participants. In an effort to minimize these concerns, my research sought to gather views about multiple types of supported housing programs as opposed to sampling from one specific supported housing service.

**Known risks of participation.** Potential risks to participants in a photovoice project are magnified when the project involves society’s most vulnerable members (Wang, Cash & Powers, 2000). As such, potential risks of participating in this research

involved emotional discomfort brought on by asking questions of a personal and sensitive nature. As well, it was possible that participants may have had trouble presenting complex or abstract ideas through their photos and that a close examination of concerning issues can cause negative feelings. In an effort to minimize such risks, interviewees were repeatedly assured that they may take a break from the interview, pass a question, or stop the interview at any time. Information for mental health crisis services was on-hand if a participant became distressed or felt they needed further emotional support.

**Privacy and confidentiality.** In accordance with the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (TCPS 2) and Saint Mary's University relevant policies, several steps were taken to ensure the privacy and confidentiality of participants. Physical files which contained participants' information (i.e., consent forms, interview guides and notes) were kept in a locked filing cabinet in a locked office at Saint Mary's University. Computer files were kept on a password-protected USB device which was also kept in the locked filing cabinet. Interviews were conducted in a private space, either an office or recreational room at the participants' supported housing location, with a closing door. Lastly, all quotes and photos have been scrubbed of participants' identifying information or any information that may be used to link a participant to the information in this thesis.

**Safety.** To ensure the safety of the participant and my own safety, several steps were taken during the data collection process. Before each photovoice training, camera collection, and interview, I notified my academic supervisor of my location and expected time of return. During participant interviews, I withheld sharing personal information about myself with participants. When entering an interview location, I made myself aware

of my surroundings and ensured reasonable proximity to exits. As well, I ensured each interview location was appropriate for both the participant and myself in terms of comfortability and safety. If ever it were necessary, I was prepared to utilize my training in Nonviolent Crisis Intervention.

## Results

In the following two chapters, I report and discuss the findings of my study. Specifically, I describe the themes and subthemes I produced through the analysis using supporting quotes from the qualitative interviews as well as photos taken by participants. I illustrate how the photos and interview with participants describe their complex experiences in supported housing. The photos I chose to display in the results were selected based on photo quality as well as each photo's ability to contextualize the participants' experiences in supported housing. At times, photos may be discussed but not pictured due to poor quality. A chart describing the themes and subthemes can be found in Appendix E.

Three overarching themes and seven subthemes were produced from the qualitative analysis. The first theme, called 'It feels like a normal house', describes elements of supported housing from the perspective of participants. Participants described the positive aspects and negative aspects of their supported housing, as well as compared their supported housing to their experiences in the forensic mental health hospital. The second theme, called 'Being responsible, being able to live independently', speaks to the participants' experiences of learning responsibilities to gain independent living skills. The third and last theme, 'Parts of it are a very restricted living environment' relates to participants' experiences in supported housing as containing elements of surveillance and contributing to a restricted living environment.

### **Theme 1: “It feels like a normal house”**

Participants often used their photos as a means of describing their experience in supported housing, and supported housing itself, in a general, and often, neutral way. As such, this theme will stick to the normative way in which participants tended to talk about their housing. Participants often chose to describe specific elements of their housing in a way that was general, as well as in terms of likes and dislikes. The title for this theme came from an interview with a participant who described his experience in supported housing using the term ‘the group home experience’. I began to use this term to refer to supported housing in the context of this study. Given my experience working in supported housing, throughout the analysis I refer to those living in supported housing as clients, as opposed to residents. This is the term participants in the study often used to refer to themselves and others living in supported housing.

For some participants, their supported housing felt—and looked like—a “normal” house: “But here, the house in general, it feels like a normal house.” And, further, “...like a normal, something. It doesn’t feel like a rooming house, it feels like you’re—just like what I grew up in, when I was living with my folks.” A different participant stated: “...the backyard and the woods and it [supported housing] reminds me of at home in the country.” In each of these quotes, the participant uses the word ‘normal’ to describe their housing, as opposed to something else. Often, the participants talked about their supported housing in comparison to places they lived in the past, such as a family home, in a parallel fashion. As supported housing sites are emphasized as being normal housing in the community, I interpreted participants’ perceptions of their housing as a comparison against more institutional treatment settings.

Ongoing changes to the group home was a prevalent part of one participant's experience. Through his photos, he shared the many upgrades and renovations to his housing that he had observed recently. He described the photos as representing that "things are constantly changing in the group home." The constant change was a source of uncomfortableness for this participant, however, he considered the changes to be positive after he took time to get used to them.

Change and updates were observed in terms of both the physical structure of the house, as well as the turnover of supported housing clients: "... the house is always changing its character. We get a lot of clients that come in and out. I would say that every six months to a year, someone moves in and someone moves out". In this quote, the participant is describing the frequency with which new supported housing clients would be moved in and out of the house. The participant's perception of the housing 'changing its character' may be related to his thoughts about the change in personalities with the change in clients.

All of the participants discussed the household amenities their supported housing had to offer, in terms of the presence of a dishwasher, washing machine and clothes dryer. Having ready access to these amenities in their supported housing sites was something that was looked upon favourable by participants: "we're all pretty happy there's a dishwasher".

Household amenities were also linked to another prominent element of the group home experience: completing chores. The photo displayed below (Figure 2) shows the layout of the kitchen in one participant's supported housing. Activities that took place in

the kitchen were spoken about at length by participants in the description of their supported housing which speaks to strong presence of chore-related activities.

**Image 2: Kitchen**



The participant shared this photo of the kitchen in his supported housing and described upgrades that had recently taken place. I interpreted this as demonstrating a sense of pride on behalf of the participant as he described a number of upgrades that had taken place, enhancing the function and look of the kitchen.

An important element of the group home experience was the weekly chore sheets that were distributed amongst those living in the participants' supported housing. The chore sheets represented the responsibilities of living in the group home which one

participant described as a “big part of the group home experience”. The chore sheets covered all sections of the house (e.g., kitchen, bathroom, living room), and were placed on a rotating schedule. Upon completion, staff approval would be sought to check the client’s work for completion and satisfaction and sign off on the chore chart. In addition to the shared house chores, a room chore sheet was also allocated to each client which dictated the tasks to be completed in each occupant’s bedroom. This chore sheet listed smaller chores to get done daily, and other larger tasks to be done on different days. One participant described chore sheets as “quite extensive” denoting a “huge value on cleanliness” at the group home. Similarly, a participant shared a photo of the mop and mop bucket (Figure 3), which for him represented the “bread and butter of chores”. For this participant, his routine often involved sweeping and mopping the floors thus prompting him to describe it as an important part of living in the group home.

**Image 3: Mop and bucket**



Another element of supported housing described by participants was the system for choosing and preparing meals. Participants shared photos of the meal plan for their supported housing, which dictated the daily meal to be served at suppertime and the person responsible for preparing the meal for each day. As with the chore sheets, the meal plans work on a rotational basis to determine who cooks each day. One participant described the structure of the meals, which include all major food groups in an effort to secure a balanced diet. One participant described that staff would often try to introduce something healthy to each meal.

Along the lines of the meals in the supported housing sites, a participant shared a photo of the dinner table where the clients sat together while eating dinner (Figure 4). Another participant shared a similar photo of the dinner table in her supported housing:

“we eat here three times a day. I’ve been here a year. We have a lot of holiday dinners...”. For this participant, a considerable amount of time was spent at the dinner table for both regular meals and special occasions.

**Image 4: Dinner table**



In relation to the above photo, the participant described the routine for preparing the table and eating dinner with the other supported housing clients living in the house.

When asked to describe her housing in a more general sense, one participant defined it as “very routine”. Participants’ supported housing was considered to be quite structured in nature, given the organization of chores and meal preparation. Further, it follows that other areas of supported housing would be organized similarly. Participants

shared other aspects of their daily routine in their supported housing, such as the area where medications were dispensed:

“It’s just something that you come across during the day. At nights, it’s just a total part of the routine, to get your meds at night. So, I just thought I’d take a picture, just because it’s such a—like, the cabinet is just something that I literally come across every day before bed. So, it’s just kind of an important part of the routine.”

For this participant, the medication cabinet was something he encountered regularly, making it an important part of his daily routine. As well, the participant’s experience of habitually encountering the medication cabinet may be interpreted as uncovering the prominent role of medication in the participant’s experience in supported housing.

As previously mentioned, participants chose to take photos of their supported housing, as well as photos of the areas outside their housing. One participant took a photo of the house’s garden, deeming it “an integral part of... being at the house” (Figure 5). The participant shared how the garden was maintained by all of the supported housing clients and described spending much of his time relaxing in the garden.

### Image 5: Garden



Figure 6 depicts a photo taken by a participant of the view outside his bedroom window which represented that his supported housing was in a “good area”. He felt his housing was in a good area because it was close to other houses, a church, and amenities.

**Image 6: View of outside bedroom window**



When asked what came to mind when looking at the photo, the participant replied, “fresh air” and described feeling happy when thinking about the aspect of his housing captured in the photo.

As well, participants’ photos pointed to the social aspects of their supported housing experience. One participant shared a photo of a washable board in his supported housing which was used to leave friendly messages and jokes from staff and other clients. Another participant described the common room, which had a television, as a social spot in which staff and clients would spend time together watching television or having conversations. Similarly, a participant shared a photo of a popular game (Figure 7) that was often played in his housing, which, for him, represented that the busy nature of the

house: “I like the fact that things are happening. That you’re in a house where things are going on around you and that you’re not coming home to this empty apartment setting, or something.” This quote demonstrates the participant’s perception of his housing as eventful and perhaps social – something which he regarded positively. The quote may also be perceived as a suggestion that an apartment setting – arguably a more independent living scenario – as lacking the social element he described in relation to his supported housing.

**Image 7: Crib board**



In relation to the above photo, the participant described supported housing staff and clients enjoying playing the game together. From my point of view, the participant described such experiences fondly.

Participants shared their experiences of encountering staff's expectations for supported housing clients, as illustrated in the following quote:

“It's very encouraged, here at the group home, to be doing something meaningful during the day. If they see that you're just kind of sitting in your room watching reruns or something all day, then they're not going to be too pleased and they're going to try to find something for you. That being said, it's not a requirement and they're not going to kick you out if you don't have things to do.”

The quote provides insight into how the participant perceives the staff's expectations related to how clients spend their time. He perceived staff as encouraging clients to spend their time meaningfully, and if not, clients would be given something else to do. On a larger scale, this points to a standard of productivity in the participant's supported housing, described further by the participant as “setting the bar”. As illustrated in the above quote, the use of surveillance by supported housing staff made it possible to enforce the standard of productivity with clients.

### **Subtheme 1a: “It's not like the Annie Orphanage”**

Participants often used their photos to share parts of their supported housing they considered to be positive or enjoyable in some way. As such, the quotes and photos in this theme describe aspects of supported housing that were looked upon favourably by participants, fitting into the normative way in which supported housing was described.

One participant spoke pleasingly about his supported housing as having lots of movies to watch, and a comfortable couch to lay on. Another participant shared an aspect of his supported housing which he considered to be positive (Figure 8):

“I usually spend a lot of time just kind of walking around the garden. I find it very relaxing, very peaceful... It’s really gorgeous, especially now; spring just came out and we’ve got these really nice flowers which are starting to come out...I can say it’s really helpful for me.”

For this participant, part of his supported housing’s environment provided him space to collect his thoughts and relax – something he considered to be helpful. He described spending time in the garden regularly, enjoying the greenery and the peace and quiet. Another participant shared a similar experience of an area of his supported housing in which he enjoyed spending time on a regularly basis. This was in relation to the common area of the house which he described as “a nice spot... a good place, it’s got leather seats and very comfortable...makes me happy”.

**Image 8: “Comfy spot”**



The participant spoke about the common area in his supported housing in contrast to the common areas in the forensic mental health hospital stating: “... all you got is wooden chairs [at the forensic hospital]”.

One participant spoke at length about the good-natured intentions of the staff and house supervisor as a positive element of his supported housing:

“[the supervisor is] ...really intent on making the living experience of the clients into something good, something that we can appreciate, that we’re all feeling comfortable in our living environment... It’s not like the Annie Orphanage or whatever; the people there that kind of make your life miserable. A lot of the time,

the staff and superintendents are really intent on making your experience positive... overall, it's really good that they care about the clients that live here.”

The quote shown above reveals how the participant perceived the intentions of the staff and superintendent as positive and caring and oriented toward making his experience comfortable. I found the participant's choice to compare his housing to 'Annie orphanage' as an attempt to set it apart from potentially negative assumptions about other types of supported living sites. The participant's use of the word "care" points to his perceptions of the treatment and demeanor of staff toward supported housing clients.

Having access to a number of recipes in one participant's supported housing was looked on positively by, as well: "... there's a recipe binder and a huge selection of meals you could potentially make". For this participant, having access to a variety of recipes was considered a positive element of his supported housing. What really made a difference, however, was having his housemates go the 'extra mile' to prepare a meal:

“It's a good thing that one person can make the meal for everyone and that we can share that duty on a different day. Generally, I think the quality of the food we eat here is pretty good. A lot of the staff try and make an effort to try to cook things that are somewhat healthy as well.”

For this participant, sharing the responsibility of making meals with the other clients and having good quality and healthy food was considered to be a positive aspect of his supported housing.

The social aspect of supported housing described previously was perceived favourably by one participant: "... I actually like that. I like the hustle and bustle and that

people are always doing stuff and there's always someone to talk to". The participant identified having someone to talk to as a positive element of supported housing. As previously discussed, participants enjoyed having a comfortable space to relax and watch television or movies with clients and staff. This often took place in common areas such as a living room.

One participant spoke optimistically about his experience in supported housing overall:

"There's a lot that can be said, people not really liking group homes because of the responsibility involved, because of the fact that you're living with many other people. The fact that there's rules and there's staff and your meds are behind lock and key, that there's curfews and things like that, but for me, I actually think it's a great—not only something that helps me towards independent living, but something that can be desired for its own sake, almost."

For this participant, elements of his supported housing – such as responsibilities, living with others, rules, staff – aid him in achieving independent living. He considered supported housing to be of enough benefit to be desired because of its multiple purposes, apart from helping him towards independent living.

Securing placement in a supported housing arrangement is often part of a package of conditions of release from inpatient forensic settings for people found NCRMD. One participant spoke about his experience in supported housing in relation to conditions of discharge: "...even if it wasn't a condition, I would really consider living here on a more permanent—I don't know about permanent, but long-term basis... I think it's been a really positive experience here at the group home". This participant's positive experience

prompted him to consider a more long-term placement in supported housing, even after satisfying the required conditions of discharge from the forensic mental health hospital.

**Subtheme 1b: “I don’t like those kind of overbearing-type policies”**

Participants also described the negative and undesirable aspects of their supported housing, as captured in this subtheme. One element of the supported housing experience that was considered undesirable was related to completing chores: “It can get frustrating, waking up in the morning and having to do a chore. Sundays, I’m not as willing as others; I will force myself to get it done but it is something that you have to get used to”. The participant’s experience highlights the requirement of completing chores regularly as well as his perception of the need to adapt to this requirement. Not only was the requirement to do the chores described as frustrating, but also the number of chores was identified by a participant as being a negative element of supported housing:

“I will say that sometimes, the amount of chores can be a little bit overreaching. For example, washing windows: I assume that most people will maybe wash their windows once a month or so ((chuckles)) and we, I mean, for just the room chore, the windows have to get done once a week. Pretty much every window in this house has to get done at least once a week or more frequently.”

For this participant, certain tasks were to be done more often than he considered necessary, contributing to the copious number of chores to be done by supported housing clients on a regular basis.

Another source of frustration for one participant was his perception of the staff or supervisor's priorities and agendas sometimes being different from his own. One example was an instance in which something in the house that was meaningful to him was not prioritized for repair: "... it's a rare scene when you see something that's not maintained for a while so for me, this represents just the fact that the house's priority sometimes conflict with my priorities". In this case, the participant had asked to have the item (a piece of furniture) repaired, to no avail. Months had gone by and the piece of furniture was not repaired. Along these lines, the participant described having to go along with the way things were done in terms of décor and strategies for organization that contrasted with his preferences.

Another negative aspect of supported housing was related to the supported housing service's policies. One policy that caused some frustration for one participant was the requirement for clients to be awake and out of bed for the day at a particular time. This was considered to be an undesirable element of supported housing, as illustrated by this quote: "... I don't like those kind of overbearing-type policies that they have to try and get people up". The participant described his experience with staff implementing policies in which clients were to be out of bed at a particular time, regardless of clients' schedules or if it was the weekend: "I'll hear in the morning a knock on the door and they'll be like "hey, you gotta be up at ten o'clock". It's not like they have work that day or something, it's just that they want people up and about by nine-thirty. I don't like the fact that they're doing that to other clients".

Another participant spoke briefly about her experience with staff, saying: “they can be rude and demanding”. The participant shared her thoughts about being away from her supported housing in relation to a photo she had taken outside (Figure 9):

Interviewer: *Does it [the photo] make you feel a particular way?*

Participant: Free, I feel free.

Interviewer: *Why do you say that you feel free when you look at that?*

Participant: Because you get to the top of the drive, you turn, and you’re gone. Like, you’re away from here.

The interview text revealed that the participant felt feelings of freedom when thinking about being away from her supported housing. She shared negative feelings in relation to her supported housing related to having to abide by rules and live with others. I interpreted this as a display of the potentially controlling or restrictive feelings she felt toward her supported housing. As such, the controlling nature of supported housing can be considered a negative aspect, based on this participant’s experiences.

**Image 9: Street view**



In relation to the above photo, the participant described wanting to share the views from her supported housing, the views she saw on a daily basis.

**Subtheme 1c: “This is more proactive, this is more positive”**

Participants described their experiences in supported housing in comparison to their previous experiences in the forensic mental health hospital. Prior to receiving a conditional discharge, all participants spent time receiving treatment in the local forensic mental health hospital.

A comparison that was drawn by one participant was related to the perceived goals of the forensic mental health hospital and goals of supported housing services, as illustrated in this quote:

“It’s very different from being in hospital—like the forensic hospital—that’s geared towards getting you better; getting you more mentally stable. This is more proactive, this is more positive, it’s about ‘okay now you’re good, you’re stable, now we want to integrate you into not only personal living skills, but also into the community at large’, in whatever way they can.”

This participant’s perception of the function of the forensic hospital was different from the function of his supported housing. For him, the forensic mental health hospital was oriented towards mental health stabilization while supported housing was aimed towards community reintegration and teaching personal living skills. Further, he considered supported housing to be more proactive and positive in its approach. Interestingly, another participant characterized his supported housing as “... a lot more laidback than the forensic hospital”. Taken together, I interpreted the participants’ experiences as shedding light on the perceived differences in approach and impressions of supported housing and the forensic mental health hospital.

For one participant, supported housing also meant not having to share things with many other people (see Figure 10): “There’s a T.V. to watch. You don’t have to share it with eleven people.” And, further: “Washer and dryer. Not industrial size but they hold more laundry than the ones at the hospital and you don’t have to share with twenty-five other people.”

The participant's comparison of his experiences in supported housing and the forensic mental health hospital point to the benefits of living with fewer people: increased access to amenities and sources of entertainment.

**Image 10: Washer and dryer**



The participant described taking the photo of the washer and dryer in his supported housing to represent the important of hygiene: "... everybody's got to keep their hygiene up and that includes washing clothes".

Participants shared their impressions of the populations they encountered in supported housing as compared to the forensic mental health hospital:

"A lot of people there [the forensic hospital] are more sick and dangerous offenders and stuff."

“It’s like NCRs... where here, they’re pretty civilized.”

Another participant stated: “The conduct is a lot better... Not as much aggression in people”. For some participants, people in the forensic mental health hospital were seen as more mentally ill, dangerous, and aggressive while the people they encountered in supported housing were considered civilized. I interpreted these experiences of participants as further shedding light on the related and differing mandates of forensic inpatient settings and supported housing services, as perceived by participants in the study.

## **Theme 2: “Being responsible, being able to live independently”**

In this theme, participants spoke about two interrelated aspects of their supported housing experiences: learning how to be responsible and being able to live independently. For some participants, supported housing involved accepting and managing responsibilities—a necessary part of learning to live independently. All participants described a desire to live more independently both in the context of their supported housing and in terms of eventually living on their own.

Accepting responsibilities were a part of learning to live independently:

“It’s not a system where you can do things at your leisure; it’s pretty much a hardline requirement of living in the group home which is good because I find that I’m able to learn those independent living skills and that’s part of the reason of the whole group home system as a whole anyways; it’s to try to train you to live independently”.

In this quote, the participant describes the system set in place which determines when and what tasks are completed by clients in supported housing; a system of responsibilities.

Interestingly, the participant uses the word ‘train’ as opposed to ‘teach’ in the context of learning independent living skills. The use of the word ‘train’ may be interpreted as pointing to a system of learning a particular behaviour related to responsibilities.

Participants described feeling frustrated over aspects of their responsibilities and the methods used to structure their time: “... chores, for anyone, is not the funnest thing I guess but it really is part of the experience and I, at least, appreciate the fact that it helps develop independent living skills”. Alongside frustration, the participant also expressed appreciation toward the system in place for learning independent living skills. Overall, he perceived the arrangement positively: “It’s a great thing... that learning to take responsibility”.

### **Subtheme 2a: “There’s virtually an expectation that things get done”**

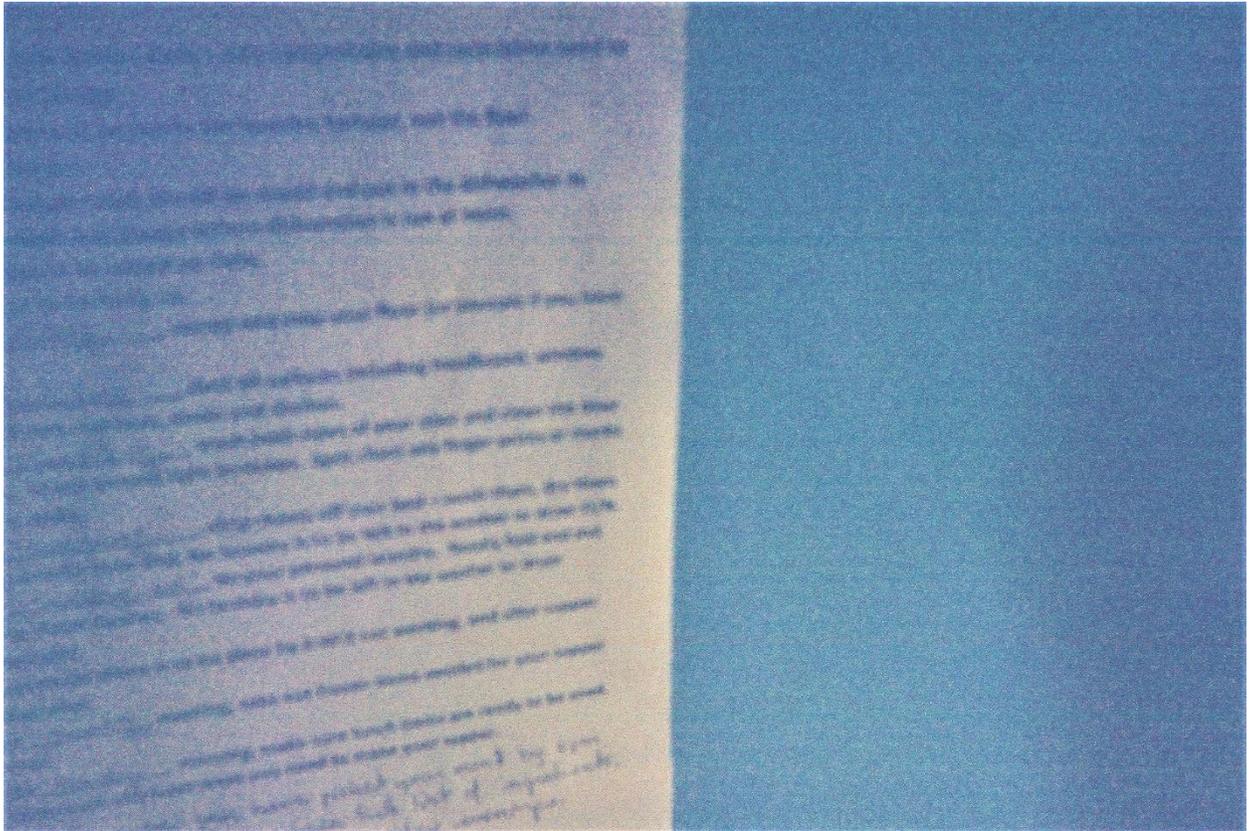
Participants’ described the implementation of the system of responsibilities as a means of learning to live independently. Responsibilities featured prominently in one participant’s experience in supported housing:

“...one of the first things that you notice when you’re living in a group home here is that there’s responsibilities to get done that’s either in the form of making meals or doing chores or keeping your room tidy, things like that.”

For this participant, responsibilities in the form of chores or other tasks were the first thing he noticed about his supported housing (Figure 11). As a result, many of the photos

taken by this participant had to do with responsibilities, since “that’s [responsibilities] just such a big part of the group home”.

**Image 11: Chore list**



Room chores, house chores, and meal plans were some of the responsibilities of living in supported housing, described by one participant as “... just more things that need to get done on a regular basis”. For this participant, the system of responsibilities often involved various household chores. The following quote summarizes one participant’s feelings towards the responsibilities of living in supported housing:

“I think they go a little overkill cause they want you to learn those skills, even if you don’t need to sweep or that you don’t really need to do the windows now or

something like that; it's all part of the process of learning how to take on responsibility and be due diligent and things like that.”

The participant is suggesting that the overall goal of the system of responsibilities in supported housing is to teach clients a behaviour, as opposed to certain tasks. This is evident in his perception of things not necessarily needing to be done (i.e., cleaning clean windows), but the practice of doing things to learn a behaviour: responsibility.

“I guess the mop and broom represents kind of this tool to get the clients kind of more disciplined in doing house chores. But my personal feeling about the necessity of that kind of stuff is that it doesn't seem as necessary as what is stressed from staff and such, at least not with me.”

Here, the participant describes how specific tasks, such as sweeping and mopping, are perceived as tools that function to help clients self-manage and conduct themselves in a particular way. The intended behaviour exemplifies responsibilities.

The emphasis on accepting responsibilities set the tone for how one participant perceived staff's expectations: “You can't just loaf around the house all day without getting spoke to. You have to usually be doing your responsibilities and if possible, doing something out in the community as well”. As a result, the participant anticipated being spoken to if he did not respond to staff's expectations which may cause him to align his behaviour to the imposed expectations.

For this participant, behaviour associated with the system of responsibilities was something to adjust to: “you learn to get it done”. In relation to meal planning, one participant shared: “... they kind of said ‘you're responsible for making these meals’ and over time ‘you're responsible for making them on your own’”. This quote illustrates how

the system of responsibilities in supported housing serve as a regulatory mechanism; a learned behaviour that eventually amounts to a learned routine.

**Subtheme 2b: “It’s kind of like a launching pad to, perhaps, independent living”**

This subtheme describes participants’ experiences in supported housing related to learning to how to live independently. As previously described, the system of responsibilities seemed to be the mechanism in which participants could learn to live independently. As such, supported housing was considered to be an empowering step towards being able to live independently: “... it’s kind of like a launching pad to, perhaps, independent living”. For this participant, supported housing provided an opportunity to learn independent living skills and acted as a platform to access independent living opportunities.

For another participant, supported housing was a step in the direction of gaining an absolute discharge from the forensic system: “Makes me happy that I’m closer to getting an absolute and getting a place to stay”. In this context, supported housing represented a move toward liberation from the forensic mental health system, as well as a step toward more independent living.

Making meals was perceived as an important part of “being responsible, being able to live independently”. Meal plans provided the structure and content of the meals, who is responsible for cooking and preparing the meals each day, and the start time for preparing the meal: “... it [meal plan] shows you who is responsible for that day... the person who is responsible for that day has to make the dinner that day... we usually start

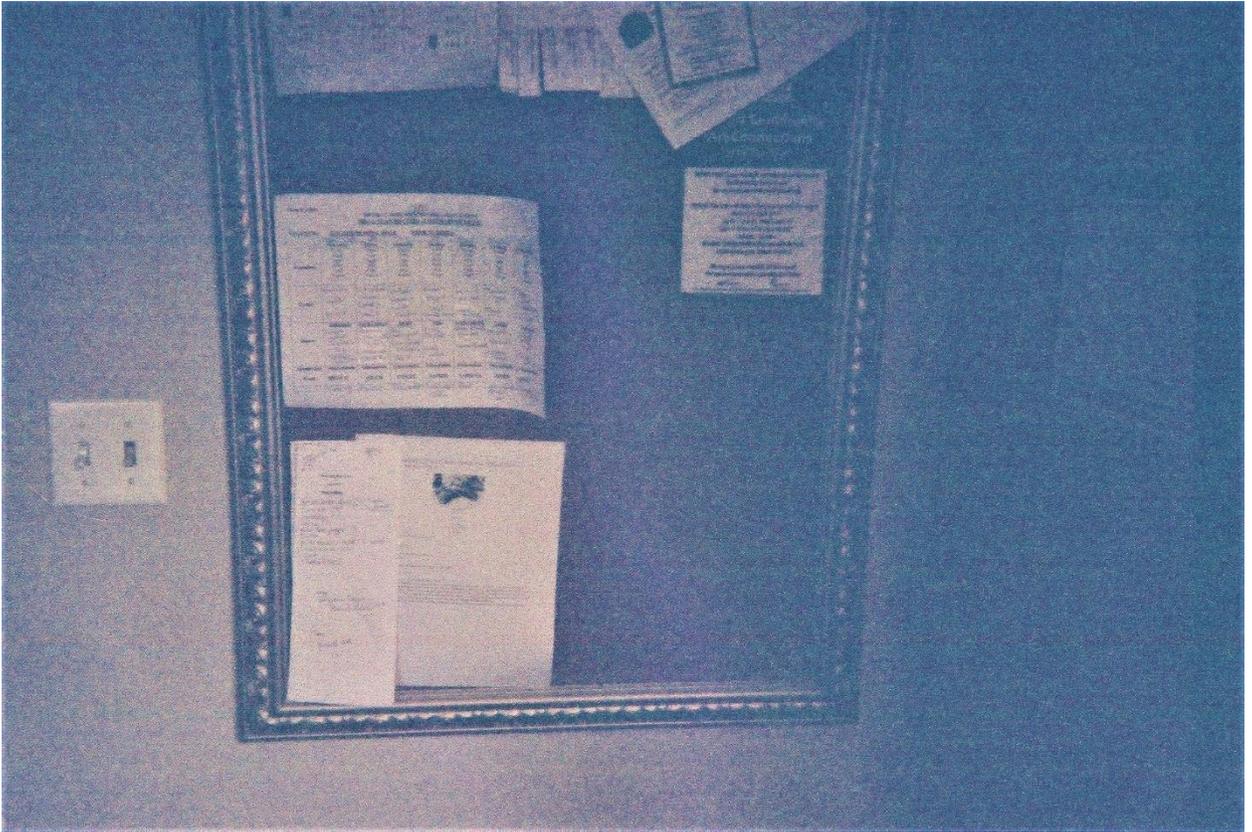
at three-thirty and go right til five... you get an hour and a half to prepare the meal”. For one participant, meal plans were characteristic of regular responsibilities: “... responsibilities we undergo on a daily basis”. Similarly, another participant shared her experience, stating: “I cook a lot”.

The preparing of meals on a regular basis was identified as a way to learn independent living skills (see Figure 12):

“... when I came into this group home... I didn’t know how to make anything. I knew how to make a grilled cheese sandwich. I’ve made a lot of meals that I’ve never... made before. I can make them by the recipe quite thoroughly, I can do it now...I would attribute much of that to the program that they have here of making the meals.”

For this participant, being required to make meals for others – as an assigned responsibility – was a push toward learning skills for independent living. Routinely making meals allowed the participant to improve his meal preparation skills, which he accredited to his supported housing.

**Image 12: Meal plan**



**Theme 3: “Parts of it are a very restricted living environment”**

The title for this theme was taken from an interview in which the participant described parts of his supported housing, such as restrictive policies which resulted in limited freedoms, as a controlling. Thus, the third theme produced from the data describes some aspects supported housing as a restricted living environment. For one participant, the restricted living environment element of supported housing was “part and parcel of living in the house”. This description points to the strong presence of restrictive elements

of supported housing, as perceived by this participant. The following quote provides further evidence:

“This is another kind of thing that you realize about living in a group which is not bad, but it’s not great either is that parts of it are very restricted living environment.... So, the freezer has a lock and key, the med box—because that’s really important—where we get our meds... What else? The staff room can sometimes be locked, the basement sometimes gets locked, certain doors get locked at certain times.”

The participant is describing encountering locked items or rooms, which attributed to his perception of supported housing as a restricted living environment. Other items that were kept locked were things such as the safe deposit box with client monies, as well as filing cabinets residents’ binders containing medication and legal information, as shown in Figure 13.

**Image 13: Locked cabinet**



The participant described coming across the locked cabinet multiple times each day during his routines, particularly in the evening when he received medications. Moreover, participants in the study described restrictive practices related to having to store and access their medications through staff. Supported housing clients were required to retrieve and sign out their medications daily: “I still have to get my pills from somebody else; I can’t take my pills on my own... all the signatures and the time it takes”.

Supported housing as a restricted living environment also referred to rules imposed on participants, such as a curfew:

“... we have to be in at eleven o’clock at the latest and if we’re not at home at eleven o’clock, the door gets locked and you have to knock. Hopefully the wake-up staff will hear you... if you’re after eleven, after the curfew, then it’s not good. You can get written up or something”.

Here the participant is describing one rule he encountered in his supported housing: the implementation of a nightly curfew. As well, the participant’s experience introduces the punishment element in the event that curfew was broken. Another participant shed light on the presence of rules in her supported housing: “... there’s rules and you have to follow what people say here”. This participant’s experience points to the obligation to follow the rules and directions of others (i.e., supported housing staff).

Another way in which supported housing represented a restricted living environment for some participants was off-limits areas: “... the staff room is kind of off-limits, certain areas of it. Certainly, we aren’t allowed to be taking food from the staff room without approval of a staff member there at that time”. Aside from describing areas that were off limits to clients in supported housing, the quote also points to the need for gaining permission for certain activities or movement, such as taking food items. Figure 14 captures an area of one participant’s supported housing in which clients required permission to access.

**Image 14: Freezer with lock**



The participant described the locked freezer as representing a way in which his supported housing represented a restricted living environment.

Participants described experiencing limitations on the amount and types of possessions they were permitted to have in the house. One participant shared: “They usually like to keep belongings and things like that to a minimum. I’ve been told that I need to cut down on clutter...”. The participant perceived his housing as preferring to keep the number of belongings to a minimum; a rule enforced by supported housing staff. Limitations placed on possessions was experienced by another participant in the study: “It [the item in the photo] means a lot to me because you can’t really own a lot here”. She chose to share a photo of a shelf-space used to store her valued personal items (Figure

15). Restricting possessions was one way in which participants' freedoms were limited and contributed to the characterization of supported housing as a restricted living environment. Taken together, the participants' experiences with rules, off-limits areas, and boundaries on possessions detail the varying ways in which their freedoms were limited in supported housing.

**Image 15: Possessions shelf**



As previously described, participants in the study perceived their supported housing as having expectations related to how clients spent their time. One participant shared:

“I wouldn't say that it's a requirement [to find something meaningful to do throughout the day] but they will try to enforce it if they see you not doing

that. So, as I said, they've set the bar somewhere which means that you're not free to do whatever you want with your time. I mean, in a very loose sense, they do enforce certain things.'

The participant is describing what he perceived as an imposed standard that clients were expected to meet in relation to how they spent their time which he experienced to be a limitation on freedom. As well, the participant suggested that the standard for how clients spend their time is enforced in some way. Another participant shed light on her experience in the context of being told how to spend her time: "I know how to take care of myself so when someone tells me what to do it makes me really mad". For this participant, having others place restrictions on how she cared for herself was an undesirable aspect of supported housing.

### **Subtheme 3a: 'It's more frustrating than anything, but it's necessary'**

The third theme describes some aspects supported housing as representing a restricted living environment. Participants spoke about aspects of their supported housing which they perceived as restricting, but also successful in serving a purpose. This subtheme describes the way in which participants considered restrictions to be beneficial, necessary, or positive in some way.

One example in which restrictions were looked upon positively was related to the requirement for medications to be locked:

"I mean, it's necessary and it's not bothering to me that meds and stuff are behind lock and key. It's not bothering whatsoever, in fact, it's probably a good thing

because I don't want anyone that isn't staff going through my binder and reading stuff off."

The participant perceived the locking of medications and sensitive information to be necessary, in terms of safety, but also a positive thing. For this participant, having access to his medications and information restricted to himself and others was desirable as it kept his personal information from being shared with others.

Another example in which the restrictions were considered a good thing was in the case of food storage:

"And once again, it's frustrating; 'oh I can't go down and get a bread from the freezer', that's frustrating. But also, if you had any food saved from the day before and you want to make sure that someone doesn't eat it, putting it behind in a place that is kind of locked away, that can also be a good thing. It depends on what the particular situation is."

This quote illustrates the how having locked items restricted particular movements from supported housing clients. Although the participant identified the fridge being locked as a frustration, it prevented others from gaining access as well. For this participant, restrictions were sometimes positive, depending on the situation.

## **Discussion**

The objective of this research was to gain a better understanding of supported housing as experienced and perceived by people found NCRMD. This was done in order to explore how forensic mental health service users negotiate tensions between the therapeutic and risk management functions of supported housing. I performed a thematic analysis of qualitative interviews with three participants, which were based on photos taken by the participants using the photovoice method. The analysis yielded three overarching themes and seven subthemes which described participants' perceptions of supported housing ('It feels like a normal house'), experiences with 'Being responsible, being able to live independently', and supported housing as a restricted living environment ('Parts of it are a very restricted living environment'). To make sense of the themes and subthemes, this section of my thesis will draw on my theoretical framework of therapeutic surveillance and will connect my findings with relevant literature.

Housing has been identified not only as a necessary ingredient of mental health recovery (Sweeney & Shetty, 2013), but also as a fundamental human right for all people (United Nations, 1974, sect. 25). Supported housing emerged as a solution to the influx of former mental health patients being treated in the community as a result of deinstitutionalization. It has been identified as necessary in the transition from institutions, such as a forensic mental health hospital, to the community to maintain care as well as provide access to mental health supports and services. The available literature on this topic tends to describe supported housing in a normative way; lacking a critical element. For my thesis, I sought to go beyond the normative way of exploring and

describing participants' experiences in supported housing to gain insight into the tensions arising from the participants' experiences.

As previously described, accused individuals may be found NCRMD if, at the time of a crime, their agency was impacted by mental illness. Such individuals are often treated in forensic mental health inpatient settings for a period of time prior to re-entering the community. Often, supported housing is used to transition people from institutional to community settings. Review boards may require that individuals found NCRMD live in supported housing as a condition of their discharge. As such, supported housing takes on the role of minimizing risk to public safety and supporting mental health recovery. Through its risk management function, supported housing acts as an extension of the forensic hospital. At the same time, it is a community alternative to institutionalization and facilitates continuity of mental health care in the community. Therefore, supported housing is at the intersection of two agendas. Supported housing clients are defined as both needing support to recover and live independently, but also needing supervision to mitigate potential threats to safety (Parr, 2010). In supported housing, various modes of surveillance are used to ensure that individuals abide by the conditions imposed on them, as well as rules of the housing agency. As a result, most areas of life are, in some way, regulated and monitored through surveillance.

What has not been thoroughly explored in the literature is how therapeutic surveillance is experienced by forensic mental health services users living in supported housing. For those found NCRMD, housing could be experienced as supportive or restrictive. As described by Moore (2011), watching people for benevolent (i.e., caring) reasons may well result in coercion and control. In a study of supportive housing in

Australia, tenants perceived surveillance to be beneficial if it intervened to stop what they deemed to be transgressive behaviours (Parsell, 2015). Surveillance was thought of as a resource to promote positive behaviours, but also limited privacy and autonomy. Tenants expressed disapproval of being monitored while acknowledging its benefits (Parsell, 2015). Boyd, Cunningham, Anderson & Kerr (2016) found that the supportive housing sites they observed were spaces where “surveillance and control were also masked with a nexus of care” (p. 6). Further, Spivakoysky (2017) found that group homes were “... dualistic sites of confinement, *and* regulated, fostered independence” (p. 380). The author suggests that group homes were sites of confinement through the use of restrictive practices as well as sites that foster independence by means of individual support plans. In the present study, participants described feelings of frustration related to accepting responsibilities and the externally imposed routines. However, they also expressed appreciation toward the system of responsibilities as it allowed them to learn independent living skills – a goal expressed by all participants. As well, participants described restrictive practices related to the storage and management of their medication, but also regarded these practices as necessary in terms of safety and maintaining confidentiality. Recall, therapeutic surveillance emphasises that elements of care and control are blended and their functions are, at times, perceived as congruent. An inductive analysis of the data I collected for this study illustrated how elements of care and control were coexistent in participants’ experiences in supported housing.

Moore (2011) suggests that therapeutic surveillance involves people watching people, many watching one, intimate knowledge of those being watched, and benevolence. In the present research, participants described experiencing a variety of

ways in which their behaviour and movements were monitored constantly by supported housing staff, such as medication monitoring, the carrying out of chores, and monitoring of off-limits areas. Constant supervision from staff was blended with continuous support. Moore (2011) describes this relationship in the following way, “without the human connections tethered to therapeutic surveillance, there would be no opportunity to form the personal relationships” (Moore, 2011, pp. 259-260). As such, supported housing staff became familiar with each client’s history, mental health diagnosis, and support needs. Some participants perceived the supported housing staff as providing a positive, caring, and helpful experience. Surveillance in the context of the supported housing site in which my research took place is key in understanding participants’ experiences.

Parsell (2015) theorizes that surveillance must be understood as a product of the exchange between those surveilled and those surveilling, and assessed within the social context of the lives of those subject to surveillance. In this way, surveillance is regarded as an exchange between support workers and clients, in the social context of the wider forensic mental health system. Supported housing acts as a mechanism to carry out the risk management and recovery functions of the forensic mental health system. Although the surveillance may not be acknowledged as such, interactions are presented as benevolent; that is, caring and in the best interests of the client. In the present study, the system of responsibilities acted as a precondition to the benevolent goal of learning independent living skills and working towards independence.

Supported housing was considered to be an empowering step toward being able to live independently as well as a platform to accessing independent living skills. As such, preparing clients for independent living represents a therapeutic—or caring—initiative

support clients through mental health recovery and, eventually, ascertain independence. In supported housing, individual programs are prepared for each client based on their mental health support needs and they are assigned responsibilities with the intention of demonstrating how to achieve structure and maintain health. Meal plans are introduced to teach clients how to structure and prepare meals. Importantly, medications and confidential information for all clients are stored, locked, and monitored to ensure continuity of care as well as mental health recovery. Aspects of supported housing were considered to be beneficial for maintaining mental health and gaining independence were prevalent in participants' experiences. Recall, within circuits of inclusion, control operates through continuous monitoring and managing of conduct of populations in order to access goods (Rose, 2000). Through circuits of inclusion, individuals are given the opportunity to make decisions that will lead to a responsible life (Rose, 2000). This allows control to act as a disciplinary mechanism to shape the behaviour of individuals. In supported housing, participants are presented with opportunities to learn independent living skills – through a system of responsibilities – with the goal of eventually living on their own in the community. In this way, the system of responsibilities represents a circuit of inclusion in which supported housing clients are monitored – through surveillance – and are given the opportunity to make decisions (i.e., accept responsibilities) that will lead to a responsible and independent life.

While being presented as benevolent, the above efforts are also experienced as restrictive and controlling by participants. Although accepting responsibilities was considered to be a part of learning to live independently, participants perceived it to be an imposed requirement and expectation of living in supported housing. To promote and

enforce the system of responsibilities, clients were monitored on a continuous and ongoing basis by supported housing staff. In this way, the intended outcome – accepting responsibility – prompted participants to alter their behaviour to meet staff’s expectations. As argued by Boyd et al. (2016), this was considered to be “site-specific coercion” involving policies and rules that resident need to abide by, such as room cleanliness, daily room checks, and meal programs. The authors suggest that, although such practices are intended to support clients, they can potentially serve as a form of coercion (Boyd et al., 2016). In her study of group homes, Spivakovsky (2017) considered such plans or regiments to make lives governable by providing them with the supports and structures necessary to eventually become responsible citizens. This is done by identifying skills needed to “find greater independent and interaction with other citizens in society” (p. ?), using the group home as the initial site of integration to the community. In essence, they are “realigning a person with a disability to the circuits of inclusion” (Spivakovsky, 2017, p. 372). The monitored individuals internalize the requirement and govern themselves, ensuring self-control (Nordberg, 2016). In the present study, surveillance functioned to prompt participants to align their behaviour to fit with the system of responsibilities in order to learn to live independently. Furthermore, supported housing staff’s expectations related to how clients spent their time suggested that participants anticipated staff’s expectations and self-governed.

Supported housing as a restricted living environment suggests that the policies and procedures encountered by participants were perceived as limiting. This was evident in the lock-and-key nature of many items in the house, including safe deposit boxes with client monies, clients’ binders containing mediation and legal information, medication

boxes, freezers, staff rooms, and other areas. On a more abstract and conceptual level, supported housing as a restricted living environment meant having to abide by rules and regulations imposed on clients which limited freedoms and restricted behaviours or movements. Participants in the study described restrictive practices, procedures, and policies, such as having to access their medications through staff and having to return to the house before a nightly curfew. Further, participants experienced off-limits areas in their supported housing as well as limitations on their possessions. Despite being experienced as frustrating, restrictive elements of supported housing were – at times – considered necessary and purposeful. In particular, participants perceived medication locking practices as necessary in terms of safety as well as to restrict others from accessing participants’ medications and information.

The restrictions living in supported housing were observed as containing aspects of care as well as aspects of control. As the forensic mental health system is mandated to prioritize public safety while providing opportunities for mental health treatment for people found NCRMD, both risk management and the treatment needs of people found NCRMD are factors in delivery of care in supported housing. The supported housing sites explored in this research acted as an extension of this system in its ability provide therapeutic and mental health recovery-oriented initiatives interspersed with elements of surveillance and control.

### **Strengths & limitations**

This research study provides insight into the ways in which people found NCRMD experience one condition – supported housing – within the context of the

forensic mental health system and its legal mandate (Part XX.1, *Criminal Code of Canada*). The findings of this research are particularly relevant to professionals working in supported housing contexts. For me, this research changed the way in which I think about the support that I, and many others, provide in the context of supported housing. Participants' experiences shared in this study have prompted me to strongly consider the ways in which the support I provide may be experienced and perceived by the clients I work with. Although participants spoke about their experiences in rather descriptive and non-critical ways, the findings of this study still challenged the normative ways in which I tended to think about supported housing. Participants' experiences shed light on a system that required them to meet expectations in order to access freedoms – a complex layer on my conceptualization of supported housing as encompassing simply desirable and undesirable elements and experiences.

Despite these strengths, there were limitations. This research is based on a very small sample size placing a significant limitation on the generalizability the findings to other supported housing contexts and NCRMD populations. As well, the reliance on photos taken by participants in the qualitative interviews introduces a limitation as participants were not permitted to take photos of themselves, others, or identifying objects. As a result, it is possible that meaningful data may be left out.

### **Implications and recommendations for future research**

The findings of this research may be used to inform policy related to supported housing for the forensic mental health population as it provides insight into the way in which supported housing is experienced by forensic mental health service users. As well,

the findings are important and relevant to those working in a support role in housing services which serve the forensic mental health population. I hope the findings of this research challenge the way in which support is provided to those living in supported housing and further, the ways in which those providing support engage in surveillance in order to manage risk in the forensic mental health population.

Future research with the forensic mental health population in supported housing contexts should further explore experiences in supported housing for people found NCRMD. More specifically, the follow-up to this study should explore the restrictive and regulatory mechanisms at play in supported housing on a more in-depth level. This may be done through an analysis of the individualized support plans in which supported housing clients are monitored and drawn into circuits of inclusion. Although it was not possible for the present study, exploring how service users experience individualized support plans and other forms of regulatory mechanisms would be beneficial to future research.

If given the opportunity to recreate the current study, in addition to looking deeper into the restrictive mechanisms of supported housing, I would include the experiences of those working in a supportive role in housing services for the forensic mental health population. This would be done in an effort to comprehensively describe the structure of supported housing services, as well as to explore the relationship between supported housing service users and those who provide support to them. I anticipate such research would shed light on the complex relationship between support staff and service users, embodying both therapeutic and controlling elements.

## Conclusions

I went into the project with the belief that the interviews would uncover the variety of ways in which supported housing was experienced as exemplifying therapeutic initiatives, or that it was experienced as a purely carceral space. Essentially, I assumed that it would be one or the other. I was surprised to learn that participants described their housing in relatively normative ways, similar to existent literature on the topic. Participants' tended to speak about their supported housing in descriptive, non-abstract ways, which, at times, made it difficult to make connections with relevant theory. The most important contribution made by this research is the insight it provides into how supported housing – as a condition of release from inpatient forensic settings – is experienced by people found NCRMD. The findings of this research revealed that the risk management function of supported housing in forensic mental health did not entirely transform supported housing into a carceral space. However, surveillance and regulatory mechanisms worked together in supported housing to contribute to participants' own self-governance to align to the conditions imposed on them. In terms of social control, I suggest that participants in this research aligned their behaviour in order to access circuits of inclusion – mental health services – and freedoms. Therefore, this research challenges thinking which suggests that supported housing is experienced as either entirely restrictive, controlling, and antecedent to independence, or as entirely therapeutic or empowering.

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## Appendixes

### Appendix A: Recruitment poster



# Forensic Mental Health *Housing* Research

A researcher is looking to explore experiences in supported housing of people who use forensic mental health services

You may be eligible to participate if you: (a) are eighteen years of age or older, (b) are able to read and communicate in English, (c) have been found Not Criminally Responsible (NCRMD) by a court, (d) are currently using forensic mental health services, and (e) are living in a housing program in Halifax, Nova Scotia

If you choose to participate, you will be asked to share your personal experience living in a housing program using photos and an individual, in-person interview

Participants will receive a small honorarium to compensate for time spent

For further information and to see if you are eligible to participate, please contact the researcher by phone or email:

**902-491-6547** or **marlee.jordan@smu.ca**



One University. One World. Yours.

## **Appendix B: Informed consent form**

Care and control: Experiences in supported housing of people who use forensic mental health services

SMU REB # 17-157

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### **Introduction**

My name is Marlee Jordan and I am a Master of Arts, Criminology graduate student at Saint Mary's University. As part of my Master's thesis, I am conducting research under the supervision of Dr. Jamie Livingston. You are being invited to take part in this research study which aims to explore people's experiences in supported housing. I have no financial interest to declare in conducting this research study.

Your participation in the study is completely voluntary. It is up to you to decide whether you would like to take part in the study or not. Refusing to participate in the study will have no impact on your housing situation. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this form carefully and take as much time as you like. If you would like to take it home with you and think about it for a while, please feel free to do so. Please highlight anything you do not understand or anything you would like explained better. After you have read the form, please ask any questions you like.

You are eligible to participate in this study if you: (a) are eighteen years of age or older, (b) are able to read and communicate in English, (c) have been found Not Criminally Responsible (NCRMD) by a court, (d) are currently using forensic mental health services, and (e) are living in a supported housing residential service in Halifax, Nova Scotia or the surrounding area.

Why is this research being conducted?

Little is known about experiences in supported housing of people who use forensic mental health services. The goal of this research is to gain a better understanding of supported housing as it is experienced and perceived by people found NCRMD in Halifax, Nova Scotia. As housing has been identified as an important element of support needed for mental health recovery, I hope to highlight both the strengths and weaknesses of supported housing from the perspective of those who have experience living in this type of housing. This is an important part of informing those who provide services. This

research asks: how is supported housing experienced by people who use forensic mental health services?

What will I have to do?

First, you will be asked to take part in a brief training session on the photovoice method being used in this research study. This training will take place at a private and convenient location. During the training session we will go over how the camera works, the ethics of taking photos, safety, instruction of what to take photos of, and ownership of the photos. After the training, you will be given a disposable camera and written guidelines to take home. We will then schedule a time to carry out the in-person, individual interview approximately two weeks after the camera is given. During the first week, you will be asked to take photos of your supported housing. During the second week, I will communicate with you to find a suitable time to retrieve the camera and develop the film.

During the interview, you will be asked to share and discuss the photos you have taken. The interviews will last approximately an hour and will be held at a private and convenient location (i.e., Saint Mary's University, a public location, your housing location). Examples of questions that you will be asked during the interview: why did you take this photo? When did you take this photo? What does this photo mean to you? What aspects of your housing does this photo represent? How do you feel about this aspect of your housing?

Are there benefits of participating in this research study?

I cannot guarantee that you will receive any benefits from this research. However, the broader research community will benefit from your participation by gaining a better understanding of experiences in supported housing of those who use forensic mental health services.

Are there risks of participating in this research study?

It is possible that you will experience emotional feelings or discomfort as a result of participating in this study. During the interview, you can skip a question, ask for breaks, or decide to continue the interview at another time. You also do not have to answer any question that makes you feel uncomfortable. All interviews will be carried out in a private location to ensure that information revealed during the interview is kept confidential.

A number of steps will be taken to protect your privacy and confidentiality. A master list containing personally identifying information (e.g., names, addresses) will be password protected. This list will be kept separate from the research data and will be destroyed after the study is completed. Participants will be assigned a study ID that will be used on any data collection forms and on the audio recordings. Paper records, such as consent forms and photos taken by participants, will be stored in a locked filing cabinet. The study results described in a final paper will not contain any personally identifiable information.

What will be done with my information?

If you participate in this research study, some personally identifiable information will be collected including your: name, age, gender, address, phone number, email, and length of time spent in supported housing. This information will be used in order to make contact with you for interview purposes. As well, this information will be used to describe

characteristics of the sample of participants taking part in the research study. Other information that will be collected is the personal views you share in the qualitative interviews that will take place. This data will be used to report the findings of the research. Those who will have access to your information include: myself, Marlee Jordan (Principal Investigator), Dr. Jamie Livingston (Supervisor), and the Saint Mary's University Research Ethics Board.

The following steps will be taken to protect your privacy. I, Marlee Jordan, will be the sole researcher in charge of collecting and storing the data. A master list containing personally identifying information will be password protected. Paper records will be stored in a locked filing cabinet. Personally identifying information will be kept for the duration of the study and will be destroyed upon completion. De-identified study data will be destroyed after five years.

In the event a photo is taken which could potentially identify you or someone else, the photo(s) will be destroyed upon development. This will be done in an effort to protect the privacy of you and others.

Once all the data are collected and analyzed for this study, I plan on sharing the information with the research community through the writing of my Master of Arts thesis, and potentially through conferences, presentations, and journal articles. You will have the opportunity to access a summary of the results upon study completion (August 2017).

Under the following circumstances, I may need to disclose personal information to the appropriate agencies or authorities. Information that leads me to strongly suspect that a child is being harmed, or is in danger of being harmed, may have to be disclosed by law. Also, information that leads me to strongly suspect that you are at serious risk of causing imminent bodily harm to either yourself or another person may result in immediate action to protect your safety and may require your information to be disclosed.

What type of compensation is available for participation?

You will be given \$20 cash for your participation in the study upon completion of the in-person, individual interview.

How can I withdraw from the study?

You are free to withdraw from the research study at any time without penalty. You can stop the interview at any time by letting the interviewer know you do not wish to continue. To withdraw after the completion of your interview, contact the Principal Investigator by phone or email. If you decide to withdraw from the study, you will be asked whether or not you would like your data to be removed from the research.

Where can I find out more about the study?

For further information about the study you may call the Principal Investigator, Marlee Jordan, who is the person in charge of this study. You may also contact Dr. Jamie Livingston who is the supervisor of the study. If you have questions or concerns about ethical matters you may contact the Saint Mary's University Research Ethics Board at [ethics@smu.ca](mailto:ethics@smu.ca) or by calling 902-420-5728. You are to contact me, the Principal Investigator, or my supervisor, Dr. Jamie Livingston, at any time to discuss the study.

In the next part, you will be asked if you agree (consent) to join this study. If the answer is “yes”, you will need to sign the form. After you have signed this consent form, you will be given a copy.

**Certification:**

The Saint Mary’s University Research Ethics Board has reviewed this research. If you have any questions or concerns about ethical matters or would like to discuss your rights as a research participant, you may contact the Chair of the Research Ethics Board at [ethics@smu.ca](mailto:ethics@smu.ca) or 420-5728.

**Signature of Agreement:**

Care and control: Experiences in supported housing of people who use forensic mental health services

I understand what this study is about, appreciate the risks and benefits, and that by consenting I agree to take part in this research study and do not waive any rights to legal recourse in the event of research-related harm.

I understand that my participation is voluntary and that I can end my participation at any time without penalty.

I have had adequate time to think about the research study and have had the opportunity to ask questions.

**Participant**

Name (Print) : \_\_\_\_\_

Signature : \_\_\_\_\_  
(Day/Month/Year) : \_\_\_\_\_

Date

**Principal Investigator**

Name (Print) : \_\_\_\_\_

Signature : \_\_\_\_\_  
(Day/Month/Year) : \_\_\_\_\_

Date

## Appendix C: Training Guide

### Training Preamble

- Introductions
- Study description
- Outline participation

First, you will be asked to take part in a brief training session on the photovoice method being used in this research study. This training will take place at a private and convenient location. During the training session we will go over how the camera works, the ethics of taking photos, safety, instruction of what to take photos of, and ownership of the photos. After the training, you will be given a disposable camera and written guidelines to take home. We will then schedule a time to carry out the in-person, individual interview approximately two weeks after the camera is given. During the first week, you will be asked to take photos of your supported housing. During the second week, I will communicate with you to find a suitable time to retrieve the camera and develop the film.

During the interview, you will be asked to share and discuss the photos you have taken. The interviews will last approximately an hour and will be held at a private and convenient location (i.e., Saint Mary's University, a public location, your housing location). Examples of questions that you will be asked during the interview: why did you take this photo? When did you take this photo? What does this photo mean to you? What aspects of your housing does this photo represent? How do you feel about this aspect of your housing?

- Informed consent
  - Remind participant that information will be kept private and confidential

Gather new or changed demographic information (if applicable):

Name:

Age:

Gender:

Address:

Phone number:

Email:

Time spent in supported housing (*If N/A, not eligible*):

Most recent decision from review board (*If N/A, not eligible*):

Diagnosis:

## Index Offense:

### Subsection 1: Photovoice Training

- Training
  - How it works: Participants will be shown how to use the camera to take photos, the mechanics of using the camera including the flash function, lighting, etc.
  - The ethics of taking photos: Participants will be informed on how to protect their anonymity, their homes, and neighboring residents while taking photos by not taking photos of identifying things (i.e., other photos, street signs). Participants will be asked to not take photos of other people at this time.
  - Safety: Participants will be instructed how to take photos safely without compromising their health (i.e., taking photos while driving).
  - Instruction: Participants will be asked to take photos of their home spaces or things in their home spaces. They will be explained the purpose of photo-taking (i.e., interview).
  - Ownership of the pictures: Participants will be informed that they will be given copies of the photos to enable dual ownership.
  - Number of photos: Participants will be asked to take as many photos as the disposable camera will allow (approximately twenty-seven). They will be asked to talk about the most important photos to them during the interview.
- Give participant camera and written background information guide to take home.
- Leave time for questions.
- Week 1: Contact participant to check in mid-week. If extra support is needed, arrange time/day to assist participant to take photos.
- Week 2: Retrieve camera, develop film, and schedule a time to carry out the in-person, individual interview.

Explain: The participant will be given a week to take photos of their supported housing. During the second week, I will communicate with the participant, by phone or email, to find a suitable time to retrieve the camera and develop the film. Then, I will contact participants to schedule an interview.

## **Appendix D: Interview Guide**

### Interview Guide

Care and control: Experiences in supported housing of people who use forensic mental health services

#### **Subsection 1: Demographic Information**

- Gather new or changed demographic information

#### **Subsection 2: Consent**

- Remind participant that their participation is voluntary and of a private and confidential nature

#### **Subsection 3: Interview Preamble**

- We're going to start the interview shortly, before starting I just want to say that if a question comes up that you don't want to answer, just let me know and we will move on.
- At the end of the interview, we will have time for you to think and decide whether there is anything else you would like to add.
- Do you have any question?
  - If no, are you ready to start the interview?

#### **Subsection 4: Interview**

- If you can, please organize your photos by importance to you; beginning with the most important photo or photos and ending with the least important photo. Then, I will label them.
  - As you know, I am researching experiences in supported housing of people who use forensic mental health services.
  - Now that we have your photos here, I'd like for us to talk about them.
- [turn recorder on]

#### **Subsection 5: Closing Statement**

- Thank you for sharing your photos and your experiences with me.
- Is there anything else that you would like to add at this time?

[turn recorder off]

#### **Subsection 6: Interview Debrief**

- How did you feel about the interview and the questions?
- Is there anything else that you'd like to share with me at this time?

#### **Interview Questions**

1. Why did you take this photo?
  - Probes:
    - What made you think to take this photo?

2. When did you take this photo?
  - Probes:
    - Was it morning, afternoon, or night?
    - What was going on at the time you took this photo?
3. What does this photo mean to you?
  - Probes:
    - What sort of things do you think of when you look at this photo?
    - What were you thinking about when you took this photo?
4. What aspects of supported housing does photo represent?
  - Probes:
    - What part of your housing does this photo stand for?
5. How do you feel about this aspect of your housing?
  - Probes:
    - Is there something in this photo that you like/dislike?
    - How does this photo of your housing make you feel?



<p>b. ‘I don’t like those kind of over-bearing type policies’</p>	<p>This subtheme describes comments which were negative in nature related supported housing, as described by participants.</p>	<p><i>because of the fact that you’re living with many other people. The fact that there’s rules and there’s staff and your meds are behind lock and key, that there’s curfews and things like that, but for me, I actually think it’s a great—not only something that helps me towards independent living, but something that can be desired for its own sake, almost.”</i></p> <p><i>“I’m happy about it.”</i></p> <p><i>“I will say that sometimes, the amount of chores can be a little bit overreaching. For example, washing windows: I assume that most people will maybe wash their windows once a month or so ((chuckles)) and we, I mean, for just the room chore, the windows have to get done once a week. Pretty much every window in this house has to get done at least once a week or more frequently.”</i></p> <p><i>“... the house’s priority sometimes conflict with my priorities.”</i></p> <p><i>“They [staff] can be rude and demanding.”</i></p>
<p>c. ‘This is more proactive, this is more positive’</p>	<p>This subtheme includes a discussion of the comparison between participants’</p>	<p><i>“It’s a lot more laid back than the forensic hospital where all you have is wooden chairs.”</i></p>

	<p>experiences in supported housing and experiences in the forensic hospital. This includes comments about the nature of supported housing as compared to the forensic hospital, as well as comments related to supported housing's intentions, population, and amenities.</p>	<p><i>"A lot of people there [forensic hospital] are more sick and dangerous offenders and stuff. It's like NCRs."</i></p> <p><i>"The conduct is a lot better."</i></p>
<p>2) 'Being responsible, being able to live independently'</p> <p>a. 'There's virtually an expectation that things get done'</p>	<p>This theme describes participants' experiences in supported housing related to learning responsibilities as a means of learning to live independently.</p> <p>This subtheme describes the implementation of the system of responsibilities as a</p>	<p><i>"It's not a system where you can do things at your leisure; it's pretty much a hardline requirement of living in the group home which is good because I find that I'm able to learn those independent living skills and that's part of the reason of the whole group home system as a whole anyways; it's to try to train you to live independently."</i></p> <p><i>"Once again, chores, for anyone, is not the funnest thing I guess but it really is part of the experience and I, at least, appreciate the fact that it helps develop independent living skills. I will say that sometimes, the amount of chores can be a little bit overreaching."</i></p> <p><i>"I think they go a little overkill cause they want you to learn those skills, even if you don't need to sweep or that you don't really need to do the windows now or something"</i></p>

<p>b. 'It's kind of like a launching pad, perhaps, to independent living'</p>	<p>means of learning to live independently.</p> <p>This subtheme describes participants' experiences related to supported housing of learning to live independently.</p>	<p><i>like that; it's all part of the process of learning how to take on responsibility and be due diligent and things like that. I guess the mop and broom represents kind of this tool to get the clients kind of more disciplined in doing house chores. But my personal feeling about the necessity of that kind of stuff is that it doesn't seem as necessary as what is stressed from staff and such, at least not with me."</i></p> <p><i>"That there's responsibilities that need to get done and that this isn't like certain independent living situation where you can do things at your leisure in terms of chores. There's virtually an expectation that things get done and it really is an important part of the whole group home experience."</i></p> <p><i>"It just represents the responsibilities of living here. A lot of these photos have to do with responsibilities of living here and that's just such a big part of the group home."</i></p> <p><i>"But for people like me, it's kind of like a launching pad to, perhaps, independent living."</i></p> <p><i>"Makes me happy that I'm closer to getting an absolute and getting a place to stay."</i></p>
<p>3) 'Parts of it are a very restricted living environment'</p>	<p>This theme involves a discussion of supported housing conceptualized as a 'Restricted Living Environment'. This</p>	<p><i>"This one shows the freezer with a lock on it. This is another kind of thing that you realize about living in a group which is not bad, but it's not</i></p>

<p>a. 'It's more frustrating than anything, but necessary'</p>	<p>includes comments related to the locking of certain items, areas as off-limits, rules enforced, and expectations of clients.</p> <p>This subtheme describes aspects of supported housing as restricting, but also successful in serving a purpose such as being beneficial, necessary, or positive in some way.</p>	<p><i>great either is that parts of it are very restricted living environment."</i></p> <p><i>"I guess this means to me, this picture, is that you have—it's about a restricted living environment: you have to live with other people and be respectful of them. Having rules and things that are under lockdown, things like that. That's just kind of part and parcel of living in the house."</i></p> <p><i>"Dislike, uh... I still have to get my pills from somebody else; I can't take my pills on my own."</i></p> <p><i>"Well, there's rules and you have to follow what people say here..."</i></p> <p><i>"It's more frustrating than anything, but it's necessary. I couldn't image certain things not being locked."</i></p> <p><i>"And once again, it's frustrating... [it] can also be a good thing, it depends on what the particular situation is."</i></p> <p><i>"I mean, it's necessary and it's not bothering to me that meds and stuff are behind lock and key. It's not bothering whatsoever, in fact, it's probably a good thing because I don't want anyone that isn't staff going through my binder and reading stuff off."</i></p>
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