

**Exploring Lived Experiences of Individuals in Supportive
Accommodation for Individuals with Mental Disorders: A
Mixed-Method Study**

Thesis submitted for the degree of Doctor of Philosophy

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Declaration

I, Lisa Maloney, declare that all of the work described within this thesis is my original work. Any published (or unpublished) ideas from the work of others are fully acknowledged in accordance with the standard referencing practices.

List of Abbreviations

- ACT - Assertive Community Treatment
- ADL - Activities of Daily Living
- ADON - Acting Director of Nursing
- AMPS - Assessment of Motor and Process Skills
- AOTI - Association of Occupational Therapists of Ireland
- AVFC - A Vision for a Change
- BELS - Basic Everyday Living Skills
- BPRS - Brief Psychiatric Rating Scale
- CASP - Critical Appraisal Skills Programme
- CAT-SA - Client's Assessment of Treatment Scale
- CATIE - Clinical Antipsychotic Trials of Intervention Effectiveness
- CBSST- Cognitive Behavioural and Social Skills Training
- CBT - Cognitive-Behavioural Therapy
- CINAHL - Cumulative Index to Nursing and Allied Health Literature
- CMHT - Community Mental Health Team
- CNQ - Community Nurse Questionnaire
- CPQ - Community Placement Questionnaire
- CSTAR - Centre for Support and Training in Analysis and Research
- CRF - Community Residential facility
- DICT – Deep Insulin Coma Therapy
- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- ECHR - European Convention on Human Rights
- ECT - Electroconvulsive Therapy
- EDA - Exploratory Data Analysis
- EEG - Electroencephalogram
- EU - European Union
- FEP - First Episode Psychosis
- FES - First Episode Schizophrenia
- FQ - Facility Questionnaire
- GAF - Global Assessment of Functioning

GP - General Practitioner
HAIL - Housing Association for Integrated Living
HoNOS - The Health of the Nation Outcome Scale
HRB - Health Research Board
HSE - Health Service Executive
ICC - Intraclass Correlation Coefficients
ICD - International Classification of Disease
IPS - Individual Placement and Support Services
KWQ - Key Worker Questionnaire
MANSA - Manchester Short Assessment of Quality of Life
MDT - Multidisciplinary Team
MHR – Mental Health Reform
MHA - Mental Health Association
MHC - Mental Health Commission
MISS - Mannheim Interview on Social Support
NETRHA - North East Thames Regional Health Authority
NHS - National Health Service
NHSPWD - The National Housing Strategy for People with a Disability
OCD - Obsessive Compulsive Disorder
OCS - Obsessive Compulsive Syndrome
OT - Occupational Therapist
OTA - Occupational Therapy Assistants
PAQ - Patients Attitude Questionnaire
PORT - Patient Outcomes Research Team
PROM - Patient Reported Outcome Measure
QLS - Quality of Life Scale
QPC-H - Quality of Psychiatric Care–Housing
QoL - Quality of Life
RCT - Randomised Controlled Trials
RKI - Recovery Knowledge Inventory
RQ - Residents Questionnaire
SBS - Social Behaviour Schedule
SF-12 - Self-Report Short Form
SH - Supportive Housing

SLDS - Satisfaction for Life Domains Scale
SMI - Serious Mental Illness
SPSS - Statistical Package for the Social Sciences
SQ - Staff Questionnaire
SUD - Substance Abuse Disorder
TAPS - Team for the Assessment of Psychiatric Services
TD - Teachta Dala
UN - United Nations
VCQ - Multidimensional Vermont Community Questionnaire
WHO-DAS - Disability Assessment Schedule
WHOQOL-BREF - World Health Organisation Quality of Life
WHO - World Health Organisation
WRAP - Wellness Recovery Action Plan

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Dedication

I would like to dedicate this thesis to all individuals living in community residential facilities, whose lives we are obligated to improve.

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Abstract

Supportive accommodation for people with mental disorders has received limited research attention. Notably, prior research has relied disproportionately on quantitative measures, that do not provide a comprehensive and holistic understanding of resident lived experiences. It is essential that residents have opportunities to voice their opinions, concerns, and perspectives regarding their treatment and care. This not only aligns with the recovery ethos, but also demonstrates respect for residents, by recognising the value and worth of their perspectives. Thus, this mixed-method study investigated the functionality of 11 supported housing residences. Quantitative measures were utilised, followed by six phenomenologically-informed focus groups. Findings revealed a concerning lack of recovery-oriented practices and philosophies in residents' overall treatment and care. This has greatly impacted on residents' lives, who are maintained in a stagnant environment that limits autonomy, impedes recovery and rehabilitation and violates human rights. There is an urgent need for governments, stakeholders, mental health professionals and policymakers to focus their attention on successfully implementing recovery and human rights-based practices. These include respecting human rights and encouraging empowerment and self-determination of individuals residing in supportive accommodation for people with mental disorders. Future qualitative research should explore the quality of life and lived experiences of residents in supportive accommodation. Thus, their individual needs, goals, and challenges can be understood in order to better tailor treatment and care to their actual needs, rather than based on their perceived needs as determined by policy makers.

Definition of Terms and Clarification of Concepts

Terminology is often defined slightly differently or may have nuanced meanings, depending on the context in which it is used. This means that determining the contextual definition of a term is particularly important. As such, this section will highlight, define and explain the important terms specific to this study.

Mental Disorder Vs Mental Illness

Kröber (2016) stated that modern psychiatry uses a theoretical concept of disorder in describing various impaired functions, without distinguishing pathological disorders from non-pathological disorders. In addition, the World Health Organisation (WHO) now recommends the use of the term ‘mental disorder’ rather than ‘mental illness’ (WHO, 2019a). For this reason, the term mental disorder is used throughout the dissertation.

Patient / Client / Service User / Consumer

The shift from the paternalistic to the patient-centred model of health care has promoted debate around the use of alternative labels to describe ‘patients’ (Costa *et al.*, 2019). Moreover, Dickens and Picchioni, (2012) stated that language is a means by which people can be stigmatised or empowered, and that personal preference should guide its construction. The researcher does not know participants’ personally preferred terms. Thus, she decided upon the use of ‘resident’, owing to its non-stigmatising quality, as it best fits her professional background and ethical viewpoint.

Community Residential Facility/ Supportive Accommodation/ Supported Accommodation

The different forms of accommodation for people with mental disorders are difficult to define, thus inconsistency exists regarding definitions within the literature (Macpherson, Shepherd and Edwards, 2004; McPherson, Krotofil and Killaspy, 2018b). Supportive accommodation best describes the accommodation of the research participants. However, community residential facility (CRF) is the term used within the local mental health service where

this study was conducted. Therefore, the researcher continued to use this term as it was a familiar term to the participants.

Recovery

From the perspective of the individual with a mental disorder, recovery means: gaining and retaining hope, having an understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self (WHO, 2012).

Recovery Model

The recovery model in an operational sense within a mental health service would be guided by these popular definitions of recovery:

The first, most widely used definition of recovery is described by Anthony (1993) as:

a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness and involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (pp. 11-23.)

Another, more modern definition of recovery is described (Lieberman and Kopelowicz, 2002) as:

full or part-time involvement in work or school; independent living without supervision by informal carers, not fully dependent on financial support from disability insurance; and having friends with whom activities are shared on a regular basis (p. 256).

Deinstitutionalisation

Deinstitutionalisation refers to the depopulation of large psychiatric institutions, which began in the United States and Europe (including Ireland) in the middle to late 20th century. The clearest vision of deinstitutionalisation in Ireland was in *Planning for the Future* (Department of Health, 1984). This governmental report outlined the need and means by which to achieve the transfer of patient care from the asylums to the community, key

recommendations from the report regarding CRFs are discussed in section 1.6.

Institutionalisation

Crane (2019) described institutionalisation as a chronic biopsychosocial state brought on by incarceration and characterised by anxiety, depression, hypervigilance and a disabling combination of social withdrawal and/or aggression. Keman (2017) identified institutionalisation as a process of developing or transforming rules and procedures, that influence a set of human interactions.

Practices of Power

Practices of power in mental health refer to the methods by which mental health professionals exert control over individuals with mental disorders, which can include the use of coercion and involuntary treatment (Svanelöv, 2020).

Vulnerable Group

The term “vulnerable group” or “vulnerable population” is used to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to, as opposed to any inherent weakness or lack of capacity (WHO, 2013).

Custodial Care

The Custodial model of care is described as the “medical model in the community” (Nelson, 2010, p. 126), whereby staff provide assistance with activities of daily living, meals and medication. Rehabilitation is limited and staff retain most of the power, keeping patients dependent (Nelson, 2010).

Supportive Housing

The supportive housing model is usually operated by nonprofit agencies and represents a residential continuum approach, that includes various settings and differing levels of care and supervision (Kyle and Dunn, 2008). This approach groups people with mental disorders together in a residential setting

and involves transitioning through CRFs of high, medium and low support with staff members onsite. The end goal for those who are successful in these transitional settings is permanent, independent housing (Henwood, Stanhope and Padgett, 2011). Moreover, residents often transition to a less restrictive setting before reaching independent living.

Supported Housing

The supported housing model provides permanent housing rented from community landlords through rent supplements (provided by the government), as opposed to accommodation provided by mental health services. Support staff assist people with mental illness to find suitable accommodation, which is the primary intervention before other services are offered. There are no pre-conditions for housing eligibility, such as that residents do not have to comply with psychiatric medication or display substance-use abstinence (Kerman *et al.*, 2018). Furthermore, clinical services and support are provided off-site by interdisciplinary community mental health teams, such as Assertive Community Treatment (ACT) teams and services that are not time limited (Henwood, Stanhope and Padgett, 2011; Padgett *et al.*, 2006). Services are recovery-oriented as people are encouraged to choose their preferred type of accommodation and location, as well as to select the intensity of involvement from mental health services (Aubry, Nelson and Tsemberis, 2015; Sylvestre *et al.*, 2007). Additionally, decision-making is shared by staff and residents and there are no rules and regulations (Wong *et al.*, 2007). The shift of the locus of control from the staff to the residents is considered a distinctive feature of supported housing models.

Chapter 1: Introduction

This chapter will outline and briefly discuss the evolution and history of CRFs, followed by a discussion of the various policy documents that have influenced CRF governance and outcomes. Furthermore, the chapter will briefly discuss the various government reports of CRFs to date. The study's rationale and an overview of the study will then be presented. The chapter will conclude with a summary of the contents of each chapter.

1.1 Brief History

The evolution of Irish mental health services has led to significant reforms, from the opening and closure of asylums to the emphasis on care in the community. These reforms will be briefly outlined below, since an understanding of the history of the provision of accommodation for people with mental disorders provides current day context of CRFs in Ireland.

Between 1825 and 1869, 22 district 'lunatic' asylums were established throughout Ireland, providing over 16,000 beds (Prior, 2003). At least initially, asylums were well resourced, had good success records, achieved quick discharges (Garton, 2009) and emphasised treatment and care (Prior, 2003). Moral therapy (Garton, 2009) was the dominant model of care, which affirmed that confining people without access to employment led to incurability (Garton, 2009; Williamson, 1970). Subsequently, treatment approaches were on patients' social, individual, and purposeful occupational needs. Unfortunately, the humane, functioning asylum system was short-lived and people with mental disorders endured a long history of injustice and mistreatment by the state.

By the mid-19th century (era of confinement), asylums were overcrowded, understaffed and had become expensive to run. This led to greater dependency on incomes received from the labour of patients (Williamson, 1970). Subsequently, asylums used patients' work to generate an income, as either free or cheap labour for the asylum, rather than as therapy to promote

healing (Brennan, 2013). Overcrowding also made it impossible for trained staff to have regular individual contact with patients. As a result, inpatients were often managed by untrained staff (Bartlett, 2017).

Following the demise of moral therapy, individuals with mental disorders in 20th century asylums were subjected to increasingly invasive treatments and continued attempts to control the patient through bodily restraints (Braslow, 1997; Robison *et al.*, 2012). Such interventions included straitjackets, and the Swinging Chair—which involved a slow swing to promote relaxation and relieve insomnia and a high rapid swing used as punishment (Hallaran, 1810). Further unscientific treatments included hydrotherapy baths, which involved placing individuals in a bathtub of hot or cold water for a few hours, up to several days, depending on their level of ‘insanity’ (Harmon, 2009). The serendipitous discovery of a malaria treatment in 1917 to improve “general paralysis of the insane” (Tsay, 2013, p. 245), a side effect of syphilis, termed neurosyphilis, involved injecting malaria into the patient’s body. This was later believed to induce hyperpyrexia to kill the bacteria responsible for dementia in syphilis. This treatment was heralded as revolutionary despite its high number of fatalities (Driver, Gammel and Karnosh, 1926) and led Julius Wagner-Jauregg (psychiatrist) to win a Nobel prize for its discovery in 1927 (Braslow, 1999; Duffell, 2001). The use of deep insulin coma therapy (DICT) also became widespread around the world, following multiple published studies in the Royal Medico-Psychological Association, forerunner to the Royal College of Psychiatrists. An improvement rate of over 88% in the treatment of psychosis in schizophrenia was claimed (Jones, 2000). This hypoglycemic coma or shock to the system was believed to precipitate remission from psychosis, but was complicated by significant neurological side effects, including brain damage and death (Jones, 2000; Kushner, 1999). It was later discredited and fell into disrepute as inhumane and without any scientific basis (Jones, 2000; Pimm, 2014).

These types of physical interventions were cruel and completely overlooked the individual’s emotional and spiritual needs, their stresses, social circumstances, social skills and their relationships with family (Braslow and

Grob, 1998). Each successive treatment was championed by its providers, advanced by the services, then ultimately withdrawn as the realities and limitations became exposed. However, these were only to be replaced by new bodily therapies. Electroconvulsive therapy (ECT), which involved the electrical induction of a controlled seizure (Patriarca *et al.*, 2021), represented a tentative change in perception regarding the role of the asylums, from one solely of confinement to one of a growing scientific awareness (Department of Health, 1966).

The 1940s and 50s saw a critical analysis of mental health care in Ireland, particularly in relation to public perception. Public opinion at this time looked unfavourably on accommodation for people with mental disorders, as the initial emphasis on healing, therapy and cure was lost. In 1961, the Minister for Health appointed the Commission of Inquiry on Mental Illness to report on the mental health services and make recommendations for improvements, which resulted in the *The Report of the Commission of Inquiry on Mental Illness* (Department of Health, 1966). This report was the first mental health policy document to recommend the use of CRFs for the purpose of rehabilitation. It will be discussed in the next section: Guiding Policies of the Irish Mental Health Services (1966-2020).

1.2 Guiding Policies of the Irish Mental Health Services (1966-2020)

1.2.1 *The Report of the Commission of Inquiry on Mental Illness (1966)*

The Report of the Commission of Inquiry on Mental Illness (Department of Health, 1966) was the first policy document to emphasise deinstitutionalization, with the primary objective of reducing the number of inpatient beds from 21,175 to 8,000 by 1981. Asylums had low rates of recovery and discharges and had become not fit for purpose (Torrey and Miller, 2007). Many issues of concern were identified immediately prior to the publication of the 1966 report (Department of Health, 1966) (Table 1.1).

Concerning Issues Identified in Asylums in 1966
Buildings were overcrowded and patients were managed by untrained staff.
Patients were not allowed to have personal possessions.
Patients were expected to retire to bed at 7pm and were required to wear uniform clothing in case they tried to escape or express individuality.
Some male patients were not provided with night attire.
Patients were discouraged from using their own initiative, which inevitably resulted in “patients walking around aimlessly” (p. 51).
Patients had little privacy, there was a widespread culture of locked doors, including toilets, and patients surrounded by high walls and bars with a gatekeeper controlling the gates.
Asylums were noted to be operating in an inefficient manner with poor recovery and discharge rates.

Table 1.1 Highlighting conditions in asylums in 1996

The 1966 report advocated for a complete change in how people in asylums were treated, which included the recommendation of alternative options for accommodation. Therefore, CRFs (formerly known as hostels) were to be established throughout Ireland. However, no implementation plan was formalised between the central and local health services, and these recommendations on paper never materialised into actual achievements (Walsh, 1988).

Although most of the issues highlighted above are less prevalent today, the privacy concern raised persists. For example, several residents in Irish CRFs are still denied permission to lock their bedroom and bathroom doors and some residents must share rooms with other residents, resulting in a lack of privacy (Tedstone-Doherty, Walsh and Moran, 2007). In addition, there are still concerns regarding the ineffective functioning of CRFs, as well as the low recovery and discharge rates as a result of inadequate staffing of rehabilitation teams (MHC, 2018 - 2019). Both issues will be discussed in Chapter two and are also a feature of this study’s findings. However, despite the non-implementation of the recommendations, it remains a testament to

the pioneers in Irish Mental Health policy that the recommendations for CRFs identified in this report remain relevant to contemporary service delivery, as the foundation for progressive, systematic change.

1.2.2 Planning for the Future (1984)

Planning for the Future, published in 1984, followed the *Report of the Commission of Inquiry on Mental Illness* (Department of Health, 1966). The main objective of this report remained the reduction of inpatient admissions, in conjunction with the development of community services, such as CRFs. Despite recommendations for the gradual discharge of patients into the community, vigorous discharges took place to lower the number of in-patients in asylums quickly. In 1985 there were 12,097 patients residing in Irish psychiatric hospitals and by 1990 there were only 7,334 (Moran *et al.*, 1992). Discharges took place without community supports and active rehabilitation programmes in place, and support consisted solely of medication. This resulted in a resettlement programme rather than a deinstitutionalisation programme (Duffy, 2013). Lack of adequate or limited rehabilitation meant places in CRFs became blocked by individuals unable to transition to more independent accommodation (Tedstone-Doherty, Walsh and Moran, 2007).

It is noteworthy to highlight that *The Report of the Commission of Inquiry on Mental Illness*, (Department of Health, 1966) and *Planning for the Future*, (Department of Health, 1984) did not call for the closure of asylums, most likely because the asylum business was lucrative for the medical and legal professions (post moral management). Physicians used asylums to advance their own social status as a profession (psychiatry), increasing their income, power and prestige, later achieving control of psychiatry in general (Brown 2015; Goode, 1960). The asylums also generated significant levels of employment within local communities, similar to a multinational company setting up in rural Ireland today (Brennan, 2013).

1.2.3 A Vision for Change (2006)

With advancements in theoretical understanding and empirical data, the next governmental policy *A Vision for Change* (Department of Health, 2006)

(AVFC) endeavored to resolve the issues highlighted above, by recommending the closure of the asylums and fundamentally switching focus towards a consumer-led service. Its main objectives were to establish a modern legislative framework to facilitate a restructuring of mental health services and promote a multidisciplinary and recovery approach to care, with individualised care planning that considers the individual’s own needs and goals.

This section will briefly discuss recommendations relevant to CRFs outlined in AVFC, including residents’ accommodation needs (Table 1.2), rehabilitation and recovery (Table 1.3) and staff training and evaluation of services (Table 1.4).

Table 1.2 presents recommendations aimed at optimising the accommodation needs of residents.

Recommendations on the Accommodation Needs of Residents
Reduction of the number of CRF places operated by the mental health services, whilst simultaneously increasing accommodation from local housing authorities
Encouragement of integration and coordination between mental health services and the statutory and voluntary housing bodies in catchment areas
Guidelines on the number of high support CRFs required per 100,000 population (three residential units with 10 places each)
Flexible tenancy agreements, which reflect individual needs to be drawn up, allowing for a transition from high support to low support to independent accommodation as recovery progresses

Table 1.2: Recommendations on the accommodation needs of residents (Department of Health, 2006)

While it was admirable that an increased allocation of accommodation from local housing authorities was recommended, unfortunately, no clear process or timelines on how this might be achieved were provided. This resulted in consistent failure to follow through on government recommendations. In addition, flexible tenancy agreements to facilitate transitions, from high

support to medium support to independent accommodation, was another policy makers’ decision which may not fit with residents’ wishes.

Table 1.3 presents recommendations aimed at increasing rehabilitation and recovery outcomes for residents.

Recommendations on Rehabilitation and Recovery
CRFs to be under the remit of 39 national specialist rehabilitation community mental health teams
Specialist rehabilitation and recovery services to develop connections with local statutory and voluntary agencies, as well as support networks, for people with mental disorders
Rehabilitation teams to adopt evidence-based approaches to training and employment for residents of CRFs
Specialist rehabilitation community mental health teams should be located in the same geographical areas as their patients
A member of the team, with the experience equivalent to a clinical nurse manager (grade three), should assume the role of team coordinator; psychiatrists should assume the role of clinical leader; and a clerical officer (grade six or seven) should assume the role of practice manager

Table 1.3 Recommendations on rehabilitation and recovery applicable to residents of CRFs (Department of Health, 2006).

AVFC recommended that CRFs should be under the remit of 39 specialist rehabilitation teams. By 2018 only 51% of CRFs had access to a specialist rehabilitation community mental health team—12 years after the publication of AVFC (MHC, 2018a). This is a significant gap in implementation of recommendations, which raises concerns that government policies are not effectively reaching the residents of CRFs. This highlights a concerning issues, where recommendations to improve the lives of residents in CRFs are not being put into practice, and therefore improvements in the care of these individuals are not achieved.

An additional criticism of the above recommendations (Table 1.3) is that relevant national voluntary support groups, self-help groups and employment

support agencies were not specifically mentioned in the report. These include Mental Health Ireland (<https://www.mentalhealthireland.ie>), Grow (<https://www.grow.ie>), Shine (<https://shine.ie>), Aware (<https://www.aware.ie>), Tuath Housing (<https://tuathhousing.ie>), SOLAS (<https://www.solas.ie>) and the Individual Placement and Support (IPS) services. This omission suggests that these services may not be considered to provide support for people in CRFs. In addition, occupational therapists (OTs) were not considered for key roles such as leadership (given to psychiatrists) or coordination roles (given to clinical nurse managers) within these rehabilitation and recovery teams, despite OTs' professional expertise.

1.2.3.1 Staff Training

AVFC recommended that all staff working within rehabilitation and recovery teams receive training in recovery-oriented competencies and principles.

Planning for the Future (Department of Health, 1984) demonstrated that staff relocating from the asylums to CRFs without additional training resulted in custodial care, leading to the development of bed-blocking and mini-institutions within the community (O'Brien, 2014; Tedstone-Doherty, Walsh and Moran, 2007). In response to this, AVFC recommended recovery-oriented training for staff appointed to rehabilitation services. This was based on the fact that the shift from asylum care to recovery cannot occur if staff responsible for the day-to-day operations of CRFs remain untrained in the principles of modern rehabilitation and recovery. However, a lack of professionals, such as psychologists and OTs, created more difficulty in implementing the recovery model (Lloyd and Williams, 2009; MHC 2018/2019).

1.2.3.2 Evaluation of Services

Evaluation of services is essential for monitoring the quality of care and treatment outcomes, as well as patient/resident satisfaction. It is also required for enabling transparency regarding allocated resources and the efficiency of the services provided (Powell and Rowen, 2022). Table 1.4

presents the recommendations outlined in AVFC on the evaluations of services relevant to CRFs.

AVFC: Recommendations for the Evaluation of Services
CRFs to have individualised care plans reflecting their particular needs, goals and potential, as well as addressing factors that may impede or support recovery.
Evaluation of CRFs should incorporate quality of life measures, as well as feedback from residents and their carers
Objective evaluation and monitoring of admissions, social support networks and community reintegration

Table 1.4: Outline recommendations for the evaluation of CRFs

The recommendations outlined in Table 1.4 are generally ambiguous. They do not specify if care plans should be reviewed weekly, monthly, or annually. Similarly, they do not specify how frequently evaluations of services should be carried out, nor do they specify how evaluations of ‘social supports’ and ‘community reintegration’ should be conducted.

Care plans can be complex and difficult to implement, and the Mental Health Commission (MHC) have repeatedly criticised Irish psychiatric hospitals for failing to implement care plans within acute wards. The MHC is a statutory body established in 2002, as a direct result of the *Mental Health Act (2001)*. One of the functions of the MHC is the development of Codes of Practice to guide those working in mental health services, as well as appointing the Inspector of Mental Health Services, who inspects mental health services annually. If care plans are not being implemented in acute wards, which are regulated by the MHC, it is reasonable to assume that they are not being implemented in CRFs, as medium and low support CRFs are not regulated by the MHC.

Since its inception in 2001, the MHC has consistently reported that service-user involvement in their care has been undervalued and under-used. Evaluation of current practices must provide specific guidance to facilitate

the seamless and efficient implementation of the above-recommended changes. In addition, evaluations of ongoing assessment of practices should be specific enough in their guidance, so that change may come easily and smoothly for the benefit of those living (and working) in CRFs. Individualised care plans will continually change as needs are met/unmet. Therefore, the only way to ensure the care plans can achieve individual goals, is to have a basis for evaluating them within the environment unique to their implementation. Simply recommending evaluation, without addressing how to go about it more usefully, inhibits improvement within the services overall.

The main difference between AVFC and its predecessors was that of allowing for input from people with mental disorders and their families, voluntary and professional groups and service providers. However, the extent of change required within the mental health services in order to meet this goal led to more obstacles than solutions. In fact, the rate of change and implementation was criticised as being slow, inconsistent and haphazard, as a result of recruitment moratoria secondary to budgetary constraints (Féich, 2019; Kelly, 2015). Limited staff training in the recovery model has also negatively affected implementation, with no clear guidelines on how to go about it (Higgins and McGowan, 2014). Apart from the above-mentioned recommendations, AVFC provided little information regarding CRFs — particularly in providing for residents’ well-being and independence (Tedstone-Doherty, Walsh and Moran, 2007).

1.2.4 Sharing the Vision (2020)

Sharing the Vision (2020) is the current policy document governing Irish mental health services. Table 1.5 outlines the recommendations relevant to individuals of CRFs, which are significantly reduced compared to those proposed in AVFC (2006).

CRF recommendations outlined in <i>Sharing the Vision</i> (2020)
Local authorities should liaise with statutory mental health services to include the housing needs of people with complex mental health difficulties as part of their local housing plans.
The Department of Health and the Department of Housing, Planning and Local Government, in consultation with relevant stakeholders, should develop a joint protocol to guide the effective transition of individuals from HSE-supported accommodation to community living.
In conjunction with supports provided by the HSE, including Intensive Recovery Support teams, sustainable resourcing should be in place for tenancy-related/independent living supports for service users with complex mental health difficulties.
The housing design guidelines published by the HSE and the Housing Agency in 2016 to promote independent living and mental health recovery should be a reference point for all housing-related actions in <i>Sharing the Vision</i> .

Table 1.5: Recommendations from *Sharing the Vision* (2020) relating to care of residents in CRFs

The initial recommendation outlined in *Sharing the Vision* (2020), regarding liaising with statutory mental health services on residents' accommodation, appears to be replicated from previous reports. Nonetheless, *Sharing the Vision* was the first national mental health policy document to recommend transitioning individuals from CRFs to independent living in the community. It was also the first to recommend sustainable resourcing, based on the identified need for tenancy-related/independent living supports for residents. Unfortunately, these recommendations are vague and as a result may prove challenging to implement. A further criticism of the report is that *Sharing the Vision* refers people to the Housing Design guidelines published by the Health Service Executive (HSE) and housing agency in 2016, despite these guidelines being mainly aspirational. Recommendations are limited to the appropriate design of housing for people with mental disorders. These include spacing, light, storage, ventilation, and gardens. Given the limited information, ambiguous recommendations regarding CRFs, and references to previously published documents, the emerging impression is that the government does not consider CRF residents an imminent priority.

In addition, Table 1.6 provides a summary of key recommendations for CRFs from 1966 to 2020. It reveals a concerning pattern of non-implementation in successive policy documents, as similar recommendations are repeated in each policy document. If these recommendations were implemented and carried out effectively, there would be no need for repetition.

Role of CRF	Community Measures	Assessments	Staff
<p><i>Report of the Commission of Inquiry on Mental Illness (1966 - 1984)</i></p>	<p><i>Planning for the Future (1984 - 2006)</i></p>	<p><i>A Vision for Change (2006 - 2020)</i></p>	<p><i>Sharing the Vision (2020 - Present)</i></p>
<p><i>CRFs to serve as 'testing ground' for transitioning to independent living.</i></p>	<p><i>High-support CRFs as alternative to long-term hospital care, with the end goal of discharge to lower-support accommodation.</i></p>	<p><i>Flexible tenancy agreements reflect individual needs, allowing individuals to transition from high to low support to independent accommodation as recovery progresses.</i></p>	<p><i>Local authorities should liaise with statutory mental health services to include housing needs of people with complex mental health difficulties as part of their local housing plans.</i></p>

<p><i>Establish community services prior to developing CRFs.</i></p>	<p><i>Rehabilitation and transfer to the community should be gradual, carefully planned and take place over several months.</i></p>	<p><i>Reduce number of CRFs under the mental health services to increase accommodation from local housing authorities.</i></p>	<p><i>In conjunction with supports provided by the HSE, including Intensive Recovery Support teams, sustainable resourcing should be in place for tenancy-related/ independent living supports for service users with complex mental health difficulties.</i></p>
<p><i>Sustain patient links with the outside world and encourage visitors.</i></p>	<p><i>Sector negotiates with local authorities and voluntary organisations to source accommodation.</i></p>	<p><i>Specialist rehabilitation and recovery services develop connections with local statutory and voluntary housing agencies.</i></p>	<p><i>The Department of Health and Department of Housing, Planning and Local Government, in consultation with relevant stakeholders, should develop a joint protocol to guide effective transition of individuals from HSE-supported accommodation to community living.</i></p>

<i>Voluntary organisations (e.g. Mental Health Associations) encouraged to develop closer connections with the mental health services.</i>	<i>Establish good relationships between the health service and local Housing Authorities.</i>	<i>3 high-support CRFs per 100,000 population, with 10 places each.</i>	<i>The housing design guidelines published by the HSE and the Housing Agency in 2016 to promote independent living and mental health recovery should be a reference point for all housing-related actions in Sharing the Vision.</i>
<i>Emphasis on planned, meaningful and purposeful occupation.</i>	<i>Careful selection of patients for resident compatibility.</i>	<i>Accommodation responsibility lies with housing authorities rather than the mental health services.</i>	
	<i>Individualised assessments carried out prior to admission.</i>	<i>CRFs under the remit of specialist rehabilitation community mental health teams.</i>	
	<i>Continuous evaluation of services, goal-oriented individualised care, and family therapy and crisis intervention provided.</i>	<i>Residents should have individualised care plans.</i>	

	<i>Staff from hospitals / asylums to be redeployed to CRFs.</i>	<i>Rehabilitation teams use evidence-based approaches to train and employ residents.</i>	
	<i>The main role of the supervisor is to provide support and reassurance to residents.</i>	<i>Evaluation of CRFs should incorporate quality of life measures and feedback from residents and carers.</i>	
	<i>Mental health nurse acts as the pivotal person involved in rehabilitation, and training syllabus to reflect use of more therapeutic interventions.</i>	<i>The main role of rehabilitation teams was to treat people with severe and enduring mental illness comprehensively in their own homes.</i>	
	<i>Nurses contact local employers to secure employment for high-functioning residents.</i>	<i>All staff appointed to rehabilitation and recovery services receive training in recovery-oriented competencies and principles.</i>	
	<i>Nurses ensure that all residents attend day-care facilities to stay occupied.</i>		

Table 1.6 Provides a comparison of recommendations proposed in all the aforementioned policy documents from 1966 to 2010.

A fundamental issue can be gleaned from Table 1.6, namely that the overall objectives of policy documents are not achieved, thereby consistently failing to improve the lives of CRF residents. It is therefore necessary to identify obstacles to policy implementation and make a concerted effort to overcome them, so that the lives of residents can be greatly improved. The lack of input from CRF residents in terms of research, government reports and policy documents is one of the reasons for this current study. Although service users were included in AVFC and *Sharing the Vision*, there appears to be no evidence of the inclusion of persons residing in CRFs. This study recognises the importance of including the perspectives of residents, which could be an integral piece in understanding the complexities of rehabilitation and recovery in CRFs.

Although reports by the MHC will now be discussed to provide a deeper understanding of the lives of residents, they do not provide the level of understanding necessary to truly comprehend what life is like for residents of CRFs. This is due to the fact that qualitative reporting from residents themselves is lacking. Nonetheless, the reports will serve as a starting point for this exploration into the truth around the treatment and care of residents in CRFs.

1.2.5 Reports on Community Residential Facilities

1.2.5.1 Happy Living Here (2007)

Given the increase in community residential facilities in Ireland since the publication of *Planning for the Future* (Department of Health, 1984), the Health Research Board (HRB) (a state funded research agency) and MHC considered it appropriate to review and evaluate community residences in Ireland and published their findings in a report titled *Happy Living Here* (2007).

Happy Living Here (2007) was published soon after the publication of the current policy document, AVFC. It was the first attempt at a comprehensive study to evaluate community residential facilities for individuals with

enduring mental disorders in Ireland. The methodology used was mainly quantitative and investigated the role and function of CRFs from residents' perspectives, as well as the extent to which rehabilitation and independence had been achieved, considering the expectations laid out in *Planning for the Future* (Department of Health, 1984). Other aspects considered were the appropriateness of accommodation, residents' satisfaction with current services, their interaction with their neighbourhood and environment, and their level of involvement in community activities. In addition, staff members' understanding of the aims and functions of the CRFs was also investigated. Study findings concluded that in general, residents were satisfied with their treatment and care, as well as their accommodation. For example, the majority of residents (65%) reported that they were happy in their current accommodation and 85% of residents stated that they were "quite happy" or "very happy" (p. 94) with the treatment and care they received. Despite the residents' overall satisfaction with treatment and care, the authors identified several failings in the system. These included strict rules and regulations that inhibited autonomy, minimal rehabilitation, and a lack of multidisciplinary input, such as occupational therapy, all of which are similar findings dating back to 1966, highlighted in Table 1.1. It was also noted that CRFs were operating more like "mini-institutions in the community" (p. 8).

While insightful, and the first of its kind in Ireland, *Happy Living Here* had significant limitations. Firstly, its focus on the achievements of CRFs was primarily based on the goals laid out in the governing policy document of 1984. Not only had those guidelines been gradually becoming obsolete, but it meant that the findings of the 2007 study would not be utilised in the creation of the most current document (AVFC, 2006). Secondly, the study did not acquire any data from the entire western seaboard of Ireland, making it less comprehensive than should have been for a national study. Finally, the focus on a quantitative methodology prevented any exploration of residents' perspectives.

1.2.6 Mental Health Commission Reports

The MHC has repeatedly criticised the care provided to residents of CRFs, stating that many 24-hour supervised residences fail to provide optimal recovery and rehabilitation opportunities, and lack multidisciplinary care planning. For example, the 2018a MHC annual report found “serious deficiencies” (MHC, 2019a p. 1) in 43 high support CRFs. Concerns included bedrooms that catered for four people, and 58% having no privacy between beds or within the bedrooms in residences with shared rooms. Moreover, residents were unable to lock their bedroom doors in 77% of residences and 58% of residences had more than 10 bed spaces, which included a combination of single and shared bedrooms. Furthermore, 19% required urgent maintenance and refurbishment. Doors were locked in 14% of CRFs and residents were not allowed to leave as they pleased. There was no access to a kitchen to make tea, coffee or snacks in 44% of CRFs. Only 51% of CRFs had access to a rehabilitation team and only 67% percent of CRFs showed evidence of social inclusion. Also noted was “a serious lack” (p. 1) of accommodation options, as well as trained staff to enable residents to move to more independent accommodation. This resulted in many individuals having to remain in high-support accommodation. In addition, the 2019a annual MHC report revealed that only 43% of CRFs complied with residents’ individual care planning. This occurred despite the MHC publishing a regulation document in 2012, titled *A Guidance Document on 'Individual Care Planning for Mental Health Services'* (2012) This document focused on ways to improve compliance with care plans by assisting staff and mental health service-users in creating care plans that met regulatory requirements.

The above findings represent a disconnect, given that the principles of recovery have been championed in Irish mental health services since 2006. Commenting on the 2018 MHC report, Dr Susan Finnerty (Inspector of Mental Health Services) stated that:

... it is concerning that some of our most vulnerable citizens, many of whom have spent decades in psychiatric hospitals, are now being accommodated in unregulated, poorly maintained residences, that are too big, are institutionalised, restrictive and are not respectful of their privacy, dignity and autonomy (MHC, 2019b, p. 1).

The 2016 MHC report also pointed out that people with mental disorders could not have a recovery-oriented service, unless staff reflected the move from a purely medical model to a more holistic biopsychosocial one (MHC, 2016).

The data informing the reports discussed were acquired through quantitative means. Nonetheless, there is a disconnect between recommendations based on the evidence collected and what practices are implemented based on those recommendations. Moreover, the reports discussed lack direct input from those belonging to the community of individuals with mental disorders, whose lives these reports and policies impact most of all.

1.3 Rationale for the Study

As previously stated, data from the Irish western seaboard were not collected in the 2007 study (*Happy Living Here*). Environment and infrastructure (e.g., employment and recreational opportunities) are important factors in the lives of residents in CRFs. Therefore, failing to include a specific geographical area, especially within a country as small as Ireland, could have negative implications on future Governmental policies and practices. Therefore, this study chose to focus on an urban setting in the West of Ireland, as it has not been included in previous research on CRFs.

The qualitative methodology incorporated into this study is deemed to be more significant than the quantitative methodology utilised. The qualitative data obtained provided a deep understanding into the level of stigmatisation, discrimination, losses and institutionalisation perceived and experienced by residents and not captured by the quantitative measures used. Furthermore, the synergistic benefits of integrating quantitative and qualitative methodologies could improve both the credibility and validity of the findings (Patton, 1999). This integration identifies inconsistencies or discrepancies between the different research methods, as was the case in this study and is discussed in subsequent chapters. Moreover, the mixed-method approach provided a clearer picture of how the overall functionality of CRFs in this

locality affects residents, both as individuals and as a community of residents. This could help mitigate marginalisation by providing policy makers, clinicians, researchers and families with a deeper understanding of residents' needs. Thus, it would allow for the development of a more person-centred approach to care.

Epistemologically, knowledge about the true functionality of CRFs was gained through first-hand accounts of residents' lived experiences, such as those expressed in focus groups. Axiologically, dissecting the mental health services available to this particular demographic provided additional evidence on the influence and input residents have (if any) on specific policies and procedures, meant to rehabilitate or improve their ability to live independently. Finally, ontologically, seeking to understand how CRFs function, as well as the residents' perspective of this, provided an informed view on future research policy changes and practices. A mixed-method study allowed for all aspects of these foundations to be investigated. This study's contribution to practice and policy are elucidated in Chapter ten.

1.4 Subjectivity Statement and Methodology

The motivation for undertaking this study came from an evolving worldview, shaped by the researcher's own lived experience, which is inextricably linked to professional training in occupational therapy. While training as an OT, the researcher had the privilege of working in a number of rehabilitation centres in Belfast and Northern Ireland, towards the end of 'The Troubles', catering to the needs of victims of paramilitary violence. This left an indelible mark on the researcher's perspective of trauma, loss, marginalization, and in particular, injustice. Training in occupational therapy subsequently afforded the researcher the appropriate context and language to advocate for marginalised groups. Moreover, it further fueled a new context, which was one of responsibility to be an agent of change for marginalised / vulnerable individuals.

While working as an OT on a community mental health team in the West of Ireland, the researcher focused her attention on one of the most marginalised

groups within a mental health service: those living within community residential facilities (CRFs) (MHC, 2018). This recovery-based background ultimately motivated undertaking this research, because of frustrating experiences in daily clinical practice under government-operated CRFs in both Northern Ireland and the Republic of Ireland. A recovery ethos was notably deficient in these contexts, or, in some cases, completely absent. This led to a desire to investigate and understand the experiences of those living in CRFs and identify potential avenues for positive change and improvement, in order to enhance their quality of life (QoL).

1.5 Study Overview

The purpose of this study was to illustrate the experiences of those with mental disorders, living within CRFs in an urban setting on the Irish western seaboard. In order to achieve this, the study objectives were to:

- Utilise standard empirical measures to provide baseline data, with which to probe further regarding the overall functionality of CRFs.
- Explore residents' perspectives, experiences and satisfaction with care and treatment within CRFs, through focus group interviewing.
- Examine the data obtained through both quantitative and qualitative methods and guide the implications for future change in the functionality of CRFs.
 - Quantitative data were collected through structured interviews (N=46) that focused on satisfaction with treatment and care.
 - Qualitative data were obtained using phenomenological-inspired focus groups from six individual houses (N=23). Phenomenological underpinnings, such as bridling and reflexivity, description and interpretation, were utilised (Chapter three).

1.6 Layout of the Thesis

Chapter one presents an overview of the evolution of CRFs following policy guidance. The chapter also addresses the rationale for the study and its aims and objectives. Chapter two provides a critical review of the literature on CRF

functionality and recovery-oriented practices. Moreover, it analyses care models that have influenced the provision of treatment in CRFs and discusses key elements of the recovery model, which currently governs CRFs. In addition, the chapter examines numerous housing models, highlighting their distinguishing characteristics, strengths, and weaknesses.

Chapter three presents the study's methodology, an explanatory sequential design, and explicates its philosophical underpinnings. This chapter also explores the context of phenomenological-inspired focus group interviewing and the role of reflexivity in the study. Chapter four provides a detailed discussion of the study's sampling and data collection. In addition, the chapter outlines the approaches to data analysis.

Chapter five presents an integrated summary of the study findings, focusing on four main themes which are presented in detail, in the context of the literature, in chapters six to nine. Chapter six presents the findings from the main theme 'Lack of Recovery'. Chapter seven presents the findings from the main theme 'Stigmatisation and Discrimination'. In addition, the chapter highlights the impact of stigmatisation and discrimination on the lives of residents, emphasising the need for greater awareness, understanding and rectification of these issues in mental health care. Chapter eight presents a critical discussion of the findings from the main theme 'Loss', as described by residents in the context of loss of normal life and loss of hope. Chapter nine presents the findings of the main theme 'Institutionalisation', in the context of the literature. Chapter ten provides an overview of the study's key findings, followed by recommendations for practice, policy and future research, as well as a discussion around the strengths and limitations of the research.

Chapter 2: Literature Review

2.1 Introduction to Literature Review

The purpose of this literature review is to identify what is already known about community residential facilities (CRFs), with regard to functionality, recovery-oriented practices and residents' overall satisfaction with treatment and care. By identifying the methodologies used in prior studies surrounding this research topic, the current study aims to bridge the gap between which of these elements has been identified; how they came to be identified; and how to best approach or influence positive change within CRF models utilising that information. Furthermore, the topic of oppressive practices within greater society is addressed throughout this review, in order to highlight the cyclical nature of dependency on CRFs, by people with mental disorders. With a primary focus on methodology, a critical analysis of existing literature has been central in the context of this study's research question:

What are the experiences of those living with mental disorders in community residential facilities in an urban setting on the Irish Western Seaboard?

The literature review process involved searching electronic databases. Moreover, the snowball technique was utilised to search through lists of references within sourced journal articles, reports, dissertations and books for other relevant literature. In addition, manual searches of the Galway University Hospital library were undertaken, in order to identify local reports on the current topic.

Electronic databases were searched throughout September 2011 to April 2023 to identify relevant literature. The following databases were searched: Academic Search Premier, PsycINFO (OVID), CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE, Wiley Online Library, Cochrane Library, Web of Science, Scopus and Lenus. In addition, searches were conducted on Google scholar and international and national government websites, such as the MHC of Canada, United Kingdom and Ireland.

The search terms used were: recovery OR recovery-oriented care; recovery AND mental health policy; recovery model and schizophrenia; community residences; mental health AND community residential facilities; mental health AND supportive housing; mental health AND supported housing; mental health AND custodial housing; mental health AND housing first; psychiatry AND asylum; schizophrenia AND asylum; residential care AND mental health; residential care and schizophrenia; (community residential facilities AND mental health) NOT forensic; (community residential facilities AND schizophrenia) NOT learning disability; (community residential facilities AND mental health) NOT dementia (quality of life AND schizophrenia) AND community residential facilities; Irish mental health reports AND recovery; schizophrenia AND unemployment; schizophrenia AND employment, (mental disorders AND community residential facilities) NOT dementia; and, experiences of people living in community residential facilities.

In keeping with professional standards, the Critical Appraisal Skills Programme (CASP) was used to critique both quantitative and qualitative studies (<http://www.casp-uk.net/checklists>).

The CASP system was initially developed in response to the need for developing skills in health care staff, to meet the challenge of evidence-based medicine. The approach to the critical analysis of this literature is guided by professional practice philosophy, which is firmly rooted within the recovery model (Brown, 2012). With CASP, there is no cut-off score to differentiate high- or low-quality studies, and the CASP system was only used to inform the narrative description of the literature review.

2.2 Inclusion / Exclusion Criteria

Inclusion and exclusion criteria were used to select relevant studies for inclusion in the literature review.

Studies were included if they were:

- published within the last ten years with additional seminal works;

- included participants living in mental health community residential facilities (CRFs) only; and,
- included participants living in mental health CRFs between 18 and 65 years of age.

Studies were excluded if they were:

- published in languages other than English;
- included participants residing in nursing home residential facilities, forensic residential facilities, learning disability residential facilities or acute mental health hospital settings; and,
- include participants under the age of 18 or over the age of 65.

Themes generated from the literature reviewed are outlined in Table 2.1. As suggested by Ridley (2008), this literature review is divided into themes and offers a discussion of relevant theories and concepts which underpin the research (Oermann and Floyd, 2002).

Main themes	Sub-themes
Models of Care	Custodial Model of Care Biomedical Model of Care Recovery Model
Housing Models	Custodial Housing Supportive Housing Supported Housing Recommended Housing
Experiences of People Living in CRFs	QoL Stigma Medication Side Effects Unemployment Limited Rehabilitation

Table 2.1 Main themes and sub-themes of the literature review

2.3 Models of Care

This section will begin by briefly discussing how various models/approaches to mental health care have evolved, due to influential methodological approaches. Relevance was determined by the trends which guided similar

methodological approaches in previous studies which the current study sought to improve upon, namely by utilising a mixed-method approach.

The current accepted best practice and firmly established approach is the recovery model (Jacob, 2015; Piat *et al.*, 2022; Sofouli *et al.*, 2022; Stein *et al.*, 2022), which guides mental health clinical practice in Ireland (Department of Health, 2006; Sharing the Vision, 2020). At the time of the study, there was no consistent, universally accepted definition for ‘model of care’. This incited Davidson *et al.* (2006a) to propose that a model of care was a multidimensional concept that defined the way in which health care services were delivered.

For the purposes of this study, the following definition has been used:

...a Model of Care outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place. (Agency for Clinical Innovation, 2013).

Historically, mental health service care delivery has reflected societal norms and attitudes (Kelly, 2016), as seen in the initial establishment of institutions that offered literal ‘asylum’ and refuge to people with mental disorders. Three main models of care have evolved over time, based on such societal influences: custodial, biomedical and recovery. Each of these models reflected the attitudes of not only society, but of the mental health professionals responsible for service provision at the time. Such attitudes will be detailed in the description of each model below.

2.3.1 Custodial Model of Care

The traditional asylums of the past represented the first model of care. This custodial approach led to overcrowded, unhygienic conditions and often resulted in fatalities, due to government neglect and inhumane practices (Kelly, 2016). Overcrowding made it impossible for trained staff to have regular individual contact with patients, which ultimately led to the practice of custodial care as it has come to be known today (Bartlett, 2017).

The model of custodial care offered basic care such as shelter and food (Raeburn, Bradshaw and Cleary, 2023; Rosenblatt, 1975). Criticisms of this model included a lack of rehabilitation, the fostering of dependency, and encouragement of the person to become a passive recipient of their own care (Drew *et al.*, 2011). The implications of this model of care were evidenced by the emerging signs of institutionalisation in the person. Institutionalisation can cause individuals to lose their confidence in making decisions, it can also cause loss of normal role functioning and exclusion from family and community roles, which can affect both the physical and psychological well-being of an individual (Crane, 2019; Verma, Chaudhury and Patkar, 2017). The Community Support and Research Unit in Toronto published a report in 2012 entitled *From This Point Forward: Ending Custodial Housing for People with Mental Illness in Canada*, which cited the violation of human rights as one of the main reasons for the dismantlement of this model.

Supporting evidence in the literature identified that the transfer from asylums to CRFs was somewhat successful, in that it increased independence and improved individuals' QoL (Trieman *et al.*, 1998). However, full independent living and integration into the community was rarely achieved, given the overarching persistence of custodial care rather than rehabilitative care (Tedstone-Doherty, Walsh and Moran, 2007). Staff received little, if any, formal training in rehabilitation when re-deployed from asylums to the new community settings. As a result, CRFs quickly became overcrowded and gridlocked and were even deemed 'mini institutions' (Friesinger *et al.*, 2019; Tedstone-Doherty, Walsh and Moran, 2007). Lack of government leadership, and a failure to adequately resource and deliver a national rehabilitation-focused service, significantly compromised the success of the CRFs (MHC, 2018). Furthermore, a shift in focus from the physical setting in which care was being implemented to the internalised symptomatology of individual patients, which would seemingly require a more medical-minded approach, appeared to influence the next model of care which was to be introduced.

2.3.2 Biomedical Model of Care

Compounding the above matters was the assumption, by primarily medical practitioners, that all diseases (both mental and physical) represented a pathological biological state, which could be fully accounted for by deviations in measurable physical variables (Engel, 1977). This ‘biomedical model’ viewed people with disabilities, (including those with mental health disorders) as having a biological dysfunction that required medical expertise to reduce or eliminate negative biological symptoms (Dewa *et al.*, 2015; Lattuada, 2022; Thompson, 2016). While the treatment of bodily parts may have alleviated some physical symptoms, it did little to address the source of the problem (Rocca and Anjum, 2020). Prior to the publication of AVFC (2006), mental health service delivery in Ireland mostly adopted the biomedical approach (Swords and Houston, 2020).

Engel (1977) criticised the medical model for displaying a restricted understanding of mental distress, which neglected the adverse impact of psychological and social variables. This model is further criticised in the literature for its hierarchical structure, in which decisions and opinions made by the doctor are widely unchallenged, effectively dismissing and disempowering patients in their own recovery as they were not included in decisions around their own care (Forrest, 2014; Gould, 2022; Gutkin, 2012). The medical model viewed the person as not having any responsibility or control over their symptoms or illness, potentially exacerbating the effects of institutionalisation. In fact, it has been highly criticised by people with disabilities, who believe that societal factors such as prejudice, discrimination and exclusion from full involvement and participation in society play a bigger role in restricting people with disabilities than their own impairments (Goering, 2015; Lawson and Beckett, 2021; McTigue, 2015). The medical model also assumes that any difficulties encountered by people with disabilities are independent of external environments (Blustein, 2012).

Over a series of influential papers (1960-1980), Engel argued that a new model must be conceptualised, one that considered these aspects of the individual’s subjective distress. He termed this model the ‘biopsychosocial’

model, and it quickly came to dominate healthcare delivery internationally (Borrell-Carriô, Suchman and Epstein 2004; Pilgrim, 2002; Wade and Halligan, 2017). In contrast to the medical model, the biopsychosocial model suggested that interactions between genetic make-up (biology), mental health and personality (psychology), and social-cultural environment (social world) contributed to the experience of overall health or illness (Taukeni, 2020). One of the aims of the biopsychosocial model was to improve upon the traditional biomedical model (Engel, 1977; Petasis, 2019). This was to be achieved by integrating the supposed elements which contributed to illness into the experiences of those seeking care.

However, Freudenreich, Kontos and Querques (2010) pointed out that this model did not indicate which element of analysis (biological, psychological, or social) to prioritise. Further criticisms included the questioning of its clinical validity (Richter, 1999), a lack of evidence base due to vague definitional testability and consequent poor implementability (Benning, 2015; Richter, 1999; Roberts, 2023). It was hoped that the biopsychosocial approach would lead to better communication between patients and the medical profession, but it has been heavily criticised in the literature for continuing to remain doctor-focused and insensitive to patients' subjective experiences (Farre and Rapley, 2017). When government and social policy "are based on medicalised individual models – of disability and 'mental illness' [...] both can be seen to be essentially unhelpful in terms of key government concerns with social inclusion and user involvement and partnership." Beresford, Harrison and Wilson (2002 p. 392). This further evidences that there is no room for input which might influence progressive policies to support those with mental disorders, who are trying to function independently, while still receiving medically appropriate treatment.

A more humanistic approach to the care of people with mental disorders evolved over time, partly as a result of widespread discontent with the previous traditional models of care, and partly because the civil rights movement empowered people to raise their voices and disclose their own personal stories of recovery. This led to the beginning of the modern recovery

model, where both the patient and mental health professionals were encouraged to engage in a shared journey of recovery (Department of Health, 2006; *Sharing the Vision*, 2020)

2.3.3 Recovery Model

This section will begin with a brief history of the development of the recovery model, including its relationship to human rights. Thereafter, key tenets of the model and progress with implementation will be discussed. A solid understanding of the recovery model is necessary, as it is the theoretical framework underpinning CRFs via the current policy documents i.e., AVFC (2006) and *Sharing the Vision* (2020).

Some authors argue that recovery has been in place since the introduction of community treatments, such as outpatient clinics in the 1970s (McCranie, 2010). However, this argument is questionable given the prevalence of the use of chlorpromazine during that time (Mellman *et al.*, 2001). According to Anthony (1993, p. 527), recovery in the mental health context refers to the process of “changing one's attitudes, values, feelings, goals, skills and or roles” in order to live a satisfying life within the limitations caused by illness. Therefore, since recovery is an ongoing process by its very nature, and with many facets to it, it is incorrect to assume pharmacological practices could solely aid in achieving all the goals set out in a recovery-oriented care plan. Therefore, medicating people with serious mental disorders and placing them in the community without any additional supports (Department of Health, 1984) does not, in fact, constitute recovery and can result in the infringement of their human rights (MHC, 2018; MHC, 2019; MHC, 2020).

From medieval times to the advent and subsequent closure of the asylums, it has long been recognised that the human rights of individuals with mental health disorders have been undermined and violated (Drew *et al.*, 2011; Mfoafo-M'Carthy and Huls, 2014). They face discrimination and barriers that restrict them from participating in society on an equal basis with others, and they are often denied the opportunity to be included in the workplace, to live independently in the community, to vote, to participate in activities, or to have

input into their own medical treatment and care (Subramaniam *et al.*, 2022; United Nations, 2018). These findings are supported in the literature and are a reality for residents of Irish CRFs, as highlighted by Tedstone-Doherty, Walsh and Moran (2007) and the MHC (2018), who recorded a series of human rights breaches for residents in CRFs (as discussed in Chapter one).

Given the mistreatment of people with mental disorders, the *United Nations Declaration of Human Rights* (1948) established the universal foundational rights of dignity, equality and liberty, and contextualised such rights with specific reference to persons with mental disorders and disabilities. A significant aim of the Recovery movement was to restore the human rights of people with mental health disorders (Australian Government Department of Health, 2013; WHO, 2019b), by encouraging and empowering them to engage and have agency over their own health and recovery.

By the early 2000s, recovery had become central to mental health discourse and policy worldwide, leading to its now internationally accepted status as best practice (Barker and Buchanan-Barker, 2011; Davidson, 2005; O'Hagan, Reynolds and Smith, 2012; Pilgrim, 2008; Ramon, Healy and Renouf, 2007; WHO 2021b). In Ireland, the MHC established a committee in 2004 to consider how Irish mental health services could incorporate the recovery model into a national service. The outcome resulted in a number of government documents describing how to incorporate recovery into the mental health services. In addition, Mental Health Reform (MHR), Ireland's leading national coalition on mental health founded in 2006, highlighted their main aim as driving progressive reform of Irish mental health services and ensuring that the human rights of people with mental disorders were respected. They are adamant that the recovery approach better recognises an individual's rights and ensures that those rights are safeguarded, upheld, and fulfilled (McDaid, 2013). *Sharing the Vision* (2020) further commands person-centred and rights-based approaches to care, in order to safeguard the human rights of individuals with mental health disorders.

A recent publication by the Health Service Executive in Ireland identified five key themes associated with recovery and a recovery-oriented service (Health Service Executive, 2017). These themes are: Connectedness, Hope, Identity, Meaningful Role and Empowerment, which form the current ‘CHIME’ model. Taken from a systematic review by Leamy *et al.* (2011), the CHIME themes were deemed integral to recovery. The current study regards these themes semantically in that, despite the specific words chosen to describe these elements, the underlying principles are the same. In order to get a better understanding of how the recovery model reflects a more holistic approach for people with mental disorders, the key elements utilised in the current study will now be discussed individually. This is done to further highlight the guiding principles and proposed mechanisms of their action on the recovery model as a whole.

2.3.3.1 Key Elements of the Recovery Model

Self-responsibility

Self-responsibility requires taking responsibility for one's own recovery (Bonney and Stickley, 2008). For the many mental health systems that remain centred around the aforementioned medical model, the obvious symptoms of illness are placed firmly in the centre of treatment, rather than in the person (in a holistic sense). The rationale for this suggests relief of the symptoms as the solution, since the symptoms themselves appear to be the essence of the problem (Ragins, 2003).

In contrast to the above, the recovery model emphasises the opposite, by placing the person at the centre of treatment in a holistic manner—with the belief that individuals can give the best insight into their unique needs and life goals (Health Service Executive, 2017).

However, negative attitudes from mental health professionals towards people with mental disorders may be a barrier to encouraging people to be self-responsible for their own health. For example, Lester *et al.* (2003) explored satisfaction with primary care in people with schizophrenia. Results indicated that 54% of study participants felt that their general practitioners viewed

schizophrenia as “an incurable life sentence” (p. 508). A later study by Thornicroft *et al.* (2009) offered a similar, and somewhat concerning view, in which mental health professionals believed recovery from mental disorders is impossible. In addition, a recent Australian study by Sreeram Cross and Townsin (2022), investigating the effectiveness of anti-stigma initiatives in healthcare professionals, found in their systematic review that mental health professionals continue to hold pessimistic attitudes towards those with mental disorders. This is despite a growing emphasis on stigma and its detrimental effect on recovery.

Notably, only eight papers out of 439 met the inclusion criteria, which may impact the generalisability of the findings and limit conclusions that can be drawn. Nonetheless, an additional recent qualitative study by Chang *et al.* (2021), exploring professional perspectives on providing recovery-oriented care (n=14), supports the aforementioned findings. These authors also found that some staff remain sceptical about recovery and continue to be of the opinion that people with mental disorders are not capable of taking responsibility for their own health and making decision regarding their own care. This belief is based on the fact that health professionals are concerned and fearful of the potential risks that come with granting more autonomy to people with mental disorders.

It can be argued that these negative attitudes towards recovery flourished as a direct result of the biomedical model. However, the WHO may also be partly to blame following the publication of the International Pilot Study of Schizophrenia in 1974, where they reported that 75% of people with schizophrenia would never fully recover (WHO, 1973). This outdated information may have permeated clinical understanding of this disorder in psychiatry ever since. Moreover, it could possibly have resulted in feelings of hopelessness, leading individuals to believe that they are incapable of taking on a greater role in the responsibility of their own health, which may well lead to poorer outcomes and QoL.

These negative attitudes held by mental healthcare staff are prevalent on a global scale in health care settings (WHO, 2022b). Moreover, these may play a causative role in the lack of progress with regard to implementation of the recovery model, which has been criticised in the literature (Slade, Adams and O'Hagan, 2012). A possible solution to this, as highlighted by Pincus *et al.* (2016), is to provide education around recovery for all stakeholders, including the public at large, in order to achieve an overall culture change in how mental health services are developed. Slade, Adams and O'Hagan (2012), in agreement with Pincus *et al.* (2016), further formulated that a complete transition to a recovery-based mental health service could only occur once society publicly acknowledged the harm caused by the above-mentioned traditional models of care.

If mental health settings were implementing recovery-based methods, it would be apparent in the ability of service-users to continue progressing successfully as a member of society, without having to be brought back into those services. As there is always potential for more challenging obstacles to occur once left to their own devices (e.g., relapses after having come off medication), the inclusion of an educated society or community on offering support could be the difference between addressing the issue productively or simply sending a person back to the beginning of a life in the mental health system. This would entail facilitating an “evidence-based approach to recovery” (Health Service Executive, 2017) within a mental health service, in order to increase the likelihood of recovery occurring. While the concept of self-responsibility requires recognition and effort from the person utilising the mental health services in order to be effective, one area that is greatly reliant on staff facilitation is that of instilling hope.

Hope

Hope and optimism regarding the future are central concepts to recovery (Jacob, 2015). Moreover, hope is a healing force that promotes well-being and allows people to identify achievable goals and believe in the possibility of leading a satisfying life (Cripps and Hood, 2020; Deegan, 1996; Holdcraft and Williamson, 1991; Snyder *et al.* 2003).

Studies have indicated that individuals with a diagnosis of schizophrenia who have hope, experience increased QoL and decreased hospital admission (Hasson-Ohayon *et al.*, 2009; Lysaker *et al.*, 2005). However, Hasson-Ohayon *et al.* found that hope was negatively correlated with insight, in that people who reported more general awareness of their mental disorder tended to express less hope, resulting in a lower QoL. This understanding could be integral not only in how their expression of hope is influenced, but also in how their perceived situations within a mental health system are impacting their overall feelings of optimism.

Regardless, the literature is inconclusive on how insight, self-stigmatisation and hope interact with one another. Dewedar *et al.* (2018) concluded that there was a negative correlation between hope and self-stigmatisation. Therefore, hope was determined by the person's self-attitude. For example, a person may be living in a CRF, experiencing debilitating symptoms and still have hope if they are not self-stigmatising. In contrast, another person living in the same environment may be symptom-free but self-stigmatising, resulting in less hope. Higher validity of this correlation could have been achieved if participants' subjective thoughts and experiences around hope and QoL had been collated in the above studies and analysed with qualitative analytical techniques. To merely acknowledge severity of symptoms and whether self-stigmatising attitudes were present does not account for environmental influences (e.g., attitudes of staff/doctors, CRF policies and procedures, experiences with the outside community) that might add to the levels of hope being expressed.

When addressing the key tenet of hope in individuals living in CRFs, under the lens of the recovery model, it is important to address the presence and degree of self-stigmatisation, as this could inhibit the potential for staff to adequately instil hope (Coşkun and Altun, 2018). Furthermore, if staff are not taking opportunities to encourage a life beyond the CRF (or other mental health facility), then self-stigmatisation is likely to increase, and hopefulness towards living independently in society likely to decrease. Hopelessness in

schizophrenia can lead to challenges, such as the inability for a person to feel empowered in terms of their recovery (Kruger, 2000), higher alcohol consumption (Hunt *et al.*, 2018) and higher rates of physical health conditions (Fortuna *et al.*, 2020). Under this model, recovery is only achievable when hope results in empowerment. Fortuna *et al.* (2020) found that having a diagnosis of a serious mental disorder is significantly associated with self-reported hopelessness.

Empowerment

In a comprehensive statement by the WHO Regional Office for Europe, entitled *User empowerment in mental health* (2010), empowerment for the individual is defined as “the process of taking control and responsibility for actions that have the intent and potential to lead to fulfilment of capacity [which means] overcoming a state of powerlessness and gaining control of one’s life” (p. 1). Lee *et al.* (2021) define empowerment as the promotion of patient autonomy, autonomous decision-making, and personal responsibility for one's health.

Empowerment is an appropriate treatment goal for people with enduring mental disorders (Lee *et al.*, 2021; Tolman and Kurtz, 2012), as they can often struggle to maintain personal power. Studies have demonstrated that empowering individuals diagnosed with schizophrenia can lead to reduced hospital admissions, increased self-esteem and social and community functioning, as well as the ability to better manage their symptoms (Corrigan, 2002; Tjaden *et al.*, 2021). Moreover, it is argued that that people with mental disorders often need other people to believe in them and to convince them to believe in themselves, by encouraging them to focus on their strengths rather than their weaknesses (Ragins, 2003). Having a mentor or coach in the recovery process can empower them to take control of their own treatment and recovery (Cano Prieto, Simó Algado and Prat Vigué, 2022; Mead and Copeland, 2000).

A qualitative study (Piat, Seida and Padgett, 2020) found that a major contributor to the mental health and wellbeing of people with severe mental

disorders living in supported housing was the opportunity to have a choice in the various elements involved in their housing. More specifically, the type of housing did not matter as much as choosing what was in their day-to-day activities and the general environment of their living space, that would make them “feel at home” (Piat, Seida and Padgett, 2020). In addition, a systematic review of qualitative studies highlighted that the process of making a home went hand-in-hand with recovery, having the potential to influence self-control and building one’s identity in a similar manner for anyone moving into their own home for the first time (Krotofil, McPherson and Killaspy, 2018). Empowering individuals with mental disorders is emphasised through therapeutic relationships between people with mental disorders and mental health professionals. Clinicians are encouraged to use their professional skills and knowledge in a coaching or personal trainer-like fashion, while assisting/empowering the person on their recovery journey (Cano Prieto, Simó Algado and Prat Vigué, 2022; Collins *et al.*, 2016).

Unfortunately, Schön, Denhov and Topor (2009) reported that two-thirds (N=58) of participants in their study described encounters with mental health professionals as detrimental to their recovery. ‘Negative’ interactions were described as professional staff showing no personal interest or involvement in the patient beyond their diagnosis. On the contrary, the staff who were described as ‘helpful’ aided the person in identifying what was important to them and showed a genuine interest in their personal experiences. This finding supports an approach whereby mental health professionals have the ability to influence patient overall experiences and outcomes, and ultimately decide how big or small of a role they play in their recovery. Further evidence of this is reported by Bacha, Hanley and Winter (2019), who described similar negative interactions between patients and mental health staff in the U.K. Participants in their qualitative study described feeling that staff did not treat them with respect and likened it to the treatment of animals or children which, in turn, only heightened their distress. Disempowerment and dehumanisation in the mental health service were dominant themes emerging from their research. They concluded that awareness of power has the potential to help practitioners reflect upon the tensions they experience in their

relationships with service users, which can improve how individuals perceive the quality of care being provided to them.

Lack of general knowledge and training in implementing the recovery model poses another challenge to mental health professionals. A study by Cleary and Dowling (2009) investigated the knowledge and attitudes on recovery of mental health professionals in Ireland (N=130), using the Recovery Knowledge Inventory (RKI) and found that only 23% had received training in recovery. Five years later, Gaffey, Evans and Walsh (2016) decided to monitor the progress of health care professionals, with regard to recovery knowledge and attitudes, by repeating the original Cleary and Dowling study. They found that the knowledge and attitudes of health care professionals remained relatively the same, despite the fact that 40% of professionals had since received training in recovery. A possible reason for this could be that recovery training was not sustained over a long period of time (Gaffey, Evans and Walsh, 2016).

Of the 20 doctors who participated in the Cleary and Dowling study (2009), only five were psychiatrists. As mental health is at the heart of recovery in patients with mental disorders, perhaps a more comprehensive look at the recovery knowledge among a wider population of psychiatrists could better validate the effects that lack of training/knowledge have on adequate implementation of the recovery model. The subsequent study by Gaffey, Evans and Walsh (2016) proved to have equally poor representation from appropriate disciplines, such as psychiatry and occupational therapy. Furthermore, by including staff working within the CRF system, as they have the most contact with people with enduring mental disorders, these studies could have allowed for a far more integrated and insightful perspective.

This lack of consistent knowledge on the recovery model, by both staff and professionals directly responsible for the recovery of individuals in their care, may be attributable to the lack of facility with which to implement such knowledge (i.e., regulated, mandatory training). However, with regard to the area of empowerment, as staff and professionals obviously take the lead in

decision-making for those individuals in care, it could be argued that if their level of input has the potential to be threatened/diminished, there could be an unwillingness to not only seek proper knowledge/training in the recovery model, but to also adhere to its implementation. As long as a ‘struggle for power’ exists in any capacity between staff, professionals, and individuals within the mental health services, attention cannot be given to proper recovery.

These implications of reluctance to encourage empowerment of individuals with mental health disorders can be extended into the practices within greater society. “What is called into question about us; the very basis of our collectivity, is the instrument by which we seek to develop our own discourse and critiques – our minds and thoughts” (Beresford, Harrison and Wilson, 2002, p. 582). When those responsible for creating mental health service policies do not have confidence in the ability of its users to cognitively understand what might be in their own best interest, decisions are made solely from the perspective of an observer. This excludes those who have experienced either mental disorders or the conditions of living within a CRF. QoL for individuals with mental disorders (especially those living under the guidance of the mental health services) is, therefore, determined by those staff and professionals. What they deem as sufficient for a ‘full and happy life’ does not necessarily include any aspect of what the individual might feel would add to their livelihood.

Meaningful Life

The recovery model emphasises building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms. Many people with enduring mental disorders lead isolating lives and have difficulty building and sustaining a meaningful and satisfying life, including finding and maintaining employment (Brouwers, 2020; Jacob, 2015; Stuart, 2008). There is a growing body of evidence to suggest that being valued by society and having an identity by participating in education, training, volunteering or engaging in employment opportunities could yield greater outcomes for recovery, self-esteem and QoL in general

(Baxter, Burton and Fancourt, 2022; Bonney and Stickley, 2008; Doroud, Fossey and Fortune, 2015; Drake and Whitley, 2014; Hine, Maybery and Goodyear, 2019). In other words, the recovery model supports the view that people with mental disorders should live their lives to the best of their ability and look beyond survival and existence. It is a journey rather than a destination, nevertheless, some professionals continue to equate ‘recovery’ from mental disorders with ‘cure’ (Jacob, 2015). The issue with interchanging these terms is associated with expectations assigned to those terms individually. ‘Recovery’ provides malleable and ongoing goals for both the patient and the mental health professionals, as the many variables contributing to their overall QoL change regularly. ‘Cure’ denotes finality and may have the potential to lead both the patient and the mental health professional into a plateau, whereby progress can become stagnant with a ‘finite goal’ that is never actually achieved.

The importance of finding the right tools and resources, for an individual with mental disorders to be able to live their life to the degree which brings the most satisfaction and meaning, is at the heart of this tenet under the recovery model. While the diagnosis may always be a part of the person’s identity, it does not have to be central to everything they do. Allowing this ebb and flow to happen within an individual’s daily life provides an ideal opportunity for the person to achieve a higher QoL, while still continually working with their individual limitations.

2.3.3.2 Criticisms of the Recovery Model

As with many approaches and treatment models, the recovery model has been met with some criticism. This may well have influenced its implementation, and will as such now be discussed in relation to its application within a CRF setting.

There is a view that many mental health services have difficulty moving away from traditional models of care (Slade, Adams and O’Hagan 2012; Clarke *et al.*, 2020; Chang *et al.*, 2021). This could be because mental health services have always been “hierarchical in nature” (Gergerich, Boland and Scott,

2019; p.529), which may be why some mental health professionals are of the opinion that recovery-orientated care devalues their knowledge, qualifications and role in treatment (Piat and Lal, 2012). However, Ørjasæter and Almvik (2022, p.400) noted that although recovery approaches emphasise placing patients “in the driver’s seat” of their own treatment and care, mental health professionals should not abdicate all responsibility, or fail to use their expertise to guide patients.

Shepherd, Boardman and Slade, (2008) posed that any such feelings, of one’s professional role being devalued by the recovery model, could be minimised by utilising appropriate strategies on intervention delivery. Therefore, the recovery approach should not be viewed as a threat by mental health professionals and should instead be used as a complementary approach to improve outcomes for people with mental disorders. In doing so, mental health professionals can maintain their clinical expertise, while also empowering patients. In addition, it is argued that joint recovery training for both the patient and healthcare professional would likely benefit both relationships (Salkeld, Wagstaff and Tew, 2013). This approach has merit, as it promotes collaboration and better understanding from both sides.

In contrast to Piat and Lal (2012), Davidson *et al.* (2006b) suggested that the recovery model should align with the profession of psychiatry more closely than with other medical specialties (i.e. cardiologists and oncologists). They maintain that this could be done by allowing psychiatrists to assess, diagnose and educate individuals on their condition and effective interventions, prior to receiving informed consent and permission to provide treatment. By separating what a medical professional is responsible for treating and what their patient feels about the treatment plan, psychiatrists might adopt a less threatened stance with regard to the patient essentially ‘taking over’.

Additional criticisms of the recovery model are highlighted by Pilgram and McGanie (2013), who concluded that the recovery model suffers from terms that are scientifically difficult to quantify, such as ‘individualised’, ‘shared journey’, ‘personal identity’, ‘empowerment’ and ‘satisfying life’—

indicating that the concept of recovery does not have a one-dimensional meaning. A similar thread can be seen in research by Chester *et al.* (2016), where they suggested that recovery can be viewed as a socially constructed conception influenced by the person's epistemological position. While this is not necessarily disputed, the notion that recovery is as individual as the person opens up potential for identifying a broad spectrum of meaning surrounding the model and its implementation. Instead of trying to quantify the terms associated with this model, research should focus on identifying common qualitative features that give evidence for its effectiveness. This, in turn, could lead to more standardised ways to measure these inherently qualitative elements of the recovery model, making it easier to research and validate its application.

Pilgram and McGanie (2013) further highlighted the additional burden on patients expected to recover and asked what became of those who did not 'launch' into recovery. In agreement, Munetz and Frese, (2001) and Garverich *et al.* (2021) further added that patients with a higher level of cognitive functioning and a greater level of insight could advocate for themselves. Thus, these patients consequently fared better in a recovery-oriented service, than those who did not possess these strengths. When it comes to those responsible for the policies guiding mental health services and practices, there is a question of which 'category' of patients are prioritised when considering policy. This would include those who possess the strengths mentioned to be able to advocate for themselves (and thus, appear to achieve recovery goals more quickly/easily) or those whose other underlying conditions or circumstances inhibit them from benefitting from an under-resourced service.

A further criticism or limitation of recovery approaches to care, identified by Vera San Juan *et al.*'s (2021) systematic review (62 studies) on recovery from severe mental disorders from the perspective of service users and informal caregivers, found that only a small number of studies included the perspectives of caregivers. The findings from this research therefore identifies a gap in the understanding of recovery approaches to care, from

informal caregivers such as family members. This is unfortunate, as understanding the recovery process of people with serious mental disorders remains a challenge (Garverich *et al.*, 2021). Therefore, feedback from family members could improve the understanding of the recovery process, identify potential barriers or facilitators to recovery. It could also inform policy and guidelines on how best to implement recovery orientated care in a way that best meets the needs of both individuals and their family members.

Slade, Adams and O'Hagan (2012) concluded that a complete transition to a recovery-based mental health service can only occur if society has publicly acknowledged the harm caused by traditional models of care. Although the medical model was not specifically mentioned, it possibly should be included in this critique, as it holds negative perceptions of disability and labels are used to emphasise deficits and incompetence (Haegele and Hodge, 2016). Similarly, Pincus *et al.* (2016) highlighted the significance of education around recovery for all stakeholders, including the public at large, in order to achieve an overall culture shift in how mental health services are developed.

2.4 Housing Models

Since the evolution of CRFs, various housing models have been developed in order to better address the needs of those utilising the services. More specifically, the Custodial Housing Model, the Supportive Housing Model and the Supported Housing Model (Table 2.2) will be discussed briefly, to assist in understanding the experiences of those living within these CRF-type environments.

	Custodial housing model	Supportive housing model	Supported housing model
Definition	Shelter, medication and meals provided; little to no rehabilitation or support	Shelter and on-site rehabilitation provided. As function improves, residents move to less restrictive settings.	Choice of accommodation with access to regular housing in the community and rent supplement given. Support is portable and not tied to housing.
Key characteristics	<ul style="list-style-type: none"> ▪ Special care homes or foster families ▪ Congregate housing ▪ Staff control ▪ In-house staff provide custodial care 	<ul style="list-style-type: none"> ▪ Group home or closer department with common areas ▪ Shared control over household decisions ▪ In-house staff provide rehabilitation services 	<ul style="list-style-type: none"> ▪ Apartment or other type of independent housing ▪ Consumers have control over their housing ▪ Staff are off-site and provide individualised supports according to needs
Strengths	<ul style="list-style-type: none"> ▪ Less expensive than institutions ▪ Does not require trained staff 	<ul style="list-style-type: none"> ▪ Residents have greater control over housing arrangements ▪ Individualised rehabilitation programme included ▪ Facilitates development of a social network with other tenants 	<ul style="list-style-type: none"> ▪ Preferred model of residents ▪ Residents have choice over type of housing and level of support ▪ Less expensive than other alternatives ▪ Ongoing support
Weaknesses	<ul style="list-style-type: none"> ▪ Lack of privacy ▪ Poor quality of housing ▪ Fosters dependency ▪ Residents have little control ▪ Can include people with different disabilities ▪ No individualised support provided 	<ul style="list-style-type: none"> ▪ Full continuum of housing often lacking ▪ Service lacks permanency with transitional housing ▪ Interpersonal demands of group living ▪ Discharge to affordable permanent housing with support may not be available 	<ul style="list-style-type: none"> ▪ Some residents report being socially isolated and lonely ▪ Lacks sufficient resources for residents to pursue leisure activities and achieve community integration ▪ Intensity of support may be insufficient

Table 2.2 Main models of care reproduced with permission from original authors: Aubry, Ecker and Jetté, 2014; Appendix 1

2.4.1 Custodial Housing Model

Expanding on the details highlighted in Table 2.2, the custodial model is described as the “medical model in the community” (Nelson, 2010, p. 126) and was the most dominant form of housing to emerge after de-institutionalisation.

This model has been resistant to reform and fosters resident dependency on the service over time (Parkinson, Nelson and Horgan, 1999; Piat *et al.*, 2017; Segal and Kotler, 1993; Sylvestre *et al.*, 2007). Literature suggests that this model is either in decline or discontinued, as is the case in the United States, Australia, the U.K. and Ireland (Department of Health, 2007; Henwood, Stanhope, and Padgett, 2011; Hill, Mayes and McConell, 2010). As a result of the custodial housing model’s failure and concerns that it violates privacy and restricts choice, housing models with on-site support (supportive housing) began to develop (Piat *et al.*, 2017).

Prior to discussing the supported and supportive housing models, it is important to note that the literature on residential housing for people with mental disorders is limited and inconsistent in terms of the positive effects on residents (Lee *et al.*, 2019). Complicating matters further is the fact that accommodation for people with mental disorders can vary widely in terms of levels of support, outcomes and discharge or moving on policies. All of these contribute to confusion regarding what accommodation for people with mental disorders should entail (McPherson, Krotofil, and Killaspy, 2018b).

2.4.2 The Supportive Housing Model

The supportive housing model is the most widely used in Ireland and represents a residential continuum approach that includes various settings and differing levels of care and supervision (Jose *et al.*, 2021; Kyle and Dunn, 2008) with staff members onsite. Residents are expected to leave their homes during the day and attend day centres, training centres or some form of employment (Leff *et al.*, 2009), with the goal of increasing independent living skills. As functioning improves, residents transition to a less restrictive setting and are expected to demonstrate a seemingly clinical definition of “housing

readiness” (Kertesz *et al.*, 2009, p. 52), which often means sobriety and compliance with psychiatric medication (Aubry, Nelson and Tsemberis, 2015; Lee *et al.*, 2019). Such restrictive and simplistic criteria do not address any elements of recovery necessary for an emotional transition to independent living, which is the end-goal for those who are deemed successful in these transitional settings (Henwood, Stanhope and Padgett, 2011).

However, Lee *et al.* (2019) noted that community integration may be a more appropriate goal than independent living. The authors collected outpatient data focusing on the physical and mental well-being of people with schizophrenia, who were both living in residential care facilities (n=76) and living with someone in a house or apartment (n=76) in San Diego. Findings indicated that individuals in residential care facilities had a lower BMI, better mental well-being, greater happiness and lower levels of depression, when compared to people with schizophrenia, living independently with someone in the community. These findings suggest that residential care settings may provide better physical and mental health outcomes than independent living for people with enduring mental disorders. Additional research in this area may shed more light on these findings.

Studies have reported that recovery communities offer a wide range of support from the very concrete (e.g., physical shelter) to the less obvious human need for connection, belonging and having a place to call home—ultimately reducing the amount of time spent within a hospital setting (Carpenter-Song, Hipolito and Whitley, 2012; McCarthy and Nelson, 1991). However, the inconsistent and unstable process of transitioning towards independent living characterises this housing model as more of a mental health service ‘limbo’. Nelson’s (2010) review of the evidence of housing for people with mental disorders from the 1950s to 2009 (20 international studies) concluded that resident stabilisation and progress resulted in disruptive moves away from the environment where supportive relationships had been established. Furthermore, few communities proved to be either able and/or willing to develop the continuum of housing required, leading to a

grid-locked system, which prevented people from transitioning to more independent settings.

Kavanagh, Nkire and Lavelle (2009) investigated the progress of 50 ‘patients’ with severe and enduring mental disorders, who accessed inpatient rehabilitation services in Dublin North East Mental Health Service between 2001 and 2006. At a one-year follow up, over three quarters of the ‘patients’ who had been discharged from the inpatient rehabilitation service were still residing in their original placement in the community. The assumption that residents no longer needed mental health services once they moved from this system to independent housing was also a concern identified by residents in Irish CRFs. Residents feared a move to independent accommodation would result in a loss of support, and consequently felt safer remaining in CRFs (Tedstone-Doherty, Walsh and Moran, 2007). These effects mirror those of the custodial housing model, in which there is potential for dependency on support services to be fostered. This further emphasises the ‘limbo’ residents may find themselves in with the supportive housing model, as they cannot seamlessly progress to an independent status of living.

Supportive housing has also been criticised for its tendency to segregate people with mental disorders (Nelson, 2010; Ridgway and Zippel, 1990). A Cochrane review (2006) concluded that while living in a CRF increased dependency on professionals, prolonging exclusion from the community, it also provided a safe environment for people in need of stability and support.

However, despite this, the majority of people with mental disorders prefer to live on their own, if given the opportunity. A review of 26 studies (totalling 4,438 participants in 17 states in the United States and one Canadian province) indicated that independent living was the preferred choice of accommodation for people with mental disorders, with 70% of participants expressing this in 20 out of 26 surveys (Tanzman, 1993). Similar findings were reiterated in a Canadian study (N=315), where 77% of participants who were interviewed between April 2004 and April 2006 indicated that they would prefer to live more independently (Piat *et al.*, 2008). In addition,

Richter and Hoffmann (2017) discovered, through a systematic review and meta-analysis (N=8 studies with 3,134 participants), that 84% of participants preferred to live independently. Despite the improvement from the custodial housing model, the general inability of residents within a supportive housing model to easily move into their desired level of independent living gives cause for even less restrictive options to housing.

2.4.3 The Supported Housing Model

The supported housing model was first described as the 'Housing First Approach,' whereby support staff providing assistance to people with mental disorders in finding suitable accommodation is the primary intervention, before other services are offered. This recovery-oriented approach encouraged choice with regard to a preferred type of accommodation and location, as well as the level of involvement from the mental health services (Aubry, Nelson and Tsemberis, 2015; Estrella *et al.*, 2021; Killaspy 2016; Sylvestre *et al.*, 2007). Decision-making is shared among staff and residents, and there are no rules and regulations (Wong *et al.*, 2007). The shift of the locus of control from the staff to the residents is considered a distinctive feature of the supported housing model. Killaspy *et al.* (2022) identified robust evidence for the Housing First model (72 papers) in their systematic review and narrative synthesis of recent evidence. In addition, Gulcur *et al.* (2003) (N=225) concluded in their study based in New York that individuals randomly assigned to the experimental group (Housing First) (N=99) demonstrated less rates of homelessness and hospitalisation versus the control group (N=126) (Supportive Housing). These findings implicate a potential solution to this transition into a successful independent-living scenario for residents of CRFs. In this solution, a supported housing model is being utilised and residents are being adequately followed up on once housing has been acquired.

While recovery-oriented practices with more resident agency comes close to an 'ideal' living scenario, development of role confusion remains a valid concern for the supported housing model. As service providers act to assist individuals in finding suitable accommodation (communicating with

landlords and co-ordinating housing placements), the clinical care aspects can sometimes be compromised. In the U.K., Chilvers, Macdonald and Hayes, (2006) identified that housing and mental health services are provided by two different organisations, which may at times result in miscommunication.

This was most likely because staff employed by housing departments often lacked awareness of mental health issues and mental health services often lacked awareness of housing issues (Johnson, 2005). The level of independent living experienced within this model can be cause for concern if the individuals do not possess the wherewithal to access clinical aid when it is most needed, and the model's system does not provide for consistent check-ins or evaluations of effectiveness with regard to recovery.

2.5 Recommended Housing Models for Irish Community

Residential Facilities

AVFC (2006) and *Sharing the Vision* (2020) did not state clearly which housing model should be followed for Irish community residential facilities. A number of documents relating to accommodation for people with a mental disorder have been published by the Irish Government within the last number of years. These documents appear to be at cross purposes in their recommendations and reflect a unified model that is not guiding policy recommendations. It is not clear why a model of preference has not been identified for Irish CRFs. Siskind *et al.* (2013) concluded that a lack of definitional clarity in supported accommodation and the absence of a widely accepted system for classifying supported accommodation models created unnecessary obstacles to service delivery. For example, AVFC recommended that local housing authorities be responsible for the provision of housing. Moreover, flexible tenancy agreements, reflecting individual needs, should be drawn up to allow individuals to transition from high-support to low-support and, finally, to independent accommodation as recovery progressed.

These recommendations (transitioning through differing levels of support) appear to be linked most closely to the supportive housing model, which offers a residential continuum approach. However, the majority of

accommodation-based recommendations in AVFC and *Sharing the Vision* (2020) appeared more closely aligned with the principles of the housing first model. The housing first model recommends that clinical services and supports be provided off-site by multidisciplinary community mental health teams, such as ACT teams.

This is very similar to recommendations in AVFC and *Sharing the Vision* (2020), where specialist rehabilitation community mental health teams provide clinical services and supports to people with severe and enduring mental disorders living in CRFs or in their own homes (provided by local housing authorities). In addition, a guidance paper published in 2012 by the AVFC advisory group entitled *Addressing the Housing Needs of People using Mental Health Services* stated that:

The goal of assessment in the area of housing supports is to enable the service user to accurately identify the type and location of housing, what housemates (if any) are preferred and the range and level of support he/she feels are needed to maintain their preferred accommodation. Identification of individual choice/preference is the core work of the assessment and housing needs with the ultimate aim of a stable and affordable place to call home (p. 12).

From the information above, it appears that Irish mental health services envisage that people living in community residential facilities will move to dispersed forms of housing in ordinary communities, provided mainly by housing authorities. In addition, residents would have the support of specialist rehabilitation teams and the same entitlements as all other citizens, such as access to GP care, public health nursing and home help services (HSE, 2011). Again, this type of model seems to align most closely with the housing first model.

In keeping with the above recommendations from AVFC, a *Review of the Housing and Support Options for People with Mental Health Related Housing Needs* (2010) was published by the Housing Agency—a government agency set up in 2010 to support the Local Housing Authorities and the Department of Housing Planning Community and Local Government. Section six of this report proposed prioritising the development of a National

Housing Strategy for People with a Disability. One year later, in 2011, *The National Housing Strategy for People with a Disability 2011-2016* (NHSPWD) and the associated *National Implementation Framework* (2011) were published jointly by the Department of Environment, Community, and Local Government (now called the Department of Housing, Planning and Local Government) and the Department of Health. The joint publication was most likely in response to AVFC, highlighting the need for both the Department of Housing and the Department of Health to communicate more effectively regarding accommodation for people with a mental disorder. The key focus of these reports was on the delivery of housing to people with all disabilities, through mainstream housing services. They recommended that every person with any form of disability (including mental disorders) undergo a housing need assessment. A phased-movement of people out of the HSE mental health facilities was one of the more notable aims mentioned, as it suggested the potential for an organised assessment of needs, systematically spread out across all government-operated services.

Unfortunately, no specific housing model was chosen to guide these recommendations. Furthermore, the reports referenced mental disorders as a generic disability. Other disabilities in the report included sensory, physical and intellectual. The rationale for grouping all disabilities together is unspecified. The grouping of people with mental health, intellectual and physical challenges under one umbrella term indicates a lack of understanding surrounding individual needs and plans of care. For example, somebody with a diagnosis of schizophrenia living in an HSE-operated CRF would have very different housing needs to someone with a diagnosis of cerebral palsy.

Plumb (1994) emphasised the importance of distinguishing between social movements meant to benefit disabled people and those who are ‘survivors’ of ‘psychiatric’ (mental health) systems or services. Beresford, Harrison and Wilson (2002) further posed that people with disabilities did not consider those with mental disorders to be ‘disabled’ in the sense that they do not have any obvious physical impairments, and “their situation may not be

permanent” (p. 389). Grouping together individuals living with ‘illnesses’ or ‘impairments’ of all varieties does not provide for an adequate assessment of needs when it comes to deciding on what to address in policies surrounding how they fit into their communities or society as a whole. This includes what type of housing situation would suit them best. While there is ample evidence documenting the frustration of people with disabilities towards these tendencies in policy-making, there has not been much effort to incorporate their opinions or experiences into the current processes. Research reliant on quantitative measures to assess a wide variety of disabilities in people, and the factors that could contribute to their overall QoL, does little to address these concerns. By incorporating a mixed-methods approach in current research, in particular qualitative exploration, individuals with disabilities have an avenue with which to provide input.

Therefore, if an individual housing assessment were to be carried out as recommended, it would require an understanding of individual needs, which is not provided in these reports. Furthermore, it is difficult and time-consuming to tease out what information is specific to people with a mental disorder and housing, since the strategic aims of the report were amalgamated for all four categorical types of disability, as illustrated in two of those strategic aims:

- “to facilitate people with a disability to access appropriate advice and information in respect of their housing needs” (p. 35).
- “to promote mainstream equality of access for people with a disability to the full range of housing options available suited to individual and household need” (p. 34).

The lack of specificity here is unhelpful with regard to guiding policies and procedures for people living in CRFs with a housing need. Unsurprisingly, the time frame for the National Housing Strategy was extended from 2016 to 2021 due to the lack of progress with implementation (Leonard, 2022).

In summarising the UN Special rapporteur response to the Republic of Ireland regarding housing, Drudy and Girvan (2017) stated that “Ireland is policy rich

but outcome and implementation poor” (p. 2). The latter specifically referenced the NHSPWD (2011) and the *Time to Move on from Congregated Settings* (2011) strategy, which aimed to transition 4,000 people with intellectual disabilities from institutionalised congregated settings to mainstream community accommodation. However, as of 2015, only 150 residents had transitioned to other community settings. Of these, 23 were transferred to nursing home accommodation. Despite the recommendations to move people with a disability from congregated settings, 41 people with an intellectual disability had actually been admitted into congregated settings during the same period (Drudy and Girvan, 2017). Of note, the third report on implementation of the National Implementation Framework (Department of Housing, Planning, Community and Local Government, 2016) detailed different figures. It stated that, by the end of 2016, 2,580 people with a disability resided in a congregated setting, of whom only 73 people successfully completed transition into the community. There has not been meaningful progress moving people with intellectual disabilities from institutional settings. However, no data are available on how many, if any, of the 73 people had a mental health disorder or if any were moved from HSE-operated CRFs. Deputy Eoin Ó Broin (TD) asked the Minister for Housing, Planning, Community and Local Government in a Daíl Éireann Debate in November 2020 (House of the Oireachtas, 2020) regarding the progress of the NHSPWD, but unfortunately, he did not provide information on the number of people with a mental disorder transferred from HSE-operated CRFs.

In July 2016, a further report, entitled an *Action Plan for Housing and Homelessness-Rebuilding Ireland*, was published by the Department of Housing, Planning, Community and Local Governments. This report added to the already extensive list of reports on accommodation recommendations for people with a form of disability (including mental health) and homelessness. Two of the 23 aims of this report related to accommodation for people with disabilities, one of which described a pilot scheme involving 15 people transitioning from mental health CRFs to mainstream accommodation. However, ending rough sleeping and the use of unsuitable

long-term emergency accommodation, including hotels and B&Bs, for homeless families, were key priorities taking precedence within the plan. Once again, these aims are mixed in with the aims of people with any one of several ‘disabilities’, as well as those categorised as homeless—whether or not these were mutually exclusive.

Moving from a traditional centre-based model (CRF) to a person-centred model can be challenging for service providers, families, governmental departments, local housing authorities as well as the residents themselves (Irish Council for Social Protection, 2017). Among the challenges of implementation are that families may be given priority for social housing, (for example, a three-bedroom house may be seen as more appropriate for the needs of a family rather than a single person). By accommodating people due to circumstance rather than ‘readiness’, a goal-oriented process towards independent living becomes hard to pursue. Local housing authorities might also consider people in CRFs as catered for, with regard to basic accommodation. This stance fails to acknowledge that some residents stay on the housing waiting lists for lengthy periods of time, affecting their readiness and confidence in their ability to succeed in their own accommodation, as they do not know when that time may come (Tedstone-Doherty, Walsh and Moran, 2007).

There are currently 5000 people with a form of ‘disability’ on social housing waiting lists (Leonard, 2022). No figures for people waiting for social housing lists, with a mental disorder or living in HSE-operated CRFs, were available. The fact that there are no separate guidelines to address the accommodation needs of those specifically with a mental disorder, living in HSE-operated CRFs, potentially adds to the lack of progress specific to this group. Notably, by not differentiating between all groups of people considered to have a disability, those directly affected by vague policies would do better to find ways to identify with each other, in order to influence change that positively impact both communities. It is argued that the overlap of people with mental disorders and those with physical impairments (e.g., acquired physical disabilities due to medication side effects or from other treatments given to

those with mental disorders), and the shared-experience of oppression and discrimination by both groups, provided strong ways by which they could identify with each other (Beresford, Harrison and Wilson 2002). While the needs of disabled people and mental health service users differ in terms of what would allow them the best chance of achieving their highest QoL, the overall sense of community and shared similar experiences between these groups provide a positive foundation in a push towards better systems and policies. A united front is the first step towards ensuring the unique needs of all individuals within both of these groups can be identified and catered to on a broader scale.

2.6 Experiences of People Living in Community Residential Facilities

This section of the literature review will focus on the literature related to the experiences of people living in community residential facilities (CRFs). This information is relevant, as first and foremost, it is aligned with a primary aim of this thesis. Secondly, there appears to be a paucity of evidence-based literature regarding the experiences of people living in mental health CRFs, both within the Irish context, and elsewhere. This section will include key elements of their experiences, namely: stigma, medication side-effects and limited access to rehabilitation. All of this will be presented through the lens of ‘quality of life’ as each of these elements directly influence the degree to which an individual considers their life to have value and meaning.

2.6.1 *Quality of Life*

QoL is described by the World Health Organisation (WHO) as:

an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (2012).

Quality of Life is a concept underpinned by two philosophical schools of thought, that utilise different approaches in defining and discussing it. The predominant school of thought, found in the literature, uses a quantitative

approach to study and understand QoL, with an emphasis on defining and measuring it (Carr and Higginson, 2001). This approach arose from August Comte's positivist theory (Pawlikowski, Rico and Van Sell, 2018) and gave rise to the empirical quantitative method. This method, at its most basic level, consisted of 'positive' data, verified through a person's senses (i.e., hearing and sight) (Peca, 2000). Essentially, the world around oneself can be measured by the process of direct interaction through the use of one's senses.

The other philosophical school is Naturalism, which, like its ethos, was derived from ancient Hindu, Chinese and Greek philosophies, and purports that the world consists of many realities and is therefore unmeasurable (Salter and McGuire, 2020). Qualitative research is subjective and influenced directly by the researcher's values, and findings are formulated through inductive reasoning. Keele (2011) concluded that, while this methodology cannot determine cause and effect, its importance lies in its primary focus: to unearth meaning from which hypotheses can be created.

Considering the above, the assessment of QoL hinges on the researcher's core methodological approach (quantitative and qualitative analysis). There is an abundance of evidence in the literature indicating the dominance of quantitative research investigating QoL in people with mental disorders, possibly because survey methods are less time consuming and expensive. More specifically, survey methods can be mailed or circulated online to participants, whereas in-person interviews take more time. However, the implications of measuring a person's QoL solely from quantitative scales can give an incomplete reflection, as QoL is highly subjective and in a constant state of flux. For example, in the event of a significant life event, such as the death of a loved one, illness or job loss, a person's reported QoL of life can change quickly and dramatically (Carr and Higginson, 2001; Haraldstad *et al.*, 2019; Katschnig, 2006).

In 1985 the Team for the Assessment of Psychiatric Services (TAPS) was created in order to evaluate a national policy in the U.K., which would replace psychiatric hospitals with community-based services (Leff, *et al.*, 2000). The

1996 seminal TAPS Project (n=773) compared the QoL of long-stay psychiatric hospital residents after being discharged to CRFs for one year, with that of long-stay residents, who were likely to remain in hospital. One of the instruments used to measure factors related to QoL in the TAPS study was the clinician-rated Social Behaviour Schedule (Wykes and Sturt, 1986). Findings indicated that participants discharged to community residences lived in less restrictive conditions, had increased social contacts and preferred to live their lives in the community (Leff *et al.*, 1996). However, there was little change recorded in their psychiatric symptoms, as well as their challenging social behaviours. The quantitative scales used could indicate the elements present in a community setting that are not present in a psychiatric hospital, which would improve upon anyone's ability to better enjoy their living situation. However, the acknowledgement of little to no change in diagnostic symptoms and social behaviour issues, without the tools to implicate how this might affect QoL, is problematic. Furthermore, since QoL is a subjective experience, obtaining a person's individual opinion is of paramount importance. Observer-based ratings do not represent the person's own point of view, but instead reflect the observer's perspective. It therefore seems sensible to consider observer-rated QoL data as additional and supportive information, rather than the singular source of insight with regard to the assessment of QoL.

McInerney *et al.* (2018) collected baseline data from long-stay residents in Ireland, prior to their transfer to CRFs and again at a 10-year follow-up. The 10-year follow up results indicated objectively significant improvements in residents' QoL. More specifically, improvements in social skills and domestic skills were recorded, which along with the Quality of Life Scale (QLS) (Heinrichs, Hanlon and Carpenter, 1984) assessment used in the follow-up, led to the inferences made. However, the QLS was not conducted at baseline, and all other proxy measures were solely based on clinician reports. Regardless, the categories assessed have been researched enough to confidently ascertain the improved QoL in a community setting over a hospitalised setting. Notably, for this study, the improvement was apparent regardless of the longevity of stay within a hospitalised setting across

participants, indicating the influence one variable (i.e., living within a more normalised community setting) has on overall QoL.

Lehman *et al.* (1993) found convergent validity in patients' and clinicians' perceptions of QoL and cautioned against relying on subjective assessment, given the cognitive deficits and lack of insight that can often be a characteristic of enduring mental disorders such as schizophrenia. A further complication is described by Nilsson and Levander (1998). They were the first authors to recognise that participants with enduring mental disorders were positively reporting satisfaction with their life situation, which would more than likely be considered inadequate by others. It is possible that people living in CRF type environments may lower their standards over time (Katschnig, 2006), particularly if they have been subject to institutionalised care (Tedstone-Doherty, Walsh and Moran, 2007). Bobes *et al.* (2022), who reviewed the literature in terms of difficulties in assessing QoL in people with schizophrenia, are of the opinion that people with schizophrenia have a worse QoL than the general population and that of other physically unwell individuals.

Some authors support the above argument, that questions whether persons with schizophrenia are capable of self-assessment of QoL, since self-reports can be influenced by persistent psychotic symptoms (Bobes *et al.*, 2007; Browne *et al.*, 1996). Others similarly concluded that the subjective/objective dichotomy is not either/or, as both are equally relevant and important in measuring QoL, particularly in schizophrenia (Awad and Voruganti, 2012; Van Hecke *et al.*, 2018). Van Hecke *et al.* (2018) concluded that the ideal method of measuring QoL is "methodological pluralism" (p. 346), which refers to gathering data from different sources (i.e., subjective and objective data, proxy and self-report as well as mixed method). Using this more holistic method, data regarding the QoL of patients are triangulated and a more comprehensive perspective can therefore be formulated. Awad and Voruganti (2012) have further identified the lack of standardised QoL measures, appropriate for use in schizophrenia and its various clinical stages, as an additional challenge. Finally, Simpson and House (2002) identified lower

levels of satisfaction with QoL, when participants were interviewed by other people who use mental health services rather than by mental health staff. A possible reason for this could be that study participants want to please the staff who provide them with care and in some cases, a home. In other words, a power difference may be at play, which could affect responses.

Vatne and Bjørkly (2008) conducted a meta-analysis of 42 published QoL studies (n=6774), which focused on people with major mental disorders (such as schizophrenia) living in the community. They found that while subjective QoL was good overall, there still remained an issue with the clinical interpretations of the data collected. Namely, that objective QoL relied on different factors that could potentially lead researchers or clinicians to interpret the subjective reports under bias. Yamauchi *et al.* (2008) sought to compare the factors that influenced both subjective and objective QoL in patients diagnosed with schizophrenia. Their results indicated that subjective QoL was more so influenced by the presence of depression and/or extrapyramidal symptoms—both of which could arguably affect self-esteem and self-perception. What can be taken from these findings is that patients with schizophrenia (or other mental disorders) have the ability to assess their QoL based on factors that only they personally experience, as opposed to what is objectively recorded.

Walker *et al.* (2023) interviewed both residents (N=37) and staff (N=48), while investigating well-being, progress and recovery in older mental health patients residing in forensic accommodation, for a qualitative study. An interesting and relevant finding was that factors such as level of autonomy, residents' relationships with staff, family and friends were identified as either enablers or obstacles to wellbeing, recovery, progress and QoL. Some of the factors contributing to poorer QoL and well-being were highly regulated environments and restrictive rules and regulations. Enablers that were considered to enhance QoL and well-being included autonomy, choice, and participation in decision making, feelings of hope, a sense of progress, engaging in activities that provide a purpose, and feelings of worth. Although this study was conducted with residents of forensic accommodation, the

findings are applicable to residents of CRFs. They can face similar challenges related to restricted autonomy, lack of choice, lack of involvement in decision making, hopelessness regarding ever moving on from CRFs and limited access to opportunities that provide a sense of purpose, such as employment (Baltazar *et al.*, 2013; Bitter *et al.*, 2016; Brodin *et al.*, 2016; Brunt and Tibblin, 2011; Killaspy *et al.*, 2016; Magliano *et al.*, 2016; MHC, 2016-2020; Roos *et al.*, 2016; Svanellöv, 2020; Tedstone-Doherty, Walsh and Moran, 2007). Although the findings may not be generalisable to non-forensic mental health accommodation, the references to previous research demonstrating similar findings in non-forensic mental health accommodation strengthen the argument that the findings are applicable outside of the study's specific context.

According to the literature, it appears to be difficult to assess QoL accurately in this population, for a combination of reasons. In the first instance, it is highly complex, elusive and difficult to define (Basu, 2004; Walker *et al.*, 2023), since it is a concept that has perceptual components and dynamic characteristics that respond to life events and life situations. Despite all of this, the current study approached these obstacles by exploring residents' QoL against their own expressed goals, within the context of focus group interviews. By comparing their current situation to one which they would hope to have (whether in the short term or the long term), QoL can be individualised and have a more measurable outcome. The scales used in previous studies (as discussed above) provide a foundation to assess the variables that would directly impact a person's QoL, namely how an individual views the quality of care being provided to them under the mental health services. Nonetheless, it is important to keep in mind that social dynamics, such as power, self-esteem and possibly internalised stigma, can also come into play. These would complicate the already challenging task of measuring QoL accurately in people with enduring mental disorders.

2.6.2 Stigma

Dudley (2000) defined stigma as stereotypes or negative views attributed to a person or group of people, when their characteristics or behaviours are

viewed as different from or inferior to societal norms. In this section, not only will societal stigma be discussed in relation to the evidence of how society views people with mental health disorders, but also self-stigmatisation, wherein people with mental disorders internalise these negative societal attitudes. People living in CRFs can also experience additional stigma within a congregated mental health setting, which will be addressed, as this is unique to the population at the centre of the current study.

Stigma can lead unjustly to discrimination against and exclusion of the individual with serious mental disorders, as society has persisting and pervasive negative and unchanged attitudes towards people with schizophrenia (Colizzi, Ruggeri and Lasalvia, 2020). Gonzales (2017 p. 1) found evidence that people with mental disorders are often viewed as “dangerous or violent, unpredictable, incompetent and less human than others”. If these stigmatising views, that are broadly endorsed by society, are internalised by people with mental disorders, this can result in the person feeling and believing that they are less valued or less valuable because of their mental disorder (Chan *et al.*, 2022; Corrigan, 2004; Hermaszewska, Sweeney and Sin, 2022; Holubova *et al.*, 2016). Stigma can profoundly and adversely affect QoL in people with enduring mental disorders. They feel excluded from society, experience decreased self-esteem, increased levels of depression and psychological distress, as well as experiencing authoritarianism from mental health professionals, where their life decisions are often made by others (Brockington *et al.*, 1993; Bunyan *et al.*, 2017; Drapalski *et al.*, 2013; Hermaszewska, Sweeney and Sin, 2022). This is particularly true for people living in CRFs, as they are living in a regulated clinical environment (MHC, 2018 - 2019). In terms of how these environments operate, reluctance to incorporate resident perspectives could stem directly from this “philosophy of public safety which primarily conceives of mental health service users as ‘a threat’ from which ‘the public’ needs to be protected and safeguarded” (Beresford, Harrison and Wilson, 2002, p.392). As people with mental disorders adopt this perception unto themselves, they have a stronger hesitancy to be included in outside society, while simultaneously inhibiting self-esteem and self-confidence. Conversely,

Corrigan and Watson (2002b) highlight that people with mental disorders can also experience benevolence, where they are viewed as childlike and therefore need to be cared for. This can also lead to institutionalisation and all the negative implications which that entails.

A longitudinal qualitative study by Whitley and Campbell (2014) supported the views and evidence outlined above. They investigated stigma in people living in congregated settings with a diagnosis of serious mental disorders, such as schizophrenia, bipolar disorder, major depression or schizoaffective disorder, over a five-year period. Using participant observation and grounded theory-analysed focus groups, they found that residents were concerned that the paternalistic actions of staff would draw attention to them or their living environment, as they felt that staff treated them as if they were “stupid [and] like children” (p. 4). In order for the rehabilitation process to be successful, the paternalistic actions of staff need to be eliminated, so that residents can develop more independence and autonomy. Further notable findings indicated that residents were intensely apprehensive of being stigmatised by others, which appeared to be the driving force behind how residents behaved on a daily basis. For example, residents put significant effort into their appearance to try and fit into society and “look normal” (p. 3). Residents also feared inappropriate actions from other residents (e.g., a resident relapsing into substance abuse), in that it might draw negative attention from neighbours. Residents also expressed that living in a congregated setting for people with mental disorders was inherently stigmatising, and they were concerned that neighbours might not want people with mental disorders living in the local community. The following comment describes these concerns: “We have the stigma because some of us are in recovery and we are affiliated with a mental agency, so nobody wants that in their neighbourhood” (p. 4).

Despite the above findings, the authors noted that experiences of stigma were rarely discussed in the focus groups. An Irish study by the HRB (Tedstone-Doherty, Walsh and Moran, 2007) reported similar findings in that only 16 out of 138 residents quantitatively reported feeling stigmatised in the

community. Some of these experiences may not even have been directly related to stigma. For example, four participants experienced a random attack (e.g., bag snatched on the street) and one experienced sexual harassment. Eight had experienced name-calling and three experienced harassment by other residents in a psychiatric hospital they were attending. As the study did not directly investigate stigma, it is difficult to know how many residents experienced stigma, as stigma with regard to mental health is often under-reported, even though it exists in many forms (Bharadwaj, Pai and Suziedelyte, 2017; Hartman *et al.*, 2013; Schnittker, 2022). For this reason, it is prudent to suspect that stigma is insidious and more prevalent than what is being reported. If stigma is under-reported there is a strong possibility that it is also under-recognised, which would indicate that people with mental disorders endure the consequences of stigma in silence, or without realising what is happening. Mental health staff need to be made aware of this and trained in how to deliver evidence-based interventions, with regard to stigma during the process of rehabilitation.

Obstacles, such as exclusion from society, negative perceptions, the internalisation of negative perceptions, experiencing suspected authoritarianism and benevolence from mental health professionals, and the under reporting and recognition of stigma are significant and difficult for staff and people with mental disorders to overcome. Moreover, schizophrenia usually involves pharmacological interventions. Notably, stigma can work against this, in that patients may have reservations and mental health staff may rely too heavily on prescribed medications as a means to achieving higher QoL.

In addition, people with mental disorders can also experience stigmatisation from mental health professionals (Sreeram, Cross and Townsin, 2022), such as rudeness, dismissiveness and a preference for social distancing (Hamilton *et al.*, 2016; Huggett *et al.*, 2018). For example, Graber *et al.* (2000) concluded that family physicians are less likely to believe that patients with a previous history of depression have a serious medical condition upon reporting physical symptoms, leading to an increased reluctance to initiate

investigations. A recent editorial in *The Lancet* (Thornicroft *et al.*, 2022) recommends that all health-care staff receive mandatory training on the needs and rights of people with mental health conditions, particularly when people with mental disorders are not treated as equal to people with physical disabilities. Furthermore, stigma surrounding mental disorders can also be extended to the side effects of medication, which will now be discussed.

2.6.3 Medication Side-Effects

Certain medications prescribed for people with schizophrenia can have a variety of adverse effects that can further stigmatise people by causing social embarrassment (Boyd, Juanamarga and Hashemi, 2015). For example, clozapine is the gold standard treatment in Treatment-Resistant Schizophrenia, and despite its superiority to other antipsychotic medications, it is associated with adverse side-effects, such as hypersalivation, or excessive drooling (Livermore *et al.*, 2022; Maher *et al.*, 2016; Sockalingam, Shammi and Remington, 2007). Over and above the physical discomfort of this type of side-effect, it also has an impact on how others perceive the patient and how they perceive themselves. For example, the person may feel embarrassment and/or humiliation as a direct result of drooling, especially in public (Sajatovic and Jenkins, 2007). This in turn may affect QoL, in that the individual may become socially withdrawn in order to avoid those negative feelings.

A study from the west of Ireland (Maher *et al.*, 2016), evaluated the prevalence and severity of clozapine-induced hypersalivation and its impact on QoL through a structured interview and validated quantitative instruments, namely, the Nocturnal Hypersalivation Rating Scale (Spivak *et al.*, 1997) and the Drooling Severity and Frequency Scale (Rashnoo and Daniel, 2015). Results indicated that 92% of participants (n=98) experienced clozapine-induced hypersalivation, with 15% reporting that it had a “moderate impact” on their QoL. However, QoL was not measured using a validated scale. Instead, a study-specific, five-point scale ranging from “no impact [on QoL] to single biggest problem in life” (p. 179) was used (Maher *et al.*, 2016). It is possible that this non-validated scale was used because there is no validated

scale specific to investigating the impact that hypersalivation has on QoL. Furthermore, little information was provided on the study's structured interview. In light of the above, it is understandable that a person with clozapine-induced hypersalivation would feel self-conscious and consequently feel less inclined to socialise with others, resulting in a poorer overall QoL.

Other adverse side-effects commonly reported from clozapine and other antipsychotic medications include: hypotension; fever, tachycardia; constipation; dizziness; headache; nausea; vomiting; blurred vision; sweating; trembling or shaking of the hands and feet; fainting; weight gain; as well as sleepiness or unusual drowsiness (Flanagan, 2008; Maher *et al.*, 2016). Medication side-effects were also identified as a barrier to wellness in a qualitative study of participants living in CRFs (n= 84) (Shor and Shalev, 2013). The study investigated participants' subjective perception of barriers to improving their wellness. Residents described a constant hunger, dysregulation of mealtimes, and increased appetite due to psychiatric medications. They also attributed inactivity to medications because of feeling physically weak and tired, which can lead to increased weight gain and, ultimately, physical health issues. However, it is difficult to ascertain the exact type of environment the residents were living in, as the authors described it as both a "psychiatric hospital" (p. 334) and "community residential setting" (p. 338), with semi-independent housing programmes (housing 30-35 residents). Despite this criticism, the findings highlight that antipsychotic medication (especially clozapine) has a substantial effect on metabolic parameters linked to cardiovascular disease, such as weight gain, raised triglyceride and cholesterol levels and hypertension (Khandker *et al.*, 2022; Lamberti *et al.*, 2006).

2.6.4 Limited Rehabilitation

In order to discuss the absence of rehabilitation in CRFs, it is important to have a clear understanding of what rehabilitation represents. Killaspy *et al.*, (2005) offers a widely accepted definition as follows:

A whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support (p. 163).

Traditional models of care, as described in Chapter two, focus solely on medication interventions in the treatment of mental disorders. Medication interventions are effective in eliminating psychotic symptoms and preventing relapse in psychotic disorders, such as schizophrenia. However, they do not have a specific effect on certain cognitive impairments, insight or social skills, whereas rehabilitation tools specifically target these deficits (Kern *et al.*, 2009; Lyman *et al.*, 2014; Schutt *et al.*, 2022). Therefore, rehabilitation interventions apply a holistic approach to recovery and can be considered as essential evidence-based interventions in the treatment of mental disorders.

2.6.4.1 Unemployment

Given the above knowledge, it becomes understandable to see how people who are enduring the consequences of stigma, side-effects of antipsychotic medication and over-sedation and living in congregated, regulated mental health facilities, can experience severe difficulty in accessing employment (Tew *et al.*, 2012). Further compounding matters include limited or no work experience, low levels of education attainment, stigma and discrimination, as well as possible cognitive impairment, which are all common in schizophrenia (Drake *et al.*, 2016; Glozier, 1998; Harnois and Gabriel, 2000; Luciano and Meara, 2014; Subramaniam *et al.*, 2022; Tew *et al.*, 2012).

Unsurprisingly, unemployment is high amongst people living in CRF accommodation (Magliano *et al.*, 2016; Martinelli *et al.*, 2022; Roos *et al.*, 2016; Tedstone-Doherty, Walsh and Moran, 2007). An Italian study (de Girolamo *et al.*, 2005), sampled 2,962 people living in CRFs (two-thirds had a diagnosis of schizophrenia) and found that 2,536 were unemployed and 1,113 had never worked. In addition, a systematic review (six studies) (N=716) of the formal support received in supported accommodation concluded that employment remains an area of social participation that is not

available to many residents of supported accommodation (Jose *et al.*, 2021). The consequences of unemployment can have a detrimental effect on a person's mental and physical well-being, such as loss of role in society (which can lead to a personal identity crisis), loss of daily routine, motivation, social contacts and confidence, feelings of shame, anxiety, depression, guilt and inadequacy, as well as exclusion from society and financial strain (Björklund *et al.*, 2015; Giuntoli *et al.*, 2015; Giuntoli, South and Whilte, 2011; Huffman *et al.*, 2015; Hiswåls *et al.*, 2017; Pultz, 2018; WHO, 2021a). The above-described consequences of unemployment may further enable the process of institutionalisation of people residing in CRFs, as they may feel like withdrawing further from society if they are experiencing feelings of shame, guilt and inadequacy. In addition, lack of finances may further impede recovery, as the person may not be able to afford to engage in social opportunities in the community, such as going to restaurants, gyms or cinemas.

Resolving the issue of unemployment for people with enduring mental disorders is particularly challenging, as additional barriers can be identified in the rehabilitation process. These can include the limited availability to evidence-based practices, specifically the IPS model, in which the main goal is to assist people with enduring mental disorders in gaining competitive employment (Bond *et al.*, 2023; Drake *et al.*, 2016; Kinoshita *et al.*, 2013; Marino and Dixon, 2014). Competitive employment is defined as “jobs paying at least minimum wage that are located in socially-integrated community settings and that are held by consumers directly and not reserved for individuals with disabilities or held by provider agencies” (Marshall *et al.*, 2014 p. 17).

Evidence in support of the IPS model is highlighted in a recent systematic review and narrative synthesis of community-based social interventions (Killaspy *et al.*, 2022). They described two high-quality studies, namely, Modini *et al.* 2016 and de Winter *et al.* 2020, that demonstrated better employment outcomes through the IPS model, when compared with traditional models of care. This supports previous international evidence for

the IPS model. For example, Marshall *et al.* (2014) investigated the effectiveness of the IPS model of supported employment by conducting a literature search of articles published from 1995 through 2012. The search comprised 12 systematic reviews. These included 17 randomised controlled trials (RCTs), that compared the IPS model of supported employment to a control sample. Results indicated that the IPS model had consistently and significantly higher rates of competitive employment. All studies compared the IPS model to various interventions, such as group skills training, psychosocial rehabilitation, sheltered workshops, “treatment as usual” (p. 19), traditional vocational services and the standard Veterans Affairs vocational rehabilitation. However, the authors grouped together the quality of systematic reviews, without using standardised approaches to achieve this stratification, and thus RCTs resulted in higher quality designation. RCTs are considered to be the gold standard for evaluating the effectiveness of interventions (Deaton and Cartwright, 2018). However, it may be inappropriate for RCTs to be considered more important than qualitative research in the field of mental health, as objective measurements do not provide a deep understanding of the subjective and lived experiences of participants.

Boardman and Rinaldi (2013) found that IPS schemes are not widely implemented, which may explain the scarcity of research regarding IPS schemes. Reasons for poor implementation were cited as unhelpful clinician and societal attitudes. For example, mental health professionals were apprehensive about placing people with mental disorders in open-market employment in case it induced stress or resulted in failure, and employers were reluctant to hire people with mental disorders. Similar threads can be seen in Irish qualitative research by Tighe and Murphy (2021) and Sharek *et al.* (2022). Tighe and Murphy (2021) interviewed six service users in their qualitative study, eight multidisciplinary team (MDT) members and eight employers, who had experience of working with people with mental disorders. Results indicated that all MDT members lacked support for individuals with mental disorders entering paid employment. Moreover, some members of the MDT were of the opinion that these individuals would never

be capable of working, due to the severity of their symptoms and extended periods of unemployment. Similarly, Sharek *et al.* (2022), who interviewed 17 IPS employment specialists and 11 occupational therapy managers through three focus groups, found that MDT members demonstrated an overwhelming sense of doubt regarding the capacity and ability of people with mental disorders to work in competitive paid employment. This lack of support from members of the MDT could be attributed to various factors. These include a lack of understanding around evidence-based approaches, such as the IPS model and how this model works, i.e., placing people with mental disorders directly into paid employment. In addition, MDT members may be concerned that placing individuals in competitive paid employment may cause undue stress or exacerbates their symptoms, which may create additional challenges.

Despite the robust evidence base for the IPS model and its success in retaining clients in vocational services (Drake *et al.*, 2016; Killaspy *et al.*, 2022; Mueser *et al.*, 2004), residents of CRFs are often encouraged to attend sheltered employment workshops (Tedstone-Doherty, Walsh and Moran, 2007), where they are expected to engage in meaningless occupation in a purpose-built, protected environment (Grove, 2015). Vocational rehabilitation programmes have often reflected the paternalistic models of care described in mental health services. Sheltered employment programmes, in particular, tend to segregate people with mental disorders and prevent them from engaging in competitive employment and even society itself. The goal of sheltered employment/workshops is often maintenance and stabilisation, rather than rehabilitation back into mainstream employment (Becker and Drake, 2003). The maintenance and stabilisation of people in sheltered workshops further contributes to the process of institutionalisation, as individuals are only mixing with other individuals who have a diagnosis of mental disorders and not with the wider society—particularly in a working environment. Autonomy and independence cannot be developed within the sheltered workshop model, and real-world struggles typically experienced within workplaces are not presented, further preventing progress towards successfully handling stressful situations.

However, sheltered workshops appear to be in decline across modern mental health services, possibly for the above-mentioned reasons, as well as the paradigm shift in mental health services towards becoming recovery-oriented. Namely, sheltered workshops result in low rates of transition to the open-labour market, the work is repetitive and oftentimes meaningless, with little or no pay and high operating costs (Becker and Drake, 2003). Unfortunately, Grove (2015) anticipates the complete end of sheltered workshops to be a slow and “painful” (p. 97) process, as staff are dependent on them for their own employment purposes.

The majority of people with enduring mental disorders want to work. Therefore, mental health services and policymakers should endeavour to provide people with access to evidence-based employment services. The anticipated benefits include regular income, social contacts outside the family, improved self-esteem, enhanced confidence, increased independence, expanded social networks, routines that encourage organising and structuring time, a sense of purpose and meaning as well as personal achievement, and improved QoL (Evans and Repper, 2000; Lindsay *et al.*, 2018; Priebe *et al.*, 1998). Beresford (2002) pointed out that “the increasing association of mental health service users with ‘dangerousness’ and the constant coupling of cruel and murderous activities with ‘mental illness’ [...] is a defining feature of early twenty-first century discussion” (p. 581). Slow progression of policies meant to benefit or help people with mental disorders to achieve any amount of status within the community can be explained by the association of mental health service users with crime, unstable thinking, and danger. The ability to contribute actively to societal economics, through employment, would act to remove the stigmatised identity of having a mental disorder and replace it with a positive social identity (Bouwman *et al.*, 2015; Drake, 2018; Harnois and Gabriel, 2000; Sherman *et al.*, 2017).

Without an income, every aspect of well-being can be adversely affected, and the risk of homelessness increases significantly (Farré, Fasani and Mueller, 2018). Once outside a mental health service, there are still limited supports in

making any steps towards full-time employment. While there exists a ‘disability benefits system’, as stated before, this targets any person coming under a state-defined label of ‘disability’—mental health disorders alongside physical impairments. Davis, Davis and O’Kane (2000) pointed out that mental health service users seemingly have more difficulty than people with physical/sensory impairments in not only accessing, but also holding on to such benefits. While most benefits are arguably in place to improve the QoL for people with disabilities living among the rest of society, those with physical or sensory impairments seem to have an easier time accessing these benefits. Those whose cognitive states are regularly called into question cannot break the unfortunate cycle they are placed in. Thus, access to benefits is difficult or limited, leading to a life of poverty or crime, and ultimately into a setting that forces them to ‘rehabilitate’ themselves, before being given another chance to pursue a more independent life.

Modini *et al.* (2016) indicated that the IPS approach is twice as likely as traditional models of vocational rehabilitation to result in competitive employment. Hence, given the efficacy and evidence for IPS, policymakers must obtain insight into the hurdles impeding widespread adoption of the IPS model of employment, so that these barriers can be removed and service recipients can have widespread access to this service. OTs could play a key role in placing people with mental disorders in open market-employment or supervising and overseeing the IPS model of employment for people [as demonstrated in research by Sharek *et al.*, 2022], given their extensive training in vocational rehabilitation, as well as their holistic and graded approaches to assessment and intervention (Chen and Lal, 2020; Drummond *et al.*, 2020).

2.6.4.2 Institutionalisation

For people living in CRFs, the fear of moving to independent accommodation can be a barrier in itself, as they may be concerned that they will not be able to financially support themselves, resulting in homelessness. This often means living for prolonged periods of time in a CRF-type of environment, which can result in institutionalisation. Furthermore, the overwhelming

absence of or limited access to rehabilitative elements within the CRFs makes remaining in them all the more damaging in terms of becoming dependent on staff, eventually leading to institutionalisation. For example, healthcare professionals or care staff can often overestimate the level of support that is actually required or identified by the person themselves (Afilalo *et al.*, 2015; Lasalvia *et al.*, 2012; Piat *et al.*, 2015). For instance, an Irish case study investigating CRFs in Ireland, highlighted how staff who do not utilise rehabilitation-specific approaches could have a negative impact on residents' acquisition of functional living skills (Kearns Murphy and Shiel, 2019). The experience of engaging in meaningful occupation within a CRF was explored and a notable finding was that higher levels of support than required were being provided by staff for activities of daily living (e.g., showering, shaving, laundry, shopping and cleaning), citing that it was "easier and quicker" to either carry out the task for the resident or provide higher assistance than what was required (Kearns Murphy and Shiel, 2019, p. 5).

However well-intended, these actions likely deskilled the residents, fostered dependence and encouraged institutionalised behaviour. Another finding was that staff's level of care was inconsistent. For example, some staff carried out certain tasks for residents, while other staff provided residents with the opportunity to carry out the same task independently, possibly confusing residents about their own abilities. Multiple other rules were enforced, such as locked bedroom doors, curfews, and lack of opportunity to prepare meals. In addition, personal finances were also managed by staff, and significant rehabilitative opportunities, such as employment, were not discussed with residents. Furthermore, the imbalance of power between staff and residents was particularly obvious (Kearns, Murphy and Shiel, 2019). Although these findings clearly highlighted the inadequacies of the programme, it is important to note the study's limitations. More specifically, its case study approach involving two residents and only one CRF, and the gender imbalance (both participants were male), does not allow for these findings to be generalised. It also is not necessarily indicative of lack of training in rehabilitation, merely lack of implementation. However, adequate training should congruently mean appropriate and adequate implementation or

applied practice. The annual MHC reports (discussed in Chapter one) consistently illustrate the failings in implementing evidenced-based rehabilitation to residents of CRFs.

Despite the above-mentioned limitations, the study supported the argument that untrained staff employed in CRFs pose a significant barrier to rehabilitation, as the majority of staff in CRFs are care assistants and are not adequately trained in recovery principles (Brunt *et al.*, 2019; Cleary and Dowling, 2009; de Girolamo and Cozza, 2000; McInerney *et al.*, 2010; Picardi *et al.*, 2006; Tedstone-Doherty, Walsh and Moran, 2007).

However, once-off training will not achieve the desired outcomes, as highlighted by Corrigan *et al.* (2001), and ongoing regular training results in better clinical outcomes. Whether this falls to the state or the senior professionals/management to regulate the level of education/training required of hired staff is debatable. Regardless, CRFs appear to be viewed less as rehabilitative environments and more as ‘care facilities’, whereby influencing the level of autonomy expected of their residents. If there is no consistency in daily recovery and rehabilitation-oriented goals, residents cannot be expected to intrinsically motivate themselves to assert independence in any facet of their lives.

2.6.5 Conclusion

The challenges identified in this literature review, namely, stigma, adverse medication side effects, unemployment and limited rehabilitation, further highlight the convoluted and impenetrable path to recovery for individuals with enduring mental disorders living in CRFs. Compounding matters further is the consistent non-implementation of government policy within the Irish mental health services, previously discussed in Chapter one. All of these variables influence the lived experiences of residents in CRFs. As attention is not paid regarding how to allow their perception to evolve around a secure understanding of the ‘outside world’, residents of CRFs will not fully identify or accurately report on their QoL. The majority of what is experienced as a sufficient lifestyle for residents appears to be highly reliant on avoiding

homelessness and/or imprisonment—as opposed to enjoying a multitude of areas which contribute to one’s livelihood. Therefore, the scales and assessments being used to determine QoL in CRF residents do not address a factor of comparison, by which residents gauge their own expectations to those successfully living independently in society (with or without mental disorders). As adequate rehabilitation and recovery are progressively achieved, residents will continue to alter and change their perceived QoL.

The overall functioning of CRFs is drawn from the models of care adopted by staff and clinicians in charge. This, in turn, influences the depth of knowledge on the recovery model, as well as the level of application within CRFs—all of which plays into the direct lived-experiences of residents within those CRFs.

By utilising a mixed-methods approach, with an emphasis on qualitative data using focus group interviews, this current study contributes to the body of literature which supports placing the lived experience of the service user at the heart of the recovery process (Health Service Executive, 2017; *Sharing the Vision*, 2020). In focusing on the key elements that constitute recovery (Leamy *et al.*, 2011; Sowers, 2022) for individuals with mental disorders, this current study also further identifies which elements to assess regularly, with service users depending on their unique needs and goals regarding their own recovery. The key to unlocking effective recovery plans is in how the information given by an individual is analysed and interpreted. The process of analysing useful information (e.g., qualitative data in the form of group interview transcripts) is also addressed in the current study and provides the groundwork for finding effective means of collecting direct data from service users, such as their lived experiences. The methodology chapter, which follows, provides a thorough explanation of the philosophical assumptions underpinning the study and details the particular methodological decisions used.

Chapter 3: Methodology

Positioned within the contextual narrative laid out in previous chapters, this chapter will outline, describe, explain and discuss philosophical paradigms, chosen methodology and research design. In addition, evidence-based examples will be used to provide contextual and theoretical support for the adopted approach, which align with the overall research question, aims and objectives as presented in Chapter one.

3.1 Research Framework

An illustration of the methodological framework (Figure 3.1) provides structured, practical guidance to demonstrate the research process adopted in this study (McMeekin *et al.*, 2020).

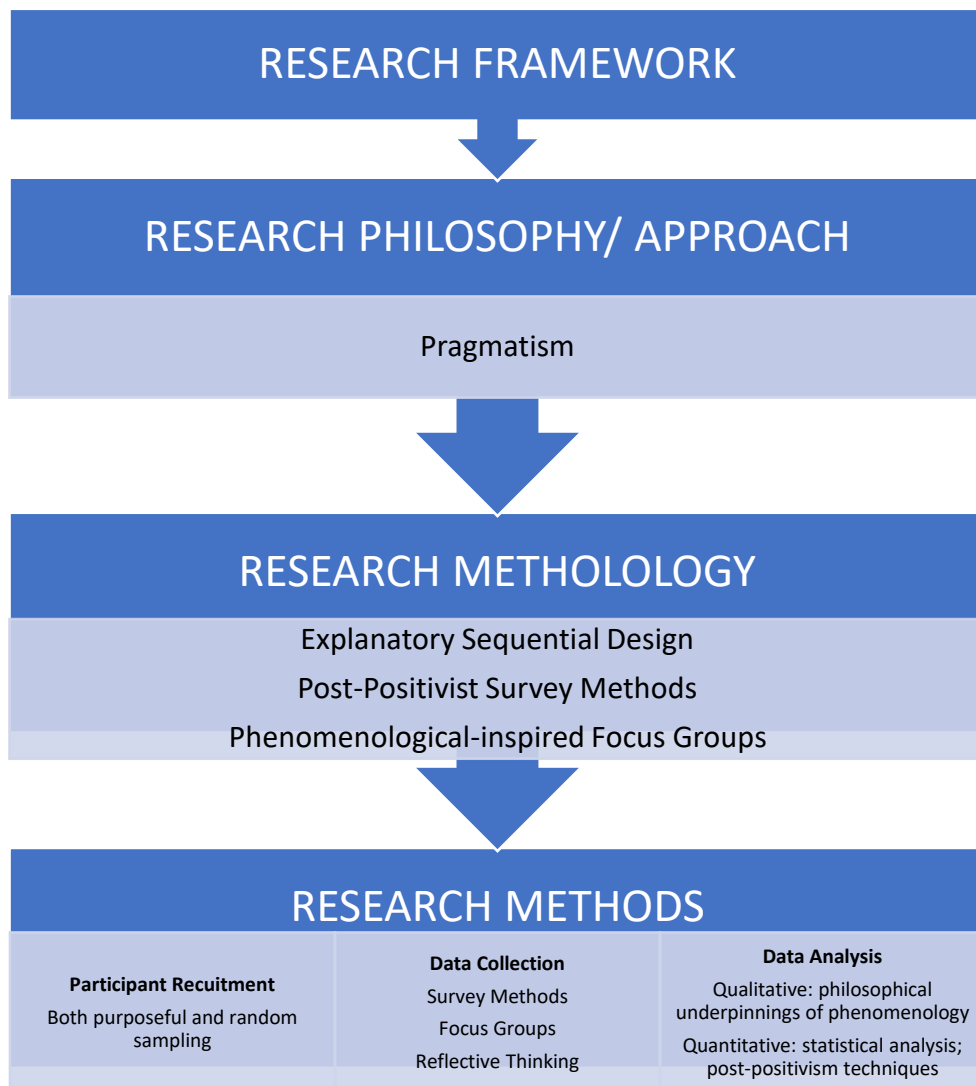


Figure 3.1: The research framework

As highlighted in Figure 3.1, the chosen research philosophy for this study was Pragmatism (Tashakkori and Teddlie, 2008). Moreover, the research methodology included an explanatory sequential design, with post-positivist survey techniques (Romm, 2013) and phenomenological-inspired focus groups (Kakulu, 2008). Research methods included both purposeful and random selection of CRFs, and mixed-method data were then collected from CRF residents. Data analysis of the quantitative data was undertaken using SPSS (IBM Corp., 2017) and philosophical underpinnings of phenomenology (Dowling, 2007) guided the approach to the analysis of the focus group data.

The 'research onion' (Saunders, Lewis and Thornhill, 2007) illustrates the processes involved in constructing a study's research framework. Saunders, Lewis and Thornhill (2019) separated the research onion into different levels of choices: research philosophy and research methodology are the two exterior layers of the onion, whilst research choices, strategy, time horizon, and data techniques and procedures constitute the inner layers of the onion. Drawing on Saunders' research onion (Saunders, Lewis and Thornhill, 2007), this section will detail the research processes from higher levels of the methodology to the research approaches used to demonstrate the construction of the research framework.

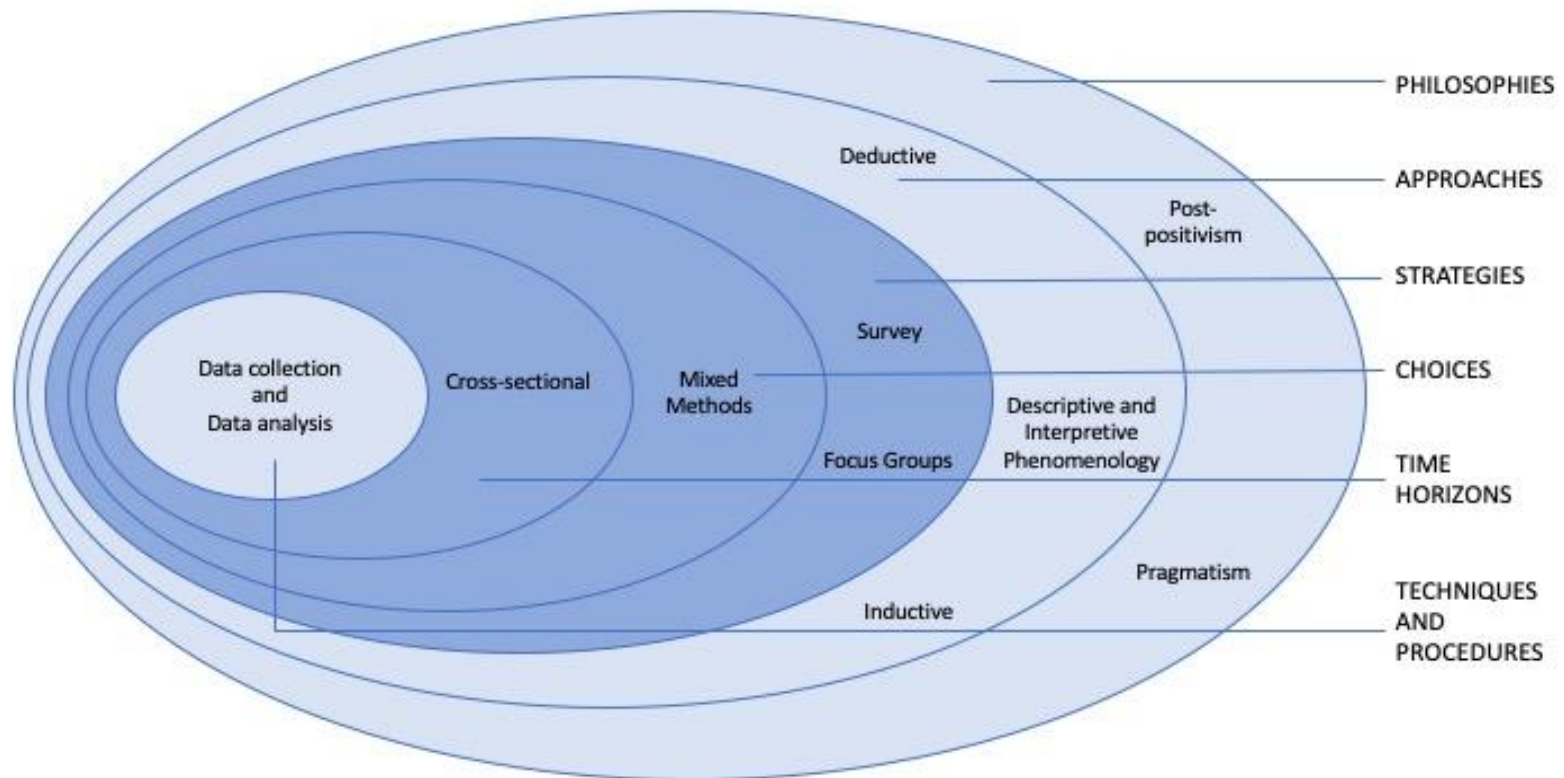


Figure 3.2: Saunders' research onion illustrating the process involved in constructing a research framework

As mentioned in Figure 3.2, the selected research philosophy was Pragmatism, since it allowed the researcher the flexibility to choose the most suitable methodologies, strategies, and processes to explore the lived experiences of CRF residents (Creswell and Poth, 2017). An explanatory sequential mixed-methods design was selected. The rationale for this selection will be explained. Finally, the various techniques and procedures relevant to the gathering and analysis of both quantitative and qualitative data will be addressed. The research process will now be explored in further depth, under the components discussed above.

3.2 Choosing the Most Appropriate Approach

Choosing research approaches and methods is a key component of the research process. The researcher must defend and explain their choice of paradigmatic or theoretical framework not just to demonstrate rigour, but also so that the audience can understand the context of the research (Brown and Dueñas, 2019). Moreover, it is important that the researcher justifies and illustrates how their paradigmatic view and methodological choices work, in conjunction with the researcher's own values, to answer the research question most effectively (Chilisa and Kawulich, 2012).

3.3 Research Philosophy

Research philosophy or paradigm, often known as a world view, is a system of beliefs that influence behaviour (Guba, 1990). Guba and Lincoln (1994, p. 105) define paradigm as the “basic belief system that guides the investigation in ontologically, epistemologically and axiologically fundamental ways”. An understanding of the assumptions underpinning research questions enables the researcher to decide which overarching theory should be adopted. Ontology, epistemology and axiology will now be defined and individually discussed.

Crotty defined ontology as “the study of being that is concerned with 'what is', with the nature of existence and with the structure of reality” (1998, p. 10). The theory of ontology assists researchers in establishing whether reality is out there in the social world or if it is a fabrication formed by one's own

mind (Dudovskiy, 2016). In its simplest form, this encompasses two main assumptions, objectivism and subjectivism (i.e., whether reality is objective or, instead, a product of individual cognition). Objectivism (also known as *externalism*) holds that factors deemed ‘external’ (i.e., outside of the psychological states of those who are acquiring the knowledge) can be conditions of knowledge, so that if the relevant facts justifying a proposition are external, they are acceptable. This assumption lends support to the implication that there is only one reality. Subjectivism (also known as *internalism* or *social constructivism*), on the other hand, claims that all knowledge-yielding conditions are within the psychological states of those seeking knowledge. This assumption supports the concept that, potentially, many realities are constructed through social interaction (Saunders, Lewis and Thornhill, 2015).

Cohen, Manion and Morrison define epistemology as “assumptions which one makes about the very bases of knowledge – its nature and form, how it can be acquired and communicated to other human beings” (2007, p. 7). In simple terms, it facilitates researchers in determining how they obtain knowledge in a research context by posing the following questions: What is knowledge? Do we have knowledge? And how can knowledge be gained? (Dudovskiy, 2016). Using facts from experts and scientific publications, for example, demonstrates an epistemology that is based on authoritative knowledge. An emphasis on logical reasoning as the correct method to establishing truth is known as rationalist epistemology or logical knowledge, while an empirical epistemology believes that knowledge is obtained from facts that are demonstrable and objective (Dudovskiy, 2016; Kivunja and Kuyini, 2017).

Within a single study, the research method may integrate all the above sources of knowledge. Regarding this study, the researcher intuitively knew that she needed to provide an opportunity for residents to be heard, and therefore chose to investigate the functionality and lived experiences of residents. Authoritarian knowledge was gained on the research topic through reading scientific publications and government reports (MHC, 2015-2020; Tedstone-

Doherty, Walsh and Moran, 2007). These served as a framework for gaining more in-depth personal experiential knowledge from the residents of CRFs themselves.

Axiology is the study of assumptions about one's own values and ethics, as well as those of research participants, and how these assumptions influence the research process (Biedenbach and Jacobsson, 2016). Those of an objectivist persuasion are not constrained by value considerations when assessing an orderly numerical reality (Aliyu *et al.*, 2015). The objectivist researcher, like the postpositivist, for example, is frequently defined by their efforts to minimise the influence of their values in order to preserve objectivity and research validity (Biddle and Schafft, 2014).

Unlike objectivists, subjectivists and phenomenologists see values and ethical considerations as intrinsic to the research process, emphasising the relevance of personal perspectives and interpretations (Biddle and Schafft, 2014). Thus, they reflect on what values guide their research and what outcomes will result from the research. For example, one axiologically-oriented question that applied to this study was: Should the researcher seek to understand the perceptions and experiences of residents living in CRF accommodation or endeavour to make changes that would represent a better life for residents? After some reflection, it became evident that both were necessary, but that a baseline understanding of residents' perceptions of the service was necessary before determining how to improve their QoL effectively.

Most researchers, regardless of their preferred methodological choices, acknowledge that axiology plays an important role when investigating certain issues over others, and results in the selection and creation of research questions (Zaidi and Larsen, 2018). However, pragmatists engaging in mixed methodologies and mixed-methods research have been criticised in the literature for frequently neglecting or ignoring ethical and value issues in their research (Biddle and Schafft, 2014; Hesse-Biber, 2010; Mertens *et al.*, 2010). As mentioned by Creswell and Poth (2018) a pragmatist's philosophy is whatever works best to answer the research question, hence it may not be correct to say they dismiss ethical and value concerns. Rather, it may be that

these issues are de-prioritised in the process of answering the research question.

In this study, the researcher explored (rather than discovered) aspects of the truth of life within a CRF through the residents' own experiences and perceptions of their own environment. This was done through acknowledging and accepting their subjective viewpoints, perceptions, and experiences. Therefore, a subjectivist approach best describes the researcher's own personal approach to understanding the multitude of experiences (realities) of the research participants living in CRFs. All subjective realities are of equal value, meaning the residents' subjective reality is of no lower or higher value than any other person's experience (Laverty, 2003). However, the researcher also realises that an objectivism approach adds more generalisable data to this endeavour. The assumption of one measurable reality allowed the researcher to carry out a quantitative deductive assessment and, in parallel, the assumption of multiple realities allowed for inductive reasoning and qualitative analysis.

3.3.1 Postpositivism

Guba and Lincoln (1994) argue that questions of research methods (e.g., which method of investigation should be employed) are only of secondary importance to questions of which paradigm is applicable to one's research. Various paradigms that are compatible or align with each other can be used simultaneously to construct the research framework.

Postpositivism is a philosophical perspective that emerged in the second half of the 20th century and challenged the prevailing positivist scientific ontological belief that reality external to oneself can be objectively observed and recorded, resulting in a complete understanding of that reality (Al-Saadi, 2014). Postpositivism, also known as the second version of positivism, believes in the existence of one reality and one truth. However, unlike positivism, postpositivism contends that reality and truth are not immediately accessible, but that elements of reality and truth can be obtained or approximated through research, and interpretation can be varied (Creswell

and Poth, 2018; Racher and Robinson, 2003; Ryan, 2006). Further, Creswell argues that truth cannot be established, since knowledge is subjective, based on our best understanding of a particular situation at any given time (Creswell, 2008). From an axiological stance, postpositivist researchers do not make their biases known, and their values remain neutral (Creswell and Poth, 2018). This could possibly be because the researcher is viewed more in terms of an instrument rather than a ‘meaning-maker’, as is the case in qualitative research.

Researchers using a belief system grounded in postpositivism will employ a scientific approach to research. They regard inquiry as a sequence of logically connected steps and base their knowledge/epistemology assertions on objectivity, standardisation, deductive reasoning, and control over the research process (Creswell and Poth, 2018). Postpositivism is frequently associated with quantitative methods and is characterised by an emphasis on precision, generalisability, reliability, and repeatability (Thomas, 2011). In addition, ethics in post-positivist research require that the researcher regard research participants as persons from whom they learn, rather than as subjects for research (Ryan, 2006). Furthermore, it requires passion, most notably a concern for justice and working towards positive change (Farias *et al.*, 2017; Ryan, 2006), all of which align with the researcher’s values.

3.3.2 Pragmatism

Pragmatism, which is one of the most used philosophical frameworks (Biddle and Schafft, 2014) was thus considered and found to be most appropriate, as it allows researchers to have freedom of choice. Researchers are ‘free’ to choose the methods, techniques, and procedures of research which are deemed best for enabling investigation of the research question (Creswell and Poth, 2018) and affecting change. This is the case, rather than disputing the validity and intrinsic value of certain methods and methodologies and intellectually debating the theoretical underlying assumptions and values that are irrelevant to achieving the research’s practical outcomes, objectives or goals (Kelemen and Rumens, 2012; Yanchar and Williams, 2006). As Rorty (1983) states, pragmatists would prefer to change the subject when confronted

with questions about truth, reality and the laws of nature. This is not to say that mixed methods and mixed methodologies are used haphazardly, but that they should be implemented with caution, by carefully selecting and integrating the results of appropriate methods for answering research questions (Denscombe, 2008). In this study, this was accomplished by conducting interviews and using questionnaires that had been effectively utilised in earlier research involving similar participants residing in comparable environments (de Girolamo *et al.*, 2002; Lelliott *et al.*, 1996; Trieman *et al.*, 1998; Tedstone-Doherty, Walsh and Moran, 2007). Integration of the two methodologies through an explanatory sequential design helped to answer the research question.

Pragmatism is not committed to any one system of philosophy and reality and has an ontology of reality being external to the researcher, which allows for multiple realities (Kaushik and Walsh, 2019). Therefore, a pragmatic approach enables researchers to be adaptable and reflexive enough to address research questions in the most practicable manner. Thus, singular and multiple realities can emerge as a result of using quantitative and qualitative research approaches (Creswell and Clark, 2011; Rorty, 1999).

From an epistemological perspective, pragmatism can examine both observable phenomena and subjective meanings, to provide acceptable knowledge (Dudovskiy, 2016). Moreover, knowledge can be realised and understood to be constructed through human actions or interactions. Active methods of inquiry are critical because, from a pragmatist perspective, methods and knowledge interact and create one another. Furthermore, the researcher can integrate different perspectives, and adopt both objective and subjective points of view if that is required, to better answer the research question and interpret the findings (Saunders, Lewis and Thornhill, 2015).

From an axiological stance, pragmatists conduct research in a way that is consistent with their own value systems. Kaushik and Walsh (2019) argued that pragmatism is an important research paradigm for social justice research. It has the potential to engage and empower marginalised and oppressed

communities, by generating practical knowledge that is useful for action in order to effect meaningful change (Goldkuhl, 2012). From this point of view, pragmatism aligns well with post-positivism in its desire to effect change.

In conclusion, central to the application of mixed-methods research in pragmatism is the integration of results from quantitative and qualitative data to answer the research question (Creswell and Clark, 2011). Pragmatist inquiry does not run the risk of overlooking aspects of social injustice that are difficult to capture through scientific inquiry and thus does not limit itself to the experiential resources generated by empirical research (Kaushik and Walsh, 2019). Consequently, researchers should be able to conduct research more effectively by promoting both methodological and epistemological pluralism. This is based on the argument that a pragmatic approach to mixed-methods research enables researchers to be flexible and adaptive in their method selection (Johnson and Onwuegbuzie, 2004). Thus, for mixed-methods researchers, pragmatism opens the door to a variety of methods, alternative worldviews, and assumptions, as well as alternative data collection and analysis techniques (Creswell, 2008). Further motivation for the mixed-method approach in this study will now be discussed.

3.4 Research Strategy

3.4.1 Study Design

The study design section relates to the structure that guides the research process, including the implementation of research methods (Creswell and Clark, 2007). This section will present the research design used to carry out this study, explanatory sequential design. In addition, other research designs, such as the convergent parallel design and the exploratory sequential design, that were found to be less appropriate for this study will be discussed. It is important to understand the logical basis, as well as the perceived value of combining two distinct methodologies. Notably, a mixed-method study will require extra resources, time and expertise, in both quantitative and qualitative methodology (Creswell *et al.*, 2011; McKim, 2017).

It has been argued however, that mixed-method studies can provide researchers with multiple windows into the lives of the less empowered, and through this, opportunities for change can emerge (Mertens, 2007; Ponterotto, Mathew and Raughley, 2013). In light of this, the additional time required for mixed-method studies may be worth the effort for researchers who seek to advance social justice. This is true for the current study, which will contribute to the national picture, as well as eliminate the gap in the current literature, regarding both the functionality and personal experiences of residents living in CRFs. By doing so, this study provided—as per national policy and recovery model recommendations (Department of Health and Children, 2006; Department of Health and Children, 2020), an important opportunity for residents to voice their own opinions regarding their personal experiences of living in CRFs. This opportunity affords the possibility of enhancing social justice, by advocating improvements that would better serve the needs of residents. This was important to the researcher, given the long history of mistreatment by the state, of people with mental disorders residing in government accommodation (Kelly, 2016).

3.4.2 Convergent Parallel Design

Convergent Parallel Design (also referred to as concurrent triangulation) is a well-known approach to mixing methods (Creswell and Creswell, 2017). This design involves simultaneously collecting qualitative and quantitative data in the same phase of the research process, analysing the data individually, and combining and comparing the data in the final analysis (Clark and Ivankova, 2015). Another defining aspect of this design is that quantitative and qualitative data are given equal weight (Ivankova and Creswell, 2006). Although this design and its purpose of converging different methods have been discussed extensively in the literature (e.g., Demir and Pismek, 2018; Metz, 2018; Özer, 2021; Sweeney, 2016) it was not appropriate for this study, since the qualitative data were deemed more significant than the quantitative data, as discussed in Chapter one, section 1.3. In addition, it would not have been possible for a single researcher to undertake both quantitative and qualitative elements concurrently within the same research phase.

3.4.3 Exploratory Sequential Design

The exploratory sequential design requires the researcher to collect qualitative data first, then quantitative data (Subedi, 2016). The rationale and objective of this approach are that qualitative data are used to investigate a phenomenon and then the findings are used to construct quantitative questionnaires to test or generalise the initial qualitative findings (Guest and Fleming, 2015) or to further explore the research topic (Fetters, Curry and Creswell, 2013). The final phase entails the integration or combining of data from the two distinct data strands, to glean additional insights that may be overlooked in a single-method study (Ivankova and Creswell, 2006). A working example of this design can be seen in a study by Berman (2017), where the findings of qualitative data were used to drive the development of a quantitative instrument to further explore the research problem. This design was used to understand researchers' current behaviours and challenges related to data management, in order to guide the development of research data services at the University of Vermont.

As described in Chapter one, the researcher's initial purpose was to provide residents in the West of Ireland with an opportunity to have their views, opinions and concerns heard after they were excluded from the national study (Tedstone-Doherty, Walsh and Moran, 2007). Following an analysis of the quantitative data, the researcher determined that a mixed-methods study was necessary to get a more comprehensive understanding of what life is truly like for residents of CRFs. Consequently, the exploratory sequential design was ruled out for this study, as the initial phase did not involve a qualitative component.

3.4.4 Explanatory Sequential Design

The explanatory sequential design entails gathering quantitative data first, followed by qualitative data, to explain or expand on the quantitative results (Subedi, 2016). The explanatory sequential design is the most popular design employed in mixed-methods research (Ivankova and Creswell, 2006).

Illustrations of studies adopting this design can be seen in Mayoh, Bond and Todres (2012) and Newton *et al.* (2015), where the quantitative results of both studies were followed by an in-depth qualitative inquiry explaining and expanding on the quantitative findings. This second qualitative phase builds on the first, and the final stage of the study connects the two phases to provide a better understanding of the overall phenomenon (Creswell, 2003).

The qualitative phase of this study aimed to follow (or connect with) the first quantitative phase (Creswell and Clark, 2011), as the quantitative data alone were not sufficient to answer the research questions. However, it did provide a baseline to springboard the semi-structured questions for the qualitative phase.

Figure 3.3 below outlines the steps involved in the explanatory sequential design used in this study, which will be discussed in more detail in the methods chapter.

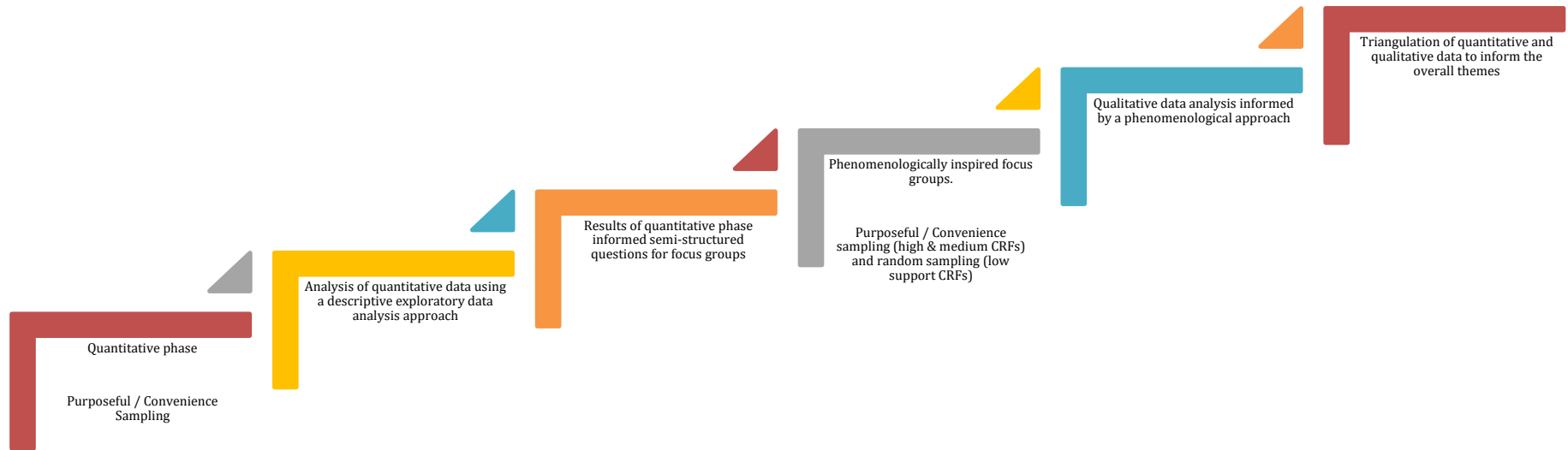


Figure 3.3: Step Up diagram indicating steps involved in the explanatory sequential mixed-method design

3.5 Identifying the Most Appropriate Philosophical Approach for the Qualitative Element of the Study

Various philosophical approaches to guide this study's qualitative component were considered, such as grounded theory, narrative research, and action research. These approaches will be discussed first, followed by an explanation of why the philosophical underpinnings of phenomenology were the most appropriate for this study.

3.5.1 Grounded Theory

Grounded theory, originally developed by Barney Glaser and Anselm Strauss in the mid-1960s, is an inductive methodology (Rieger, 2019). It sets out to discover or construct (depending on which variation is used) theory from data about social phenomena (Chun Tie, Birks and Francis, 2019). Today, there are several approaches to Grounded Theory (Turner and Astin, 2021). The traditional or classical grounded theory (GT) approach is associated with Glaser (1978), commonly known as Glaserian grounded theory. Classical GT rejects the positivist approach (that a researcher can be an independent observer of the social world) and is situated within the post-positivist paradigm (Rieger, 2019), believing that reality exists external to the researcher and research participants, but that the researcher must endeavour to stay as objective as possible (Levers, 2013). This requires the researcher to be distant and removed, with no prior knowledge of the phenomenon under study, as this could negatively influence the concluding theory (Charmaz, 2006; Sebastian, 2019; Wu and Beaunae, 2014).

Straussian grounded theory, developed by Strauss and Corbin (1990) and commonly known as interpretive grounded theory (IGT), is positioned within the interpretivist paradigm (Sebastian, 2019), which is conceptualised as having a relativist ontology with a subjectivist epistemology (Levers, 2013). Therefore, IGT differs from classical GT in that the researcher actively interprets the data, prior knowledge is viewed as strengthening the research, and reality is viewed as the unknown, but can be interpreted, and therefore is constructed (Annells, 1997; Sebastian, 2019).

Constructivist grounded theory (CGT), developed by Charmaz (2000), frames its ontological and epistemological ideas within the constructivist paradigm (Fernandez, 2012; Levers, 2013). CGT aligns more with IGT than GT with regard to the researcher's role and prior knowledge, as it allows for interpretive understandings and iterative logic (Sebastian, 2019). However, it rejects the notion that social reality is objective and supports the perspective that social reality is subjective and discovered through the interactive process (Mills, Bonner and Francis, 2006). Thus, constructivist GT holds that everyone constructs their own reality, as opposed to merely interpreting it. CGT, therefore, considers the researcher as the creator of reconstruction of experience and meaning (Mills, Bonner and Francis, 2006).

Grounded Theory was deemed to be inappropriate for this study as constructing meaning from the lived experiences of residents would prevent residents from constructing their own meaning, which would contravene the purpose of this research. Furthermore, CGT, although praised for the opportunity to employ grounded theory without embracing the positive assumptions of GT (Charmaz, 2017), has been criticised for reducing the analytic and authoritative potential of grounded theory by deploying lengthy interviews, while ignoring the GT techniques that render the data objective (Glaser, 2002). One may assume that if analytical and authoritative power is diminished, it becomes more challenging to establish whose truth is accurate.

Similar to GT, IGT has also been criticised for creating a power difference between the researcher and participants, by focusing on analytical tools for data analysis that can interfere with the research sensitivity to the data if, for example, the research gets driven by attributes of the software (Evans, 2013; Rieger, 2019; Welsh, 2002). This may result in uncertainty regarding whose interpretive frame is guiding the analysis, which is problematic for the researcher. For example, if the interpretive framework of the research process is not crystal clear it may compromise the trustworthiness of the data. This approach has also been criticised for its potential to prioritise the researcher's expertise (Rieger, 2019). As a result, it may undermine the participants' credibility and authority when discussing their personal experiences, which

is problematic when working with vulnerable populations, such as those in CRFs.

In addition to the above, grounded theory in general is more concerned with discovering and theorising original research (Charmaz and Thornberg, 2020) and is a useful methodology to use when there is no theory relevant to the social phenomenon being studied (Creswell and Poth, 2018). In contrast, the topic central to this study (CRFs) had been extensively reported on from a quantitative perspective (Killaspy *et al.* 2009; Killaspy *et al.*, 2012; Killaspy *et al.*, 2019; Killaspy *et al.*, 2016; Lelliott *et al.*, 1996; Macpherson, *et al.*, 2009; McInerney *et al.*, 2010; McInerney *et al.*, 2018). This study was both exploratory and descriptive by intent, as the purpose was to give a voice to a group of individuals who have been repeatedly excluded, both nationally and internationally, from sharing their perspectives around living in a CRF. Considering that grounded theory avoids contextual descriptions and descriptive interpretations of the empirical data (Carey, 2021) it would not have been appropriate for this study. Therefore, the qualitative phase was best guided by the philosophical underpinnings of phenomenology, which seeks to understand the lived experiences and perspectives of individuals, rather than the building of theory through the analysis of data, as in grounded theory (Starks and Trinidad, 2007).

3.5.2 Narrative Research

Narrative inquiry gained prominence among researchers, such as Connelly and Clandinin (1990) and Riessman (2008), as a means of deviating from positivism, which was the dominant epistemological paradigm. Contrary to positivists' views that the very nature of knowledge is objective and definite, narrative research questions unitary modes of knowing and contests this view (Kim 2008).

The main steps of narrative research involve the researcher spending a significant amount of time with the research participants who are willing to share their life experiences. Participants may keep journals, the researcher

may observe the participants for prolonged periods of time and take field notes (Breheny, Horrell and Stephens, 2020). Researchers may collect letters sent by the individuals, gather information from family members, obtain documents such as medical notes, or obtain images such as photographs, to assist the participant in building their story (Squire *et al.*, 2014).

Initially, narrative research was considered to guide the qualitative phase of this study, because of its recognition for giving a voice to marginalised people in society (Squire *et al.*, 2014). It was, however, found to not be appropriate, as its primary objective is to document, analyse, and interpret at every stage. These stages include: conception; data collection; writing the research text; and, reporting on the stories of experiences of either a single individual or a small sample of individuals (Josselson, 2006).

Furthermore, Barbour (2007) argues against the use of focus groups in narrative research, due to the risk of generating data that are difficult to organise and analyse, as a result of several participants communicating their detailed stories. Côte-Arsenault and Morrison-Beedy (1999), on the other hand, claim that narratives may be extracted from focus group discussions if the researcher employs smaller groups. Given the amount of time required to extract individual narratives from unstructured and unrestricted interviews, as is the norm in narrative research (Connelly and Clandinin, 1990), the consequences of employing smaller groups in this study may have nullified any advantages of using focus groups instead of one-on-one interviews. Due to limited resources, it would not have been possible to conduct individual interviews. Thus, some residents may have been denied the opportunity to participate, resulting in a less comprehensive understanding of the residents' shared reality of living in a CRF.

In addition to the above, given the challenges of writing and presenting lengthy stories, extensive findings and analysis, researchers may find it difficult to decide how to edit and analyse stories in order to make them fit within the word limit and formatting guidelines of a journal article, thesis, book or conference paper (Creswell and Poth, 2018; Squire *et al.*, 2014).

These constraints may compel researchers to consider the most effective method of communicating their findings to an audience. As a result, they may be tempted to emphasise their own research arguments, raising ethical concerns about how another person's life story may be interpreted by others (Kim, 2016). Given this potential risk and the aforementioned reasons, it was determined that narrative research was unsuitable for this study.

In contrast to narrative research, the philosophical underpinnings of phenomenology can elucidate the shared meaning of multiple individuals' lived experiences through focus group discussions (Love, Vetere and Davis, 2020). Furthermore, in phenomenology, it is the interpretations of the participants that define the commonalities of the lived experience and not the researcher's own understanding of the phenomenon (Jackson, Vaughan and Brown, 2018), as is the case in narrative research. Thus, common lived experiences of residents living in CRFs can be gleaned to establish a baseline for intervention. Finally, from an ethical standpoint, narrative research recommends observation and note-taking of participants. This may be distressing for residents, as the majority have a diagnosis of schizophrenia, where elements of paranoia and suspicion are not uncommon.

3.5.3 Action Research

Action research (AR) is a process involving individuals whose goal is to improve existing circumstances or achieve transformational changes in aspects of the participants' social world (Carr and Kemmis, 1986; Meyer, 2000; Parkin, 2009; Reason and Bradbury, 2006). The process of action research involves identifying the issue that requires change, gathering information and evaluating relative literature, developing a research strategy, collecting and analysing data, and developing an action plan, which is the action part of action research and must be continually monitored (Clark *et al.*, 2020). One of the distinguishing features of action research is the axiological role of the researcher, who is viewed as a co-learner who works with and for people rather than on them.

With regard to this research, action research was initially considered, because of its strong connections to social justice, focusing on the power imbalances of marginalised and underrepresented populations (Brydon-Miller and Damons, 2019; Cockburn and Trentham, 2002), such as those living in CRFs. However, as much as action research resonates with the researcher and the core principles of occupational therapy, it was not appropriate for this study as “action research demands that participants perceive the need for change” (Meyer, 2000 p. 178). Therefore, it may not have been appropriate to work with the residents to make a positive change without the participants knowing the specifics of what exactly needed to be changed. Moreover, it may be difficult for residents to determine what needs to be changed, particularly if they are living in a controlled or oppressed environment, as oppression is often embedded in mental health services (Corneau and Stergiopoulos, 2012). In addition, Healy (2001) argued that while action researchers state that power is shared, the researcher often leads and facilitates the research process, utilising institutional knowledge and social advantage. This may be viewed as another form of power imbalance, which may lead to participants feeling less valued and disconnected from the researcher. This, in turn, may lead to conflicting understandings of what exactly the transformative change should be.

It is undeniable that the researcher was motivated to ensure the residents' views and perspectives were included in plans and actions for their care and progress and growth through recovery. However, she did not put on lenses that only allowed her to see power imbalance or oppression power dynamics, i.e., the study delved deeper by investigating their lived reality. Her focus was more holistic, focusing on the overall experience of living in a CRF. Furthermore, as action research goes beyond asking participants to answer questions, it requires participants to realise that they play an active role in the study and the change process, which can involve activism. Hence, the change process can be threatening (Meyer, 2000). Therefore, a professional conflict of interest would have arisen if action research had been applied to this study, as it can involve activism and political agendas rather than recovery (Williamson, 2002).

3.5.4 Phenomenology

All phenomenological approaches are concerned with lived human experience and derive from two major origins. The philosophical views of descriptive (eidetic) phenomenology are derived from Edmund Husserl (1889–1938) and, more recently, Amadeo Giorgi. Whereas interpretative (hermeneutic) phenomenology has its origins in the work of Martin Heidegger (1889–1976) and subsequently Max Van Manen (Lavery, 2003; Mayoh and Onwuegbuzie, 2015; Spinelli, 2005; Sundler *et al.*, 2019). The Dutch (Utrecht) School of phenomenology emerged in the 1950s and 1960s at Utrecht University, as a third school of phenomenology (Dowling and Cooney, 2012). It advocates the combination of elements from both descriptive and interpretative phenomenology (mixed phenomenology) (Cohen and Omery, 1994; Dowling and Cooney, 2012). This section will endeavour to explore these three main types of phenomenology: descriptive, interpretive and the Dutch school— each with its own set of shared and distinguishing characteristics (Dowling, 2007). Following that, the use of focus groups informed by phenomenology will be discussed, as well as how phenomenology's philosophical underpinnings relate to the qualitative phase of this study.

3.5.4.1 Descriptive Phenomenology

Husserl, a pure phenomenologist and the founder of phenomenology, generally believed that reality manifested itself in the consciousness and was internal to the knower (Mayoh and Onwuegbuzie, 2015; Neubauer, Witkop and Varpio, 2019). For this reason, Husserl believed that research needed to begin without hypotheses or preconceptions and should seek to describe rather than explain (Lester, 1999). Therefore, he developed a scientific approach—transcendental phenomenology—to distil the essential components of people's lived experiences, given that human beings generally went about their daily lives without critical reflection on their experiences (Lopez and Willis, 2004; Neubauer, Witkop and Varpio, 2019). Husserl was the first to articulate the concept of the 'life-world' and used this term to "indicate the flow of experiential happenings which provided the 'thereness' of what appeared prior to categorising it into packages" (Todres, 2005, p.

104). In other words, individuals' realities are inextricably shaped by their environment (Lopez and Willis, 2004).

The main goal in descriptive/transcendental phenomenology is to establish transcendent subjectivity— a state in which the researcher's impact on the inquiry is constantly assessed, and prejudices and preconceptions are neutralised, so that the object of study is not influenced (Lopez and Willis, 2004). From an epistemological perspective, the researcher must disentangle himself or herself from the world, including one's own physical being, in order to arrive at a state of transcendental bias-free descriptive understanding of the phenomenon (Neubauer, Witkop and Varpio, 2019). By suspending all pre-existing assumptions acquired through the conscious experience of perception, thought, memory, imagination and emotion, a description of true reality can emerge (Reiners, 2012).

Kockelmans (1987) provided a possible explanation of Husserl's view, paying specific attention to his psychological assumptions of mathematics, as Husserl's background was in mathematics and physics. Phenomenology arose from an attempt to connect mathematics and logic with lived experience. In turn, this became an attempt to describe pure consciousness by de-voiding oneself of attitudes, values assumptions and beliefs. The implications of Husserl's perspective for contemporary research are that there are significant distinctions between mathematics, logic, and people. Thus, this approach may not be appropriate for modern-day studies investigating a person's lived experience. For example, in order to achieve transcendent subjectivity, the researcher is required to actively cleanse his or her mind of all prior personal biases and expert knowledge. This extends even to the point that some researchers advocate that the descriptive phenomenologist should avoid conducting a literature review prior to initiating a study, out of concern that it will contaminate the mind or influence thinking (Dunne, 2011; Streubert and Carpenter, 1999). This process is termed 'bracketing' and is often used interchangeably with the terms 'epoche' or 'reduction' (Stutey *et al.*, 2020). Despite this being a central concept in descriptive phenomenological research, it is also a contentious topic (Dörfler and

Stierand, 2021). The reason for this is possibly because, on an epistemological level, phenomenological approaches are based on a paradigm of subjective knowledge and experience (Lester, 1999).

Some researchers dispute the need for the strict bracketing process outlined by Husserl and Carr (1970). Plummer (1983) and Stanley and Wise (1993) argued that it is impossible to begin a research study without assumptions or prejudices, and instead emphasised the significance of portraying the researcher as a subjective participant rather than an objective spectator. Van Manen (1990) further supported this argument by emphasising that it is impossible to achieve complete bracketing of the researcher's clinical impressions and clinical knowledge, when the researcher is also an experienced clinician. However, Carpenter (2007) stated that bracketing enhanced trustworthiness of the data collection and analysis process in most phenomenological studies. This is done by encouraging researchers to be aware of their own preconceptions about the phenomenon being studied, in order to minimise their influence on the research (this will be discussed further under reflexivity, section 3.6.1). Therefore, in descriptive phenomenology, the researcher's role in analysing and writing the data is to consider phenomena from different perspectives in order to identify meanings, which are then clustered into themes, to capture the essence of the phenomenon in a textural description (Neubauer, Witkop and Varpio, 2019).

In more recent trends, the idea of 'bridling' developed by Dahlberg (2006) has come to the foreground as a more realistic way of approaching bracketing. Vagle, Hughes and Durbin describe 'bridling' as a self-reflective process in which the researcher examines their own process of understanding in order to avoid grasping concepts "too quickly or carelessly" (2009, p. 350-351). In other words, the researcher deliberately slows down to examine meaning. Unlike bracketing, during the bridling process, the researcher does not need to completely cleanse the mind of pre-understandings and background information on a phenomenon (Dahlberg, 2006). Instead, bridling should take the form of a reflective stance in which the researcher "loosens understandings from prior experiences" (p. 16) in order to better understand

the phenomenon. This should be viewed as an ongoing process that takes place throughout the research process (Stutey *et al.*, 2020).

Bridling is interwoven with reflexivity. The latter is commonly seen as the analytical focus on the researcher's role, in which the researcher engages in self-criticism and self-evaluation and explains how his or her own experiences should not influence the research process (Koch and Harrington, 1998). Therefore, reflexivity enables researchers to reflect on and articulate their position and subjectivities (worldview, viewpoints, biases), so that readers can understand the lenses through which questions were formulated, data were collected and analysed, and conclusions drawn. From this perspective, bias and subjectivity are unavoidable. Thus, they should be expressed in a manner that is transparent and easily understood (Gilgun, 2008; Sutton and Austin, 2015).

Stutey *et al.* (2020) suggest that the bridling process, which includes reflexivity, may lead to personal growth for the researcher in the form of personal transformative change and genuine relationships with research participants. This makes sense, given the process of self-reflection is linked to personal growth (Ash and Clayton, 2004). However, Probst (2015) asserts that there are no empirical studies on how researchers practise reflexivity. Moreover, Finlay (2002b) warns that reflexive analysis is difficult and risky, comparing it to a “swamp” (p. 532) of murky and confusing terrain, because it is possible for the researcher to engage in an endless process of self-analysis at the expense of study participants. In addition, Patai (1994), Finlay (2002a) and Pillow (2003) caution that one should not assume that their work is more valuable just because it is reflexive, since being reflexive is not a solution to the challenge of capturing another person's experience. This implies that, despite the significance of reflexivity, researchers must exercise caution to avoid embarking on an infinite process of self-analysis.

3.5.4.2 Interpretive or Hermeneutic Phenomenology

Interpretive or hermeneutic phenomenology was developed by Heidegger, who received training in phenomenology from Husserl, while they both

worked at Freiburg University. Heidegger eventually dissociated himself from Husserl and his work (Lavery, 2003). This split may have been because Heidegger disagreed with Husserl's emphasis on the significance of description rather than understanding (Racher, 2003). It could also have been based on the rigorous and unbiased approaches (e.g., bracketing) to the lived experience, in attempts to gain an understanding of the human consciousness (Dowling, 2007).

Heidegger's ontological view is that the lived experience of an individual's life/world should be interpreted, not simply described. Therefore, when using interpretive phenomenology to investigate the meaning of a phenomenon, the researcher does not bracket their biases or pre-interaction with the topic under investigation, as is required in descriptive phenomenology. This is because, epistemologically, Heidegger believed that the researcher was not bias-free as a human who was also part of the broader world. Instead, the researcher understands phenomena by interpretive means, and contrary to Husserl's view, Heidegger believed that consciousness cannot be separated from the way human beings interact with the world (Dowling, 2007).

Supporting interpretive phenomenology, Smith and Osborn (2007) purported that understanding a phenomenon or experience entails the researcher attempting to understand the participants, who are themselves attempting to make sense of their own experiences. Thus, the researcher is viewed as a collaborator in the co-creation of participants' meaning. Therefore, the researcher's role in data collection entails reflecting on central themes of participant experience with the phenomenon, while also reflecting on his or her own experience (Neubauer, Witkop and Varpio, 2019). This differs from descriptive phenomenology, where the focus is on finding the 'essence of truth' in the data through bracketing and 'not over analysing' it (Reiners, 2012).

Matua and Van der Wal (2015) stated that choosing phenomenology as a research method necessitated a robust understanding of different approaches in phenomenology, to allow the researcher to make critical methodological

decisions that would demonstrate the study's scientific rigour and phenomenological trustworthiness (Dowling and Cooney, 2012). Therefore, in interpretive phenomenology, the researcher's role in analysing and writing the data involves repetitive cycles of capturing and writing reflections in order to produce analytically rigorous findings. Additionally, the researcher must consider how the data contribute to the advancement of knowledge about the phenomenon (Neubauer, Witkop and Varpio, 2019).

Despite the above, Hein and Austin (2001), in their study comparing empirical and hermeneutic approaches to phenomenological research in psychology, concluded that essentially the exact same answers were arrived at when analysing a transcript from both a descriptive and interpretive approach. Based on their analysis, they further concluded that there is no correct way to conduct phenomenological research and that the approach required is largely determined by the purpose of the research. This analysis by Hein and Austin (2001) is consistent with the logic of pragmatism, because it allows researchers to be adaptive and reflective enough to approach research issues in the most pragmatic way.

Dahlberg and Dahlberg (2019) further suggest that the distinction between interpretive and descriptive approaches represented a false dichotomy. They argue that it reflected a misunderstanding of the original philosophical foundations, particularly regarding meaning. More specifically, they pose "Merleau-Ponty's assertion that human beings are condemned to meaning," (p. 2) rendering it unavoidable. The implications of this are that, even when purely describing a phenomenon, it is inevitably described in the context of the person's own sense of meaning of the phenomenon. In other words, interpretation occurs within the context of meaning and meaning exists independent of interpretation. However, Zahavi (2019) further ignited the debate, asserting that certain well-known authors in the field (e.g., van Manen and Smith) were publishing confusing information concerning the nature of phenomenology. This resulted in published data which in some cases were either diametrically opposed to or illogically connected with the original texts.

However, Heidegger's theory has also been criticised for being too complex and difficult to understand. Phenomenology in general is considered intimidating, particularly to novice researchers, due to its complexity and dearth of detailed implementation guidelines (Cerbone, 2008; Christensen, Welch and Barr, 2017; Dörfler and Stierand, 2021; Neubauer, Witkop and Varpio, 2019; Sheehan, 1998; Sundler *et al.*, 2019). Given the above, it is unsurprising that many researchers struggle with phenomenology's philosophical underpinnings, and it is reasonable to question if any researchers stay true to either Husserl's or Heidegger's original concepts.

3.5.4.3 The Dutch School Tradition

The Dutch (Utrecht) School of phenomenology emerged in the 1950s and 1960s at Utrecht University. This practical and reflective phenomenological approach aimed to better understand aspects of everyday and professional life through the lens of social participation, personal responsibility, and humanism (van Manen and van Manen, 2021b). An example of this mixed phenomenology is represented by Langeveld's exploration of how young children begin to experience things in their life, and the need to both describe and interpret the phenomenon from the child's perspective, to obtain a deep understanding of the phenomenon (van Manen and van Manen, 2021a).

Intellectual members of the Dutch School consisted of a mixed assortment of like-minded phenomenologically-orientated psychologists, educators, doctors, criminologists and jurists, who became interested in phenomenology as a practical and reflective practice (*phenomenology of things*) (Levering and Van Manen, 2002). This approach of phenomenology did not emphasise or prioritise philosophy and combined elements of descriptive and interpretative phenomenological schools (Cohen and Omery, 1994; van Manen, 2007).

Humanism is rooted in the constructs of social justice and human rights and is characterised by attitudes and behaviours that demonstrate care and respect for the psychological, social, and spiritual concerns and values of individuals (Ikiugu and Molitor, 2021; Lee Roze des Ordon, *et al.*, 2018). A possible

reason for this humanistic approach to phenomenology was that members of the Dutch School were concerned about the future of their country's youth in the chaotic aftermath of World War II, who had become dislocated and disenfranchised by the post-war turmoil (Levering and Van Manen, 2002).

Unfortunately, the Dutch School eventually succumbed to a combination of retirements and emigration of some of the leading proponents, and the ineluctable pressure of behavioural and empirical analytic science emanating from both the United Kingdom and the United States (van Manen and van Manen, 2021a). Nevertheless, despite its demise, the philosophical phenomenological influence of the Dutch School in the fields of education, health sciences, and psychology, such as the revival of reflective interpretative practises with an emphasis on experiential perspectives, remains widespread and significant (Levering and Van Manen, 2002), particularly in the field of nursing (Dowling, 2007).

The influence of the Utrecht School is also evident in Max van Manen's work, such as in his text, 'Phenomenology of Practice' (1990). Here, van Manen discusses the practical application of phenomenology, as well as the core concept of phenomenology as a reflection on lived experience. He explains that we are always in the 'now' and because we are always in the 'now' we can never not be in the 'now' - we will always be too late to grasp it, so therefore we need to reflect on it. Similarities in van Manen's writings and his approach to phenomenology can also be seen in others' writings (Berndtsson *et al.*, 2007; Smith, Flowers and Larkin, 2009).

In addition, van Manen further emphasises the benefit of this practical and pragmatic approach to phenomenology in his most recent book *Classic Writings for a Phenomenology of Practice* (2021). He proposes that engaging in philosophical arguments is unhelpful for analysing and explicating ordinary meanings of experiential phenomena. Like Heidegger, van Manen rejects Husserl's position on bracketing and questions if researchers deliberately attempt to dismiss or disregard what they already "know", as preconceived ideas may persist and infiltrate the minds of researchers (van

Manen, 1990 p. 47). Moreover, van Manen believes that any descriptive act is an interpretation, as making lived experience explicit with speech or in a text requires interpretation (Errasti-Ibarrondo *et al.*, 2019; van Manen, 2014; van Manen, 2015).

3.6 How the Philosophical Underpinnings of Phenomenology Relate to the Qualitative Phase of this Study

The guiding pragmatic paradigm of this study enabled the researcher to use aspects from each of the three phenomenological schools. This approach is reflective of Moran (2002), who concluded that phenomenological researchers often have diverse and conflicting interests in terms of their interpretation and application of phenomenology. This is possible because phenomenology is flexible and adaptable to a broad range of inquiries (Garza, 2007). Indeed, Mayoh and Onwuegbuzie (2015) assert that designations, such as interpretative and descriptive phenomenology, are themselves commonly used interchangeably without due consideration to their philosophical underpinnings.

The main phenomenological underpinnings utilised in this research were bridling and reflexivity, description and interpretation. Examples of how these elements of phenomenology were used are described below.

3.6.1 Bridling and Reflexivity Reflexive Box

Similar to van Manen (1990) I felt that I would not have been able to achieve complete bracketing of my clinical knowledge and experience. As a result, I applied the process of bridling and reflexivity rather than bracketing throughout the research process, to ensure that I did not influence the residents in expressing their lived reality (Stutey *et al.*, 2020). A challenge arose during the focus group discussions in a particular house (house #3) when residents went to what I considered considerable efforts to reassure me that they were happy living in a CRF and that everything was good in their house and in their lives. In this specific example, the process of bridling and bracketing allowed me to dissuade myself from any

previously held negative assumptions about living in a CRF and collect data on the residents shared lifeworlds, without any undue interference.

During this particular focus group, I recall feeling a little disappointed with residents' positive responses since I had worked with one of the individuals in this specific house, and I was aware that there was no occupational therapy or psychological input with the other residents who lived there. I was also concerned that the information I had gathered may be of limited value, and I pondered whether I might have acquired more useful information by asking alternative questions without influencing the residents' responses. I found it difficult to understand why they would want to portray their lives in the shining light that they did when I knew that they were not getting the opportunity to live their lives to the best of their ability.

Following the focus groups, the process of bridling and reflection enabled me to first determine whether I needed to accept the residents' comments at face value or if I needed to delve deeper to analyse them.

Upon reflection it became clear that I needed to evaluate if what the residents were telling me was what they thought I wanted to hear; or if they were trying to please me as an employee of the same organisation that was providing them with shelter and care. They may also have been afraid of the impact of my research; in that they might be transferred to a different CRF as a result of their comments.

I had to be open to the possibility that their "all (was) wonderful here" perspective reflected their actual reality. From an axiological and interpretivist phenomenological perspective, my values as a person and an occupational therapist compelled me to delve deeper in the hope that this learning may better their lives.

During the research process, I found myself consciously and consistently attempting to separate my own perceived ideas and emotions in order to remain rigorous in the principles of descriptive phenomenology (Neubauer,

Witkop and Varpio, 2019). The process of bridling and reflexivity allowed me to consciously slow down and analyse my own understanding process (Vagle, Hughes, and Durbin, 2009), enabling me to apply detail-oriented thought to both prior and new knowledge. This further enabled me to gather multiple constructs of reality. I could also balance the reality presented to me by the residents with prior knowledge, information gathered from staff on the ground, information presented in the literature, as well as contradictory information from residents in other CRFs who engaged in the focus groups.

Engaging in the processes of bridling and reflexivity ensured that I did not override the voices of the residents or represent their reality based on my own perspectives or beliefs. In other words, the data analysis/interrogation did not compromise their perspective and voice. Since I did not take these particular comments at face value could be construed as a contradiction, because the purpose of the study was to provide an opportunity for residents to describe what life is like in a CRF. However, in reality, my interrogation of the data presents a more comprehensive understanding of the experiences within CRFs. This described process of reflexivity included cognitively thinking on numerous levels, being aware of what was influencing my response to the data (self-awareness), while simultaneously being aware of my reasons for doing the research as well as my relationship to the research participants (Dowling, 2006), and the implications of the research itself (Mayoh and Onwuegbuzie, 2015).

If I had ignored the above tenets of reflexivity and followed the strict process of bracketing outlined by Husserl and Carr (1970), I would have been required to bracket all prior knowledge, as well as the thoughts and feelings I was experiencing. Moreover, I would have had to disconnect myself from the world in order to arrive at an objective description of their reality (Neubaier, Witkop and Varpio, 2019). The only alternative would have been to accept the residents' comments at face value, which would

have led to a less comprehensive knowledge base of what life is like for CRF residents.

3.6.2 Description and Interpretation

As detailed in section 3.5.4.1, the process of description in phenomenology emphasises the “pure” description of people's experiences (Matua and Van Der Wal, 2015 p. 22) and ensures that the object of the study is not influenced by the researcher's biases and preconceptions (Lopez and Willis, 2004). In this study, the descriptive element involved extrapolating direct quotes from residents, to describe their experiences. The researcher then provided a more cohesive account of their experience through interpretation, employing reflexivity as indicated in one example provided in the reflexive box below.

3.6.3 Description and Interpretation Reflexive Box

Some residents in one of the houses occasionally spoke with a hint of sarcasm, and one subject of discourse that comes to mind is a discussion about neighbours. When residents were asked if they would like to get to know their neighbours, the response was as follows:

“Our neighbours, oh yes, we know our neighbours, Mr. X, don't we?”

The sarcastic tone of the comment, combined with other comments stating that the residents were attempting to “go around undetected”, as well as my own experience of working in CRFs and knowledge gained from the literature, enabled me to carefully extract the comment's meaning without dismissing or overriding the residents' voices.

In other words, I was very aware of retaining objectivity while engaging in reflexivity to minimise my own biases. Through thorough analysis I was able to comprehend and interpret the above statement by deconstructing it, while simultaneously thinking in depth from different perspectives, as is required from a phenomenological researcher and particularly when incorporating reflexivity (Mortari, 2015). From an axiological standpoint,

I was aware, for instance, that all sorts of stigma may be prominent in CRFs and experienced in people with mental health disorders (Gonzales, Chan and Yanos, 2017). However, I did not want to rush to this conclusion without thorough analysis.

Although the data were analysed through a descriptive and interpretive phenomenological lens. I also ensured that discussions took place with an occupational therapy manager regarding the data analysis process. In this way any biases or assumptions I may have had did not impact my interpretation. If I had not analysed and interpreted the above comment via the lens of mixed phenomenology and reflexivity, I may have missed the less-than-obvious signpost signaling that stigma was an issue within this specific CRF.

The principles of descriptive phenomenology were applied to enable residents of CRFs to communicate their lived experience in their own words. At times, some of their comments required the researcher to move beyond description and look for meaning to gain a deeper understanding (Mayoh and Onwuegbuzie, 2015). In this case, the principles of interpretive phenomenology were applied. Utilising the principles of mixed phenomenology allowed for both the description and interpretation of the residents' shared lifeworlds.

3.7 Focus Groups in Phenomenology

This study adopted phenomenological approaches. However, some claim that focus groups are not appropriate for, or are incompatible with, phenomenology given its focus on individual experience (Blake *et al.*, 2007; Dowling, 2007; Webb, 2003; Webb and Kevern, 2001). Others, such as Bradbury-Jones, Sambrook, and Irvine (2009) state that there are examples of nursing research where focus groups and phenomenology are integrated, but criticise the researchers for failing to explain their approach, specifically mentioning the work of Baldwin (1996) and Sikma (2006). Sikma's primary justification for utilising phenomenology in their study (which included focus groups) was that phenomenology emphasised the importance of empathy and

involved participants' reality. However, they did not justify their chosen methodological approach or use of focus groups, therefore it is no surprise that their work has been criticised.

Conversely, Jones *et al.* (2013) employed focus groups in their phenomenological research. They explored the challenges that children and their families experienced while seeking optimal asthma treatment outcomes and found it advantageous. In addition, Kooken, Haase, and Russell (2007) discovered that their phenomenological-oriented focus groups yielded unexpectedly rich data on Afro-American women's cancer survivorship.

Bradbury-Jones, Sambrook, and Irvine (2009) further purported that focus groups were valid in both descriptive and interpretive phenomenology, but only if researchers understood and defended the philosophical basis of their phenomenological work. However, the absence of linking philosophical underpinnings to the method used appears to be problematic with many qualitative studies and not just phenomenological studies (Stubblefield and Murray, 2002). Nonetheless, it is important to recognise that as qualitative research evolves, using a phenomenological approach with focus groups has merit and is gaining wider acceptance (Le Boutillier *et al.*, 2022; Love, Vetere and Davis, 2020; Phillips, Montague, and Archer, 2016). For example, Le Boutillier *et al.* (2022) used semi-structured interviews (N=18) and six focus groups (N=26) to successfully explore shared experiences of living with breast, prostate and colorectal cancer, using interpretive phenomenological analysis.

Given the above, the researcher concluded that focus groups, guided by key phenomenological tenets, were the most effective way for providing a rich account of residents' shared experiences. These also facilitated persons who were excluded from the national study to participate in this study. This pragmatic approach of the researcher enabled her to present authentic and accurate findings by interviewing as many residents as possible, within a practical and reasonable time frame.

3.7.1 Rigour

According to Hofseth (2018 p. 21) “if science isn’t rigorous, it’s reckless”, rigour ensures the robust and unbiased design, methodology, analysis, interpretation, and reporting of results. Given the distinctions between quantitative and qualitative research methodologies, rigour is judged and described differently based on the methodological approach (Forero *et al.*, 2018). Quantitative terms, such as validity, reliability and objectivity, are often described in qualitative research as credibility, transferability, dependability, and confirmability (Guba, 1981; Lincoln and Guba, 1985; Morse, 2015). In addition, the concept of reflexivity has grown with qualitative research advancements, arguing for the incorporation of a reflective account to enhance the rigour of the research process (Jootun, Mcghee and Marland, 2009). The next section will examine how rigour was applied to the quantitative and qualitative aspects of this study.

3.7.1.1 Credibility and Validity

Credibility refers to the conscious effort to establish confidence in the data, by ensuring that interpretations are true, accurate and trustworthy (Whittemore, Chase and Mandle, 2001). Credibility can be enhanced through triangulation, which is described as the use of multiple methods or data sources to develop a comprehensive understanding of the phenomena (Patton, 1999). In this study, triangulation was accomplished by conducting focus groups with the residents of CRFs and surveying community nurses involved in the care of CRF residents. Triangulating more than one data source in a single study, known as data triangulation, improves the credibility of the study (Carter *et al.*, 2014). In addition, the triangulation of both quantitative and qualitative data in this study, known as *methods triangulation*, further enhance credibility as it mitigates the weaknesses found in single methods (Nobel and Heale, 2019). Furthermore, the researcher enlisted the help of a colleague who was unfamiliar with the study's participants to obtain their perspectives on the anonymised data and corroborate themes from the data, without prior discussion with the researcher. This form of triangulation is known as *investigator triangulation* and is an additional way to enhance credibility (Carter *et al.*, 2014). It can also be argued that the fourth form of

triangulation, known as *theoretical triangulation*, was also applied to this study, as the findings from the data were also confirmed by a professional outside of the field of occupational therapy (NE) (Carter *et al.*, 2014; Guion, Diehl and McDonald, 2011). Member checking in qualitative data analysis is also another way to improve credibility (Doyle, 2007). However, the researcher decided not to engage the participants in member checking, since some of the residents were illiterate and needed assistance in completing the resident's questionnaire. As a result, the researcher was concerned that requesting residents to verify conclusions from the data may result in shame or embarrassment for certain individuals and consequently opted against doing so.

From a quantitative perspective, the validity of a research study refers to the degree to which the results among the study participants correspond to the actual findings among comparable persons outside of the study (Patino and Ferreira, 2018). To establish external validity, researchers must first establish internal validity, which is the extent to which the findings truly represent the reality of the study participants (Halperin, Pyne and Martin, 2015). In other words, it must be ruled out that the findings resulted from methodological flaws. With regard to this study, it is argued that external validity has been achieved, since the results from this study were comparable to those from the national study examining CRFs in Ireland (Tedstone-Doherty, Walsh and Moran, 2007). Furthermore, some of the findings are also relatable to the annual findings reported by the MHC over the past number of years.

3.7.1.2 Transferability

Transferability is synonymous with generalisability or external validity in quantitative research and refers to the degree to which the results of qualitative research can be transferred to other contexts or settings with other subjects (Coghlan and Brydon-Miller, 2014). In this study, detailed, rich descriptions of residents' experiences in the context of living in a CRF were documented. These thick descriptions can enhance transferability in so far as they become more meaningful to the reader (Korstjens and Moser, 2018). It is argued that the qualitative findings from this study are generalisable to

other CRFs in Ireland. This opinion has been formed through the researcher's own professional observations, experience and discussions with colleagues who work in CRFs in different locations in Ireland and indeed the UK. However, it is the responsibility of the reader to make 'transferability judgements' on the applicability of these findings to their own settings (Lincoln and Guba, 1985).

3.7.1.3 Dependability and Reliability

Dependability in qualitative research is the ability of another researcher to follow the researcher's decision trail and arrive at the same findings, interpretations, and assumptions regarding the data (Guba and Lincoln, 1989). Reliability in quantitative research refers to the degree to which a research instrument consistently provides the same results when applied multiple times in the same context (Heale and Twycross, 2015).

The dependability of the study's qualitative findings was ensured by meticulous documenting of the research process, which is represented by a flow diagram illustrating the steps taken during the research process (section 3.1). Moreover, the data analysis processes followed Colaizzi's (1978) phenomenological method, which offers rigorous, resilient, and acceptable guidelines for qualitative analysis (Wirihana *et al.*, 2018). In addition, digital audio recordings were utilised to facilitate exact verbatim transcription for thematic analysis and transcripts were compared to audio recordings to account for any missing information or inaccuracies (Tessier, 2012). Interviews were also transcribed as quickly as possible following the completion of each focus group, so the researcher could become immersed in the data and the 'lifeworld' of the participants (Burnard, 1991; Tuckett, 2005).

Utilising questionnaires (the Facility Questionnaire, Residents Questionnaire, and Community Nurse Questionnaire) that were previously used within three international studies (de Girolamo *et al.*, 2002; Lelliott *et al.*, 1996; Trieman *et al.*, 1998) and adapted by the HRB for national Irish use in the *Happy Living Here Report* (Tedstone-Doherty, Walsh and Moran, 2007), increased

the reliability of the quantitative findings of this study, as results were similar in all studies.

3.7.1.4 Confirmability and Objectivity

Confirmability in qualitative research and objectivity in quantitative research describe the degree of neutrality or the extent to which the findings reflect participants' opinions and experiences, rather than the researchers' opinions and biases (Korstjens and Moser, 2018; Kynagäs, Kääriäinen and Elo, 2020; Maher *et al.*, 2018). In order to reduce bias (Polit and Beck, 2012; Rodgers and Cowles, 1993; Sell *et al.*, 2015) an external person reviewed the researcher's interpretation of the qualitative data and conclusions, to ensure they were consistent with the researcher's initial findings, thereby enhancing confirmability.

3.7.1.5 Ethical Framework

Ethics in research are moral principles that govern how researchers should carry out their work in order to protect the dignity, rights and welfare of research participants (WHO, 2021c). Each research philosophy has its own set of core values and ethical norms, as do several health-care professions. Core values that guide OTs, namely, altruism, equality, freedom, justice, truth, and prudence were applied to this study. This was done in conjunction with Beauchamp and Childress's (2001) widely used biomedical ethic principles of beneficence, nonmaleficence, autonomy and justice. In addition, the potential ethical vulnerabilities related to this study and the mechanisms used to mitigate these vulnerabilities will be discussed in detail below.

3.7.1.6 Beneficence (To Do Good)

Beneficence, as defined by Beauchamp and Childress (2001), is to do good and benefit research participants in a tangible way. Beneficence was overtly addressed through the main aim of this study, to improve the QoL and well-being of residents living in CRFs. The research itself was initiated by the researcher's innate intention toward beneficence, as evidenced by daily challenges with government-run CRFs and a wish to improve the situation

for recipients of the service. As previously mentioned in Chapter one, section 1.4, several CRFs where the researcher worked, noticeably or totally lacked a recovery mindset. The education received through training in occupational therapy prepared the researcher for her current role as an advocate for those living in government-run community residential facilities (CRFs), which serve the mental health needs of the most marginalised members of society.

Residents' needs were formally addressed in this study, which aimed to enhance their well-being. The research findings will hopefully be used as a catalyst for change, resulting in increased independence, and improved clinical and rehabilitation outcomes for residents. As a result of this research, beneficence, or a commitment to the greater good of others, was demonstrated.

3.7.1.7 Nonmaleficence (Minimising the Risk of Harm)

One ethical consideration identified in this study was whether the research was justified. In this regard, the researcher was intensely aware that entering the residents' home environment was disruptive, and that conversations in focus groups could potentially cause vulnerabilities such as psychological anguish. Therefore, it was important to the researcher that this risk was outweighed by the potential benefits and overall value of the study.

Upon reflection on the above and applying clinical and ethical reasoning skills, the researcher evaluated the study's overall goals and concluded that the study was beneficial and justifiable from a pragmatic axiological standpoint. However, risk had to be minimised to the greatest extent possible. As a result, prior to focus groups, participants were informed that sensitive topics would be discussed, and they would have immediate access to staff if needed. The researcher sought to minimise distress and disruption, while also remaining cognisant of any unwanted intrusion into their private lives. Identifying ways of limiting discomfort and assessing participants for signs of distress are critical components of effective ethical practice (Walker 2007) and if participants become negatively affected by the research, the research must be suspended until the issue is resolved.

Given the above, the researcher concluded that the benefits of conducting the research. These included, enhancing knowledge and awareness so that others can effect change and improvement, that far outweighed the risks associated with the main vulnerability identified, fear of psychological anguish. This decision-making process entailed being aware of potential risks and knowing how to mitigate them. As a result, Beauchamp and Childress's (2001) ethical principle of nonmaleficence, avoiding harm to vulnerable persons, was followed.

3.7.1.8 Autonomy and Informed Consent

Throughout the research process, the researcher placed a high emphasis on autonomy, as it is the foundation for informed consent, truth-telling, and confidentiality (Varkey, 2021). Informed consent was one of the vulnerabilities identified under the autonomy principle. Residents, for example, rely heavily on the system for shelter, food, and mental health care, and it is probable that residents regarded the researcher as an authority figure. As a result, the researcher wondered if participants' level of dependence and possible perceived authority towards the researcher had an impact on the validity of the actual consent form. Thus, the researcher questioned if participants would feel obligated to participate, given the researcher's advantaged position (Räheim *et al.*, 2016).

In order to mitigate this vulnerability as much as possible, the researcher communicated the absolute truthfulness and authenticity of the study's purpose as advised by Karnieli-Miller, Strier and Pessach, (2009). In this scenario, the researcher aligned with one of the core values in occupational therapy (veracity), by being honest and truthful in explaining that the study's main goal was to ascertain if the residents were happy living in a CRF, if they were satisfied with the service they were receiving, and if they would like to see any changes made to the service. Participants were reminded that they have the right to make decisions about their own care that directly affect their lives (CORU, 2019).

Further attempts to mitigate the above identified vulnerability around consent, included ensuring that the information leaflet (Appendix 2) detailed the study's title, goal, rationale, and actions involved. Thus, participants could fully understand the meaning of the study prior to making any decisions around participation. The researcher also ensured that each resident had full capacity to provide written consent for each phase of the research, by liaising with a member of their treating team. Participants were informed that they were under no obligation to answer any questions and that they may leave the study at any moment and for any reason, without jeopardising their ongoing treatment.

3.7.1.9 Confidentiality and Anonymity

Participants were made aware that all discussions in the focus groups were private and were requested to respect the privacy and confidentiality of other residents when sharing their experiences, as outlined by Walker (2007). In addition, residents were informed in writing that all information provided would be anonymised and not linked to their name, and would not be shared with other residents or staff, unless there was a risk to themselves or others. With regards to the safe keeping of data, participants were assured that all data would be stored and destroyed in accordance with the University of Galway (UoG) data protection policy. As per HSE guidelines, UoG guidelines and Data Protection Act 2003, all information was treated in the strictest confidence, recorded anonymously, stored securely and made available only to those who have a legitimate right to access it. In keeping with the latter, professional codes of conduct and legal responsibilities under the Data Protection Act, 2003, the European Convention on Human Rights Act, 2003, European Union and World Health Organisation directives regarding professional conduct and the rights and dignity of people with mental disorders, were adhered to.

Residents were also informed of the expected distribution of the information and ensured that their experiences would be transcribed and analysed as truthfully and accurately as possible, which is a significant ethical consideration in qualitative research (Walker, 2007). Finally, under the

core value of veracity in occupational therapy, the researcher ensured that intellectual property and authors of previous research were acknowledged for their contributions and that their work was properly referenced in this study.

3.7.1.10 Justice

Justice was approached from two perspectives: from a research perspective, as well as from an occupational therapy perspective, by attempting to alleviate an existing injustice in which residents in Irish CRFs do not have fair and equal access to quality care. For example, the previous national study (Tedstone-Doherty, Walsh and Moran, 2007) established that residents are not receiving adequate treatment, as many spent extended periods of time in CRFs secondary to not receiving adequate rehabilitation.

From a research perspective, a further vulnerability was identified in that the researcher has previously worked with some of the residents in a professional capacity, either one-on-one or in a group setting during hospital admission. This had both positive and negative effects. For example, residents with whom the researcher had previously worked with appeared more relaxed and communicative in the focus groups. This was potentially beneficial in that it could have made other participants who did not know the researcher feel more at ease, and thus more comfortable sharing information. The establishment of good rapport can be critical to gaining in-depth information (Lester, 1999). On the negative side, participants who knew the researcher well, tended to deviate off topic rather than staying focused on focus group topics, so the researcher needed to maintain strict boundaries. This familiarity may have left residents who did not know the researcher feeling a little excluded. However, this was mitigated by ensuring that all participants were treated equally and without prejudice. That is, the researcher did not demonstrate a preference to those with whom she had previously worked.

Further to the above, the relationship and intimacy that develops between researchers and participants in qualitative studies have been noted to bring

ethical challenges (Sanjari *et al.*, 2014). One challenge applicable to this study is the possible power imbalance between the researcher, (who was also employed by the service at the time of data collection) and vulnerable persons with mental disorders living in CRFs, as alluded to in the paragraphs above. To minimise any potential power imbalance, a common epistemological foundation in qualitative research (Karnieli-Miller, Strier, and Pessach, 2009), the researcher applied the principle of beneficence, as well as general ethical considerations in occupational therapy (Occupational Therapy Code of Ethics, 2015). The highest standards of personal integrity, being respectful and dignified, transparent, and holding all participants in unconditional positive regard were maintained (Bailliard and Aldrich, 2017; Pezalla, Pettigrew and Miller-Day, 2012). In addition, the researcher developed a reflective practice to maximise her conscious awareness to stay outside of power imbalance and minimise “objective separateness” (Guba and Lincoln, 1989, p. 94).

With regards to justice from an occupational therapy perspective Bailliard and Aldrich (2017) argue that OTs should be encouraged to view their practice as justice promoting efforts. This should be done by striving to create a society in which all people are free from oppression, treated fairly and equitably, and receive appropriate treatment for their needs. The national study (Tedstone-Doherty, Walsh and Moran, 2007) demonstrated that CRF residents in Western Ireland, by being excluded, were denied the opportunity to have their voices heard.

Pragmatism reinforces meaningful research. Thus, pragmatists frequently begin with a desire to improve the world (Wolfe, 1999), as pragmatism and social justice research on the above-mentioned themes (equity, fairness, and freedom from oppression) are inextricably linked (Kaushik and Walsh, 2019). Thus, occupational therapy’s core ethics and values, as well as Beauchamp and Childress’s (2001) ethical principle of justice, when combined with a pragmatic worldview, perfectly align with the researcher’s desire to address social injustice, caused by the systematic authority or power that continues to

oppress residents living in CRFs. This is done by ensuring that residents' voices are heard.

3.7.1.11 Ethical Approval

Finally, in accordance with the Association of Occupation Therapy, Ireland's (AOTI) code of ethics, the entire research process was conducted with the permission and approval of the local and relevant governing bodies: the Research Ethics Committee, the Clinical Director, the Director of Nursing, and the local Health Service Executive Manager (a copy of all relevant approval letters can be found in the appendices list). Additionally, each resident's treating consultant psychiatrist was notified of their participation in the study through writing (Appendix 4).

Throughout the study, participants' dignity, rights, safety, and well-being were the most important considerations, along with ensuring that data and intellectual property are protected (Kirilova and Karcher, 2017; Walker, 2007). Recognising and resolving ethical issues is a rigorous process that requires comprehending the complex dynamics of the situation, assessing the consequences, applying clinical reasoning skills, acting, and reflecting on the outcome (Occupational Therapy Code of Ethics, 2015). However, it is crucial to note that ethical action is more than adhering to these rules, it reflects one's moral character and reflective thought.

Chapter 4: Methods

Chapter three presented the chosen philosophical paradigm (pragmatism) and the study design (explanatory sequential design). This chapter will provide an overview of the research process, and detail the methods used for data collection and analysis.

4.1 Research Process

Figure 4.1, below, illustrates the phases of data collection and analysis. It provides a graphic representation of the process, which will be discussed in more detail below.

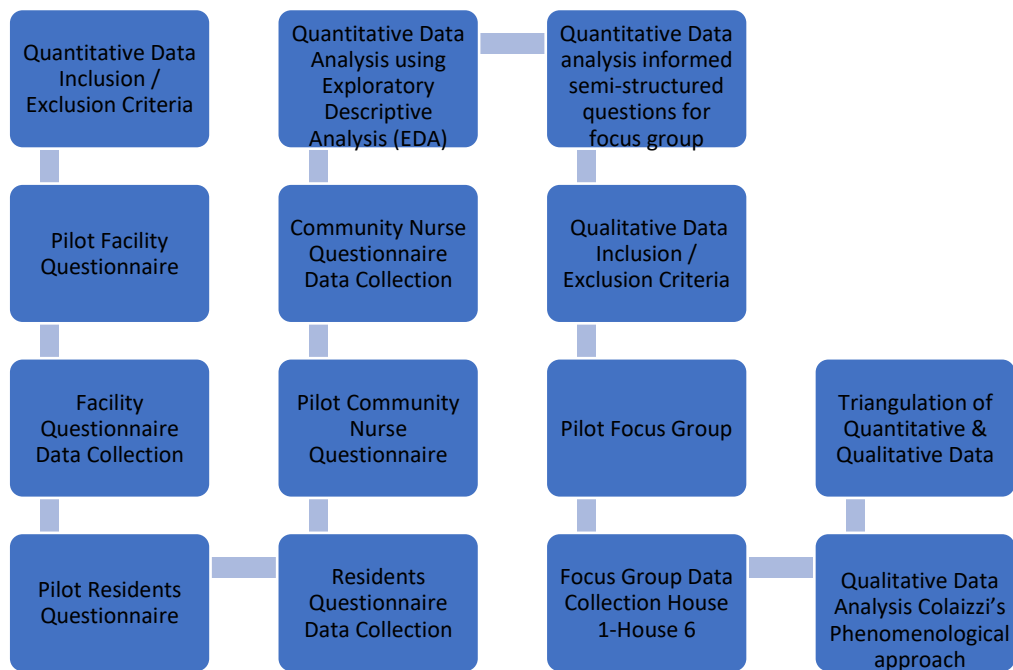


Figure 4.1: Illustrates the phases of data collection and analysis

Figure 4.1, above, shows that the research process involved the collection of qualitative and quantitative data, and that the quantitative data informed the qualitative data collection process. Steps outlined in Figure 4.1 will now be discussed in greater detail, along with the methods used to analyse the data. Descriptive exploratory data analysis (EDA) approach (Tukey, 1977) was used to analyse quantitative data, using the Statistical Package for Social

Sciences (SPSS) (IBM Corp., 2017). Colaizzi's phenomenological approach guided the analysis of qualitative data (Colaizzi, 1978). Thereafter, the quantitative and qualitative data were triangulated to inform the overarching themes.

4.2 Inclusion / Exclusion Criteria for Participants Involved in the Research Process

The inclusion/exclusion criteria were the same for both the quantitative and qualitative phases. Residents had to have resided in a CRF for a minimum of three months in order to qualify for participation in the study. This was based on the researcher's assumption that individuals who had lived in a CRF for more than three months would be able to provide a more accurate description of what it was like to live in one. Residents were excluded from the study if they had an acute relapse of their mental disorder, were continuously floridly psychotic, had a diagnosis of dementia documented in the medical chart, or an acute risk of suicide/suicidal ideation. This was to ensure that residents had full capacity to give consent to participate in the study, and that all participants were able to give an accurate account of their experiences of living in a CRF. In addition, any resident who staff deemed too unwell to participate in the study was excluded. Finally, residents had the ability to exclude themselves or withdraw from the study at any stage.

4.3 Quantitative Data Sampling and Recruitment

Sampling and recruitment are an integral component of all research design (Abrams, 2010). Sampling strategies include probability and/or non-probability sampling (Ayhan, 2011). Non-probability sampling, as used in this study, is defined as sampling techniques in which the sample population is selected using a non-random based procedure, and includes several methods such as purposive, quota, convenience and snowball sampling (Ayhan, 2011; Galloway, 2005).

In order to ensure optimal sampling, advice was sought from the Centre for Support and Training in Analysis and Research (CSTAR), regarding sampling and recruitment. Initially, the idea of including a long-stay

rehabilitation unit was considered, as well as including CRFs from rural settings on the West coast of Ireland. However, CSTAR were careful to differentiate with respect to the complexity that long-stay hospitals represented, in that most residents had been institutionalised for a long period of time, and some had even been born into an asylum type system and never lived outside of a hospital environment. CSTAR, therefore, advised that if residents from the long-stay hospital were included, it would likely represent an outlier in terms of data. Further advice included focusing on an urban setting only, as including CRFs from rural settings was considered beyond the scope of one researcher.

Considering the above recommendations, this study focused on convenience sampling, also known as opportunity sampling (Farrokhi and Mahmoudi-Hamidabad, 2012). This is a non-random sampling approach in which participants are recruited based on practical criteria such as accessibility, geographical proximity, availability, and desire to participate in the study (Acharya *et al.*, 2013; Etikan, Musa and Alkassim, 2016).

Purposive sampling, also known as judgement sampling, is a non-random approach that involves the researcher's purposeful selection of participants, based on their knowledge and expertise of the topic under inquiry (Andrade, 2021; Creswell and Clark, 2011; Martínez-Mesa *et al.*, 2016; Sharma, 2017). Purposive sampling was deemed appropriate for this study, as residents living in CRFs are the only individuals who can give an account of what it is like to live there.

Table 4.1 below outlines the overall number of individuals currently residing in high, medium and low support CRFs in an urban setting in the West of Ireland, as well as the total number of residents who participated in this study. In order to maintain confidentiality, the actual name of the geographical area has been omitted.

Details of Community Residential Facilities			
Level of Support	Number of Community Residences	Number of Total Individuals Residing in CRFs	Number of Individuals who participated in the study
High (24-hour nursing care)	1/11 (9%)	7 /53 (13%)	4 /53 (8%)
Medium (Morning, evening & overnight supervision by non-nursing staff)	2/11 (18%)	13/53 (25%)	11/53 (21%)
Low (Support ranged from morning & evening supervision by non-nursing staff to staff visiting on a regular basis)	8/11 (73%)	33/53 (62%)	31/53 (58%)
Total	11 (100%)	53 (100%)	46/53 (87%)

Table 4.1: Details of the number of residents in high, medium and low support CRFs

Fifty-three individuals are currently residing in community residential housing in the selected urban area: (n=7 / 13%) are receiving high support, (n=13 / 25%) are receiving medium support, and (n=33 / 62%) are receiving low support. Participating in the study were 46 out of 53 (87%) residents of high, medium, and low support community residences. One person was excluded because nursing staff did not believe they were well enough to participate, one resident was unable to answer the questions owing to cognitive impairment, and five residents chose not to participate. The average age of the 46 residents who participated was 32 years; 28 were male and 18 were female.

4.4 Quantitative Data Collection

As previously explained in Chapter one [page 20], the primary purpose of this research was to provide residents of the West of Ireland who were excluded from the national study a chance to have their voices heard. Considering this,

the questionnaires employed in this research, namely, the Facility Questionnaire, Residents Questionnaire and Community Nurse Questionnaire, intended to replicate as closely as possible those used by the HRB in the national study (Tedstone-Doherty, Walsh and Moran, 2007).

The HRB stated that the aims of their study (Tedstone-Doherty, Walsh and Moran, 2007) could not be met by existing questionnaires. Therefore, in addition to standardised questionnaires, measures were developed and customised to meet the study aims. They further explained that international research guided the questionnaire design and that all questionnaires were informed by three international studies, namely, the Mental Health Residential Care Study: Classification of Facilities and Description of Residents (Lelliott *et al.*, 1996), the TAPS Project 41: Homes for Life? Residential Stability Five Years After Hospital Discharge (Trieman *et al.*, 1998) and Residential Care in Italy, National Survey of Non-Hospital Facilities (de Girolamo *et al.*, 2002).

In this study, the Facility and Residents questionnaires required minor adaptations for local use and all standardised scales remained unchanged. The title key worker questionnaire (used in the national study) was changed to the 'Community Nurse' questionnaire in this study, as this service did not have keyworkers. In addition, just two sections of this specific questionnaire were used (appropriate placement and the World Health Organisation Disability Assessment Schedule 11 (WHO DAS 11) (WHO, 2012), as the remaining sections were not relevant to the facilities in question or the overall study objectives. This will be discussed in more detail below. Furthermore, this next section will now offer a summary of the adjustments made to each individual questionnaire, and the process of implementing the questionnaire to gather data for the study. A detailed description of the amendments to all questionnaires is provided in the appendices list.

4.5 Facility Questionnaire

The facility questionnaire was designed to gather information on the appropriateness of each premise and the extent to which it meets the needs of

residents (Tedstone-Doherty, Walsh and Moran, 2007). It was completed by the acting director of nursing (A/DON), who oversees all the facilities. It was used in this study to allow comparison of data between this study and the national study. The diagram in Figure 4.2, below, outlines the data investigated by the facility questionnaire.



Figure 4.2: Various elements of the Facility Questionnaire, Appendix 6

As illustrated in Figure 4.2, the data elements addressed in the questionnaire included the following: level of support; building location and ownership, as well as the number of rooms and type of rooms; access to services such as GP, shopping and post office; rules and regulations, such as those governing the residents' daily activities; and privacy and control over finances. Inquiry was made into who provides the meals, the number of staff and the hours they work, formal admission procedures, exclusion criteria and bed use. The type and frequency of meetings in the residence, health and safety, rights of residents, complaints and health initiatives were also investigated. Other data elements included: resident characteristics such as number, age, gender; diagnosis and employment status; activities offered to residents; and activities that promote community integration, such as integrated social activities and activities to facilitate re-housing and employment.

Questions regarding the location of the building were omitted, as all CRFs are situated in an urban setting along the Western Seaboard. Moreover, the question requesting building measurements was omitted, as it was not considered relevant to the study. Additionally, the question enquiring if the CRFs had a kitchen was omitted, as all CRFs had a kitchen.

As all CRFs were in an urban setting, questions regarding the length of time it would take to reach community facilities and services such as post office, pubs, GP and more were omitted. Some questions regarding strict rules within CRFs were omitted, as they are only appropriate for use within high support CRFs, of which there was only one in the local area. Questions regarding the number of staff and hours they worked per scheduled shift were amended to match scheduled shifts for this service. Questions regarding emergency call services were omitted, as all residents are aware through notices in each CRF that the local hospital offers a 24-hour emergency call service.

Questions regarding policies for respite and crisis admissions and beds for other uses were omitted, as the CRFs do not offer these services. The questions regarding decisions on the placement and discharge of residents provided answer options, one of which was 'specialised rehabilitation team.' This option was substituted for 'other' because the service does not have a specialised rehabilitation team. In addition, the question querying meetings between 'the specialised rehabilitation team and residential staff' was changed to 'multidisciplinary team and residential staff', as this service did not have a specialised rehabilitation team.

The following question was added to the questionnaire: "Are residents involved in drawing up their treatment/care plan?" (p. 414), as it was deemed to be clinically relevant to the study. Questions regarding evaluation plans underlying the CRF service were omitted, as questions in the previous section inquired about the evaluation of the CRF service from the residents' and relatives' perspectives, and this was sufficient for the study. A small number of questions regarding system files and regulations were omitted, as they were not deemed relevant to this study. For example, "Are there guidelines or/and regulations in respect of dangerous situations staff may be dealing with?" (p. 151). These types of questions were omitted as they were not focused on the residents' perspective of what it is like to live in a CRF.

The question regarding feedback for residents and families was omitted, as this was asked previously in the **Meetings** section of FQ (Are there meetings for relatives and families of each resident?). Questions regarding the residents' occupational functioning were omitted, as this area was addressed in the residents questionnaire. The section on diagnosis was shortened to include schizophrenia/psychosis, affective disorders and other disorders to increase statistical power.

The original questionnaire inquired if the service provided a range of options regarding employment status and community social integration. These options were grouped into two categories; 'vocational training' and 'social skills training and participation in social events within the community'. Services such as physiotherapy and substance misuse counselling were omitted, as residents are referred to these services within the Health Service Executive (HSE) if necessary. Please refer to Appendix 6 for specific details regarding all amendments to the Facility questionnaire. The Facility questionnaire resulting from these amendments and used in this study had a total of 10 sections with 87 questions in total (Appendix 7).

4.5.1 Facility Questionnaire Data Collection Process

The researcher organised a meeting with the A/DON and a Mental Health Association (MHA) employee, who was responsible for CRF maintenance. The reason for the meeting was to pilot the FQ so that all questions not applicable for local use could be isolated and omitted. Once the FQ was formalised, both the ADON and MHA staff member completed the 11 FQs (one for each residence). Each questionnaire would have taken approximately 20 minutes to complete.

4.6 Residents Questionnaire

The residents questionnaire was designed to allow residents themselves to report on their lives and their levels of satisfaction with the current service provision (Tedstone-Doherty, Walsh and Moran, 2007). The original questionnaire used by Tedstone-Doherty, Walsh and Moran (2007) was

adapted for local use and all modifications to the questionnaire can be found in Appendix 8. The adapted version, Appendix 9, was used in this study to allow comparison of data between this study and the national study. The diagram in Figure 4.3, below, outlines the data investigated by the residents questionnaire.

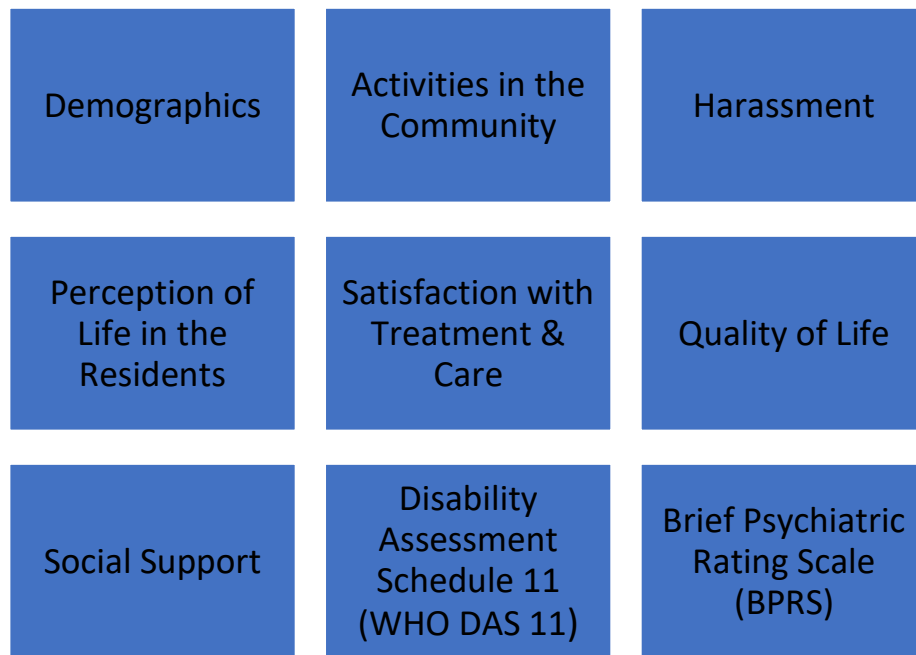


Figure 4.3: Various elements of the Residents Questionnaire, Appendix 9

As illustrated in Figure 4.3, the data elements addressed in the questionnaire included resident demographics, the interaction of residents with the community, and harassment. Their perception of life in the CRF was investigated by utilising the **Perceptions of Life in the Residence** scale. This was devised by the authors of the national study (Tedstone-Doherty, Walsh and Moran, 2007) and remained the same for this study. This section had 12 questions that focused on what it was like to live in the house. For example: How good do you think it is to live in this house? Answer options were as follows: (1) Not good at all (2) Good sometimes (3) Good most of the time (4) Great. Examples of other topics covered included the level of involvement residents had with running the house, how well residents got on with each other and staff, how much control they had to lead their life as they wished, and their level of independence in the community.

QoL was investigated by utilising the **Satisfaction for Life Domains Scale**, which was based on the Satisfaction for Life Domains Scale (Tempier, Mercier and Caron, 1997). The original instrument measures QoL in 16 life domains, with a Cronbach alpha of 0.90 and a test-retest reliability score of 0.73 (Tempier, Mercier and Caron, 1997). The instrument used by the authors of the national study (Tedstone-Doherty, Walsh and Moran, 2007 (p. 159) included two additional life measures: “How do you feel about - the way people in your neighbourhood treat you?” and “your drug treatment”. This study used the adapted 18 domain version, with permission from the author of the original Satisfaction for Life Domains Scale (SLDS) (Tempier, Mercier and Caron, 1997) (Appendix 13).

Functional disability was assessed using the **World Health Organisation Disability Assessment Schedule 11 (WHO DAS 11)**, developed by the World Health Organisation (WHO, 2012). This was specifically designed for use within psychiatry, to assess disability and functional impairment in everyday situations for the previous 30 days (Axelsson *et al.* 2017). The instrument is a 12-item scale measuring global disability in six domains: understanding and communicating; mobility; self-care; getting along with people; life activities; and participation in society (Luciano *et al.*, 2010). Internal consistency (a measure of the correlation between items in a scale) for the WHO-DAS 11 was excellent with a Cronbach’s coefficient of 0.86 (Noonan *et al.*, 2009; Ustun *et al.*, 2010). Many studies have evaluated the psychometric properties of the WHO_DAS 11 (Buist-Bouwman *et al.*, 2008; Luciano *et al.*, 2010; Noonan *et al.*, 2009), indicating good internal consistency, test-retest reliability, construct validity and responsiveness to change. In this study, the WHO-DAS remained unchanged and written permission to use the instrument was granted by the World Health Organisation (WHO) (Appendix 16).

Social support was investigated in the national study by using a “scale similar to” (p. 46), the **Mannheim Interview on Social Support (MISS)** (Veiel, 1990). The MISS is a structured interview and was originally designed to

enable social science researchers to evaluate and cross reference information about an individual's subjective and objective social support network and the structure of this social support. It was proven to have good test-retest stability of .66 to .88 over a four-week interval (Veiel, 1990). Four basic categories of support are identified in the MISS: psychological everyday support; instrumental everyday support; instrumental crisis support and psychological crisis support. This study used the MISS assessment utilised in the national study. Unfortunately, the original author of the MISS instrument could not be contacted to request permission for use, Appendix 15.

Severity of psychiatric symptoms were assessed using the **Brief Psychiatric Rating Scale (BPRS)** (Overall and Gorham, 1962), which is a 24-item scale that rates the severity of psychiatric symptoms over the previous two weeks (Levitt *et al.*, 2009). Symptoms are rated on a seven-point scale, with higher scores indicating greater severity of symptoms (Burger *et al.*, 2005). The BPRS has been used in similar studies (Hobbs *et al.*, 2002; Levy *et al.*, 2005; Weiner *et al.*, 2010). It is one of the most widely used rating scales in psychiatry because of its proven reliable, valid results with reliability coefficients and Cronbach's alpha measurements averaging approximately 0.80 or higher (Leucht *et al.*, 2005; Weiner *et al.*, 2010). Written permission was received from the *Journal of Psychological Reports*, who hold copyrights for the BPRS, Appendix 14.

The national study also employed **Open-ended Questions** such as: What are the best bits about living here? What would improve living here? Where do you see yourself living in the future? What are your hopes for the future? These questions were asked verbatim in this study.

The researcher trialled the residents questionnaire with the ADON, which resulted in some modifications for local use. The following is an overview of the modifications.

The section on **Your Treatment and Care** was adapted for local use. The national study (Tedstone-Doherty, Walsh and Moran, 2007) used a 22-item

questionnaire, which was based on a section of Core Assessment and Outcomes Packages for Mental Health Services (Clifford, 1998). Only 10 of the 22 questions were included in this study. Twelve questions were omitted, as they focused on questions about key workers, which this service does not have. One statement was added in “I am aware of the role of each member of the multidisciplinary team,” as the researcher felt that residents should be aware of the different members of the team and the services they offer.

Demographics, such as marital status, remained mostly the same. Options for employment and education status were condensed to six options, as opposed to eight for education, and seven options as opposed to nine for employment. The question “Are you happy with your current employment status?” was added, as the researcher felt this information was important to know, since occupation is a significant part of the recovery journey (Doroud, Fossey and Fortune, 2015). Questions on accommodation, community involvement and harassment in the community remained the same. The residents questionnaire used in this study had a total of eight sections with 107 questions.

4.6.1 Residents Questionnaire Data Collection Procedure

The A/DON contacted the supervisors at each CRF through email, to advise them that the researcher would be in contact with residents regarding participation in the study. Supervisors were asked to explain to residents that their participation in the study was completely voluntary and this information was again reiterated in the information leaflet and consent form that was subsequently mailed to each resident (Appendix 2).

Following this, the researcher arranged to visit each CRF (via a staff member from the MHA and CRF supervisors). It was explained to each resident, who wished to participate in the study, that they had a choice of completing the questionnaire in their own time and returning it to the researcher at a later stage, or completing the questionnaire with the researcher’s assistance at a time that best suited them.

All residents who took part in the study requested assistance from the researcher, which was carried out in the form of structured interviews, also known as researcher-administered surveys (Rashidi *et al.*, 2014). The researcher felt that this was an important choice to offer residents, as some residents had difficulties with literacy. Thus, they could not have participated in the study even if they had wanted to, without assistance from the researcher. Furthermore, as most residents had negative features of schizophrenia, of which lack of motivation is prominent (Strauss, Bartolomeo and Harvey, 2021) the researcher believed that structured interviews were a way to counteract the possibility of residents not completing the questionnaires, secondary to a lack of motivation. The structured interview process ensured that everyone who wished to participate in the study had the option to do so, with the added benefit of ensuring that no data were missed (Fowler, 2002). In addition, it prevented any residents who may have had difficulties with literacy from feeling uncomfortable around the challenge of completing questionnaires. As a result, this process enhanced integrity owing to the interviewer's presence, which helps to eliminate ambiguity (Wagenaar, 2005).

However, the disadvantages of structured interviews are that an interviewer's characteristics and attributes can influence responses (Bryman, 2012). In this study, however, this was minimised as much as possible by reading the questions verbatim and recording responses word for word as per Harrell and Bradley's (2009) recommendations for administering structured interviews. Furthermore, it was explained to each participant that if they did not understand a question, the researcher would repeat it, but would not be able to rephrase the questions because changing the words could alter how the question is interpreted, thereby altering the participant's responses (Harrell and Bradley, 2009). All residents were interviewed individually in a private room setting during the evenings and weekends. That was the most suitable time for residents as they usually attended day centres during the day. Throughout the interview, residents were reminded that their name was not recorded anywhere on the questionnaire and that all information would

be treated in the strictest of confidence. Each interview took approximately 40 to 45 minutes to complete.

4.7 Questionnaire Number Three: Community Nurse Questionnaire

The title Key Worker Questionnaire used by Tedstone-Doherty, Walsh and Moran (2007) was changed to the Community Nurse Questionnaire (CNQ), as the service did not have key workers. This questionnaire was designed to gather further information such as residents' psychiatric history, appropriateness of placement, general functioning, and physical health. However, only appropriateness of placement and general functioning were investigated in this study as the remaining sections, which are briefly described below, were not relevant to the research question. Figure 4.4 below outlines the data investigated by the Community Nurse Questionnaire, Appendix 10. A list of all modifications made to the CNQ can be found in Appendix 11.



Figure 4.4: Elements of the Community Nurse Questionnaire

As illustrated in Figure 4.4, this questionnaire focused on two elements of the original questionnaire used in the national study; the appropriate placement of residents and the WHO DAS 11 (Üstün *et al.*, 2010). Staff members were asked if they believed residents were correctly placed and what they perceived to be the challenges to appropriate placement. This was an important question, as residents of CRFs are frequently misplaced due to a lack of available housing choices (MHC, 2018). In addition, the WHO DAS 11 was repeated in this questionnaire, to determine whether staff members assessed the residents' functioning as higher, lower, or at the same level as the residents themselves.

The remaining questions were omitted, since they were not relevant to the research question. For example, questions regarding former place of

residence were omitted, as most residents came from the acute psychiatric unit. All residents received a disability payment, thus questions addressing their income were omitted. Questions regarding previous hospital admission were omitted, as the information was not relevant to the research question. Questions regarding the participation of residents in activities within the CRF were omitted, as no activities take place within the CRFs. The Physical Health Index was omitted, as it was not relevant to the research question. The resulting amended Community Nurse questionnaire used in this study had a total of two sections with 16 questions.

4.7.1 Community Nurse Questionnaire Data Collection Procedure

The researcher initially considered asking CRF supervisors to complete the questionnaire, but ultimately opted against it, given their lack of formal training in mental health. All community nurses were given a pamphlet outlining the aims and objectives of the study, after which they were contacted by phone and appointment dates were set to meet with each nurse individually. This was done to maximise the likelihood that all questionnaires would be completed, as community nurses reported having a high caseload and may therefore not have given participation in research studies priority. During the predetermined appointment times, each nurse completed the CNQ for each resident on their caseload. The nurse in charge of clozapine completed questionnaires on six residents, because their community nurses believed this staff member had greater interaction with these residents and would therefore have a better understanding of their social and occupational functioning. Each questionnaire required roughly thirty minutes to complete. A summary of all topics addressed in each questionnaire is outlined below in Table 4.2.

Summary of Sections Addressed in each Questionnaire		
Facility Questionnaire	Residents Questionnaire	Community Nurse Questionnaire
Rules and regulations	Community Activities	Appropriate Placement
Staff working hours	Perceptions of Life in the Residence	Disability Assessment Schedule (WHO DAS11)
Evaluation Process	Treatment & Care	
Resident Characteristics	Quality of Life	
Meals	Social Support	
Admissions Procedures & Meetings	Disability Assessment Schedule (WHO DAS 11)	
Policies & Regulations	Brief Psychiatric Rating Scale (BPRS)	
Activities	Open-ended Questions mainly about what it is like to live in a CRF	

Table 4.2: Topics addressed in each questionnaire

4.8 Quantitative Data Analysis

The quantitative data in this study were primarily analysed using a descriptive EDA approach (Tukey, 1977). EDA is a technique that employs descriptive statistics and graphical tools, to identify outliers and abnormalities, and is primarily used to gain a deeper understanding of the data (Camizuli and

Carranza, 2018). Exploratory techniques are typically graphical and descriptive, therefore tests such as ANOVA, chi-squared, t-test and F-Test are not required. Since the pioneering work of Tukey in 1977, EDA has acquired widespread acceptance as the method of choice for analysing data sets (Komorowski *et al.*, 2016). In this study, data were analysed using the Statistical Package for Social Sciences (SPSS) software programme, version 25 (IBM Corp., 2017), in order to produce descriptive statistics for triangulation with qualitative findings. EDA was used since the limited sample size of residents from CRFs with high, medium, and low levels of support did not satisfy the criteria for inferential statistics (Hopkin, Hoyle and Gottfredson, 2015). Specifically, small sample size yields low statistical power, inflated false discovery rate, inflated effect size estimation and low reproducibility (Lorca-Puls *et al.*, 2018). EDA, however, allows for meaningful analysis of these types of data sets (Cox, 2017).

4.8.1 Qualitative Data Sampling and Recruitment

This section will describe the recruitment process and sampling of the participants for the qualitative phase of the study. Three different sampling methods were employed to recruit participants: convenience, purposive and random sampling. Purpose sampling and convenience sampling are non-probability sampling approaches that are useful when the sample population is small, the researcher has limited resources and when the study does not seek to generalise to the entire population (Etikan, Musa and Alkassim, 2016). Table 4.3 illustrates the sampling and recruitment process for the qualitative element of this study.

House Number (n=6)	Number of Residents who participated in focus groups (n=23)	Level of Support	Type of Sampling (Purposive & Random)
House 1	3	Low	Purposive
House 2	3	Medium	Purposive
House 3	5	Medium	Purposive
House 4	4	High	Purposive
House 5	5	Low	Random selection from 7 low support CRFS
House 6	3	Low	Random selection from 7 low support CRFS

Table 4.3 Outlining the number of individuals who participated in the focus groups, as well as the sampling and recruitment process

Convenience sampling was initially used to identify CRFs near the researcher (urban setting in the West of Ireland). Purposive sampling was used in the selection of the high and medium support CRFs, as the service only has one high and two medium support CRFs. Purposive sampling was further used in the selection of one of the low support CRFs to participate in the pilot study, as the residents in this particular house expressed an interest in the research. The remaining seven low support CRFs were assigned a random number from a gold standard random number table (Rand Corporation, 2001), leading to the random selection of two additional CRFs for participation in the focus groups.

4.8.2 Qualitative Data Collection

Qualitative data were collected via six semi-structured focus groups. Focus groups are used to gain an in-depth understanding on the phenomenon under study (Moser and Korstjens, 2018) and were appropriate for this study, as outlined in section 3.7.

The focus group interview guide (Table 4.4) was designed based on the analysis of the questionnaire and the researcher’s clinical experience and knowledge of the literature and underpinned by Van Manen’s (1990) four lifeworlds. Van Manen’s lifeworlds of lived space, lived body, lived time and lived human relations are referred to as ‘existential’ themes and are often used to understand lived experience (Moene, Bergbom and Skott, 2006). Please refer to Appendix 12 for a full list of questions.

Examples of Focus Group Interview Questions

Focus	Question / Theme	Rationale for Link with Life World Themes
Lived space - Spatiality	The importance of the name Food in the CRF Residents’ perception of the role of the CRF Role of supervisor Impact of illness	The significance of the CRF's name can be related to the lived space, but it can also have an effect on the lived body if the name is stigmatising in any manner, such as mental health facility. Questions around food in the CRF could be placed within spatiality and lived body, as the food is provided within the space of the CRF, but it is also experienced by the body’s senses. Residents’ perception of the role of the CRF could be contextualised in terms of spatiality, given that the CRF provides a space and form of shelter for residents. The residents’ perspective of the supervisor's role within the CRF could be attributed to both spatiality and relationality, since supervisors frequently spend many hours per day within the CRF, depending on the amount of support required. Impact of illness can be placed within spatiality as the reason residents are possibly living in a CRF because of their illness. It can also be placed within lived body as illness is experienced by the body.
Lived body – Corporeality	Food in the CRF The importance of the name Stigma Recovery Model	Discussed under spatiality Discussed under spatiality Stigma is experienced as negative emotion (Lilis <i>et al.</i> , 2020) perceived by the lived body.

	<p>What facilitates recovery Barriers to recovery What does recovery mean?</p> <p>Reasons for living in a CRF</p> <p>Positive & negative aspects to medication</p> <p>Impact of illness</p> <p>Pets in the CRF</p>	<p>Questions around recovery can be situated within the lived body, as recovery is or is not experienced by the body.</p> <p>Living in a CRF is possibly a consequence of illness which is experienced by the lived body.</p> <p>The body can experience both negative and positive side effects when taking medication.</p> <p>Discussed under spatiality</p> <p>A connection with a pet can be perceived through the body's senses. This too, however can be viewed through multiple lifeworlds – relationality and spatial included.</p>
Lived time – Temporality	<p>Future living arrangements</p> <p>Moving on from the CRF</p> <p>Should CRFs be homes for life?</p>	<p>Questions on future living arrangements and the duration of time spent in a CRF can be included within lived time, since they relate directly to the passage of time.</p>
Lived human relations – Relationality (lived relationship between the self and others)	<p>Love Life Neighbours Visitors to the CRF Overnight Visitors to the CRF</p> <p>Family awareness and understanding of mental disorders</p>	<p>Questions around love life, neighbours, visitors and partners visiting the CRF can be placed within relationality, as they speak directly about the lived relationship between the residents and others.</p> <p>Family awareness and understanding of mental disorders can directly affect family relationships.</p>

Table 4.4: Summary of topics covered in focus groups which are organised into van Manen's existential themes

A pilot focus group was carried out to trial the interview schedule and researcher skills. This is important as it increases the researcher's experience, as well as increasing accuracy with finalising questions (Thabane *et al.*, 2010). For this to be successful, the researcher selected a CRF through purposive sampling, because residents in the selected CRF were

communicative and expressed interest in assisting and providing feedback. Three residents participated in the group (two males and one female). Before the group began, the researcher introduced herself (LM) and her assistant (MG) (OT from another mental health service) and explained the aim of the study, confidentiality and anonymity, consent for recording and group rules. All groups lasted approximately 60 - 80 minutes. The researcher then requested that everyone introduce themselves and tell the group what their favourite food was. This type of exercise is called an icebreaker and is commonly used in groups to help ease anxiety and facilitate dialogue (Doody, Slevin and Taggart, 2013).

Following the pilot focus group, the following four questions were added to the interview schedule:

1. What is the role of the CRF?
2. Do you think residents should be allowed to live in the CRF permanently?
3. How would you feel if you were asked to move out in six months' time?
4. Where do you see yourself living in five years' time?

The implementation of the remaining focus groups commenced once the A/DON notified the supervisors at each residence (through email) that the researcher would be contacting residents regarding their participation in the study. Following this, an information leaflet describing the study and focus groups was distributed to each resident and voluntary participation was emphasised. The supervisors in each CRF facilitated the researcher by arranging convenient dates and times for the residents. Consequently, most focus groups were held in the evenings. In total, 22 residents participated in the six focus groups (10 males and 12 females).

4.8.3 Qualitative Data Analysis

Six phenomenologically-inspired focus groups were carried out and qualitative data analysis was guided by underpinnings of phenomenology. The focus group data, in the form of transcribed recordings, were analysed in two phases. Phase one of the analysis involved individual analysis of each house and phase two involved a cross analysis of all the

houses. The qualitative data analysis was guided by Colaizzi's seven step process for phenomenological data analysis (Morrow, Rodriguez and King, 2015, p. 34), which is presented in Table 4.5 below. Edward and Welch (2011) describe Colaizzi's approach as a rigorous method of analysis that assures the dependability and trustworthiness of the study's findings by allowing researchers to identify patterns and themes and their interconnected links (Wirihana *et al.*, 2018). This study used a modified version of Colaizzi's (1978) data analysis procedure in that the seventh step, which sought to verify the fundamental structure, was omitted and is shown in Table 4.5 in a faded manner to reflect its omission. Each step will now be discussed in detail, including the rationale for omitting the seventh step.

Format for Qualitative Data Analysis	
1. Familiarisation	Each transcript was read and re-read in order to obtain a general sense about the content. Each group was transcribed in writing.
2. Identifying significant statements	For each transcript, significant statements that pertain to the phenomenon under study were extracted and recorded on a separate sheet.
3. Formulating meanings	Meanings were identified from these significant statements.
4. Clustering themes	The distilled essences were then sorted into categories, themes and clusters of themes. There were no pre-existing categories identified.
5. Developing an exhaustive description	The findings of the study were then integrated into an exhaustive description of the phenomenon being studied by distilling the essences of the finer specific strands of the phenomena within the overall phenomenon.
6. Producing the fundamental structure	The fundamental structure of the phenomenon was described.
7. Seeking verification of the fundamental structure	This step was omitted as some residents were illiterate. Thus, the researcher did not return to the participants for validation.

Table 4.5: Colaizzi's process for phenomenological data analysis (Morrow, Rodriguez and King, 2015, p. 34)

4.8.3.1 Step One

All focus group transcripts were transcribed at the earliest opportunity and checked for accuracy against the recording, so that any mistakes could be identified, such as missed or misheard words (Knight, 2023). Following this, multiple reads of each transcript were required in order to gain an in-depth understanding of the content. During this step, reflexive notes were kept so that the researcher could examine any preconceived beliefs that resulted from her prior clinical experience with an occupational therapy manager and a research supervisor. This ensured that the phenomenon under study was investigated from the perspective of the residents, as outlined in the reflexive boxes, [pages 105-108].

4.8.3.2 Step Two

Significant statements that pertain to the phenomenon under study were identified, extracted and recorded on a separate sheet. Figure 4.5 provides an example of extracted significant statements and describes why they were deemed to be significant from house five during phase one of the analysis.

These statements were found to be significant as they reflect residents' perceived thoughts about how their illness has impacted their lives:

Carol: *"not able to be a full-time mom anymore"*

Sarah: *"I would like to have more children, but I am kind of scared because I'm scared of passing on the gene that made me unwell, Yeah I'm scared of passing that gene".*

Thomas: *"It has changed it unbelievably yeah, I had my own business, and I was married, and I had children and I lost it all you know, it was my fault really. You can't blame anyone (else) for mental illness, you know".*

Barbara: *"I'm a very capable person and a very independent person but ye all know my past and I won't go through it again okay because it upsets me emotionally. I have three grown up daughters that I love a lot, but I don't see them much but that's my own business and I keep that in my heart, and I keep it to myself. I won't talk about it cause it only upsets my feelings but I love them very much and all I have is their photographs up in the room and their letters and little bits and pieces belonging to them"*

Thomas: *"well we are not really allowed to socialise, a nurse said it to me"*

Barbara: *"exactly, that would be nice, but we are not allowed anymore. We are stopped every move we make to go out and if we go out, we are told not to drink only the limit of a pint or two, sure you would only be starting that time you want three or four at least to enjoy the night"*

Barbara: *"you could go out then, whatever night you want to go out or maybe two nights you could go as you please and go out what ever weekend you want or every second weekend or every weekend there is no-one to stop you"*

Figure 4.5: Examples of significant statements and an explanation as to why these statements were viewed as significant

4.8.2.3 Step Three

Meanings were formulated from the significant statements. Each underlying meaning was coded in one category as they reflect an exhaustive description. The formulated meanings were compared to the original meanings by the main researcher and the research supervisor to ensure the consistency of the descriptions. Table 4.6 provides examples of how significant statements were converted into formulated meanings. All names have been changed for confidentiality reasons.

Significant Statements	Formulated Meanings
Carol: <i>“not able to be a full-time mom anymore”</i>	Carol feels that her illness means that she is not capable of being a full-time mother anymore.
Sarah: <i>“I would like to have more children, but I am kind of scared because I'm scared of passing on the gene that made me unwell, Yeah I'm scared of passing that gene”</i>	Sarah would like to have more children but is fearful of her children inheriting the same symptoms that she experiences.
Thomas: <i>“It has changed it unbelievably yeah, I had my own business, and I was married, and I had children and I lost it all you know, it was my fault really. You can't blame anyone (else) for mental illness, you know”</i>	Thomas believes that he has damaged relationships with his wife and family and lost his business as a result of his illness.
Barbara: <i>“I'm a very capable person and a very independent person but ye all know my past and I won't go through it again okay because it upsets me emotionally. I have three grown up daughters that I love a lot, but I don't see them much but that's my own business and I keep that in my heart, and I keep it to myself. I won't talk about it cause it only upsets my feelings but I love them very much and all I have is their photographs up in the room and their letters and little bits and pieces belonging to them”</i>	Barbara believes that she has lost her three daughters as a result of her illness.
Thomas: <i>“well we are not really allowed to socialise, a nurse said it to me”</i>	Thomas perceives that residents are not allowed to socialise.

<p>Barbara: “<i>exactly, that would be nice, but we are not allowed anymore. We are stopped every move we make to go out and if we go out, we are told not to drink only the limit of a pint or two, sure you would only be starting that time, you want three or four at least to enjoy the night.</i>”</p>	<p>Barbara perceives staff to be preventing residents from going out and dictating how much alcohol they drink.</p>
<p>Barbara: “<i>you could go out then, whatever night you want to go out or maybe two nights you could go as you please and go out what ever weekend you want or every second weekend or every weekend there is no-one to stop you</i>”</p>	<p>Barbara perceives living in a CRF as restrictive as she cannot go out and socialise whenever wants to.</p>

Table 4.6: Examples of how significant statements were converted into formulated meanings.

4.8.2.4 Step Four

Step four involves grouping formulated meanings into categories. Table 4.7 provides an illustration of how the themes ‘impact of illness’ and ‘strict rules and regulations’ were constructed from different clusters of themes and formulated meanings. This process was replicated for all the themes, and tables illustrating the resulting themes are presented in the results chapter [Chapter 5] and further discussed in the discussion chapters [6-9].

Examples of Formulated Meanings	Theme Clusters	Emergent Theme
<p>Carol does not feel that she is capable of being a full-time mother anymore.</p>	Loss	Loss
<p>Sarah would like to have more children but is fearful of her children inheriting the same symptoms that she experiences.</p>	Loss of expected future	
<p>Thomas believes that he has damaged relationships with his wife and family and lost his business as a result of his illness.</p>	Loss & trauma	
<p>Barbara believes that she has lost her three daughters as a result of her illness.</p>	Loss & trauma	

<p>Thomas perceives that residents are not allowed to socialise.</p> <p>Barbara perceives staff to be preventing residents from going out and dictating how much alcohol they drink</p> <p>Barbara perceives living in a CRF as restrictive as she can't go out and socialise whenever wants to.</p>	<p>Restrictions on socialising</p>	<p>Strict rules and regulations</p>
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Table 4.7: An example of how two of the themes were constructed

4.8.2.5 Step Five

Phase one of the data analysis involved the formation of theme clusters from each individual house. Phase two of data analysis involved the aggregation of theme clusters from phase one, to form a further exhaustive description of theme clusters, by investigating the similarities and contrasting elements of themes. Thus, the fundamental structure of the overall phenomenon being studied could be identified. Table 4.8 below demonstrates how similar themes across houses were consolidated to form the main themes.

<p>Emergent Themes</p>	<p>Main Theme</p>
<p>Loss</p> <p>Restrictions on socialising</p>	<p>Loss</p> <p>Strict rules and regulations</p>

Table 4.8 Provides an example of similar themes across all houses were aggregated to form the main theme

4.8.2.6 Step Six

In this step, a reduction of findings was carried out. This involved the elimination of redundant or overestimated descriptions, in order to prevent repetitions and enable a clear description of the main phenomena.

4.8.2.7 Step Seven

In this study, Colaizzi's (1978) data analysis process was modified in that the final step, member checking, was omitted. Member checking involves returning to the participants to ascertain if they would like to make any adjustments to the findings in order to validate the essence of the phenomenon and ensure that their experiences have been accurately conveyed by the researcher. This final step (member checking) is viewed as controversial by Giorgi (2006), as he believes that the researcher and the participants have different world views. This is mainly because the researcher is viewing the data from a phenomenological perspective and the participants are reporting the data through the lens of their lifeworld. However, it is possible that Giorgi's criticism of Colaizzi's final step is due to Colaizzi having developed his method under the supervision of Giorgi (1970) and essentially modified Giorgi's 1970s approach and added the additional final step of validating the findings (Edward and Welch, 2011). Consequently, rivalry may exist between them.

Since the findings in this study are based on group interviews, as opposed to individual ones, it was not possible to return to verify the results. Furthermore, Trevisan (2021) argues that member checking is an unsuitable approach to use with people who find it challenging to engage with written text, as was the case in this study, and instead suggests iterative checking (asking confirmatory questions) as a method of validation. Iterative checking was used consistently throughout the focus group data collection phase to ensure information was being interpreted correctly, ensuring credibility (Johnson, Adkins and Chauvin, 2020). Nonetheless, Colaizzi's approach is described as a rigorous method of analysis, that assures the dependability and trustworthiness of the study's findings by allowing researchers to identify patterns and themes and their interconnected links (Edward and Welch, 2011;

Morrow, Rodriguez and King, 2015; Wirihana *et al.*, 2018). The findings of both the quantitative and qualitative phases of the study will now be discussed in the next chapter, Chapter five.

Chapter 5: Summary Overview of Study Findings and Data Integration Results

Chapter four presented an overview of the research process and detailed the methods used for data collection and analysis. This chapter presents a summary of both the quantitative and qualitative findings. Appendices 17, 18 and 19 provide a detailed analysis of the quantitative results and Appendix 20 provides a comprehensive analysis of each individual house.

Both the quantitative and qualitative results are presented within a pillar integration table [Table 5.1] in order to provide a comprehensive overview of the overall findings, to enable effective visualisation and analysis of the similarities and discrepancies between the quantitative and qualitative results. The descriptive quantitative data presented in Table 5.1 represent responses to the facility questionnaire (FQ), the resident questionnaire (RQ), and the community nurse questionnaire (CNQ). The qualitative data also presented in Table 5.1, represent descriptive phases from residents. In order to avoid lengthy sections of text in the table, clarifying comments have been added [in brackets] to provide context of the text. The themes and subthemes that emerged following data analysis are presented under the heading pillar themes.

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
<p>Lack of Rehabilitation</p>	<p>0 policies or procedures in place for length of stay (FQ). Range of length of stay was between 0-10 years: 8 had a stay of 6-10 years and 5 had a stay of over 10 years (RQ). Only 4 of the 11 CRFs had a waiting list (of up to 25 weeks) (FQ).</p>	<p>LACK OF RECOVERY</p>	<p><i>Role of CRF</i></p>	<p><i>I have lived in different places and they [CRFs] change every so often (H3)</i></p> <p><i>I don't know [why I live here] (H3)</i></p> <p><i>Need something to keep me locked away (H4)</i></p> <p><i>It's a sanctuary for moving on (H4)</i></p> <p><i>Roof over your head and a place to sleep (H5)</i></p> <p><i>To make us independent (H1)</i></p> <p><i>To do chores (H6)</i></p> <p><i>To meet different people (H6)</i></p> <p><i>It [CRF] does stuff for you that your mother did for you when you were between 0-10 (H4)</i></p> <p><i>This [CRF] appears to be maternal (H4)</i></p> <p><i>To play it's part in what the doctors want [CRF]</i></p> <p><i>It prevents me from isolating myself (H5)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>24 (52%) residents were unaware of the role of each member of the MTD</p> <p>Staff reported that each resident had a treatment plan with a clear aim (FQ), but 85% of residents did not know what their care plan was</p> <p>Staff reported that ADL training takes place in all CRFs and is facilitated by nursing staff (FQ), however, 17 residents (37%) reported difficulty ranging from mild to moderate with carrying out household responsibilities (RQ)</p> <p>Vocational training is provided by local training centres (FQ)</p> <p>Social skills training is only available to residents living in two CRFs (FQ)</p> <p>Staff reported that participation in social events within the community is promoted (FQ)</p> <p>26 residents (57%) reported difficulty ranging from mild to</p>	<p>LACK OF RECOVERY</p>	<p><i>The Role of Staff</i></p>	<p><i>Implementing the house rule [...] and the house law (H4)</i></p> <p><i>Just here to form atonement [staff] (H4)</i></p> <p><i>They write about us every day (H4)</i></p> <p><i>Not much they [staff] have to do</i></p> <p><i>Sitting around drinking tea and coffee (H4)</i></p> <p><i>Keep our rooms spotless (H6)</i></p> <p><i>Keep the bathroom and kitchen all parts to the house spotless (H6)</i></p> <p><i>That you take your medication (H6)</i></p> <p><i>To teach the patient how to be on the ball [with chores] (H4)</i></p> <p><i>Allocating work to us [role of staff]</i></p> <p><i>If you needed to go to the unit [for admission] they would help you (H2)</i></p> <p><i>They [staff] know the time for everybody to get their medication (H2)</i></p> <p><i>They see the case as closed (H4)</i></p> <p><i>They [staff] get you ready for adulthood in a childish way (H4)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>severe with regard to participation in community activities (RQ)</p> <p>Staff reported that leisure activities are available to residents, however, 29 residents (63%) reported feeling bored during the week</p> <p>Psychological therapies were only available to residents in two CRFs even though 31 residents (67%) reported to be moderately to severely affected by their mental disorder (RQ)</p> <p>Family education was not provided</p>		<p>Lack of Rehabilitation</p>	<p><i>According to Dr X, this is my home, and I will never be moved (H3)</i></p> <p><i>They [staff] don't really initiate counselling (H4)</i></p> <p><i>It [recovery] just doesn't seem to be an option (H1)</i></p> <p><i>I was told [by doctor X] I would never recover (H4)</i></p> <p><i>The supervisors here... they all have been very helpful (H2) [residents were unable to give specific details on how supervisors are helpful]</i></p> <p><i>I'm four years here in this house [house X] but ah, five or six more years here and I will improve myself (H3)</i></p> <p><i>What's that [when asked if anyone had heard of the Recovery model?]</i></p> <p><i>I don't know if I have learned an awful lot since I have been here [5 years] (H2)</i></p> <p><i>They don't talk to us about that [moving on]</i></p>
<p>Strict Rules and Regulations</p>	<p>Restricted access to kitchen in the high support CRF, 1 medium support and one low support CRF (FQ).</p>	<p>LACK OF RECOVERY</p>	<p>Strict Rules and Regulations</p>	<p><i>They [staff] are preventing me from mixing with other people (H3)</i></p> <p><i>They [staff] could give us more freedom (H4)</i></p> <p><i>They [staff] should let me drink (H4)</i></p> <p><i>Not really allowed to socialise (H5)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
<i>Strict Rules and Regulations</i>	<p>Permission to lock bedroom and bathroom doors was denied in two CRFs (1 high & 1 low support) (FQ).</p> <p>Residents were required to check back at certain times when leaving the premises in 3 CRFs (one high, one medium, and one low support) (FQ).</p>		<i>Strict Rules and Regulations</i>	<p><i>Stopped at every move we make to go out (H5)</i></p> <p><i>I can do my own cooking when one of the cooks supervises (H3)</i></p> <p><i>I get to go set dancing too, if I'm allowed (H3)</i></p> <p><i>They should let me do what I want (H4)</i></p> <p><i>That's the way we have to live (H3) [a nurse must be present if residents are cooking]</i></p> <p><i>You are not allowed to drink (H5)</i></p>
<i>Dissatisfaction with Care</i>	<p>25 residents (54%) reported that they had little to no input into their treatment (RQ)</p> <p>20 residents (43%) reported that their psychiatrist was not keeping them informed of their progress (RQ)</p> <p>19 residents (41%) were not aware of the possible side effects of their medication (RQ)</p> <p>10 residents (22%) reported that they felt "mostly</p>	LACK OF RECOVERY	<i>Dissatisfaction with Care</i>	<p><i>I would rather not have ever got involved with the unit [Dept of Psychiatry] H6</i></p> <p><i>I'd love to be at home again (H2)</i></p> <p><i>Houses [CRFs] can be overcrowded (H1)</i></p> <p><i>Not very communicative [doctors] (H1)</i></p> <p><i>I don't feel any confidence in them [doctors] (H1)</i></p> <p><i>Not really listening [doctors] (H1)</i></p> <p><i>I can't communicate with them [doctors] (H1)</i></p> <p><i>Ask the same questions [doctors](H1)</i></p> <p><i>I don't need to go every few months [for appointments] (H1)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>dissatisfied” with their drug treatment and a further seven residents (15%) were “equally satisfied and dissatisfied” with their treatment (RQ)</p> <p>17 residents (37%) reported that they did not receive enough information on their diagnosis (RQ)</p>			<p><i>We feel like lower down children again</i> [when told that going out and drinking alcohol is not allowed] (H5)</p> <p><i>We are not animals in a cage</i> [expressed frustration with staff who do not allow residents to socialise] (H5)</p> <p><i>We do not WANT to be treated like children</i> [expressed frustration with staff who do not allow residents to socialise] (H5)</p> <p><i>We do not want to be treated like animals</i> [expressed frustration with staff who do not allow residents to socialise] (H5)</p> <p><i>Once they</i> [psychiatric services] <i>get their clutches on you, you are there for life</i> (H1)</p> <p><i>Feel like you are trapped</i> [in the psychiatric services] (H1)</p> <p><i>The less they are in my life the better</i> [staff] (H1)</p> <p><i>They are laughing with each other all day</i> [the staff] (H4)</p> <p><i>Sitting around drinking tea and coffee</i> (H4)</p> <p><i>They just drug you up</i> (H4)</p> <p><i>I was told</i> [by doctor] <i>I would never recover</i> (H4)</p> <p><i>They</i> [staff] <i>don't know enough to be able to apply a label to you, like schizophrenia</i> (H4)</p> <p><i>I put on 4 stone and they</i> [staff] <i>keep saying “you eat too much”</i> (H4)</p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
				<p><i>If I touch a drop of alcohol, I'll be locked away in a hospital (H4)</i></p> <p><i>I don't know if I have learnt an awful lot since I have been here [5 years] (H2)</i></p> <p><i>I feel like I am being poisoned [medication] (H4)</i></p> <p><i>You don't get enough information [on medication]</i></p> <p><i>I feel like I have very little control [over life] (H1)</i></p>
<i>Stigmatisation and discrimination</i>	3 (6%) residents reported experiencing harassment in the community	STIGMATISATION and DISCRIMINATION	<i>Self-Stigmatisation</i>	<p><i>They [people] might treat you as if you are not as good as everyone else (H1)</i></p> <p><i>I don't tell anybody (H5) [about mental disorder]</i></p> <p><i>Feel different to other people (H6)</i></p> <p><i>Depression, but it is schizophrenia they are treating me for [resident may not have wanted to identify with a diagnosis of schizophrenia for fear of stigmatisation and preferred to say he had depression] (H3)</i></p> <p><i>I just feel that people around here look down on you (H6)</i></p> <p><i>They [people] might treat you as if you are not as good as everyone else (H1)</i></p>
<i>Stigmatisation and discrimination</i>		STIGMATISATION and DISCRIMINATION	<i>Perceived stigmatisation and discrimination from staff</i>	<p><i>Not been treated with respect [by staff] (H3)</i></p> <p><i>It makes me hurt [not been treated with respect] (H3)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
				<p><i>Don't want to know you [staff] (H3)</i></p> <p><i>They [staff] should call them [CRFs] social centres (H4)</i></p> <p><i>They [staff] don't know enough to be able to apply a label to you, like schizophrenia (H4)</i></p> <p><i>No, expect the doctor [people do not attached labels to residents, but the doctor does] (H4)</i></p>
<p><i>Stigmatisation and discrimination</i></p> <p><i>Stigmatisation and discrimination</i></p>		<p>STIGMATISATION and DISCRIMINATION</p>	<p><i>Perceived Stigmatisation from Neighbours</i></p>	<p><i>[Residents] trying to go around undetected (H4)</i></p> <p><i>[Neighbour] had given her [supervisor] a lot of complaints (H5)</i></p> <p><i>I don't bother with anybody along this estate or I don't intend to [because of neighbours complaining to staff about residents leaving cigarette butts and empty alcohol cans outside their house, which residents deny] (H5)</i></p> <p><i>They don't want to get to know us (H5)</i></p> <p><i>They are a bit weary of you (H6)</i></p> <p><i>They keep their distance (H5)</i></p> <p><i>People around here look down on you (H6)</i></p> <p><i>Our neighbours, oh we know our neighbours [said in a sarcastic tone] H4</i></p> <p><i>They [people] don't want to know you [if they know the person has a mental disorder] (H6)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>36% residents (78%) reported to be “mostly satisfied” regarding their relationships with their friends (RQ)</p> <p>31 residents (78%) reported to be “mostly satisfied” regarding their relationship with their family (RQ)</p>		<p><i>Perceived Stigmatisation from Friends / Family</i></p>	<p><i>I have told them [friends] my situation and none of them have called me again (H5)</i></p> <p><i>Some [friends] are scared (H5)</i></p> <p><i>I don't tell them [friends] the full story (H5)</i></p> <p><i>I don't want to be bringing friends in (H1) [to the CRF]</i></p> <p><i>They [people] talk about you in a more comforting way [if they know the person has a mental disorder]</i></p> <p><i>There is still a bit of stigma (H5)</i></p> <p><i>It is very hard to broach the subject [having a mental disorder]</i></p> <p><i>They might treat you as if you are not quite as good as everyone else (H1)</i></p> <p><i>Some are scared I find [because the resident has a mental disorder] (H5)</i></p> <p><i>Feel a bit isolated (H6)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
Loss	<p>30 (65%) of residents reported only having moderate or little control over their lives (RQ)</p> <p>12 residents (26%) reported to be “slightly happy” with their level of independence and 23 residents (50%) reported to be “happy most of the time” (RQ)</p>	LOSS	Loss of Autonomy	<p><i>The house is awful strict (H4)</i></p> <p><i>Not allowed to drink (H4)</i></p> <p><i>They [staff] could give us more freedom (H4)</i></p> <p><i>Should let me do what I want (H4)</i></p> <p><i>They [staff] are preventing me from mixing with other people (H3)</i></p> <p><i>They [staff] could give us more freedom (H4)</i></p> <p><i>They should let me drink (H4)</i></p> <p><i>Not really allowed to socialise (H5)</i></p> <p><i>Stopped at every move we make to go out (H5)</i></p> <p><i>I can do my own cooking when one of the cooks supervises (H3)</i></p> <p><i>I get to go set dancing too, if I'm allowed (H3)</i></p> <p><i>They should let me do what I want (H4)</i></p> <p><i>That's the way we have to live [a nurse must be present if residents are cooking (H3)</i></p> <p><i>You are not allowed to drink (H5)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>26 residents (57%) had not finished secondary school and 42 (91%) were unemployed (RQ)</p> <p>40 (87%) of residents were single (RQ)</p> <p>42 residents (91%) were unemployed, 31 residents (67%) attended local training centres and day centres (RQ)</p> <p>20 residents (43%) reported to be unhappy with their love life and a further 14 residents (30%) reported to be “equally satisfied and dissatisfied” with their love life (RQ)</p> <p>Loneliness, fear and isolation were cited as barriers to independent living by 26 (57%) residents (RQ)</p> <p>23 residents (50%) reported difficulty with maintaining a friendship (RQ)</p> <p>14 residents (30%) choose employment as a hope for the future (RQ)</p>	LOSS	Loss of Normal Life	<p><i>I have three grown up daughters that I love but I don't see them much (H5)</i></p> <p><i>All I have is their [daughters] photographs up in the room (H5)</i></p> <p><i>Looking forward to getting home (H4)</i></p> <p><i>Preferred my old life (H4)</i></p> <p><i>[the medications] destroyed me (H5)</i></p> <p><i>Not able to be a full-time mom anymore (H5)</i></p> <p><i>I think that's everyone's wish that they would like to have a place of their own (H5)</i></p> <p><i>No one really comes to see me (H5)</i></p> <p><i>We haven't got our own place (H5)</i></p> <p><i>Priadel [medication] that has caused me to be on dialysis today (H5)</i></p> <p><i>Would have rather'd a different life (H6)</i></p> <p><i>Drooling [medication side effect], I find that the worst (H6)</i></p> <p><i>I would love to have lived and had a good job and got myself educated H6)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
				<p><i>It [having a mental disorder] has a real mess made out of it [life] (H6)</i></p> <p><i>If we had our own places, we would have more freedom (H5)</i></p> <p><i>I would like to have more children, but I am kind of scared because I'm scared of passing on the gene that made me unwell (H5)</i></p> <p><i>Feel a bit isolated (H6)</i></p> <p><i>You see very few people (H1)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>8 residents (17%) reported having no hopes for their future</p>	<p>LOSS</p>	<p><i>Loss of Hope</i></p>	<p><i>You have to stay in House No 1 [expressed in sad tone] (H4)</i></p> <p><i>I could move on a feel better about myself [in response to the question “What does recovery mean for residents?”] (H4)</i></p> <p><i>I’d have something definite to look forward to [in response to the question “What does recovery mean for residents?”] (H4)</i></p> <p><i>There is a feeling that I would love to be at home again (H2)</i></p> <p><i>I lost it all [business and marriage] (H5)</i></p> <p><i>I was told [by doctor] I would never recover (H4)</i></p> <p><i>I find it hard to see myself getting out of this situation [living in a CRF] (H1)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
<p>INSTITUTIONALISATION</p>	<p>4 residents (74%) reported to be “mostly satisfied” with their life in general and 50% of residents reported to “happy most of the time” with their level of independence (RQ) despite strict rules and regulations</p>	<p>INSTITUTIONALISATION</p>	<p><i>Institutionalised Thinking</i></p>	<p><i>Different world since 1978</i> [date of admission to the psychiatric system] (H3)</p> <p><i>We should have a few more rules in the house</i> (H3)</p> <p><i>Was it any harm to say that?</i> [disclosed that staff do not speak to residents about moving on] (H5)</p> <p><i>Not in the unit</i> [dept of psychiatry] [in response to: “Do people treat you differently?”]</p> <p><i>I’m under the doctor’s care</i> (H3)</p> <p><i>I have to take my tablets now</i> [comment was made in the middle of the group] (H6)</p> <p><i>I suppose that might not be for us to say</i> [when asked if residents partners should be allowed to stay overnight] (H2)</p> <p><i>According to Dr X, this</i> [CRF] <i>is my home</i> (H3)</p> <p><i>We are all settled here</i> [the CRF] (H3)</p> <p><i>I don’t meet that many people outside the services</i> (H1)</p> <p><i>The people I know are actually within the services</i> (H1)</p> <p><i>I think it should be permanent living</i> [the CRF]</p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
	<p>Staff reported that rehousing was facilitated in 100% of CRFs by either social workers or nursing staff (RQ), however, 40 residents (87%) wished to stay in their current accommodation (RQ)</p> <p>Due to challenges with finding suitable accommodation staff anticipated that all 46 residents would remain in their current accommodation long-term (CNQ)</p>	<p>INSTITUTIONALISATION</p>	<p>Dependency on Mental Health Services</p>	<p><i>I wouldn't be without a nurse (H3)</i></p> <p><i>I'm under the doctor's care (H3)</i></p> <p><i>Might need a nurse overnight (H3)</i></p> <p><i>I need someone to check up on me (H3)</i></p> <p><i>We need this house (H3)</i></p> <p><i>I'd like to stay here (H5)</i></p> <p><i>I don't want to move out (H6)</i></p> <p><i>I would like to stay here (H6)</i></p> <p><i>It would be scary going into rented accommodation (H1)</i></p> <p><i>I think it should be permanent living [the CRF]</i></p> <p><i>You see very few people (H1)</i></p> <p><i>According to Dr X, this is my home, and I will never be moved (H3)</i></p> <p><i>I get everything done [for me] (H5)</i></p>

Quantitative data	Quantitative findings	Pillar themes	Qualitative categories	Qualitative data
		INSTITUTIONALISATION	<i>Institutionalisation Through Erosion of Identity</i>	<p><i>My house [CRF] would be here and the family would be there (H3)</i></p> <p><i>It's more my cup of tea [higher support CRF] (H3)</i></p>

Table 5.1: Summary of both quantitative and qualitative findings, which are presented under the relevant categories, themes and subthemes

Table 5.1 summarises the relevant quantitative results. Each result category identified in Table 5.1 will now be briefly described, before moving on to an in-depth discuss of the results in relation to the literature.

5.1 Lack of Recovery

Lack of recovery was evident from both sets of findings and presented in the form of various factors. These included confusion around the role of the CRF, possible confusion and negative perceptions around the role of staff, strict rules and regulations, and an obvious lack of rehabilitation with high unemployment rates and difficulties with engaging in the community, resulting in some residents residing in CRFs for more than ten years. In addition, results highlighted an overall sense of dissatisfaction with treatment and care in terms of limited information around their diagnosis, medication side effects, poor communication from doctors and limited input into their treatment and care.

5.2 Stigmatisation and Discrimination

Although only three residents (6%) quantitatively reported experiencing harassment in the community, qualitative findings uncovered the magnitude of the various types of stigma and discrimination experienced by residents. This allowed for a greater understanding of the subjective lived experience and hidden aspects of stigmatisation and discrimination that quantitative measure failed to capture.

5.3 Loss

Findings revealed various dimensions of loss experienced by residents, which affected many different aspects of their lives. Loss of autonomy, resulting from strict rules and regulations, resulted in a diminished sense of independence. In addition, a number of factors, such as a lack of opportunities and achievements in terms of education and employment, resulted in residents leading a less fulfilling life. Social functioning was also impaired, resulting in the loss of meaningful connections outside of the CRF. All of these issues contributed to a sense of hopelessness about the future.

5.4 Institutionalisation

The quantitative findings did not provide much insight into the concept of institutionalisation amongst CRF residents. However, the qualitative findings reflected institutionalised thinking, particularly in terms of their acceptance with rules and regulations. These also revealed that residents may have developed a dependency on the mental health services.

The quantitative and qualitative findings relating to each theme will now be discussed and explored in separate chapters (6-9), in the context of existing literature.

Chapter 6: KEY FINDING 1: Lack of Recovery

This chapter will critically discuss the findings from the main theme, **Lack of Recovery**, and its subthemes: *apparent confusion over the role of CRF*, *lack of understanding around the role of staff*, *strict rules and regulations*, *absence of rehabilitation*, and *dissatisfaction with care* (Table 6.1) in the context of the quantitative findings and relevant literature

Main Theme	Sub Themes
Lack of Recovery	Apparent confusion over the role of CRF
	The role of staff
	Strict rules and regulations
	Absence of rehabilitation <ul style="list-style-type: none"> • No formal assessments prior to admission • Unemployment • Impaired social functioning • Activities of daily living (ADL)
	Dissatisfaction with care

Table 6.1. Lack of recovery and subthemes

6.1 Apparent Confusion over Role of Community Residential Facilities

This sub-theme refers to residents' understanding of the role of the CRFs in their recovery process and evolved as a result of a direct question posed to participants during the focus group discussions. When asked: "Why do you believe you need to live here?", participants' responses indicated that they were unsure as to why they were living in a CRF. Moreover, they did not

seem to have a clear understanding of how living in a CRF is assisting in their recovery. For example, Anna felt that she needed to live in a CRF in order to have access to staff in case of an emergency and Simon felt that he was living in the CRF to be medically supervised by doctors.

Anna (H3): *“I wouldn’t be without a nurse, if I moved house, I might need a nurse overnight if something happened like”*

Simon (H3): *“Under the doctor’s care”*

Anna’s and Simon’s comments indicate that they have placed themselves in the sick role. According to Levine and Kozloff (1978), a person who plays the sick role has certain privileges denied to other types of social deviance. This would explain why they believe they need constant access to nurses and doctors and will be discussed further under **Institutionalisation**. However, they also reveal inadequate reasons and an obvious lack of understanding as to why they feel the need to reside in a CRF. Similarly, responses from other residents further indicate a lack awareness around the general goals of living in the CRF.

Joe (H4): *“Need something to keep me locked away”*

Carmel (H3): *“I don’t know”* [why I live here]

Thomas (H5): *“Roof over your head and a place to sleep”*

As evidenced from the residents’ comments above, Thomas did not seem to consider the CRF as serving any other function except providing shelter and Carmel did not know why she was living in a CRF. Most residents were aware that they were there to *“get better”* but were unable to elaborate any further. It is possible that residents did not feel comfortable discussing their reasons for living in a CRF within a group setting. However, Sandhu *et al.* (2017) found comparable results in qualitative research conducted in the United Kingdom. The findings of interviews with 30 residents and 30 staff members from supported housing revealed that there was widespread

agreement among residents that they were there to improve their mental health. However, the authors noted that residents lacked a solid understanding of the aims and purposes of supported housing. Although staff had greater clarity on the goals of supported housing, 15 of the 30 staff members interviewed were in a management role. Therefore, it is probable that they had a more formal understanding of the general aims of supported housing, in comparison to both the non-managerial staff and the residents who were also interviewed.

Nonetheless, the findings of both Sandhu *et al.* (2017) and the current study contradict those of Killaspy *et al.* (2019), whose qualitative interviews with 30 residents and 30 staff members from supported housing, residential care, and floating outreach services across the United Kingdom revealed a shared understanding among staff and residents regarding the goals and purposes of supported housing. However, Killaspy *et al.* (2019) used purposive sampling, and the residents were known to the researchers following the completion of data collection for another portion of the same study. Consequently, the chosen individuals may have had good communication skills and would have been able to articulately respond to questions on the purpose and function of the CRF. Furthermore, it is unclear how many of the 30 participants were recruited from supported housing. If 10 participants were selected from each type of housing, ten could be considered a small sample size to represent supported housing across the UK.

Joe (H4) also perceived the CRF as somewhere that keeps him “*occupied*”, but also believed that he needed to be confined in a CRF in order to keep him on the “*straight and narrow*”. CRFs are not intended to function as a place of confinement for residents. Rather, they are intended to be spaces where rehabilitation focuses on achieving personal goals in social and occupational domains (Lopes *et al.*, 2022). They aim to mimic living independently in a community setting (CIZ, 2014) and are completely different to residing in a hospital environment or locked ward (Fakhoury and Priebe, 2007). However, Joe's comment suggests that his CRF resembles a hospital setting more than a rehabilitation environment.

In addition, the preliminary quantitative results of this study highlighted that no CRFs had policies, procedures, or guidelines pertaining to duration of stay, which resulted in some residents residing in a CRF in excess of 10 years. National and international research has shown that this appears to be a common practice within CRF spaces, with reported lengths of stays of 25 years in Irish CRFs (Tedstone-Doherty, Walsh and Moran, 2007), 19 years in Canadian CRFs (Kirsh, Gewurtz, and Bakewell, 2011) and 14 years and 11 years in UK CRFs, respectively (Killaspy *et al.*, 2019; Sandhu *et al.*, 2017). CRF placements are usually time limited to 24 months, with the expectation that residents will progress to more independent accommodation (Killaspy *et al.*, 2019; Sandhu *et al.*, 2017).

The fact that people stay in these facilities for years may imply that the staff do not regard CRFs to be transitory. This might be due to (a) a shortage of suitable accommodation, or (b) that CRFs are not regulated to ensure that residents receive evidence-based rehabilitation to assist them progress toward independent living, or (c) both. For instance, quantitative data from this study suggested that community nurses viewed 100% of residents as continuing in their current accommodation owing to a shortage of housing. Moreover, the MHC has regularly expressed its concerns with the lack of regulation of medium and lower supported housing (MHC 2018 - 2019). If staff consider residents to be permanent rather than transitory, for whatever reason, they may be less inclined to invest effort into assisting with rehabilitating residents.

Similarly, no policies or formal structure appeared to be in place for CRFs in this study, with regards to waiting lists, as just four of the 11 CRFs had a waiting list (up to 25 weeks in length). Similar findings were identified by Tedstone-Doherty, Walsh and Moran (2007) in their review of Irish CRFs, where only 31% of high, 32% of medium and 5% of low support residences had waiting lists. There did not appear to be any scientific literature available on the international trends of CRF waiting lists. However, it is reasonable to assume that a working waiting list for CRFs is an indication of effective

functioning, as it shows movement through the system. The lack of waiting lists possibly leads to a ‘first come, first served’ and unstructured approach to admissions, which may indicate an insufficient and unfair admissions criterion. However, a plausible reason for the absence of waiting lists may be attributable to the lack of movement or flow through CRFs. Staff may be of the view that a waiting list serves no use if spaces never become available or CRFs become gridlocked (Ridgway and Zippel, 1990). Considering that staff in this research regarded lack of housing as a substantial barrier to independent living, this seems a logical conclusion.

Based on residents’ comments, it appears that they are not adequately informed of the aims and objectives of living in a CRF. This lack of clarity and vague understanding surrounding placement in a CRF, treatment objectives, and duration of stay, highlighted by this sub-theme, alludes to ineffective communication regarding the function of CRFs within the broader mental health system. This, in turn, may lead to uncertainty among frontline staff over the daily administration and management of CRFs, possibly resulting in residents’ lack of understanding. This may have further implications, in that residents who do not understand the purpose of the CRF or how long they will be residing there, may not meaningfully participate in rehabilitation.

Clear policies and procedures, and training that outline the role of the CRF, the ideal duration of stay and individual treatment objectives, may prevent this loop of uncertainty from happening. Thus, these could support the service’s basic goals, ultimately enhancing QoL and improving patient outcomes (American Psychiatric Association, 2020; Coulter *et al.*, 2015; Department of Health, 2006).

6.2 The Role of Staff

This sub-theme relates to how residents perceive the role of staff within the CRF system. It represents residents’ responses, when asked how they perceive the role of CRF supervisors and what the staff can do to best prepare them to live more independently. For some reason, residents were either

reluctant to respond to these questions or were unable to express their understanding of the role that staff play in their rehabilitation. For example, they complimented the staff on how “lovely” and “helpful” they were, but they did not specify how the staff support or assist them in increasing their independence as illustrated in the following responses:

Anna (H3): *“Staff do their very best for all of us here and they will give us as much help as you need or as you want and I'm happy with the staff here because they look after you so well”*

Carmel (H3): *“The staff are very good here to us”*

Delia (H2): *“The staff are nice, oh there is nothing wrong with them at all”*

Residents may have been unwilling to discuss the intricacies of how staff assist or do not assist them in their recovery out of apprehension of offending the staff, or out of fear that they may be reprimanded, transferred to another CRF, or asked to leave the facility altogether. In addition, as the researcher worked for the institution that provided shelter and care to the residents, they may have been hesitant to criticise the staff. As stated in Chapter three, page 117, every effort was made to reassure residents that they could talk freely and in confidence; yet this may have still influenced their responses. However, another plausible explanation may be that residents do not have a clear understanding of the role of the staff as indicated by the comments below:

Harry (H4): *“There is not much they have to do, except be there for us if we need a bit of counselling”*

Joe (H4): *“They are there laughing with each other all day, ya know, to be honest, sitting around drinking tea and coffee”*

The above comments suggest that residents perceive the role of staff as relatively easy, with a great deal of free time for conversing with each other.

Similar findings were identified in a Swedish study by Bengtsson-Tops, Ericsson and Ehliasson (2014, p. 414) who found that residents (n=29) of supported housing perceived staff to be “*lazy*”, preferring to sit and talk with each other rather than with residents.

However, staff may not be ‘lazy’ or disinterested in engaging with residents as the above comments alluded to, but they may be unaware of their perceived role as ‘counsellor’, believing that that this role is best suited to psychologists or professional counsellors. Residents, on the other hand, may view staff as counsellors who should engage them more in this area, implying that residents may wish to discuss personal matters informally with staff. However, because staff may be unaware that this is a potential unmet need for some residents, they may appear unmotivated or uninterested to residents.

In addition to the above, residents do not appear to realise that administrative duties, such as documentation, is an important component of their role:

Harry (H4): *“They take notes every day, they write about us every day and every morning and every night, they know exactly what’s going on, what you had for dinner, do you know what I mean, everything.....”*

Harry appears to believe that the documentation that nurses and other care staff are required to complete is either unnecessary or excessive. While this may be a fair opinion, it was not something that was investigated in this current study. However, Clarke *et al.* (2019) highlighted that staff are required to fulfil many tasks within the facility, preventing them from concentrating on their primary responsibilities as care providers. Therefore, if staff are engaged in tasks such as meetings and paperwork, this may reinforce residents' perception that staff are unavailable to assist them with their specific and self-identified needs, such as needing someone to talk to.

Further evidence suggests that residents do not view the staff’s role as rehabilitative, but rather one of enforcing house rules and ensuring that residents take their medication and perform household chores:

Angie (H2): “*they are always on the ball with that*” [ensuring residents take their medication]

Selena (H4): “*implementing the house rules [...] and the house law*” [ensuring residents do their chores]

Jonathon (H4): “*To teach the patient how to be on the ball*” [with chores]

Lana (H6): “*they are there to see that you do your chores and that you take your medication and that you are cleaning yourself and that you are dressing nicely*”

Residents perceived staff to place a significant focus on ensuring residents take their medication, engage in household chores and ensuring that residents are not going around looking dirty or dishevelled. It is difficult to determine if this view is the outcome of a misunderstanding because residents have not been informed of the staff’s role, whether it is the result of the residents’ personal experiences with the staff, or whether it is a combination of both. Staff of supported housing interviewed in a study by Parker *et al.* (2017) were concerned that they were focusing too much on residents keeping their rooms clean and tidy, particularly since this was not a priority for residents. Given that nursing and allied health staff were represented in the study, staff may have been familiar with the recovery model and evidence-based practice and therefore had the relevant insight to realise that they were focusing too much on residents keeping their rooms tidy. Regardless of the cause, it seems from the responses in this study that the focus is on how the CRF and its residents should appear to the outside world, rather than how the CRF and its staff are benefiting the residents themselves.

Svanelöv (2020) purports that there is a fine balance between empowering residents to achieve greater independence and the counter current of the institutional nature of CRFs. He viewed various staff behaviours and demands as “Practices of Power” (p. 1420), which reflected this institutional culture and outdated historical attitudes toward disability. Svanelöv (2020, p. 1435) further reported that these behaviours [practices of power] were

commonplace in supported housing and dictated what residents should do, to be seen as “normal” and cautioned that all too often, staff adopted a paternalistic approach towards residents, one in which “what was good for them” (P. 1435) was imposed. Axelsson and Qvorsebo (2017) supported this concept as their study found that, despite the best of intentions, the quasi-institutional setting of group homes fostered conformity and ‘disciplinary power’ and attempted to mould residents into upstanding and acceptable members of society.

Given the residents’ responses, it is reasonable to assume that Svanelöv (2020) and Axelsson and Qvorsebo (2017) may be correct in their opinion that staff possibly perceive that the CRF and the residents it houses, must be kept to a standard that is ‘acceptable and normal’ to society so as not to be stigmatised as being different. However, a second plausible argument is that CRF staff who were transferred from asylums to CRFs as part of the deinstitutionalisation process (Department of Health, 1984) may continue to employ outdated models of care from the asylums where people with mental disorders were disciplined (Foucault, 2006; Philo, 2004), and may have passed these outdated models of care on to new staff. For example, Harry (H4) perceived the role of staff as punitive: “*Just here to form atonement*” [staff].

Even if staff interactions with residents are limited to 'strongly influencing' them to do their chores and take their medications, staff may assume that they are fulfilling their responsibilities and without training and knowledge in recovery (Brunt *et al.*, 2019; Tedstone-Doherty, Walsh and Moran, 2007), it may not be fair to expect them to do better. Baltazar *et al.* (2013) provided an explanation for why staff in supported accommodation are not expected to have specialised training in recovery and that is that their function is often compared to domestic housekeeping positions.

However, the issue around lack of recovery does not seem to be limited to staff working within supported accommodation. Clarke *et al.* (2020) investigated the experiences of community mental health workers using the

REFOCUS intervention to support personal recovery [the REFOCUS Programme] (Slade *et al.*, 2015). This was a five-year research programme, directed by King's College London (2009 to 2014), aimed at increasing the focus on recovery within mental health services. Semi-structured individual interviews (N=28) and four focus groups (N=24) were conducted with staff from assertive outreach, support and recovery, forensic and psychosis community based mental health teams. Data from focus groups exploring staff attitudes towards personal recovery, indicated that “power and control is something that’s very overlooked in the system” (p.29) and that empowering clients to take more control over their treatment and care “isn’t even on the radar” (p.29).

This lack of theoretical clarity around implementing and supporting recovery-based practice has been identified as a systematic review of 22 mixed-methods studies, with a combined 1163 participants, detailing staff understandings of recovery-orientated mental health practice in the United Kingdom (Le Boutillier *et al.*, 2015). The findings however, must be interpreted with caution, given that the narrative analysis represented a secondary investigation of data that focused on the original authors’ interpretations. However, the lack of understanding on the part of the residents in this study and possibly the staff, may be related to the identified lack of recovery training for care staff in CRFs (Brunt *et al.*, 2019; Tedstone-Doherty, Walsh and Moran, 2007).

A possible solution may be for managers to mandate recovery training on a regular basis for staff, since one-time training may not be sufficient to motivate staff to apply recovery-oriented practises, as highlighted by Gaffey, Evans and Walsh (2016) and discussed in Chapter two. This may also offer a solution to the finding that some staff are resistant to change. This is made evident by Gilbert *et al.* (2013), who investigated team member perceptions of recovery-oriented practice in the UK mental health services. Although teams were generally open to the recovery model, the authors noticed that some team members were reluctant to change. An additional recommendation is the implementation of recovery training for both residents and staff

(Salkeld, Wagstaff and Tew, 2013). This approach has merit, as it promotes collaboration and a deeper knowledge of the recovery process on both sides, and it would also raise resident awareness of the role of staff.

Further evidence in this study, consistent with the narrative of a lack of recovery in CRFs, was that residents did not have a care plan, were unaware of their care plan, and/or were not engaged in its development, as reported by 87% in the resident questionnaire. This information from the resident questionnaire was contrary with what staff reported in the facility questionnaire, which was that 100 percent of residents had “*a treatment plan with a clear aim*”. Since the facility questionnaire was answered by management responsible for CRF residents, rather than frontline staff, they may have been unaware of the specifics and process of care plans for individual residents, or that the care plans represented the staff’s ideas of what was in the best interests of the residents, without their participation. This last explanation possibly aligns with the opinion that the hierarchical nature common to psychiatry may be a primary reason for poor resident participation and engagement in decisions about care (Brunt *et al.*, 2019). However, the British Institute of Human Rights (2016) states that individuals in supported housing should be given the opportunity to participate in, and have control over, decisions about their own healthcare and treatment. A possible solution may be for residents and staff (non-clinical and clinical staff) to collaborate on care planning. This approach has led to more meaningful and integrated care planning with increased resident engagement (Dadich, Fisher and Muir, 2013).

Although compliance with care planning in high support CRFs has improved significantly in recent years, with 43% of CRFs engaged in individual care planning for residents in 2019 (MHC, 2019a) this can possibly be attributed to the MHC’s regulation of high support CRFs and staff awareness of routine inspections. Nonetheless, the MHC’s (2019) report identified that care plans were not multi-disciplinary, medical staff (doctors and nurses) were mainly responsible for their implementation and were reviewed on an annual basis only (MHC, 2020). If care plans are only evaluated once a year and do not

include multidisciplinary input, residents' rehabilitation may not be as effective. The United Nations (2022) state that the individually prescribed care plan for persons receiving mental health care should be discussed with the individual and routinely reviewed. This implies that individuals receiving mental health care are entitled to or have a fundamental right to have their care plan reviewed on a regular basis. Failure to comply with this recommendation may constitute a violation of residents' human rights, because they are not receiving the highest quality mental health care available. Considering that medium and low support CRFs are not regulated by the MHC, the possible absence of care planning in these facilities remains a concern.

Nonetheless, it is unfortunate that there appears to be a lack of care planning in CRFs, particularly medium and low support CRFs. Regularly reviewed, individualised care plans would facilitate discussions between staff and residents regarding care expectations and appropriate goals, as well as provide an opportunity to explain and discuss the role of staff within the CRF and the multidisciplinary team. It is important to note that 52% of residents in this study were unaware of the role of each member of the MDT. This is consistent with the qualitative findings of ambiguity and lack of awareness/knowledge of the role of staff within the system.

Given the staff's 'practice of power' and lack of evidence-based approaches in the absence of care plans and the residents' misunderstanding or lack of understanding of the staff's role, it seems that the custodial model of care dominates in the abovementioned CRFs. As a result, residents perceive staff to be uninvolved and disinterested in their well-being. The extent of this misunderstanding indicates inconsistency in the management of staff and staff routines. Therefore, clarification is required, so that both staff and residents' expectations can be met. Furthermore, staff training with a focus on recovery must be provided regularly and made available to residents, in order to improve the quality of care for residents in supported housing.

6.3 Strict Rules and Regulations

This sub-theme relates to the rules and regulations within the CRF that are imposed on residents, as well as residents' perception of these rules and the impact these restrictions have on their lives. For instance, quantitative findings from the facility questionnaire indicated that residents in some CRFs were required to check back at certain times when leaving the premises in three CRFs (one high, one medium and one low support) and residents in two CRFs (one high and one low support) were not allowed to lock bathroom or bedroom doors. It is unclear why residents of one CRF with medium support and one CRF with low support had restricted access to the kitchen, while residents of the remaining CRFs had full access to the kitchen. Nor is it clear why residents of three CRFs with varying levels of support were not permitted to lock their bathroom or bedroom doors, while residents of the remaining CRFs were permitted to do so. These inconsistencies highlight yet another area where policies and guidelines are lacking regarding the overall governance of CRFs.

Qualitative findings were consistent with quantitative findings in that some residents reported restricted access to the kitchen:

Anna (H3): "I can do my own cooking when one of the cooks supervises, I can do my own cooking, there has to be a supervisor here like one of the girls (cooks) or a Nurse here for insurance wise if a fire started. That's the way we have to live"

The above comment from Anna indicates that she is capable of doing her own cooking, but that regulations pertaining to health and safety will not allow her to cook independently. Anna seems to recognise that this is not a normal environment and that a normal functioning adult should be able to cook their own meals. Delia's comment below also indicates a restrictive environment.

Deila (H2): "the trouble is that staff might consider the BBQ a fire hazard so it would have to be in care of the supervisor"

Delia appears to accept that a barbecue is not an option, which suggests institutionalised thinking, which will be further discussed in Chapter nine.

However, her comment also indicates that instead of having policies and procedures in place to support rehabilitation and recovery, there appears to be regulations in place. These have a strong focus on health and safety policies, which are used as a method to prevent residents from reaching their full rehabilitative potential while living in a 'rehabilitative' CRF. These 'health and safety' regulations are compromising residents' autonomy and will be explored in further detail later.

Although the residents questionnaire did not enable residents to specify whether their autonomy was being restricted or not, the facility questionnaire indicated that this was the case as outlined above. Qualitative findings were consistent with this conclusion in that residents in this study were particularly frustrated at not being permitted to socialise and drink alcohol. They repeatedly used this point throughout the interview to illustrate how restrictive and abnormal their living environment is:

Harry (H4): *“you're not supposed to be drinking, you're not allowed to drink”*

Barbara (H5): *“we are stopped every move we make to go out and if we go out, we are told not to drink only the limit of a pint or two”*

Joe (H4): *“you're not supposed to be drinking, you're not allowed to drink [...] if I touch a drop of alcohol I'll be locked away in a hospital”*

Joe was of the opinion that if he drank alcohol he would be confined in a hospital. Regardless of whether or not this is the case, this is his perception of the rules of the CRF and the consequences for disobeying the rules. Residents in H4 spoke about the strict rules of the house and felt that this house was particularly strict compared to other CRFs. However, similar evidence of restricting autonomy was shared by residents in in H3 and H5:

Anna (H3): *“I get to go set dancing too, if I'm allowed”*

Thomas (H5): *“well we are not really allowed to socialise a nurse said it to me”*

Brian (H3): *“yeah, at times I feel they are stopping myself from being with other people”*

Whether or not staff are preventing residents from socialising and mixing in society, it is certainly the perception of residents that staff are purposefully stopping them from mixing in the community. There is evidence in the literature that residents in supported housing are not permitted to consume alcohol (Gilmer *et al.*, 2015; Parker *et al.*, 2017). However, there seems to be no direct evidence that residents of supported housing are not permitted to interact with other members of the community. Nonetheless, if this is actually occurring, it not only compromises the autonomy of residents but also violates their human rights (United Nations, 2022).

Some residents were significantly aware of living in an abnormal environment with strict rules and regulations, which was completely different from the living environments of most ordinary citizens. For example, when the researcher asked residents how they would feel about having their romantic partner stay overnight in the CRF, residents in H1 seemed aghast that the researcher would even ask the question:

Harry (H4): *“Oh my God!”*

Joe (H4): *“That’s like saying we are allowed to bring a crate of beer into the house”*

Their response was one of shock and laughter and Joe thought this question from the researcher was so absurd that he compared it to the apparent and perceived intractability of the no drinking rule. The following are further examples supporting a regimented medication system:

Thomas (H5): *“if you're in another house, it's up to yourself, you're not told to come in at certain times to take it [medication]. But that's all part of it if you're staying here, that's the rules”*

Angie (H2): *“I get them [medication] morning, evening and night-time. They [staff] are always on the ball for that”*

Thomas, like Angie with regards to restricted access to the kitchen (mentioned above), perceived the rules as mandatory if they want to continue living there. A comment from Jackson (H6): *“I have to take my tablets now”* was exclaimed mid-interview, when he suddenly became aware of the time, while discussing a topic not related to medication. In addition, residents perceived their restricted environment as negatively impacting their love life:

Thomas (H5): *“well you can go to a pub and have a few drinks you might meet someone. If you go to a bowling alley or somewhere, you are not going to pick somebody up there, that’s all been tried and tested. It just happens when you are out [in a bar], you meet someone, and you can’t deny that”*

The above comment from Thomas was stated in a low, sad tone with diminished gaze, which implies that he felt that this rule had a detrimental effect on his life. Other comments from residents consistent with the implementation of strict rules included:

Harry (H4): *“They [staff]could give us more freedom”*

Jonathon (H4): *“The house is awful strict “*

Joe (H4): *“They should let me do what I want”*

The above comments indicate that residents live in a restricted environment, where strict rules and regulations are being enforced and are compromising residents’ autonomy. These findings demonstrate close alignment with both national and international research. For example, a Swedish study investigating the development of supported housing and housing support models for the “psychiatrically disabled” found that 38% (n=2513) of residents lived in CRFs in which they were not allowed to come and go as they pleased, did not have possession of their own room key or were not allowed guests in their room without permission (Brunt and Tibblin, 2011, p. 54). Brolin *et al.* (2018) conducted a qualitative review (also in Sweden), investigating the best and worst aspects of living in supported and unsupported housing from the residents’ perspective. Thirty-three participants (30%) living in supported accommodation reported that within

the CRF they had limited involvement in decisions about daily life and were not allowed to have control over their own finances or go outside by themselves. Additional evidence highlights how residents of supported housing are living under control, illustrated with an example from one house in a study which had a barbecue, but residents were not allowed outside while the food was being prepared (Baltazar *et al.*, 2013). Moreover, in an Irish investigation of CRFs, robust evidence of strict rules within CRFs is reported with staff in 10% of low support CRFs appearing to restrict residents' autonomy by supervising their comings and goings (Tedstone-Doherty, Walsh and Moran, 2007). They also noted that, similar to this study, rules were not uniformly applied across all CRFs (Tedstone-Doherty, Walsh and Moran, 2007). An inspection of supervised residences by the MHC (2018) in Ireland also found strict rules and regulations in CRFs, with almost one third of CRFs not allowing residents to have access to the kitchen, even to prepare a snack or make a cup of tea.

It is clear that the strict rules and regulations in CRFs revealed in this and previous studies are impacting on residents' autonomy and rights. Residents' daily lives appear to be ruled by staff and the CRFs appear to be functioning as mini-institutions which resemble Goffman's (1961, p. XXI) description of a 'total institution' which he defines as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for a considerable period of time, together lead an enclosed, formally administered life". Although the CRFs described above do not entirely oppress and rule over residents, it seems that there are 'practices of power' at play in terms of restricting residents' autonomy. Goffman (1961) speaks about this split between residents and staff, where staff tend to feel superior and righteous, and residents tend to feel inferior. This aligns with the observations of Svanelöv *et al.* (2019), that residents must conform to, resist or negotiate these practices and position themselves within its hierarchy, and residents in H5 appeared to do exactly this:

Barbara (H5): "*we should be allowed to socialise and I'll say it at the next meeting when she is here herself* [community Nurse

manager], *I intend to speak up. I'll be speaking up for everybody in the house, we should be allowed to socialise*"

Barbara appears to recognise that she and other residents are in a subordinate position within the hierarchy of the CRF and attempts to resist or rebel against the practices of power displayed by staff. It is unfortunate however that residents feel subordinate to staff, as this is contrary to recovery. While it may not be accurate to postulate that staff are exerting power over residents for the purposes of feeling superior, there does appear to be a culture of 'control and restriction' in psychiatry, the only medical profession that has authority to restrict an individual's liberty if they meet the criteria for involuntary hospitalisation. Given the history and evolution of psychiatry, it may be difficult to resolve this issue of deep-rooted control. In addition, restricted environments allow fewer staff to oversee a greater number of people and a smaller workforce provides the organisation with human resources and financial advantages. For example, the possibility of rehospitalisation or eviction may have a powerful role in resident compliance with CRF rules, and demanding a no alcohol rule for residents is easier than residents arriving home late at night inebriated. Ultimately, strict rules and regulations may make life easier for staff at the expense of residents' autonomy.

It is significant to note the duration (15 years) from when the national study first pointed out the restrictive nature of CRFs in Ireland, to a recent MHC report (2020). Residents in some CRFs are still denied access to the kitchen to prepare meals or snacks and do not have keys to their own bedrooms. In real terms, little has changed in this timeframe, as the conclusions of annual MHC reports have continued to reinforce the findings from national and international research that emphasises the restrictive nature of CRFs. Living in a CRF should emulate community living (Parker *et al.*, 2017), however, the strict environments described above do not support this statement for residents of CRF in this study. Notably, the rules and regulations described above are in direct contravention of the main principles of Recovery and also violate residents' human rights, as they do not preserve and enhance residents' personal autonomy (United Nations, 2022). As recommended by

the British Institute of Human Rights (2016) and the United Nations (2022), mental health services should examine their policies, procedures, and regulations to ensure that they respect residents' human rights, so that they may live in the least restrictive environment possible.

6.4 Absence of Rehabilitation

Absence of rehabilitation was the most dominant subtheme under the theme 'lack of recovery'. Indicators of a lack of rehabilitation included lack of formal assessments prior to admission, limited unemployment/vocational rehabilitation, poor social functioning and some impairment in function with regards to activities of daily living. Each of these categories will be discussed individually.

6.4.1 No Formal Assessments Prior to Admission

Although it is highlighted in the literature that residential facilities are not clearly defined with distinct models of care (Gustafsson *et al.*, 2009; Isaac, 2007; McPherson, Krotofil and Killaspy, 2018b; Priebe *et al.*, 2009; Tedstone-Doherty, Walsh and Moran, 2007), more transparency and clarity on the various forms of care provided by different housing services is required, so that residents and referring clinicians know what to expect from such services (McPherson, Krotofil and Killaspy, 2018a). Residents should be accurately matched to the appropriate levels of support, and CRFs should be defined in terms of their degree of support (de Girolamo *et al.*, 2002; de Girolamo *et al.*, 2005; Goering *et al.*, 1992; Priebe *et al.*, 2009; Wellesley Institute in Canada, 2015).

In this study however, only 18% of CRFs reported undertaking formal resident assessments prior to admission. This is a finding similar to those reported in a systematic review of six studies from the United States, Australia, Sweden, and Taiwan, examining the level of support received by individuals with serious mental illness (SMI) in supported housing, (Jose *et al.*, 2021). A lack of waiting lists in Irish CRFs has also been highlighted, with only 55% of CRFs reporting to carrying out assessments prior to admission (Tedstone-Doherty, Walsh and Moran, 2007)

It is unknown why services do not carry out formal evaluations prior to admission, however it may be due to a shortage of appropriately trained staff. For instance, AVFC (2006) recommended 12 to 15 mental health nurses and two OTs, social workers, and psychologists per MDT to serve a population of one hundred thousand. Currently, nurses are the gatekeepers of CRFs. However, they may lack the necessary skills to conduct assessments in instrumental activities of daily living (IADL). Such assessments include an individual's ability to use public transportation and shop for groceries, manage finances, prepare meals, manage household duties and general home maintenance, ability to communicate effectively and manage medications, as it is not a central tenet of nurse training (Edemekong *et al.*, 2022).

OTs on the other hand are highly trained in assessing functioning, as it is a core aspect of occupational therapy (Hagelskjaer *et al.*, 2021; Lloyd *et al.*, 2008). Furthermore, Fossey *et al.* (2006) hypothesised that the results of ADL assessments, using the assessment of motor and process skills (AMPS), which measures a person's performance capacity for ADL and/or independent living (Gary, 2011), could be used to match residents' levels of functioning to appropriate levels of support. The authors also noted that OTs, given their expertise in this area, were deemed best suited to lead this service initiative. In addition, research indicates that healthcare staff frequently overestimate the level of support a person requires (Lasalvia *et al.*, 2012; Piat *et al.*, 2015). OTs were not included in these studies. However, it is unlikely that they would overestimate a person's level of support, given that a core principle of occupational therapy is to increase independence (LaFrance *et al.*, 2019).

In conclusion, without a comprehensive evaluation or functional waiting list as discussed on page 170, residents may be placed in any CRF that has a vacancy. This is likely why older, lower-functioning residents resided with younger, higher-functioning residents in the CRFs included in this study. The implications of this are possible sub-optimal recovery for all residents, as not all residents have the same level of basic functioning to begin with. For example, both Tedstone-Doherty, Walsh and Moran (2007) and Parker *et al.*

(2017) emphasised how residents often have varying degrees of requirements, due to people who were moved from defunct asylums versus new residents coming from acute psychiatric units. Given their varying degrees of functional impairment, both questioned whether it would be practical to put these individuals in the same residence. Environments that do not meet residents' needs can stagnate and undermine recovery (de Heer-Wunderink *et al.*, 2012; Krotofil, McPherson and Killaspy, 2018; Sanches *et al.*, 2019). The repercussions of this include extended time in CRFs, owing to lack of progress with recovery. Therefore, it is crucial that accurate assessments by OTs are conducted prior to admission, so that residents may be matched with the appropriate level of care and rehabilitation in order to expedite recovery.

6.4.2 Unemployment / Vocational Rehabilitation

This theme relates to the lack of evidence based employment options for residents and the impact of unemployment on their lives.

Employment enables a person to earn a living, which in turn provides financial independence, increased QoL, personal growth and self-worth, a feeling of accomplishment, identity, social inclusion, provides a structured routine and a sense of purpose as well as decreased symptoms of depression (Drake and Wallach, 2020; Muirhead, 2004; Posel, Oyenubi and Kollamparambil, 2021; Schultz, 2000; WHO, 2021). Participation in meaningful employment has been linked to recovery from various mental health conditions and represents a core tenet of the recovery model (Department of Health, 2006; WHO, 2021b). Having a diagnosis of schizophrenia (or another enduring mental disorder) should not prevent individuals from pursuing meaningful employment (Marino and Dixon, 2014). Furthermore, evidence-based vocational training and support should be made widely accessible to all residents living in CRFs (Drake *et al.*, 2016), as the right to work is a basic human right for people with mental disorders (United Nations, 2022).

Findings from this study revealed that residents want to work. For example, the residents questionnaire had a limited number of open-ended questions, one of which asked residents about their hopes for the future, to which 30% indicated that they hoped to find employment. Despite wanting to work, 91% of residents in this study were unemployed. These results are similar to Irish research on CRFs, in that only 5% of residents were in paid employment in the community (Tedstone-Doherty, Walsh and Moran, 2007) They also reflect international trends, with regard to unemployment amongst residents of supported housing (Bitter *et al.*, 2016; Killaspy *et al.*, 2016; Magliano *et al.*, 2016; Mirza *et al.*, 2008; Roos *et al.*, 2016), despite the fact that 90% of people with mental disorders wish to be in employment (Wheat *et al.*, 2010).

One resident spoke about how he finds it difficult to get back into the work environment since losing his job:

Troy (H1): *“I find it hard enough trying to get back into the work environment, you were always with friends like and you would have the bit of fun like [...] I met a lot of people now like being in the [names place of work] and they have customers coming in and you get to know them”*

Troy's comments indicate that he misses the social side of work, which enabled him to interact with others and “*have a bit of fun*”. Troy disclosed that he was now attending the local training centre, but he did not indicate that he was receiving any assistance from staff in re-entering mainstream employment. Another resident claimed that she was urged to pursue employment by other residents, rather than by staff:

Angie (H2): *“Ms X [resident] is always on to me about getting a job, but I’m not ready for it yet”*

The majority of residents surveyed attended the local training centre, which is run by the health service and are usually specifically designed for people with mental disorders (Becker and Drake, 2003; Grove, 2015; Tedstone-Doherty, Walsh and Moran, 2007) as previously discussed in Chapter two, page 70.

Residents are often engaged in meaningless occupation within this protected environment, despite their lack of evidence for recovery (Grove, 2015). Notably, one resident (Eliza) described the local training centre as ‘a one size fits all’ attempt by the service to encourage individuals to engage in activities that were not relevant to the open job market:

Eliza (H1): “but not just anything, some people make the mistake of thinking you know, a routine, we need a routine but if that routine is mind numbingly boring [...] it’s deadly, I’d rather not have routine you know. So, I think when it comes to, if you got an interest in work or an interest in study, fair enough but otherwise, no. I don’t think that having routine for routine sake is a good thing [...] and I think that is something in the services that is quite bad, they seem to think routine for its own sake is good for people and I think that’s quite a prevalent think in the service and I think it’s really bad”

Eliza’s comment indicates her belief that staff perceive residents requiring a routine and any routine would suffice, in that, it does not need to be meaningful. Although this meaningless routine is often imposed on residents in CRFs (Grove, 2015), it was only criticised by one resident in this study, but deemed important to highlight given its implications for residents. For example, maintaining a person in unemployment has repercussions, such as financial constraints, social exclusion, a lack of purpose, diminished QoL, and an absence of self-identity, all of which can hamper the process of recovery (Muirhead, 2004; Posel, Oyenubi and Kollamparambil, 2021; Riach and Loretto, 2009; Schultz, 2000; WHO, 2021b).

Encouragingly, in recent years, there has been significant efforts to provide Irish mental health service users with access to IPS services, given its validated success in placing individuals in competitive employment (Burns *et al.*, 2007; de Winter *et al.*, 2020; Drake and Bond, 2011; Killaspy *et al.*, 2022; Kinoshita *et al.*, 2013; Marino and Dixon, 2014; Marshall *et al.*, 2014; Mueser, Drake and Bond, 2016). This is possibly owing to the commitment of ongoing open communication between mental health professionals and employers (Drake, Becker and Bond, 2019). IPS services first emerged in the Irish mental health services in 2019 (MHC, 2018/2019) but is still receiving

resistance from mental health professions, in that some are of the opinion that people with mental disorders are incapable of working or that they may relapse secondary to the stress and pressure of work (Sharek *et al.*, 2022). In addition, findings indicated that occupational therapy managers (who oversee the programme) received referrals for patients, without the referring clinician first discussing this with the person and a consultant objected to a patient driving for a living in case “he became unwell” (Sharek *et al.*, 2022, p. 852). These findings by Sharek *et al.* (2022) indicate that psychiatry's paternalistic, clinician-led decision-making/controlling culture is still thriving in 2022.

Historically, persons incarcerated in asylums for mental disorders were forced to perform manual labour to increase the institution's revenue or contribute to its upkeep (Brennan, 2013; Williamson, 1970). In the past century, this appears to have shifted to ‘influentially encouraging’ them to attend archaic training centres, designed specifically for people with mental disorders to actual evidence based vocational rehabilitation (Brennan, 2013; Williamson, 1970). However, the issue of why it has taken such a significant amount of time to reach this stage of progress remains pertinent. Mental health professionals are required to engage in continued professional development (CPD) and the importance of purposeful employment was emphasised in government policy for mental health in 1966 (Department of Health, 1966). Yet, mental health staff are still of the opinion, 56 years later, that people with mental disorders are incapable of working. This persistent mindset in mental health services is difficult to comprehend, especially given that vocational guidance, training, and placement is a basic human right for individuals with mental disorders, and services that do not comply with these requirements violate residents’ human rights. Moreover, the longer an individual is unemployed the more likely they are to become socially excluded (Wynne and McAnaney, 2004). Furthermore, fewer social networks are associated with poorer mental ill-health (Smyth, Siriwardhana, Hotopf and Hatch, 2015). The impact of social exclusion on residents is further discussed in the next subtheme.

6.4.3 Social Inclusion / Functioning

Further to the restrictions on socialising caused by the strict rules and regulations of CRFs discussed in section 6.3, this sub-theme relates to residents' limited social function and the impact on their lives. Even though poor social functioning is common in people with schizophrenia (Brando *et al.*, 2021), there appears to be a paucity of research in this area (Velthorst *et al.*, 2016). Harrison *et al.* (2020) and Jose *et al.* (2021) state that there is a need to enhance social functioning outcomes across various forms of supported accommodation. Moreover, more research is required to determine how both formal and informal supports can facilitate the progress of people with serious mental disorders towards recovery.

Social functioning refers to a person's ability to function in their social environment. This level of functioning can range from basic living skills and self-preservation, to interpersonal relationships with others (Dodell-Feder, Tully and Hooker, 2015; Tyrer and Casey, 1993). The relationship with others in society is significant to positive social functioning (Hossain and Ali, 2014) and most definitions of poor social functioning emphasise a lack of participation in social activities as the core characteristics of poor social functioning (Morgan *et al.*, 2007). Killaspy *et al.* (2022) highlighted significant obstacles in delivering effective social interventions to improve social outcomes, including insufficient family support, discrimination and stigma, inadequate protection of human rights, and limited access to services. Killaspy further highlighted that social interventions are possibly the most complex of all mental health interventions, since they must be individualised and context specific.

Residents in this study reported difficulties with social functioning, particularly limited community engagement. For instance, 57% of residents reported difficulty ranging from mild to severe regarding participation in community activities and minimal involvement with leisure centres, social clubs, libraries and activities such as bingo ($\leq 17\%$). This is despite staff reporting that they promoted participation in social events/activities within the community. The reason for this discrepancy is unknown. It is possible that

staff are encouraging residents to participate in community activities, but residents may not have the motivation, confidence or skills required and may require a graded rehabilitative approach to same. Consequently, residents appeared to be more comfortable with meeting other residents or individuals with mental health disorders, rather than meeting people from outside the services:

Eliza (H1): *“You see very few people, the people I know are actually within the services and I don't meet that many people outside the services”*

Lana (H6): *“I don't know why we couldn't get together ourselves. Bring people around like and meet up with the other residents in the CRFs, and not be waiting for the hospital to put on another social outing to go out”*

Although the above comment from Lana is suggestive of institutionalised thinking, it also indicates that residents do not even consider meeting people from outside of the services and are not provided with many opportunities to do so, indicating that rehabilitation in social functioning is absent. The implications of this are limited social contacts [from outside the CRF] may act as a barrier for residents, who wish to engage in social activities in the community. Therefore, residents are left with the only option of building friendships with other residents within the mental health system. This viewpoint is supported in a number of studies (Cleary, Woolford and Meehan, 1998; Roos *et al.*, 2016; Tedstone-Doherty, Walsh and Moran, 2007; Ware *et al.*, 2007), with all noting that people living in congregated mental health settings felt more comfortable and accepted amongst other residents. Residents appreciated that other residents had similar experiences, resulting in more mutually supportive relationships, all of which proved more difficult to achieve in a main stream society/community setting.

In this current study, restricted autonomy, a sense of fear in discussing their situation with neighbours or potential future friends/romantic partners (both in terms of diagnoses and current living arrangement) and a lack of finances were found as reasons for lack of engagement in society:

Eliza (H1): *“financial opportunities aren’t there to go out and socialise as much so the social life basically maybe isn’t there for meeting people “*

The above comment from Eliza indicates that lack of finances has a negative impact on her social life and unemployment is most likely a compounding factor. In light of compromised social networks among people with SMI (Hengartner *et al.*, 2017), there is a need for greater leadership and guidance from management to raise residents’ level of social functioning. For example, the MHC report on the inspection of 24-hour nurse staffed CRFs (2016) in the West of Ireland documented that residents were engaged in a weekly discussion on current newspaper topics which involved simply ‘chatting’ about articles in the newspaper. It can be argued that while such a task is technically socially appropriate, newspaper groups are not evidence based and such groups do not necessarily take into consideration residents’ individual preferences, nor do they facilitate residents meeting people outside of the mental health services. More interventions based on evidence-based research may facilitate a more positive association with social engagements of various types. For instance, evidence-based approaches to leisure activities and social inclusion, such as the Patient Outcomes Research Team (PORT) (Lehman *et al.*, 2004), have played a significant role in the development and dissemination of evidence-based practices for individuals with schizophrenia to improve social skills function. Compounding the issue is staff specialised in rehabilitation, such as OTs, seem to only work with residents on an as-required basis (MHC, 2020). People with a diagnosis of SMI require intensive rehabilitation in many different areas, given the nature of SMI (Drake and Whitley, 2014) and access to rehabilitation specialists ‘as required’ is not going to significantly increase social functioning amongst residents.

A possible solution to these challenges may be the introduction of virtual reality-based interventions that focus on increasing social functioning in people with complex mental disorders. Virtual reality (VR) refers to the interactions between an individual and a computer-generated environment that stimulates multiple sensory experiences, including visual, auditory, and

tactile experiences (Cornick and Blascovich, 2014). A recent study by Schroeder *et al.* (2022) (N=745) investigated the effectiveness of VR, based on psychological interventions for social skills training via a narrative analysis (N=18 studies). All of the 18 studies indicated that VR-based psychological interventions are enjoyable to do, and can improve cognitive, social and vocational skills in people with complex mental disorders. VR has previously been used in the treatment of anxiety disorders (Donker *et al.*, 2019) in a single-blind RCT (N=193), where participants were randomly assigned to either the intervention group (N=96) or control group (N=97). The results indicated that the VR intervention group had significant reduction in symptoms, which were assessed through self-reported measures. People with complex mental disorders, such as those living in CRFs, may benefit from the VR-based intervention as they could possibly practice in their own environment as often as they wanted, provided they had access to the necessary technology. This would allow for repeated exposure to social situations tailored to their own individual needs and would hopefully result in newly learned skills that could be transferred to real-life situations, as recently demonstrated by Michalski *et al.* (2023).

6.4.4 Activities of Daily Living

Moderate to severe impairment in functioning, with regard to ADL, is common among people with schizophrenia living in supported residential rehabilitation settings (Ayres and John, 2015; Ayres, Ngo and John, 2019; Fossey *et al.*, 2006; Harvey *et al.*, 2022; Kirsh *et al.*, 2011; Samuel, Thomas and Jacob, 2018). For instance, Samuel, Thomas and Jacob (2018) assessed the Instrumental Activities of Daily Living in 100 individuals with schizophrenia and captured the following dysfunctionality: difficulties in handling medications (86%), preparing food (85%), shopping (78%), handling finances (61%), doing laundry (52%), housekeeping (47%), using public transport (32%), and using phones (5%). Notably, only 2% of participants were completely independent in their instrumental activities of daily living.

Although ADLs were not formally assessed in this current study, 37% of residents reported quantitatively that they experienced difficulties with household activities. However, it was not specified whether these difficulties were as a result of physical or mental health issues. From a qualitative perspective, the majority of residents reported having no issues with ADLs:

Barbara (H5): *“Not at all, we are all okay with that”*

Additional qualitative data from the residents questionnaire [“What difficulties do you think you might have with living independently?”] further supported the qualitative findings, with only 4% of residents indicating that they may have difficulties with ADL if living independently. However, residents’ perception that they do not need assistance with ADLs may be attributable to staff at certain CRFs providing a higher level of support than is necessary:

David (H5): *“I get everything done [for me]”*

David’s comment suggests that he does not see the point in living independently as he gets *“everything done”* for him in the CRF. This comment aligns with findings reported earlier in Chapter two, page 72, where staff were providing a higher level of support than necessary (Kearns Murphy and Shiel, 2019). As a result, staff are strengthening residents’ dependency on them and the CRF rather than their independence, hence prolonging the length of time people may remain in a CRF.

Residents tended to view support with psychological and emotional issues as more important. This could be because 57% of residents reported difficulties with participating in community activities, 89% reported that they were emotionally affected by their mental health difficulties, 50% reported difficulty interacting with unfamiliar people, and 50% reported difficulty maintaining friendships. Residents qualitatively highlighted, for example, their fear of stigmatisation and the trauma they endure as a result of their

illness. Both of these will be discussed in further detail in the next theme, dissatisfaction with care, and subsequent themes of stigmatisation, and loss.

6.5 Dissatisfaction with Care

Dissatisfaction with care is the final subtheme of the theme, **lack of recovery**. Elements of dissatisfaction with care includes communication difficulties with doctors, a sense of being infantilised and disrespected by staff, dissatisfaction with progress, as well as undesired pharmaceutical side effects.

Initial quantitative analysis found that doctors were not informing residents of their progress (43.5%), a conclusion supported by qualitative findings:

Anna (H3): *“I’m four years here in this [house X] but ah, five or six more years here and I will improve myself”*

Angie (H2): *“I don’t know if I have learnt an awful lot since I have been here [5 years]”*

Both Barbara and Angie are aware of their limited progress after residing in a CRF for four and five years respectively. In addition, some residents expressed frustration around the manner in which staff communicate with them:

Troy (H1): *“yeah, I find they ask the same questions”*

Eliza (H1): *“I just find that they are not very communicative to be honest like, when I go and see a registrar or whatever, I’m talking to them and I feel that they are not really listening, they just want you to give the right answers to their questions you know, and they just ask you the main questions for about half an hour or so and you are just sitting there going “yes, no” and there is no real communication like. Maybe that’s my fault but I can’t communicate with them and that’s the way I feel”*

Eliza believes that doctors are not very communicative and do not listen to her. As a consequence, she is unable to discuss her symptoms freely with staff. In addition, Eliza became upset by the above and questioned if she was

to blame for the communication issues with staff. Troy, in agreement with Eliza, indicated that doctors ask the same robotic questions. Eliza began to cry at this point and was therefore offered the opportunity to speak to staff after the interview. However, she wished to continue with the interview and described feeling trapped by the services:

Eliza (H1): "I get sent a letter every so often saying go and see a psychiatrist you know, and I don't always do it because I was told that I should only go once a year but they keep on sending me letters every few months and I know I don't need to go every few months. It's this sort of thing you know, it's like they won't let go of you and you just feel like you are trapped. I find it hard to see myself getting out of this situation [...] that I'm in. Once they get their clutches on you, you are there for life"

In addition to having robotic conversations with doctors, Eliza recounts similar communication from the mental health services in the form of letters requesting visits she does not believe she needs. Eliza's comment suggests that she would like to have control over the issue and be given the option to arrange an appointment when she believes she needs one, as opposed to the services making these choices for her. As emphasised earlier, staff in mental health services are still making choices for patients without prior discussion with the patient. This may imply that recovery training is not happening on a regular basis (Sharek *et al.*, 2022)

Communication issues between psychiatrists and patients are highlighted in the literature (Maguire and Pitceathly, 2002; Silverman, Kurtz and Draper, 1998). In addition, guidelines on how psychiatrists can improve communication with patients include a focus on the patient's concerns, positive regard and personal respect, and appropriate involvement of patients in decision making (Priebe, *et al.*, 2011). Moreover, Loman (2017) suggests that communication can be improved by avoiding medical jargon and encouraging the patient to repeat back what he or she understands to be the key points of the consultation.

In addition to the above criticisms of doctors, residents in three CRFs perceived that they were not treated with the dignity and respect they rightly deserved and described feeling infantilised by staff:

Barbara (H5): *“We feel like lower down children again”* [when told that going out and drinking alcohol is not allowed] [...] *“We are not animals in a cage. And we do not WANT to be treated like animals and we do not want to be treated like children”* [expressed frustration with staff who do not allow residents to socialise]

Barbara’s tone was stern, and her voice was raised while she was describing feeling like a caged animal or a misbehaving child when staff restricted her autonomy. Barbara perceives that restricting her autonomy is not necessary and possibly wrong, as she further explains that she will communicate same to the nurse in charge at the next meeting:

Barbara (H5): *“they [residents] should be allowed to socialise and I’ll say it at the next meeting when she is here herself [head nurse], I intend to speak up”*

Infantilisation is a behavioural pattern in which a person in a position of authority interacts with or treats another person as if he or she were a child (Marson and Powell, 2014) and is often a common behaviour observed in institutional settings. For example, a qualitative Canadian study (Kirsh *et al.*, 2011, p. 22) outlined important characteristics of supported housing for individuals with serious mental disorders, and reported that residents wished to be treated with respect and related to “like a human being”. Treating residents and all individuals with mental disorders with humanity and respect is a fundamental right (United Nations, 2022). If residents are not treated 'like a human being' and with respect, they may feel undervalued and have a low self-esteem and a diminished sense of worth, which does not align with the concept of recovery, and violates their human rights. As previously discussed in Chapter two, staff should empower residents rather than disempower them, particularly since persons with an SMI often struggle to retain personal authority (Tolman and Kurtz, 2012).

Discontent with staff putting a significant focus on medication as the only form of treatment is another issue for residents:

Joe (H4): *“They just drug you up”*

Joe believes that he is medicated instead of receiving rehabilitative services. In addition, quantitative results indicated that 41% of residents felt that they lacked sufficient knowledge on the potential adverse effects of medications. Qualitative data further supported this:

Eliza (H1): *“you don't get enough information about what it is you have been given you don't get enough information about the side-effects”*

Furthermore, residents reported undesirable side effects of their medication:

Joe (H4): *“I feel like I am being poisoned [medication]”*

Harry (H4): *“I put on 4 stone and they [staff] keep saying “you eat too much”*

Barbara (H5): *“they [medications] destroyed me, one particular one of them anyway, Pridael that has caused me to be on dialysis today [...] it affects your kidneys”*

Joe feels that he is being poisoned with medication and Harry claims to have gained a significant amount of weight as a result of the medication. It is commonly acknowledged that psychiatric medications can cause considerable weight gain (Parks and Radke, 2008; Schimmelmann *et al.*, 2013; Stroup and Gray, 2018), which can be distressing to the individual as well as raises the risk of adverse health outcomes (Schimmelmann *et al.*, 2013). However, it seems that the staff are blaming Harry for his increased appetite rather than considering it a probable side effect of the medication, which is not in line with the concept of recovery.

Barbara has also detailed severe physical effects, resulting in a life-altering harm to her kidneys as a result of medicine with serious implications, as she must now find the time to attend dialysis three times per week in order for her

kidneys to remain functioning. Additional adverse effects of medication reported by residents' in H6 included comments on “*breathlessness, bloating, dizziness, weight gain, memory disruptions, difficulty concentrating, blurred vision, difficulty waking in the morning, drowsiness and tiredness.*”

Residents have clearly voiced dissatisfaction with certain aspects of the service. They believe that they have not made significant progress in becoming more independent, that doctors are not keeping them informed of their progress, that they are treated disrespectfully by staff, and that they do not receive adequate information on their medication and potential side effects. These findings do not indicate a rehabilitation philosophy in CRFs. Rather, they indicate a power imbalance, as residents perceive that they are treated and spoken to as children. Poor communication from doctors is further evidence of poor therapeutic relationships between residents and staff.

Involving residents in decisions about their care (shared decision making) can increase autonomy (Joosten *et al.*, 2011), as well as other positive benefits such as increased responsibility of own care, a reduction of stigma and improved outcomes in terms of recovery (Hamann *et al.*, 2020; Joosten *et al.*, 2009). According to Shepherd, Shorthouse and Gask (2014, p. 2) “shared decision making is characterised by the bilateral flow of information, between clinician and patient, with deliberation and decision making divided between the two parties”. However, engagement in shared decision making does not always happen, given the misconceptions that people with SMI lack insight and/are incapable of making decisions around their own care (Day and Bentall, 1995; Hamann *et al.*, 2016; Hamann *et al.*, 2020; Seale *et al.*, 2006).

Residents in this study perceive that staff consider them to be inferior. The recovery model calls for people in care to be treated with respect by systems of care (Health Information and Quality Authority, 2019) and conflict between residents and staff is viewed by both parties as unhelpful (Killaspy *et al.*, 2019). Negative therapeutic relationships with staff result in lower satisfaction with care (Loh *et al.*, 2007; Priebe and Miglieta, 2019). Therefore, recovery training for staff on the importance and benefits of

improving therapeutic relationships and engaging in shared decision making should be prioritised within mental health services. Furthermore, no patient reported outcome measure (PROM) exists to specifically evaluate residents' views of the support they receive. However, Sandhu *et al.* (2016) are firmly of the opinion that direct and open communication between patients and clinicians about patients' experiences, appraisals and wishes represented one of the most important approaches to capture residents' satisfaction with care.

This chapter critically discussed the findings from the main theme, **lack of recovery**, in relation to the literature. Findings demonstrated a lack of awareness and understanding around the role of the CRF and the role of staff from residents' perspectives. In addition, it noted the absence of evidence-based treatment, notably in terms of individualised care planning, occupational and social functioning, as well as the restrictive environments that violate the human rights of residents. As a result of these issues, residents are dissatisfied with the care they are receiving, which aligns more with the custodial model of care rather than the Recovery mode of care. In order to meet international human rights standards, the WHO (2021a) argues for a much faster transition from mental health services, that focuses almost exclusively on the use of medication to manage symptoms, to a more holistic approach that focuses on individualised care and treatment. The next chapter will critically discuss the findings related to stigmatisation.

Chapter 7: KEY FINDING 2: Stigmatisation and Discrimination

This chapter critically discusses the findings from the main theme **Stigmatisation and Discrimination**, with a focus on how these impact residents’ lives. Quantitative findings indicated that residents did not identify stigma or discrimination as a significant issue. However, when the topic of stigma was further explored through focus groups, residents described an instinctive awareness of stigmatisation and discrimination which informed the development of the following three subthemes illustrated in Table 7.1: *social / public stigmatisation and discrimination, mental health professional and structural stigmatisation and discrimination and internalised stigmatisation.*

Main Theme	Sub Theme
Stigmatisation	Social Stigma
	Mental Health Professional Stigma and Structural Stigma and Discrimination
	Internalised Stigma

Table 7.1: Illustration of the main theme stigmatisation and subthemes, self-stigmatisation, receive stigmatization from staff, neighbours as well as from friends and family

Each sub-theme will be individually discussed below in the context of the quantitative findings, where applicable, and within the context of the literature.

The most established definition of stigma was proposed by Goffman (1963) in his seminal work: *Stigma: Notes on the Management of Spoiled Identity*. Goffman (1963, p. 3) defined stigma as an “attribute that is deeply discrediting” and as something that reduces the bearer “from a whole and usual person to a tainted, discounted one”, hence Goffman's term ‘spoiled identity’. Goffman (1963 p. 2) also described stigma as the “situation of the individual who is disqualified from full social acceptance”. The definition of

stigma varies considerably, but it is used ambiguously to refer to “the cooccurrence of its components: labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” or a “mark of disgrace or shame” by means of which people are “stereotyped or rejected” (Link and Phelan, 2001, p. 364). Stigma is conceptualised as a negative stereotype, from which discrimination can emerge as a behaviour (The Mental Health Commission of Canada, 2023), and involves the mistreatment of people living with or perceived to live with certain identities, characteristics, or attributes (Earnshaw *et al.*, 2018 p. 2).

Given the above, it is important to note that perceived stigma and discrimination reported in the literature by persons with mental disorders is more than just experiencing isolated or continuous incidents of harassment (Berzins, Petch and Atkinson, 2003), exclusion in the community (Hall *et al.*, 2019) or discrimination in employment and inadequate housing (Corrigan and Watson, 2002b). For instance, disbelief, overprotectiveness, and dismissiveness from family members towards individuals with mental disorders can be viewed as stigma and discrimination by those with mental disorders (Huggett *et al.*, 2018; Thornicroft, Rose and Kassam, 2007). Thornicroft (2006) described stigma as having three related problems, namely, ignorance or lack of knowledge and understanding, prejudice which feeds fear, anxiety and avoidance, and discrimination in which living a normal life becomes more challenging. Hamilton *et al.* (2014) carried out structured telephone interviews with randomly selected mental health service users (n=537) from five National Health Service Trusts in England. Twenty-three interviews were audio-recorded and qualitatively analysed, to develop a form of classification of discrimination experiences. Seven types of discrimination against people with mental disorders were identified: organisational decisions made on the person’s behalf; mistreatment; social distancing; stereotyping; dismissiveness and overprotectiveness; and lack of understanding. There is a paucity of literature around linking stigma and discrimination to lack of understanding, dismissiveness and overprotectiveness. However, it is important for mental health professionals to recognise that stigma is a complex issue that can manifest in subtle ways

as well as the obvious ways cited above (American Psychiatric Association, 2023).

7.1 Social Stigma

The sub theme social stigma refers to how residents are impacted by what they perceive to be stigma, and disapproval or discrimination from members of society, including friends, family and neighbours. Within the context of this study, therefore, social stigma occurs when people endorse negative stereotypes and act in a harmful and discriminatory way toward people with mental disorders (Livingston, 2020). Social stigma toward people with mental disorders is widespread and residents in this study offered a considerable amount of information to demonstrate that they had experienced stigmatisation from family, friends, and neighbours. For example, residents reported that their families are overprotective and lacked understanding around their mental disorder:

David (H5): *“My family, they make a big thing out of things you know, they are overprotective, and they are on your case ringing you and I prefer if they would just let me live my life and I come and see them on the weekends...I don’t want them interfering”*.

David perceives his family to be overprotective and interfering, by continually contacting him, and describes how he would prefer to have a degree of separation from his family. Although regular family contact could be interpreted as caring and supportive, it has been reported that support and empathy may also lead to over-protectiveness. The person with the mental disorder may interpret this as a belief that they are incompetent or overly sensitive, leading them to perceive overprotectiveness as a discriminatory or stigmatising behaviour (Hamilton *et al.*, 2016).

A possible explanation for overprotectiveness is that family members view their loved one with benevolence (wrapping them in cotton wool and overprotecting them) or authoritarianism, in which family members believe they know what is best and therefore attempt to control their loved one's life (Papadopoulos, Leavey and Vincent, 2002). However, another possible

explanation is that family members are attempting to protect their loved one, themselves, or both, from stigmatisation, termed associated stigma (Fox, 2021; Goffman, 1963) in the community, by attempting to have more input into their loved one's life in order to prevent embarrassing behaviour that could cause them to feel stigmatised. For example, Catthoor *et al.* (2015) investigating stigma in family members of psychotic individuals (n=150) in Belgium, found that 86% of family members experienced associative stigma. As a result of associated stigmatisation, family members may attempt to conceal their loved one's diagnosis. This might lead their loved one to perceive this concealment as confirmation that their symptoms are abnormal and shameful, which may then be internalised, resulting in the construction of a negative self-image.

Carol describes feeling bullied by her family, which was most likely rooted in a lack of understanding and stigmatisation.

Carol (H5): *“It has taken them nearly over 15 years to understand, I suppose over the last two years now they are more understanding and accepting, it was hard you know there was a lot of bullying going on for a long time with them now but now they are understanding”.*

Although Carol does not describe the exact details of bullying that she experienced by family members, it is possible that she perceived her family members as dismissive and disbelieving of her symptoms. This was previously reported by participants in other studies, who cited fear, self-blame, and shame as reasons for their family's behaviour (Hamilton *et al.*, 2014; Morgan *et al.*, 2017).

Sarah describes being grateful to have enough insight to realise that her family do not understand her illness:

Sarah (H5): *“I'm lucky that my medication works well with me, so I have enough insight to talk to them to know that they don't fully understand. Yeah, they don't realise how serious ill I can be, even my friends, you know.”*

Participants in Hamilton *et al.*'s (2014) study cited lack of understanding as a root cause of stigma and discrimination, as stigma often results from a lack of understanding or fear (American Psychiatric Association, 2023).

Other residents stated that their families disregard their mental health issues:

Jackson (H6): *"they don't think there is anything wrong with me at all, my sister said to me "you are fine John there is nothing wrong with you, get your mind off things, go wash your hair, go do things."*

Lana (H6): *"that's the way my family think too you know, just get out there."*

Both Jackson and Lana describe their families as being dismissive and nonbelieving towards their mental disorders, which can be an indication of stigma and discrimination. For instance, participants in Hamilton *et al.*'s (2014) qualitative study described dismissiveness of their symptoms by family members as refusing to believe that their mental disorder was genuine or that the person experienced symptoms of it. This is viewed as discriminatory behaviour (Hamilton *et al.*, 2014). Jackson revealed further insights about his turbulent relationship with his mother and father, who possibly lack understanding of his mental health issues. For instance, Jackson believes that his mother attributes *"everything"* to his former alcohol use, even though he has refrained from alcohol for many years.

Jackson (H6): *"you know the mother blames it all on the drink, anything that happens to you "it's the drink doing it to you" she says". "You know, I was supposed to go to Medjugorje (in the past), and my mother was going with me but I couldn't go because my blood pressure got high and it went high because they put me on olanzapine so I couldn't go that year, anyway and my mother still said to me "it was the drink now that did that to you."*

Jackson further described how he perceives his father to be *"ignorant"* towards his mental health issues:

Jackson (H6): *"I bite my nails right; I was biting my nails in the car last Friday he [father] said 'what's wrong with you' he said, 'biting your nails' and I said 'it's a bad habit I have' I said. He said, 'are*

you on tablets for it' he said. Are you on tablets for it?' For biting my nails like, I mean how ignorant could he be?"

It is reasonable to assume that Jackson was disappointed that he was unable to travel to Medjugorje with his mother due to his medical issues. However, his mother did not believe that his medical issues were caused by the medication and instead blamed his previous alcohol misuse, which must have exacerbated his disappointment. Both Jackson and Lana's comments imply that their families may be oblivious, insensitive, or unconcerned towards their mental health issues. This may negatively affect family relationships and possibly impede recovery further (Hamilton *et al.*, 2016; Shepherd *et al.*, 2012).

Similar findings were reported in the UK, arising from an annual telephone survey (n=985) of people with a mental health diagnosis to evaluate an anti-stigma campaign (Time to Change). Of the 985 participants, 84 individuals took part in a qualitative interview, of which 50 interviews were transcribed and analysed (Hamilton *et al.*, 2016). Results revealed recurring themes regarding family that included a lack of understanding and being dismissive of mental health issues.

Similarly, Morgan *et al.* (2017) conducted telephone-survey interviews (n=5220) in Australia, 1381 of whom disclosed having mental health issues. Participants reported experiencing discrimination from friends and family (25.8%) with regards to their depressive and anxiety disorders. A lack of understanding by family members was also noted, with some family members frequently dismissing mental health conditions by implying that they were not real. Families who have a family member with a psychotic disorder such as schizophrenia, as in this research, may find it much more difficult to understand given its complexity (Sawa and Snyder, 2002). This may result in significantly strained family relationships for people with SMI, which is unfortunate, as positive good supportive family relationships can support recovery and increase adherence to treatment (Zoppei *et al.*, 2014). Therefore, it is vital for mental health services to recognise that families can have

negative attitudes and hold prejudiced views toward family members with mental health disorders. Moreover, they need to implement evidence-based treatments that reduce such attitudes that can lead to stigma and discrimination in people with mental disorders.

In addition to perceived stigmatisation from family, residents also communicated perceived stigma from friends and neighbours. One resident, Sarah, described how none of her friends contacted her again after she disclosed to them that she had a mental disorder:

Sarah (H5): “You know on Facebook I found my old friends from before, all of them I have told them my situation and none of them have called me again, so the next person I won’t say anything, so there is still a bit of sigma [...] Some are scared I find. Yeah, they don’t know what your next move will be, cause my friend told me the last time, ‘I hope you won’t make a karate move on me.’ She was joking but she was serious at the same time.”

This behaviour described by Sarah, is known as avoidance, and is often characterised in the literature as a form of stigma or prejudice faced by those with mental disorders (Pryor *et al.*, 2004). According to Corrigan *et al.* (2016), avoidance is a behavioural manifestation of public stigma, as opposed to the cognitive manifestation, which is the belief that persons with mental disorders are dangerous and unpredictable and which is the most damaging form of stigma. Due to the behaviour of her friends, Sarah seems to have experienced both the behavioural and cognitive consequences of social stigma. As Sarah’s friends chose to avoid her after she revealed the truth about her mental health, she indicated that she will not disclose this information to people in the future. This may hamper Sarah’s ability to recover, as she may internalise her friends’ behaviour and conclude that she is considered as dangerous due to her mental disorder. This is particularly relevant when the “mental patient” label is associated with preconceived notions about the danger posed by those with mental disorders (Link and Phelan, 2001, p. 369; Gonzales, 2017).

Other residents expressed feeling discriminated against by their neighbours. For instance, residents experienced unpleasant confrontations with neighbours, who accused them of pacing up and down in front of their home and throwing cigarette ends and empty beer cans on the footpath outside their house:

Carol (H5): *“she [neighbour] said that we were pacing out the front and there was drink bottles and everything outside, alcoholic cans, everything outside and there wasn’t.”*

Thomas (H5): *“they are complaining about smoke being on their clothes on the line from where we were out the back, it’s virtually impossible for that to happen but and she [neighbour] has given her [supervisor] a lot of complaints.”*

Barbara (H5): *“I walked over and I said, ‘excuse me, I said, I always mind my own business, I go up and down to the shop and I don’t look left or right and that’s the way I intend to have it’. And I turned on my heel and I walked back into the smoking area, and I finished my cigarette. I don’t bother with anybody along this estate, or I don’t intend to.”*

Residents felt wrongly accused. Thomas stated that *“no one was pacing”* and the residents were not responsible for the cigarette ends. Furthermore, Thomas believes that it is impossible for the neighbour’s clothes to smell of cigarette smoke as a consequence of residents’ smoking in the garden next door, indicating that he believes they are being discriminated against. Thomas may be correct in his opinion as Lasalvia *et al.* (2021) compared both experienced and anticipated discrimination among people with schizophrenia, affective and anxiety disorders. Participants were recruited at random (n=2155), schizophrenia (n=773), affective disorders (n=1010) and anxiety disorders (n=372), from 57 participating hospitals across five EU countries (Belgium, Germany, Italy, Poland and the UK). Compared to those with anxiety and affective disorders, those with schizophrenia (which was the diagnosis of most residents in this study) reported greater instances of discrimination in their interactions with neighbours, mental health professionals, and housing.

With regards to this study, the residents' neighbours may feel justified in their prejudice against the residents' perceived discrimination. Link and Phelan (2001) suggest that when individuals are labelled, they may be associated with negative characteristics, and a justification can be established for devaluing, rejecting, and excluding them. This seen or observed prejudice towards residents may increase the risk of residents severing relationships with neighbours, who may prefer social distance from residents (Zoppei *et al.*, 2014).

Harry (H4): *“Our neighbors, oh we know our neighbors, don't we Joe? [Mr. X] is his name... The others have grandchildren playing in the garden [...] We are trying to go around undetected.”*

Barbara (H5): *“Did ye ever hear it said, ye didn't probably, ye are younger than me, good fences make good friends, keep your distance.”*

Harry's original comment was delivered in a sarcastic tone, hinting tensions between residents and their neighbours, and as a consequence, they preferred to avoid interacting with them. Residents in H5 also shared this perspective. These findings are consistent with earlier studies (Boydell *et al.*, 1999; Çapar and Kavak, 2019; Granerud and Sevenrinsson, 2003; Link and Phelan 2001), which concluded that individuals who experience stigma and discrimination prefer to remain anonymous and self-isolate and not draw attention to themselves. People can become sensitive to discrimination and end up engaging less and less in their community (Zoppei *et al.*, 2014), resulting in a reduced social network.

Clearly, stigma and discrimination from members of the community is a complex issue and requires a monumental effort from governments, mental health services and society as a whole to reduce unfavourable attitudes towards people with mental disorders. Congregated settings can be stigmatising to residents (Chow and Priebe, 2013; Granerud and Sevenrinsson, 2003) and may attract the attention of neighbours, due to the large number of adults (approximately 4-12) living in a single house (Barbato, Civenti and D'Avanzo, 2017; MHC, 2018). Therefore, mental health services

and social housing departments should work more effectively together to find alternative housing for those with mental disorders. By maintaining many individuals with mental disorders in the same facility, mental health services may inadvertently expose residents to prejudice and stigmatisation, which can have a detrimental effect on recovery. In addition to residents experiencing stigma and discrimination from family, friends, and neighbours, they also experienced stigma from mental health professionals, which will now be discussed.

7.2 Professional and Structural Stigma and Discrimination

The subtheme professional and structural stigma and discrimination will examine the effects of professional and structural stigma on residents' lives. Although the impact of both structural and mental health professional stigma is underreported and under-researched (Hatzenbuehle and Link, 2014), it is increasingly acknowledged that both are major sources of stigmatisation identified by persons with SMI, particularly schizophrenia (Mestdagh and Hansen, 2014; Schulze, 2007; Valery and Prouteau, 2020). Moreover, they are associated with significant obstacles to the well-being of people with mental disorders (Evans-Lacko *et al.*, 2012; Fox 2021; Klein, Fairweather and Lawn, 2022).

Professional stigma will be discussed first, followed by structural stigma. Professional stigma is described as health professionals carrying stigmatised beliefs towards patients (Ahmedani, 2011). Although residents did not recall staff making statements that could be interpreted as stigmatising attitudes toward residents, they did describe instances in which they felt dismissed and disrespected by staff, which can be indicative of stigma (Hamilton *et al.*, 2016; Huggett *et al.*, 2018):

Anna (H3): "Sometimes I feel myself that I'm not being treated with respect half the times, and they don't want to know you."

Anna went on to provide an example of what she meant:

Anna (H3): *"'oh we are sick of talking to you, we'll talk to you today and you tomorrow and you the next day' that's the kind of thing that goes on, I don't like that. It makes me hurt, to be honest [...] if they know you have an illness, like, they don't want to know you and they will say 'Oh I want to talk to (husband) or I want to talk to such a person' and they will be gone out the door. That's the way I see it and that's been honest like."*

Anna's comments suggest that she perceives the staff to be disrespectful and dismissive, since they prefer to communicate with her husband or another relative rather than with her. She described feeling that staff "*don't want to know*" her and that they are "*sick of talking*" to her, which may cause Anna to perceive that staff regard her as inferior to them. Anna describes experiencing emotional distress "*it makes me hurt*" as a direct result of her perceived discriminating treatment by staff. Anna is clearly upset about this issue, as when the researcher moved on to the next topic, Anna interrupted by stating that she "*will walk away and leave them*" if staff refuse to speak with her.

Residents are adults living in CRFs in the community, that are intended to resemble community living (CIZ, 2014; Parker *et al.*, 2017). They should not feel like five-year-old children living under the care of someone with complete control over them (similar to parents of a five-year-old child). In addition to Anna's experience, Barbara also implied that residents felt disrespected by staff who denied them permission to socialise, as she described not wanting to be "*treated like animals*" or "*children*" as it makes residents feel like children again:

Barbara (H5): *"I feel like a 5-year-old again. Like mammy telling me to go into bed and get up and don't do this and don't do that."*

Barbara's comments, described here and in section 6.5, indicate that she feels disrespected, discriminated against, and stigmatised by staff, since ordinary citizens are not treated like children and animals in cages, page 198. Feeling stigmatised may lead to feelings of guilt and/or personal failure (Heflinger and Hinshaw, 2010), which may prevent residents, such as Anna and Barbara, from seeking support from staff in the future if required. This is contrary to

the Recovery model, according to which mental health practitioners are expected to empower, not instil feelings of shame and failure (Shepherd, Boardman and Slade, 2008).

Qualitative researchers investigating the experiences of stigma among persons with mental disorders have revealed similar findings to those described by Anna. Participants experienced negative attitudes from mental health staff, such as rudeness and dismissiveness, and perceived mental healthcare professionals as preferring to distance themselves from people with mental disorders (Hamilton *et al.*, 2016; Huggett *et al.*, 2018). This finding may be explained by mental health professionals having similar stigmatising views toward individuals with mental disorders as the general public (Heflinger and Hinshaw, 2010; Henderson *et al.*, 2014; Schomerus *et al.*, 2012). Furthermore, mental health professionals have been found to view people with mental disorders as having no control over their emotions (Foster *et al.*, 2008; Handan-Mansour and Wardam, 2009) and being, unpredictable (Magliano *et al.*, 2004), dangerous individuals who should be separated from society and should not be allowed to marry or have children (Angermeyer and Dietrich, 2006; Arvaniti *et al.*, 2009; Magliano *et al.*, 2004; Nordt, Rössler and Lauber, 2006). Acker and Lawrence (2009) provide a plausible explanation for why mental health professionals may hold such negative attitudes toward people with mental disorders. They suggest that mental health professionals may develop their own biases as a result of their family background and early life experiences or as a result of burnout in their own working roles, particularly when working with individuals with SMI. Moreover, people with schizophrenia can receive disproportionately negative media coverage when involved in violent incidents, which increases beliefs about the dangerousness of people with schizophrenia (Chan *et al.*, 2019). Thus, another possibility is that the media has negatively influenced the perspectives of mental health professionals in a manner similar to that of the general population.

Given the above, it is reasonable to conclude that stigma is ingrained in society as a whole and intertwined with the culture and practices of mental

health care. As a result, residents and people in general who are receiving mental health care may be susceptible to stigma and discrimination from every angle, even from those in the caring profession, whom they may be least likely to suspect as facilitators of stigmatisation. Reflective practice, examining one's own attitude toward persons with mental disorders, may be a useful beginning point for resolving this complex issue, along with ensuring that staff participate in continuous professional development and apply evidence-based interventions. Participation of service users in assessment and development of programmes aimed towards reducing stigma in mental health professionals may benefit mental health practitioners in changing unfavourable perceptions of individuals with mental disorders. For example, a UK study (Friedrich *et al.*, 2013) revealed that anti-stigma training for medical students (n=1452) resulted in the intervention group demonstrating significantly greater improvements in stigma-related knowledge and reductions in stigma-related attitudes relative to the control group. However, results were not maintained at six months follow-up, indicating that ongoing, regular training is required to reduce professional stigma.

In addition to experiencing public stigma and stigma from mental health professionals, residents also experienced structural stigma, which is sometimes referred to as institutional stigma (Heflinger and Hinshaw, 2010). Structural stigma was first identified by Link and Phelan (2001) and can be defined as the “societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatised populations” (Hatzenbuehler, 2016 p. 742).

Institutional practices that create policies, procedures, or practices that disadvantage or restrict opportunities of people with mental disorders, such as those described in section 6.3 under the main theme **Lack of Recovery**, result in social inequities or injustices for these individuals (Corrigan, Markowitz and Watson, 2004). Results of this study align with this assertion in that the strict rules and regulations masquerading as health and safety policies are obstructing the recovery of residents, as discussed in section 6.3. As a result, these social injustices compromise their human rights. For

instance, in this study, some residents claimed that they were denied access to the kitchen (page 181) and others claimed they were not permitted to go out and socialise as normal adults (page 182), because of the rules and regulations within the CRF. The results of this study also reflect those reported from a Mental Health Commission of Canada (Livingston, 2020) study that explored mental disorders and drug use-related structural stigma in health-care settings. Focus groups (n=20) revealed that there was a culture of caring, marked by prejudicial attitudes such as punitive and controlling practices, a lack of emphasis on recovery principles and person-centered care, impersonal and dehumanising treatment and interactions, and the perception that people with mental health disorders are always at the bottom of the list for care.

Further compounding matters for people with mental health disorders is the negative stereotyping attached to labels, particularly that of schizophrenia as discussed above. Although this discussion around labelling in psychiatry may be categorised as stigma from mental health professionals, the researcher decided it belonged under structural stigma, since cultural norms and institutional practices have always facilitated the labelling of persons with mental disorders (Lewis-Fernández and Aggarwal, 2015). Residents in this study were of the opinion that doctors apply labels without sufficient knowledge:

Joe (H4): *“I think the balloon is going to burst, they haven’t enough research, they don’t know enough to be able to apply a label to you, like schizophrenia.”*

Interviewer: *“Do you feel that people attach labels to you?”*

Joe (H4): *“no, except the doctor”*

Joe further expresses his objection to being stigmatised by labels, by expressing his disdain/dissatisfaction with the phrase ‘mental illness’:

Joe (H4): *“I don’t believe in mental illness; It’s not a nice name.”*

Another resident quickly echoed Joe's opinion:

Harry (H4): *"I don't believe in it either; people are born equally like animals; you don't see mental illness on a jaguar that's running through the forest."*

Joe's comments indicate that he is unhappy with having to deal with the repercussions of having a label attached to his identity, and therefore may recognise that the term 'schizophrenia' is associated with stigma. Unfortunately, as described on page 219, Joe is accurate in his perception that this label has undesirable connotations, so much so that Japanese psychiatrists have replaced the term 'schizophrenia' with 'integrative disorder' to reduce stigma associated with the term schizophrenia (Maruta *et al.*, 2014). Changing the term 'schizophrenia' to a less stigmatised term may be advantageous for people with mental disorders, as widespread acceptance of these stereotypes (e.g., dangerousness) results in punitive policies and/or endorsement to continue, maintain, or implement coercive care within mental health services (Livingston, 2020). Punitive policies and the maintenance of coercive care are counterproductive when attempting to transition mental health services from custodial and medical models to recovery-oriented and human rights- based care.

Joe further believes that doctors may attach this label to people without sufficient evidence and his opinion is supported in the literature. For example, a systematic review of 51 qualitative analyses of stigma in acute mental health care settings concluded that individuals with mental health disorders were stigmatised through an over-arching pattern of labelling and stereotyping, at both the professional and organisational level (Perry, Lawrence and Henderson, 2020). The implications for psychiatric labelling, particularly schizophrenia, comes with damaging consequences, which elicit beliefs that people with a diagnosis of schizophrenia are dangerous as described above, page 219. This, in turn, results in an increased desire for social distance from both parties (Angermeyer and Dietrich, 2006; Dietrich, Matschinger and Angermeyer, 2006; Nordt, Rössler and Lauber, 2006).

It is important to note that stigma from health professionals towards people with mental disorders is not limited to mental health care settings. Individuals with mental disorders, who sought help for physical complaints, reported receiving inferior physical healthcare compared to the general population (Thornicroft, Rose, and Kassam, 2007). A potential strategy for erasing stigma against persons seeking health care in general, may be for health services to require all employees and not just employees attached to mental health services, to undergo training on evidence-based strategies for removing stigmatising attitudes.

Although little is known about how organisations can effectively tackle structural stigma and produce sustained changes (Sukhera and Knaak, 2022), it is evident that interventions to address structural stigma will require advocating for changes to restrictive policies that impede recovery and rehabilitation. However, to produce sustained attitudinal and policy change, Valdiserri (2002) concludes in her writings on reducing stigma around HIV, that it will require individuals with expertise in public health, law, medicine, social science, journalism and leaders of organisations that have the authority to change policies. Furthermore, Sukhera and Knaak (2022) claim that structural stigma is prevalent in clinical learning environments and can be transmitted through role modelling. Sukhera *et al.* (2017) provided an example of how this occurred in one of their studies. Health professionals in an emergency department, who labelled and avoided patients with mental disorders, influenced medical students to behave similarly in the future by avoiding such patients. Sukhera *et al.* (2017) therefore advocate for educational interventions that increase empathy, understanding, and awareness. Furthermore, they emphasise generating alternative and more humanising labels, to urge health professionals to connect more with individuals with mental disorders, rather than avoid them.

7.3 Internalised Stigma

The sub-theme self-stigmatisation refers to how self-stigmatisation can impact residents' lives. Self-stigmatisation, also known as “internalised stigma” or “self-stigma”, is the absorption of others' biases and

preconceptions about individuals with mental disorders into one's own ideas about themselves (Hill and Startup, 2013; Lucksted and Drapalski, 2015 p. 99). As a result, they anticipate a negative reaction from others about their diagnosis (Chan *et al.*, 2022). The concept of internalising stigma and anticipating discrimination, without objectively experiencing it, has been widely reported in the literature (Assefa *et al.*, 2012; Cechnicki, Angermeyer and Bielańska, 2011; Fox and Earnshaw, 2022; Üçok *et al.*, 2012; Valery and Prouteau, 2020; Whitley and Campbell, 2014; Wong *et al.*, 2018;). Yilmaz and Okanlı, 2015). Internalised stigma is therefore common amongst people with mental disorders and its consequences can lead to feelings of inadequacy, worthlessness and shame, poor self-esteem, lower self-efficacy, decreased treatment adherence, and having a negative association with recovery, such as feeling helpless and low self esteem (Chan *et al.*, 2022; Corrigan and Watson, 2002a & b); Holubova *et al.*, 2016; O'Keeffe *et al.*, 2016; Yılmaz and Okanlı, 2015). Fox (2021, p. 64) asserts further that persons who internalise stigma endorse stereotypes about themselves, resulting in “self-discriminating behaviours”, such as self-imposed isolation, due to the negative associations with the term schizophrenia.

Residents in this research reported attempting to conceal their true diagnosis of schizophrenia from others, most likely because they were fearful of being stigmatised:

Barbara (H5): *“I don't tell anybody [...] nobody knows what I have or what is inside me, they don't know everything about me, that's the good of living in a city.”*

Carol (H5): *“I do hide things, like sometimes I would tell them I have post-natal depression after my daughter, I don't tell them the full story.”*

Eliza (H1): *“I think if they do view you as having mental illness, they might treat you as if you are not quite as good as everyone else, like you know you're in some way deficient.”*

Brian (H3): *“Depression, but it is schizophrenia they are treating me for.”*

Barbara expressed her gratitude for living in a city where she can keep her privacy regarding her mental health, while Carol acknowledged that she does not always tell people the truth about her mental health difficulties. Brian claimed that although his doctors are treating him for schizophrenia, he believes he has depression. Given his lengthy period of stay in a CRF (>10 years), it is quite likely that Brian does have a diagnosis of schizophrenia. However, he may not want to identify with a diagnosis of schizophrenia and may therefore be reluctant to disclose his true diagnosis in a group setting. Given the perceptual differences between the two diagnoses, it is entirely understandable why an individual would prefer to believe that they have or are being treated for depression rather than schizophrenia, as depression may be viewed as a disorder that can strike anyone, whereas schizophrenia may be viewed as stigmatising.

Fox (2021) is a social worker, an academic, and a person with lived experience of stigma and discrimination as a result of schizophrenia. She described in commentary how she is comfortable speaking about her diagnosis and experiences in academic circles, because she wants to use her expertise by experience to bring about positive change for people with mental disorders. However, she described being acutely aware of the need to protect herself and conceal her diagnosis from others, who may lack understanding of her condition, including some members of her family.

Similar findings were revealed in a study evaluating the level of anticipated discrimination in people with schizophrenia (n=732) from 27 countries throughout Asia, North America, and Europe (Üçok *et al.*, 2012). Data were collected from individuals with a diagnosis of schizophrenia, who were attending in-patient, day-patient, out-patient, and community psychiatric services. Results indicated that 72% felt the need to conceal their diagnosis because of anticipated discrimination. In addition, 64% has stopped applying for work, training or education because of anticipated stigma and discrimination. However, these findings must be interpreted with a degree of caution, given that enrolled site directors were asked to involve clients they felt were reasonably representative of the diagnosis of schizophrenia. This

could introduce the confounding effect of selection bias, as the chosen participants may not represent an accurate reflection of target population.

Notably, internalised stigma has been found not limited to people with schizophrenia, when compared with anticipatory discrimination, among people with schizophrenia, affective and anxiety disorders across five European countries (Lasalvia *et al.*, 2021). Results indicated that people with anxiety disorders more frequently stopped themselves from having close, personal relationships and felt the need to conceal their diagnosis in comparison to people with schizophrenia or affective disorders. Nevertheless, the above findings suggest that a lack of understanding in society towards persons with mental disorders may be a major factor contributing to the various levels of stigmatisation faced by people with mental disorders. This lack of knowledge may translate into anxiety and fear, and hence social distancing may seem to be a viable option for those who lack understanding. However, this causes persons with mental disorders to feel excluded, marginalised, and disrespected. In order to protect themselves from potential stigma and discrimination, they self-isolate, which is counterproductive to their recovery (WHO, 2022a).

Another resident described feeling stigmatised by living in a mental health facility and described how people can be “weary” of people with mental disorders:

Lana (H6): *“I just feel that people around here look down on you when they see you going in here [CRF] [...] Well, I think that if you had a broken hand or a broken leg, people have more... but when it’s the mind, people are kind of...stay away from you like, they don’t want to know you, they are a bit weary of you but if you had a broken arm they’re like ‘oh God I have to meet you’ and all this.”*

Lana’s word choice describing when neighbours see her “going in here [to the CRF]” indicates that she perceives living in a CRF as different from her neighbours and as a result feels stigmatised by her different living situation. Supported housing can have many positives. One reported by Watson, Fossey and Harvey (2019) in their qualitative meta-synthesis of experiences of

people with mental disorders, was that living in supported housing increased residents' confidence to rebuild an identity and meaning in life. However, congregated settings, such as supportive housing, can also be regarded as humiliating (Chow and Priebe, 2013) and living in a CRF blatantly identifies the residents as people with mental health disorders (Granerud and Sevenrinsson, 2003). Similar findings were also reported in a longitudinal qualitative study, conducted over five years, investigating stigma in people with SMI, who were living in congregated settings in Washington D.C (Whitley and Campbell, 2014). As previously discussed in Chapter two, page 63, their study highlighted residents' intense fears of being stigmatised by others. They would put significant effort into their appearance to try to fit into society and "*look normal*" and expressed concerns that staff coming and going or other residents becoming unwell would draw unwanted attention from neighbours (Whitley and Campbell, 2014, p. 3). This may help explain why residents in H3 repeatedly expressed how important it was to keep the house, as well as themselves, "*clean and tidy and neat*". Lana, who lived in H3, indicates that she is acutely aware of the possibility of potential stigma and discrimination associated with mental health disorders, as opposed to physical health conditions [page 223]. Further compounding matters for Lana, is the physical side effects of her medication which causes her to hypersalivate:

Lana (H6): "*drooling, I find that the worst, drooling, you wake up in the morning and your pillow is wet and you go through the day and people are looking at you and they don't understand and you're drooling and you're trying to get the tissue to wipe your mouth. And you wake up in the morning and your pillow is wet.*"

Lana indicates that she feels stigmatised by her hypersalivation, a well-recognised complication of clozapine, that can lead to social embarrassment (Praharaj, Arora and Gandotra, 2006) and can have a negative impact on QoL (Maher *et al.*, 2016). Moreover, fear of social embarrassment may lead to further minimising or avoiding all social interaction. Internalised stigma is synergistically linked with social, professional, and structural stigma (Sukhera *et al.*, 2017; Sukhera *et al.*, 2022) and any one form of stigma can

provide a fertile ground for other forms (Hermaszewska, Sweeney and Sin, 2022).

Stigma in general is a global, complex phenomenon, which requires an understanding from the perspectives of the general public, healthcare providers, individuals with mental disorders and their families (Mak and Cheung, 2008). Marketing campaigns focusing on challenging stigma have had some success through increasing education, encouraging social contact rather than social distancing, challenging stigmatising media coverage, promoting help seeking and empowerment of people with mental disorders (González-Sanguino *et al.*, 2019). For instance, the Time to Change (<https://www.time-to-change.org.uk>) campaign in the United Kingdom was one of the longest-lasting anti-stigma programmes in the world, extending from March 2007 to March 2021 and including 1,500 companies, 3,500 secondary schools and colleges, as well as youth organisations <https://www.time-to-change.org.uk>.

Although findings suggested yearly incremental progress in lowering public stigma (Hazell, Fixsen and Berry, 2022), the overall picture is disappointing, as results fall short of the necessary change in attitudes to eliminate stigma towards individuals with mental conditions (Hermaszewska, Sweeney and Sin, 2022). Furthermore, despite the prestigious campaign funded by Big Lottery, endorsed by celebrities, and evaluated by the Institute of psychiatry at Kings College London, results did not demonstrate a reduction in reports of discrimination from either mental health professionals or physical health care professionals (Henderson, Evans-Lacko and Thornicroft, 2013).

National developments over the past 10 years have seen the establishment of an organisation called *See Change*, which is committed to ending mental health stigma in Ireland. Their main objectives are to reduce stigma and discrimination, promote greater support, understanding and acceptance of people with mental health issues, as well as empower them to gain equality, respect, and rights. Public awareness campaigns, partnerships with national and community-based organisations and providing a platform to people with

lived experience, are used to achieve these objectives. However, a specific focus on internalised stigma, stigma from mental health professionals and structural stigma does not appear to be on their agenda. Given their expertise and caring nature, people may believe that educators and health care workers do not hold stigmatising attitudes and views. However, there is sufficient evidence that professional and structural stigma is widespread (Corrigan, Markowitz and Watson, 2004; Heflinger and Hinshaw, 2010; Hatzenbuehler, 2016; Link and Phelan, 2001; Perry, Lawrence and Henderson, 2020; Sukhera and Knaak, 2022). Without awareness and intervention in this area, persons with mental disorders may continue to face prejudice from healthcare professionals.

This chapter highlighted residents' experience of stigma from families who are either perceived as "*overprotective*", "*ignorant*" or lack understanding into the challenges residents experience due to mental health issues. Residents also described experiencing stigma from friends and are fearful of disclosing their mental health issues to people in case they will be stigmatised and discriminated against. As a result, they are concealing their diagnosis from people, which suggests that they are internalising negative stigmatising beliefs associated with psychiatric labeling. In addition, residents are experiencing stigma from mental health professionals, whom residents perceive as disrespecting and dehumanising them by treating them like "*children*" or "*animals in cages*". Furthermore, the structural stigma surrounding their environment is restricting their autonomy through unnecessary health and safety regulations. Health services need to be aware of the impact of the varying degrees of stigma to which service users are exposed to and prioritise financing for continuous education programmes, to reduce or eliminate all types of stigma in health care environments.

Chapter 8: KEY FINDING 3: Loss

Previous research has tended to concentrate on the perceived loss experienced by families with a family member having a mental disorder, as opposed to the perceived loss experienced by the person who has a mental disorder (Buchman-Wildbaum *et al.*, 2020). This chapter will thus explicate residents' perceived loss with living in CRFs and the impact these losses have on their lives.

Losses identified in this theme are outlined in Table 8.1 and described under two key themes: *loss of normal life* and *loss of hope*. Four additional subthemes were developed from 'loss of normal life': loss of independence; loss of autonomy; loss of opportunities, and loss of connections. Each sub-theme is individually presented and discussed and related to quantitative findings, where applicable. The findings are also discussed within the context of relevant literature.

Main Theme	Sub Themes
Loss	Loss of Normal Life <ul style="list-style-type: none">● Loss of Independence● Loss of Autonomy● Lost Opportunities● Lost Connections
	Loss of Hope

Table 8.1: Representing the main theme and subthemes within Loss

8.1 Loss of Normal Life

This theme represents the consequences of residents being unable to live independently, the loss of autonomy they experience. It also represents the

consequences of missing out on opportunities, such as education and employment, and the loss of connections with family, friends, and the community.

8.1.1 Loss of Independence

The sub sub-theme loss of independence, developed from the sub-theme, loss of normal life, encompasses residents' loss of independence and the impact on their lives. A severe mental disorder, such as schizophrenia, can cause a significant deterioration in functioning, to the point where it prevents individuals from living independently in the community (Kaya and Öz, 2019). Although living in a CRF is supposed to resemble life in the community (Parker *et al.*, 2017), research indicates that this is not always the case, and as a result residents can perceive their independence as being eroded (Chilvers, Macdonald and Hayes, 2006). For example, previous studies discussed on page 182-184, (Baltazar *et al.*, 2013; Brolin *et al.*, 2018; Brunt and Tibblin, 2011; Tedstone-Doherty, Walsh and Moran, 2007), all reported that residents of CRFs were living under strict rules and regulations. This implies that residents do not have the same level of autonomy and independence as other citizens. In addition, having regular or constant support from staff may further diminish a person's independence as residents become accustomed to having "*everything done*" for them as described by David, [page 197].

Both quantitative and qualitative findings from this study indicated that residents did not require assistance with ADL, and most residents claimed that they are independent with voting, visiting their GP, and managing finances. However, only 24% of residents reported being completely satisfied with their level of independence. Because residents are mostly independent with ADL, this may imply that they would prefer to live in a more autonomous form of housing, in order to have greater independence than a CRF allows. Although the quantitative data revealed that 87% of residents expressed a desire to stay in their current housing, the qualitative data highlighted a contrasting viewpoint, indicating that residents would prefer a more autonomous form of accommodation. The next chapter on

Institutionalisation will explore potential factors that may have led to this divergence between the two sets of findings.

The following are examples of residents' preferences for a more independent form of accommodation:

Tom (H3): *"Oh I'm on my last leg, I'd like to leave here I suppose [...] I'd like to get a house [...] start renting, you know."*

Tom was an elderly man who regarded himself as being on his "last leg" indicating that even though he is elderly, he would still like to become more independent, by renting a house and living independently in the community. Barbara agreed with Tom and stated that all residents would most likely prefer to live independently rather than in a CRF:

Barbara (H5): *"I think that's everyone's wish that they would like to have a place of their own, council house or a flat or something."*

Other residents agreed with Barbara's statement:

Angie (H2): *"I'd love to be at home again."*

Troy (H1): *"yeah, I would like to have my own place."*

Jonathon (H4): *"you would be looking forward to getting home like"*

In response to the question: What would recovery mean for you? Carmel indicated that it would mean being able to move on from the CRF and another resident gave the impression that she did not have a choice around living in a CRF:

Carmel (H3): *"to leave here"*

Selena (H1): *"You have to stay in [House No 1]."*

The above findings imply that residents would prefer to move out of the CRF and into their own homes or rented accommodation. Therefore, it is reasonable to conclude that increasing their independence around living in a

more autonomous environment is important to them. Furthermore, Selena gave the impression of possible coercion into living in a CRF. She communicated in a sad tone, with eyes gazing downwards, that she does not have a choice around living in a CRF, indicating a sense of hopelessness regarding her circumstances. Despite the absence of a definition for a normal life, it is reasonable to assume that a normal life includes being able to make decisions and choices around where and who one lives with. Selena's comments imply that she does not have this option, and she may perceive that she lacks the authority to choose where she lives.

Furthermore, it does not appear that staff support residents in their desire to live more independently. For example, one resident reported that staff do not discuss transitioning on from the CRF:

Barbara (H5): *"they don't talk to us about that"*
Interviewer: *"about moving on, is it?"*

Barbara (H5): *"yeah they could talk a bit more maybe about it [moving on from CRF] or we could talk to them about it and get them started then to talk to us about it"*

The above comment from Barbara appears to be at odds with what was reported by staff in the facility questionnaire, who reported that rehousing was facilitated in 100% of CRFs by either social workers or nursing staff. It is of course possible that staff are pursuing housing for residents, but that a lack of suitable housing is impeding their efforts. Community mental health nurses reported in the Community Nurse Questionnaire that they anticipated all residents would remain in their current housing for the foreseeable future due to housing shortages. However, if staff are not actively engaging with residents and discussing exit strategies from the CRF, this may result in residents remaining at their current dependent level of functioning, which may impede their rehabilitation and recovery process.

Current housing programmes for persons with mental disorders do not provide sufficient options to choose from and placement is influenced by

availability (Barbato *et al.*, 2020). However, evidence suggests a preference for independent housing amongst residents of CRFs. In 20 out of 26 studies reviewed by Tanzman (1993), at least 70% of participants had stated a preference for living independently. In addition, a more recent systematic review and meta-analysis of studies reporting preferences rates for persons with mental disorders for independent living, found that 84% of participants preferred to live in their own apartment, with family or persons of their own choice (Richter and Hoffmann, 2017).

The United Nations Convention on the Rights of Persons with Disabilities, (2007) states that people with mental health disorders have the right to decide where and who they wish to live with. Moreover, the previous national policy, AVFC (2006), the current national policy, *Sharing the Vision* (2020), and a government report, titled *Ensuring Independent Living and the United Nations Convention on the Right of Persons with Disabilities* (House of the Oireachtas, 2022), all recognise that people living in CRFs would benefit from living independently. However, the new and current national policy provides little information on how to achieve this goal. The policy is a rehash of previous recommendations in AVFC, such as the collaboration of the relevant organisations, i.e., the Department of Health and the Department of Housing, Planning, and Local Government, and key stakeholders to assist people living in congregated settings to transition to community-based living. The latter report from the government highlighted that progress to date is slow in transitioning people from congregated settings and that it may take an additional 20 years before congregated settings are consigned to history.

It is therefore possible that people will continue to reside in CRFs for the foreseeable future. *Sharing the Vision* (2020) has stated that Intensive Recovery Support teams will be available on a national scale to support those with complex mental health needs and help prevent them from entering restrictive settings. However, if individuals already living in CRFs are unable to transition out of them in the near future, mental health services need to prioritise the implementation of recovery principles and demonstrate a human rights-based approach to service delivery, where people's rights to make

decisions or choices around all aspects of their own recovery (Le Boutillier *et al.*, 2011). This should include where they live, in order to improve care, and residents' QoL, independence and autonomy.

8.1.2 Loss of Autonomy

The sub sub-theme loss of autonomy, developed from the sub-theme, loss of normal life, addresses residents' loss of autonomy and the impact this has on their lives. Autonomy refers to a person's ability to self-govern his or her own beliefs, behaviours and choices (Collier, 2002). Barriers that obstruct autonomy in health care include staff that do not implement actions or supports to promote autonomy, an overprotective approach to care or a culture within the organisation that does not respect service-user autonomy (Health Information and Quality Authority, 2016). Therefore, loss of autonomy can occur when individuals are not participating in decisions about their own care, whereas empowering individuals to have control over their own life and mental health can instil personal dignity, value, and respect, as well as enhanced self-esteem and confidence (Department of Health, 2006; WHO, 2010; WHO, 2022).

In this study, there was consistency in the quantitative and qualitative results around loss of autonomy. Quantitatively, just 35% of residents reported having 'a lot' of control over their own lives, while 63% reported having 'moderate' or 'little' control with 2% reporting having 'no control' over their own lives. In addition, and as previously discussed on page 181, staff reported that residents in some CRFs were not allowed to lock their bathroom or bedroom doors, some CRFs required residents to notify staff when they were leaving the building, and residents in some CRFs were not allowed to access to the kitchen to cook independently. Qualitatively, residents highlighted how prohibitive health and safety regulations and strict rules and regulations were restricting their autonomy:

Anna (H3): *“I can’t do my own cooking, there has to be a supervisor here like one of the girls [cook] or a nurse here for insurance wise if a fire started. That’s the way we have to live.”*

Harry (H4): *“They [staff] could give us more freedom.”*

Johnathon (H4): *“They should let me do what I want to do.”*

Anna (H3): *“I get to go set dancing too, if I’m allowed.”*

Anna appears to be aware that the way residents “*have to live*” is abnormal and Harry and Johnathon believe that they should have “*more freedom*” to do as they please. In addition, residents indicated that having a barbecue to get to know their neighbours would be pointless, since staff would likely be required to attend for health and safety reasons:

Delia (H2): *“the trouble is that staff might consider the BBQ a fire hazard so it would have to be in care of the supervisor”*

If residents were living in ordinary housing in the community, they would not require permission to have a barbecue or prepare a meal in their kitchen. These are additional instances demonstrating that life in a CRF does not resemble communal living.

As mentioned in the previous sub sub-theme, residents in CRFs have their behaviour and activities regulated by staff, however residents also feel monitored by staff:

Harry (H4): *“they take notes every day, they write about us every day and every morning and every night, they know exactly what’s going on, what you had for dinner, do you know what I mean, everything, everything”*

If residents perceive staff are monitoring their every move, they may feel scrutinised, or feel that their privacy is invaded. This may also create a sense of mistrust or unease between residents and staff. Parsell (2016) interviewed residents in supportive housing regarding their perceptions of camera surveillance. The findings concluded that surveillance could restrict autonomy, but that understanding the reasons for surveillance can help to

support autonomy. Although circumstances between Parsell's (2016) findings (camera surveillance) and this research (surveillance by documentation) are different, parallels can be drawn. If staff explain their rationale for what is viewed as excessive notetaking by residents, residents may not perceive their autonomy as being compromised. For example, if staff explain their level of responsibility in managing a mental health facility, and that part of that responsibility is having to keep up-to-date accurate and detailed records of the people in their care (Pullen and Loudon, 2006) in order to ensure a safe environment for everyone, residents may have a better understanding of why they are being 'monitored'. Without explanation, residents may question their ability to make decisions if their every move is recorded, resulting in diminished autonomy, which in turn can decrease a person's sense of dignity, worth, respect, self-esteem, and confidence (Mendonça, 2019; WHO, 2022), all of which are damaging to the recovery process (Le Boutillier *et al.*, 2011; WHO, 2010).

Additional comments, previously discussed in Chapter six, under the theme **Lack of Recovery**, also indicate that residents' autonomy is restricted where they reported "*not [being] allowed to socialise*", "*stopped at every move*" they make to socialise, will be "*locked away in a hospital*" if they consume alcohol and that the house "*is awful strict*". Another resident perceives staff to be restricting his autonomy by controlling his behaviour and actions:

Brian (H3): "*yeah, at times I feel they are stopping myself from being with other people like*"

Brian believes that staff are preventing him from mixing in the community. There could be an element of paranoia to Brian's thinking, given that most residents have a psychotic illness, although all residents who took part in the study were deemed well enough to take part by their consultant. However, as previously mentioned, a plausible reason for residents' comments may be that staff may find it more convenient if residents refrain from alcohol and socialising, so that evening and overnight shifts are incident-free. Staff may be fearful that residents will engage in risky behaviour if they consume

alcohol and having residents out at night may disrupt the sleep of other residents and staff. Alternatively, as previously noted under the stigmatisation theme, staff may harbour stigmatising views and attitudes toward residents and, as a result, restrict their interaction with the community. This may imply that staff are overprotective and paternalistic in their care, if they attempt to protect residents from discrimination, harassment, and stigmatisation from society. Nonetheless, staff are controlling the behaviour of residents to achieve a desired outcome (deCharms, 1968). Although we do not know for certain what that outcome is, the behaviour of staff towards residents is violating their human rights. For instance, Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which recognises people with long-term mental health difficulties as having a disability, specifies that people with disabilities have the right to access the personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation from the community.

In addition, residents are concerned that the enforced restrictions on their autonomy are preventing them from meeting a potential life partner:

Thomas (H5): "well you can go to a pub and have a few drinks you might meet someone. If you go to a bowling alley or somewhere, you are not going to pick somebody up there, that's all been tried and tested. It just happens when you are out, you meet someone and you can't deny that, you know"

Thomas believes that he is more likely to find a partner in a bar than elsewhere, but he considers restrictions on his autonomy as having a damaging effect on any possibilities of finding a partner. There may be an association between this finding and the quantitative finding of 73% of residents reporting being mostly dissatisfied or having mixed feelings regarding their satisfaction or dissatisfaction with their love life, i.e., only 26% reported to be satisfied with their love life.

However, this possible association cannot be confirmed, as residents did not want to seem to explore the topic of intimate relationships further:

Interviewer: *“Do you remember the questionnaires you filled out? There was a question asking, ‘how happy are you with your love life.’ The answers that I got back showed that most residents living in CRFs are unhappy with their love lives. Why do you think that is the case? Why do you think residents are unhappy with their love life?”*

A long silence followed this question. The researcher then asked the question again; “Why do you think residents are unhappy with their love life?” Another long silence followed and, finally, a resident responded with:

Delia (H2): *“Hmm, yeah [...] The supervisors you mean, is it?”*

Interviewer: *“No the people in the CRF’s... I’m just wondering why such a large number of residents said they were unhappy with their love life”*

Angie (H2): *“There is another thing too, it’s kind of on my mind, I thought I might let it out and say it to you. Now I go to a day centre myself and usually they are on about my timing you know, getting out there at 10 in the morning...”*

Interviewer: *“We will have a chat about that after the group, if that is okay? Because [resident X] is in a rush to go.”*

Similar responses occurred in other houses, with long silences and avoidance of the topic. This may imply that residents did not feel comfortable discussing such a personal topic in a group setting. However, it is known that people with persistent mental disorders such as schizophrenia may find it difficult to form intimate relationships due to psychotic symptoms, which can result in social withdrawal and fear of discrimination, stigmatisation or internalised stigmatization (White, Haddock and Varese, 2019). In addition, a qualitative analysis reports that people with mental disorders may not get involved in intimate relationships because of: low self-esteem; an inability to express needs; social isolation; medication side effects, such as weight gain or sexual dysfunction; fear of involving another person in the negative aspects of their illness; or fear that they will leave if a relapse occurs; as well as having to prioritise staying well, and not having time for relationships (Östman, 2014). In addition, Östman (2014) concluded that individuals who reported lower

levels of satisfaction with intimate relationships also reported lower levels of overall life satisfaction.

Given the above and following recommendations from AVFC, (2006); *Sharing the Vision*, (2020) and the UNCRPD (2006), staff should empower residents to engage in personal relationships if it is important to them. If staff are concerned about risky behaviours from alcohol misuse, they should consult with residents to determine how best to assure safety in relations to alcohol or drug misuse, if necessary.

In conclusion, the comments from this sub sub-theme suggest that there is a culture of disregard for residents' autonomy. For residents to feel more in control of their own lives, mental health services must emphasise the significance of empowering them to make decisions around their own care and autonomy. The empowerment process is a multidimensional process, through which individuals overcome a state of powerlessness and gain control of their lives (WHO, 2010). In addition, mental health services must ensure that staff have a comprehensive understanding of the individual's human rights under their care, in order to defend those rights and enhance the quality of their care. Furthermore, service users should be assisted in becoming aware of their own rights, as this may help them to feel empowered and more in control of their own lives.

8.1.3 Loss of Opportunities

The sub sub-theme loss of opportunities, developed from the sub-theme, loss of normal life, addresses the loss of opportunities encountered by residents and the impact this has had on their lives. The losses experienced by people with mental disorders can be multifaceted, including both practical and symbolic losses, such as loss of ability to function and live independently, loss of identity and losses of hopes and dreams for the future (Buchman-Wildbaum *et al.*, 2020).

Residents in this study experienced losses around education and employment. For instance, quantitatively 57% of residents had not finished secondary

school and 91% were unemployed. From a qualitative perspective, residents shared instances of educational and professional losses as a consequence of their illness, revealing a loss of future expectations and goals:

Lana (H6): *“I would have rather have not ever got involved with the unit (Department of Psychiatry) and would have rather that I never got sick like, you know. I wish my life would have gone down another road, you know. I would loved to have lived and had a good job and got myself educated and I would have rather a different life you know.”*

Lana's comments suggest that she may be grieving for a life that was not attainable to her, because her mental disorder disrupted or prevented her plans to obtain an education and employment. Lana perceives that she has not lived a fulfilling life and would have preferred never being ill or involved with psychiatric services, indicating that she is experiencing a lot of regret, sadness and possibly grief and loss of hope. Instead of having an identity through employment, Lana's comments would suggest that she now identifies with a role of being “*sick*” and attending the mental health services.

Similar to Lana, Jackson also suggests opportunities lost because of his illness:

Jackson (H6): *“Oh I don't know sure you could do anything like you know, you know what I mean, you could do anything.”*

Jackson believes that he could do “*anything*” and have a future full of limitless opportunities if he was to recover from his mental disorder.

Another resident described a sense of loss for his previous life before becoming unwell:

Joe (H4): *“It [mental disorder] has taken away my life and given me a new one.”*

Interviewer: *Which is a good thing, is it?*

Joe (H4): “*No, it’s very bad, I much preferred my old life compared to my new one.*”

Joe describes a loss for a previous way of being. He may be recalling happier times before he became unwell, and he may be comparing those times with his present life, which entails living in a regulated clinical setting due to his mental disorder, which is not the life he had anticipated for himself. Other residents also shared examples of living a life they had not anticipated for themselves. For example, Carol disclosed that she needed to place her child in full-time care:

Carol (H5): “*not able to be a full-time mom anymore*”

Carol then slowly, silently and sadly showed the researcher a photograph of her child who is in full-time care. A sense of hopelessness was palpable, and Carol revealed to the researcher after the group that she feared she would never be able to care for her daughter. This is a significant loss to bear and may have a long-term negative psychological impact on both Carol and her child. In addition, Carol may feel that she has lost her identity as a mother.

Given the significant trauma that Carol is experiencing, she should have access to counselling supports. However, the facility questionnaire indicated that residents in some CRFs did not have access to psychological therapies. Although the reasons are unknown as to why some residents had access to psychological therapies and others did not, one can assume that this was due to a shortage of resources (Ward *et al.*, 2022). Nonetheless, this unequal access to health care provision (in this case, psychological therapies) is almost certainly unintentional, but it could still be argued that it is a breach of fundamental freedoms as laid out by UNCRPD (2006). This issue may be rectified in the near future as the *Sharing the Vision* (2020) report has recommended that counselling supports and talk therapies should be available in the community to all mental health service users.

Another resident, Sarah, may also be grieving the loss of children she never had:

Sarah (H5): *“I would like to have more children, but I am kind of scared because I’m scared of passing on the gene that made me unwell, Yeah I’m scared of passing that gene.”*

Sarah perceived her illness to have such a profound negative impact on her life that she decided not to have any more children, in case they may also develop the same condition. Therefore, Sarah may be grieving the loss of her expected future.

The above comments indicate that residents are not living their best life, since their life is not as meaningful as they would like to be. It is important that staff are aware of the significance of empowering residents to regain a meaningful life through the resources available to them through the mental health services and voluntary and community services. For example, because of the Recovery model, mental health services have implemented several new measures in the last number of years, such as the Individual Placement and Support employment model discussed on page 191, and the promotion of advocacy services. The *Sharing the Vision* (2020) report also outlines other potential changes, such as providing a consistent income to individuals with mental health issues, who have to leave their job due to a relapse. Furthermore, primary care and community mental health teams should have access to directories about voluntary and community support services, which can be shared with service users. Moreover, each service user should be assigned a key worker from the community mental health team (CMHT) to create and implement personalised recovery care plans. However, with the introduction of all new policies, significant investment is always needed for transformation, as well as leadership for successful implementation (MHC, 2009). Unfortunately, the Irish mental health services do not have a proven track record in these areas, as outlined in Chapter one.

8.1.4 Lost Connections

The sub sub-theme loss of connections, developed from the sub-theme, loss of normal life, will address the loss of connections encountered by residents

and the impact on their lives. Positive social functioning is reliant on relationships and connections with others in the community, as well as engaging in social activities (Hossain and Ali, 2014; Morgan *et al.*, 2007).

As previously reported in Chapter six the majority of residents in this study reported difficulties in joining community activities, opting to interact with other residents instead of the wider community, a finding corroborated by others (Cleary, Woolford and Meehan, 1998; Roos *et al.*, 2016; Ware *et al.*, 2007). This sub sub-theme will further demonstrate how lost connections with family and the wider community impact residents:

Barbara (H5): *“I don’t have anyone calling here; only one person that’s all and he won’t come in”.*

Thomas (H5): *“I don’t have anyone either.”*

David (H5): *“No-one really comes round to see me.”*

Eliza (H1): *“you see very few people”*

Grace (H6): *“feel a bit isolated”*

The above comments indicate that residents lead an isolating life outside of life in the CRF. Barbara’s next comment may provide an explanation as to why residents do not have visitors calling to the CRF:

Barbara (H5): *“You don’t feel comfortable inviting people in, if a friend calls, you go to the door and they don’t want to come in right, you would want them to come in and make a nice cup of tea and a biscuit for them but they don’t want to come in because they feel they would be invading on your privacy.”*

It is possible that visitors do not call to visit residents in the CRFs, as they may feel that they are invading the privacy of all the residents who live there. However, the implications for this are an increased sense of loneliness and self-isolation, which in turn can decrease a person’s QoL (Shioda, Tadaka and Okochi, 2016). The above comments also indicate that staff are not working with organisational or personal social networks to improve connection with family members, friends and the community. AVFC

recommended that specialist rehabilitation and recovery services develop connections with local statutory and voluntary agencies, as well as support networks for people with mental disorders. The benefits of attending support groups include decreased admission rates, shorter length of hospital stay, increased sense of belonging, emotional support, helping one's peers cope better with mental disorders, in addition to representing an effective advocating tool for formal treatment for those in need (Solomon, 2004). Examples of organisations providing these services include Mental Health Ireland (<https://www.mentalhealthireland.ie>), Grow (<https://www.grow.ie>), Shine (<https://shine.ie>) and Aware (<https://www.aware.ie>). In addition, the new *Sharing the Vision* (2020) report acknowledges that enhancing the social functioning of people with complex mental disorders requires a multifaceted approach, claiming that enhanced access to housing, employment, income, and education or training, will result in enhanced social functioning.

In addition to the above, it was also reported in Chapter seven, **Stigmatisation**, that residents have experienced turbulent relationships with family and friends. For example, David described his family as overprotective, Carol claimed that she experienced bullying from her family, and Sarah recalled how her family do not understand how ill she can become, and described all her friends never contacting her again once she disclosed to them that she had a mental disorder. Additional evidence of lost connections includes estranged family relationships:

Barbara (H5): *"I'm a very capable person and a very independent person but ye all know my past and I won't go through it again okay because it upsets me emotionally. I have three grown up daughters that I love a lot but I don't see them much but that's my own business and I keep that in my heart and I keep it to myself. I won't talk about it cause it only upsets my feelings but I love them very much and all I have is their photographs up in the room and their letters and little bits and pieces belonging to them."*

Barbara described a deep sense of loss and hopelessness and began to cry after acknowledging and recognising the emotional pain that she experiences

because of the communication breakdown between herself and her daughters. Even though Barbara did not provide specifics on the cause of the breakdown in communication, it is possible that it was a direct outcome of her mental disorder. Her words imply that she would like to reconcile and reconnect with her children, as she communicated immense love for them.

The facility questionnaire revealed that family education was not being offered to residents. Although AVFC (2006) encouraged family involvement, the new policy document *Sharing the Vision* (2020), recommends that families are at the centre of designing, developing and delivering services, and taking a leading role in recovery planning. Family engagement is important and beneficial. For example, it is highlighted that structural measures of support including family support can contribute to the maintenance of remission through the patient's perception of emotional support (Tempier *et al.*, 2013). Moreover, family intervention can improve social impairment and the levels of expressed emotion within the family (Pharoah *et al.*, 2010).

However, family involvement is not without its challenges. For instance, Peters *et al.* (2011) found that relatives chose not to get involved in their relatives' care, due to time constraints or work commitments. In addition, participants themselves described hostile and critical relatives who they did not want to involve in their care and raised concerns that doing so may put their family members in a position of power, which they might manipulate. Therefore, services need to be aware of the challenges as well of the benefits when involving families of people in their care, particularly when national policy documents do not discuss these.

8.2 Loss of Hope

The sub-theme loss of hope, developed from the main theme, **Loss**, addresses residents' perceived loss of hope and the impact this has on their lives. Hope is an elusive concept, with 49 definitions identified (Schrack, Stangheillini and Slade, 2008).

Hopelessness is more easily described as having negative attitudes towards one's future (Beck et al., 1974). Furthermore, hopelessness can be a direct symptom of mental illness, but it can also be caused indirectly by the stigma and discrimination associated with it, which has serious consequences, such as an increased risk of suicide (Schrank, Stangheillini and Slade, 2008). Moreover, according to Ahern and Fisher, a belief in one's ability to recover is essential to recovery (2001).

Some of the residents' comments that suggest a lack of hope have already been presented. To summarise briefly, Barbara's comments around her estranged relationships with her daughters implied a loss of hope, in that she may never reconcile with them. Carol indicated a loss of hope through her verbal and nonverbal communication, when discussing not being able to care for her daughter who is in care. Lana described how she would have loved to have achieved an education and employment and described how she would "*have rather'd a different life*" indicating a sense of hopelessness in that these options are no longer available to her. Finally, Sabrina conveyed a sense of hopelessness around having to stay in a CRF.

Additional comments, from residents indicating a sense of loss of hope, include the following:

Jonathon (H4): "*I'd have something definite to look forward to* [in response to the question "What does recovery mean for residents?]"

Eliza (H1): "*I suppose it would mean having a sense of well-being instead of being depressed and having more control over your own life, you know, as well.*"

Joe (H4): "*It would mean I could move on and feel better about myself, life would be pretty different*" [in response to the question: What does recovery mean for residents?]

These comments offer further evidence that residents do not have anything to look forward to. Residents perceive that they are not able to move on with their lives, which did not exactly turn out the way they had hoped or anticipated. Residents' use of language implies a sense of hopelessness about

the future. For instance, they avoided using the phrase “*it will mean*” which is a more definite and confident use of language. Additional comments have a similar tone:

Angie (H2): *“There is a feeling that I would love to be at home again.”*

Eliza (H1): *“I find it hard to see myself getting out of this situation” [living in a CRF] [...] “it’s had a very bad effect on my life [having a mental disorder]. I think it’s a really grim thing you know [...] you feel like you are really trapped in this cycle of taking medicine that you don’t want to take, but you feel like you have to take it, so it’s a bit like been in a trap, for me anyway.”*

Angie expressed a desire to reside at home again. After living in a CRF for six years, it is possible that the longer she remains in a CRF the more likely it is that she will lose hope of ever leaving the CRF. Eliza describing having a mental disorder as “*grim*” and feeling “*trapped*”, which further implies a sense of despondency over her life circumstances. Furthermore, residents did not convey any indication that they anticipated their situation would improve. Other comments also indicated a sense of hopelessness around their mental disorder and their recovery prospects:

Harry (H4): *“I was told I would never recover by Dr. X and his team.”*

When a doctor informs a person that he or she should not expect to recover from their mental disorder, feelings of hopelessness and despair may be inevitable. Eliza described feeling depressed and having no control over her own life, [page 353] and cried during the group discussion when discussing her experience around living in a CRF. Eliza’s verbal and nonverbal communication reflected sorrow and despair regarding her situation.

In addition, Thomas blames himself for the devastation he and his family have been through as a result of his mental disorder. He recalls the loss of his business, his marriage, and his children:

Thomas (H5): “*It has changed it unbelievably yeah, I had my own business, and I was married, and I had children and I lost it all you know, it was my fault really. You can't blame anyone (else) for mental illness, you know.*”

When communicating, Thomas lowered his head, took a deep breath that ended in a sigh, and displayed a sad expression. His nonverbal communication suggested a sense of hopelessness about his circumstances.

Residents did not visualise or refer to the future, which may be another indication of hopelessness. Fortuna *et al.* (2020) found that having a diagnosis of a serious mental disorder is significantly associated with self-reported hopelessness. *Sharing the Vision*, (2020, p. 16) places hope as one the core values of the new national policy for mental health and recommends that interactions during the course of service delivery are “full of positivity, and empowerment, with a strength-based focus”. This is consistent with conclusions reached by Schrank, Stanghellini and Slade, (2008). In order to nurture hope in mental health, they outline four components for consideration: **affective** (e.g., trust, confidence, humour, positive emotions); **cognitive** (e.g., reflecting on past experiences, goal-setting, planning, assessing the likelihood of success); **behavioural** (e.g., motivation, personal activity); and **environment** (e.g., availability of resources, health care, relationships) (Schrank, Stanghellini and Slade, 2008). In addition, services can promote recovery by hiring people with recovery competences and screening them for important recovery-related knowledge, attitudes, and abilities (Le Boutillier *et al.*, 2011, p. 1473). This can be accomplished by giving candidates the opportunity to express their values during interviews by asking them questions such as, “Why do you think persons with mental disorders want to work?” Lack of resources, however, is the greatest obstacle to putting these practices into effect.

Chapter 9: KEY FINDING 4: Institutionalisation

This chapter will critically discuss the findings from the main theme, **institutionalisation**, and its subthemes, institutionalised thinking, dependency on the mental health services, and institutionalisation through erosion of identity (Table 9.1). These will be discussed in the context of the quantitative findings, where applicable. Findings will also be discussed within the context of relevant literature.

Main Theme	Sub Theme
Institutionalisation	Institutionalised Thinking
	Dependency on Mental Health Services
	Institutionalisation through Erosion of Identity

Table 9.1 Demonstrating the main theme and subthemes

9.1 Institutionalised Thinking

Goffman (1961) argued that psychiatric institutions were closed systems that were isolated from the rest of society and that residents of these settings can become institutionalised over time (Williamson, 1970). During the institutionalisation process there is a change in self-concept, as the patient begins to accept or internalise the hospital's definition of him /her as sick and eventually the person believes they are sick, acts sick and are not capable of functioning efficiently outside of the institution (Townsend, 1976).

The deinstitutionalisation movement, discussed in Chapter one, aimed to increase QoL and reduce institutionalisation in people who were residing in asylums for long periods of time, by transferring them to community settings (Chowdhury and Benson, 2011; Shen and Snowden, 2014). However, the organisational cultures of those institutions closed in the deinstitutionalisation process are now often replicated in smaller congregated settings such as CRFs (Drake, 2014), resulting in re-institutionalisation, a process known as trans-institutionalisation (Primeau *et al.*, 2013).

In an attempt to conceptualise institutionalisation, Chow and Priebe (2013) identified four main themes contributing to institutionalisation: bricks and mortar i.e., the physical aspects of the building; policy and legal frameworks that limit patients' autonomy; clinical responsibility and paternalism in clinician-patient relationships; and patients' adaptive behaviour to institutionalised care. The first concept, bricks and mortar, is not as relevant to CRFs as it was to asylums, since CRFs are not usually located in remote areas with high fences and walls, and are not concealed from society in a way that asylums were (Caldas de Almeida and Killaspy, 2011). Whereas the other three concepts are applicable to institutionalisation within CRFs. For example, policies limiting residents' autonomy have been highlighted and discussed in previous chapters, evident in restricted access to kitchens and socialising. The paternalistic resident/staff relationship and uneven power dynamics between staff and residents are further illustrated in Chapter six, where staff may have misused their authority over residents by denying them permission to leave when they wished and to use the kitchen as they pleased. As a result, this section will focus on how residents have adapted to institutionalised care, one of the themes identified by Chow and Priebe (2013).

Residents in this study were entirely accepting that they may not be allowed to have a barbecue without staff present, page 248, and quickly deflected the researcher by promptly sharing that they are very happy to have pizza once a month instead:

Delia (H2): *"Sometimes like now maybe once a month on a Friday we get in a pizza and its great you know."*

It would appear from the above comment that residents have adapted or conformed to institutionalised care as outlined by Chow and Priebe (2013). This is reflective of Goffman's (1961) theory that all aspects of individual life of those who live in institutions, were subordinate to and dependent on the institution's organisation and authority.

Further evidence of institutionalised thinking emerged when residents in H3 were asked why they think they needed to live in a CRF. Responses were mainly centred around needing structured environments, such as the CRF and access to the local workshop. The following is an example of one of the responses:

Simon (H3): *“I’m under the doctor’s care, so I don’t mind living here, like, I’m on tablets you know.”*

It is evident from the above response that this resident has adopted the ‘sick role’ and abdicated all responsibility for himself to staff. In addition, when residents in H3 were asked if they would like to comment on the rules of the CRF, residents stated that additional rules would be welcome:

Anna (H3): *“We should have a few more rules in the house I think, and this house would be perfect.”*

Given that residents of this house are not permitted to use the kitchen unsupervised, the above comment illustrates residents' adherence to structure and order. Another example highlighting institutionalised thinking emerged from H6 during a discussion on socialising. Residents felt that they do not get enough opportunities to socialise and proposed an idea to increase social opportunities:

Lana (H6): *“I don't know why we couldn't get together ourselves. Bring people around like and meet up with the other residents in the hostels and not to be waiting for the hospital to put on another social outing to go out.”*

Although the above comment reflects a desire for independence, it also reflects institutionalised thinking, as Lana only views herself mixing with other residents in the mental health services. Furthermore, when asked for their thoughts on why so many residents reported to be unhappy with their love life (in the quantitative part of the study), residents suggested that it can be difficult for two people to be together when they both have a mental disorder:

Lana (H6): *“because when they are up you are down or when they are down you are up or they might not be supported”*

Jackson (H6): *“It’s something to do with tablets anyway.”*

The above comments indicate that residents only view themselves having relationships with other residents or people who have a mental disorder. Finally, residents in H2, H3, H5 and H6 all stated that they would not like their husband, wife, boyfriend, or girlfriend staying overnight in the CRF. Many responses from residents were instantaneously “no”, followed by comments such as:

Grace (H6): *“I wouldn’t like it, [...] we are all settled here.”*

Angie (H2): *“No, No, No, Oh No”* [followed by a slight giggle] [...] *“I suppose that might not be for us to say.”* [when asked if residents partners should be allowed to stay overnight]

The above comments indicate that residents are comfortable with the status quo and do not want change. The comment from Angie indicates that she perceives that staff have complete authority over residents and that residents have no say in important decisions, such as whether their partners are allowed to stay overnight. In rented or privately owned accommodation, people do not have to ask permission to have a partner stay overnight. Therefore, this is another example of how residents have conformed to structure and order and adapted to institutionalised care within the facility. While it is important that the CRFs have policies in place to ensure the safety and well-being of all residents, it is also important for residents to have a voice and to have the opportunity to express their opinions.

Another comment from a resident in H5 also indicates that residents are not encouraged to express their opinions:

Barbara (H5): *“Was it any harm to say that?”* [disclosed that staff do not speak to residents about moving on]

Barbara appears to be apprehensive about voicing her view about the staff's unwillingness to explore choices for moving on from the CRF. Perhaps Barbara is fearful of getting in trouble with staff and is concerned about repercussions if they discover what she has said. However, the implications of remaining fearful in expressing one's opinions is that the residents will continue to conform to structure and order, which in turn will have a negative impact on mental health and recovery.

Additional evidence of institutionalisation emerged during a discussion around stigma and family support, when a resident in H3 referred to life outside the hospital as the "*outside world*":

Brian (H3): "*There is little discrimination here or in the workshop but outside that there might be.*"

Brian (H3): "*I have relations outside [address] it's a different world since '78.*" [date of admission to psychiatric hospital]

Brian (H3): "*If I got the chance, then I'd give it a chance [a move to a higher support facility]. I mentioned it to [Nurse X] she is in the community and she said it's hard to get into [House No Two] now, but it's more my cup of tea.*"

Brian's choice of words indicates that he has internalised the hospital's view of him as a patient and believes that he is not capable of functioning in the 'outside' world, as he wants to transition to a CRF that will provide him with a higher level of care. This is similar to how Townsend (1976) described the institutionalisation process, where eventually patients believe that they can not function efficiently outside of the institution.

Finally, quantitative results indicated that 74% of residents reported to be 'mostly satisfied' with their life in general, despite living with a serious mental disorder in a restricted environment. It has also been reported elsewhere that residents also highly rated their QoL despite similar living conditions (Tedstone-Doherty, Walsh and Moran, 2007). As discussed in Chapter two, a recurring finding amongst people with enduring mental disorders, such as schizophrenia, is their satisfaction with environmental and

life conditions, which would more than likely be considered as inadequate by others (Hayhurst et al., 2014; Katschnig, 2006; Nilsson and Levander, 1998). Tedstone-Doherty, Walsh and Moran (2007) attempt to explain residents' greater than expected reports of satisfaction with their level of independence and living conditions, by suggesting that they no longer expect the basic rights and freedoms that others take for granted.

9.2 Dependency on Mental Health Services

Dependency on mental health services is another subtheme of institutionalisation. When the underlying model of care is paternalistic, as opposed to recovery- or rights-based, the consequences include a decline in autonomy, lower self-esteem, and a restriction on a person's ability to make decisions (O'Brien and Golding, 2003). The clinical paternalism of staff may cause persons to become dependent on receiving care from services, which in turn may cause residents to lose confidence in their ability to make autonomous choices, which eventually leads to institutionalisation (Chow and Priebe, 2013). Consequently, considering that Chapter six demonstrated that recovery-oriented care is lacking in CRFs, and paternalistic care is dominant, it is not unexpected that residents' communications revealed a dependency on mental health services.

For example, the previous sub-theme highlighted how Brian would prefer to live in a higher support facility. Furthermore, Chapter six highlighted how some residents perceived that they needed access to a nurse overnight in case "*something happened*" and because they needed "*somebody to check up on*" them and because they are "*under the doctor's care*". This sub-theme demonstrates additional evidence that some residents appeared to perceive the local hospital as a safe environment that allowed them quick access to a doctor or admission to the Department of Psychiatry as primary options when experiencing a relapse:

Anna (H3): *"it's very convenient cause if you wanted a doctor there is a doctor there, they have a number on call, like if someone gets sick in the house, they ring the unit [local psychiatry hospital] and they come out. We need this house."*

Delia (H2): *“If you needed to go the Unit, they [staff] would help you. They would ring nurse X or someone to bring you in [for admission].”*

Both Anna’s and Delia’s comments indicate paternalistic care, and as a result they seem to equate the need for living in a CRF and having constant or quick access to staff as a way of keeping well or preventing relapse. The word choice of *“need”* is informative and suggests a dependency. Residents may view the CRF as an extension of the hospital. This is because they are surrounded by other residents with mental health disorders, medication is stored away and given in a regimented fashion, nursing staff call on a regular basis and CRFs have similar health and safety policies (i.e., barbecues or the independent use of kitchens would not be allowed in a hospital environment either).

Without the autonomy and ability to make independent decisions, residents are held in relationships of long-term dependency (WHO, 2010). However, reflective practice can address clinical paternalism in nursing staff (Bladon, (2019). For example, Graham (2000) documented the engagement of UK mental health nurses with residents over the age of 65 in an inpatient facility over the course of one year, with a focus on a structured period of self-reflection. Participants represented a broad variety of nursing grades, from service manager to junior staff nurses. Although the actual number of participants and their gender were not disclosed, the findings revealed that reflective practice helped nurses to better understand their work and interactions with patients.

Notably, some evidence of residents’ internalised desires to live independently was also evident:

Barbara (H5): *“I think what is really wrong down deep inside is that we haven’t got our own places.”*

Simon (H3): *“I’d like to be at home [...] getting on with work.”*

Angie (H2): *“I wouldn’t like to see myself here any longer.”*

However, others communicated a desire to remain living in a CRF:

Jackson (H5): *“I don’t want to move out.”*

David (H5): *“I would like to stay here.”*

Anna (H3): *“I think it should be permanent living.”* [the CRF]

Anna (H3): *“According to Dr X, this is my home, and I will never be moved.”*

The above comments are also supported by the quantitative results, where 87% of residents reported that they wished to stay in their current accommodation, previously mentioned in Chapter eight, which may be indicative of institutionalisation.

However, when this was further explored from a qualitative perspective, as outlined in previous chapters, residents do not want to be attached to a system that stigmatises and labels them. Instead, they want to be viewed as ‘ordinary’ citizens leading ‘ordinary’ lives in a ‘normal’ living environment, which means not living in a CRF. This section explicates why residents may want to continue living in a CRF, but also have a desire to live independently. For instance, there appears to be a combination of factors that keep residents institutionalised or at risk of institutionalisation: paternalistic care; lack of evidence-based rehabilitation and discussions about moving out, which were discussed in Chapters six and eight; in addition to unemployment; financial concerns: fear of not being able to manage independently; fear of potential stigmatisation; lack of alternative housing, and comfort, with the status quo as a result of living in CRFs for many years. As a result, residents feel unable to move on with their lives:

Eliza (H1): *“I find it hard to see myself getting out of this situation [...] there is a big waiting list for the council housing and that is kind of off putting, you know [...] well the alternatives don’t feel very safe apart from maybe council housing but there is a big waiting list for the council housing and that is kind of off putting, you know. I think for me personally it would be scary going into rented accommodation.”*

Jackson (H6): “*From what I can get is that this is as far as you go like, after that it’s your own place.*”

Residents were acutely aware that alternative accommodation may be difficult to source and supports received, while living in a CRF would significantly decrease upon leaving the CRF system.

Eliza (H1): “*financial worries would be the main thing*” [preventing people from moving out]

Unemployment may be contributing to financial concerns around living independently, as Eliza highlighted that it would be a “*scary*” experience with financial concerns being the main preventative factor.

From this perspective, it seems clear why residents provided conflicting information when asked about their current accommodation. Similar findings are reported elsewhere, where most residents were content living in a CRF, but also expressed a desire to have their own home (Granerud and Severinsson, 2003; Piat *et al.*, 2009; Richter and Hoffmann, 2017; Tedstone-Doherty, Walsh and Moran, 2007). This conflicting information from residents may be explained by residents perceiving the CRF as providing a safe and secure environment, which protects them from homelessness, loneliness and conflict with family members (Bengettson-Tops, Ericsson and Ehliasson, 2014; Brolin *et al.*, 2015). In a recent systematic review, which synthesised services users’ perspectives and experiences of supported accommodation services, Krotofil, McPherson and Killaspy (2018) reported that residents can feel comfortable and accepted by other residents and form supportive friendships. In addition, the nominal rent residents pay is affordable to them, compared to the open rental market. Moreover, Krotofil, McPherson and Killaspy, (2018) concluded that services with high levels of support, and a lack of emphasis on rehabilitation and moving to independent accommodation, can lead to residents feeling “*stuck*” in substandard conditions and unable to formulate expectations for their future (p. 791). If residents are dependent on staff, are not undergoing rehabilitation, and there is little emphasis put on moving out, it seems logical that they are or

will become institutionalised. This viewpoint is supported by Chow and Priebe (2013), who highlighted how dependency on staff is a common outcome of residing in a CRF long-term. This places residents at a disadvantaged starting position at the beginning of their journey to recovery.

In addition, the lack of available adequate resources, such as housing and insufficient staffing of rehabilitation teams, can have a detrimental impact on residents transferring to more independent housing by keeping them in CRFs for longer than required (Killaspy *et al.*, 2020). This may increase the risk of institutionalisation and are additional challenges for residents in this study, in terms of avoiding institutionalisation particularly when it may take in excess of 30 years before CRFs are dissolved (House of the Oireachtas, 2022). The MHC has repeatedly criticised the under-resourced rehabilitation teams and the lack of adequate housing and accommodation options to allow residents to progress towards independent living and cited residents' "frustration and anger" with the lack of progression in this regard (MHC, 2018; MHC, 2019, p. 20).

Furthermore, anxiety is a significant obstacle to people transitioning to independent housing, particularly in relation to the availability of supports (Killaspy *et al.*, 2019; Sandhu *et al.*, 2017). Killaspy *et al.* (2019) reported that this may possibly manifest as resistance from residents, which is best managed by open and ongoing dialogue about moving to more independent accommodation. However, this is problematic for residents in this study, as they previously mentioned that staff do not discuss options for moving forward.

A multifaceted strategy is necessary to address the issue of institutionalisation and its damaging impact on the lives of residents. Promises regarding timeframes for dismantling congregated settings must be kept. Recommendations in AVFC (2006) and *Sharing the Vision* (2022) must be implemented, such as delivering a recovery- and human-rights based approach to service delivery and empowering residents to choose where they

wish to live. The government must invest heavily and demonstrate a strong commitment to fund housing options for people with mental health disorders.

9.3 Institutionalisation through Erosion of Identity

Institutionalisation through identity was another sub theme developed within the theme **Institutionalisation**. Psychotic disorders often separate the individual from their pre-psychosis self and with this comes a loss of identity (Gergel and Iacoponi, 2017). Loss of one's identity has been proposed as a key feature of institutionalisation (Chow and Priebe, 2013). Goffman (1961) describes how psychiatric residents in long-term custodial environments (historically over-represented by individuals with schizophrenia, but not exclusively so) undergo a "mortification of self" (p. 21), which further compounds their loss of personal identity and autonomy. This 'mortification of self' occurs when residents no longer engage in their past roles, but instead take on a purely institutional role which lacks independence and responsibility (Bonavigo *et al.*, 2016).

Many residents in this study have assumed a purely institutional role by attending non-evidence-based local mental health workshops [discussed in Chapter six], to participate in vocational tasks which may not necessarily be of interest to them as individuals (i.e., baking, flower arrangement, upholstering furniture, and more). Given the high number of residents attending these centres, it is likely that residents are 'strongly encouraged' to attend and engage in meaningless activities. As a result, this may gradually erode residents' individuality, causing their illness to precede their person. This type of identity loss is termed "illness identity", defined as the set of roles and attitudes a person develops in relation to his or her understanding of having a mental disorder (Yanos, Roe and Lysaker 2010, p. 73).

Further evidence of 'illness identity' was demonstrated in residents' reasons for living in a CRF, because it was "*what the doctor had ordered*" or "*because I need somebody to check up on me*" and in their total acceptance of the rules and regulations governing their living environment. In addition, some residents positively expressed their placement in a particular residence on a

permanent basis, with yet another resident repeatedly expressing a desire to attend a higher support facility:

Anna (H3): “my house would be here, and the family would be there and that would be that”

Anna (H3): “I would never be lonesome, there is so many things going on in my house, I’d never be lonesome, that’s been honest.”

Brian (H3): “it’s more my cup of tea...the area is more relaxing and the place itself is more relaxing...it’s very close to the bus stop for the workshop”

Barbara considers the CRF as her “home” and envisions herself living apart from her family in the future. However, she instantly attempts to persuade herself or the researcher, or both, that she would never be lonely because of continuously residing in a CRF. In addition, Brian referenced to transferring to a higher support facility and attending the workshop several times, indicating that he identifies with both institutions, the workshop and psychiatric facilities which possibly suit his ‘illness identity’ more comfortably.

In a qualitative study, residents living in a CRF have reported feeling separated from their former identities (Bengtsson-Tops, Ericsson and Ehliasson, 2014). Residents communicated that leading an oppressed life caused them to reflect on their earlier (pre-psychosis) life roles in which they recounted freedom, independence, worldwide travel and a close family life and/or employment. They further communicated that their present life of living in supportive housing was a life of adjustment, being in need and being dependent. This situation can form barriers to recovery. For example, it is argued that if people with mental disorders feel that they are incompetent and inadequate secondary to their disorder or ‘illness identity’, this may prevent them from applying for jobs, socially interacting and trying to assimilate into their communities (Yanos, Roe and Lysaker, 2010). Therefore, they emphasise the importance of constructing a new sense of self as a significant aspect of recovery. Notably, cognitive behavioural therapy (CBT) and narrating one’s own recovery journey can have a positive and favourable

impact on tackling ‘illness identity’—both solutions are supported in many studies (Corrigan and Calabrese, 2005; Gallagher, 2003; Holmes and River, 1998; Lysaker *et al.*, 2003; Myers and Ziv, 2016).

Moreover, both AVFC (2006) and *Sharing the Vision* (2020) strongly support the recovery model, which emphasises the importance of rediscovering one’s personal identity separate from illness or disability, as noted by Shepherd, Boardman, and Slade (2008). While this appears positive, the mental health governing policy in Ireland in 1966 warned against providing meaningless occupation for psychiatric facility residents, instead emphasising the need for meaningful occupation to counteract the negative effects of institutionalisation. The report stated that institutionalisation could “destroy patients’ individuality and erode their emotional, physical, and social functioning” (p. 41) and cited the *World Health Organisation's Technical Report Series No. 73*, which claimed that organised and purposeful activities were crucial for patients and a form of recovery. The report listed several benefits of purposeful occupation, including increased responsibility, improved confidence, the development of new interests, the acquisition of new or lost work skills, enhanced social skills, increased initiative, the formation of positive habits, and enhanced physical abilities (p. 43). Therefore, based on the evidence discussed in Chapter one, it appears that mental health services have consistently ignored the recommendation to prioritise meaningful occupation and the development of a positive self-identity for at least 57 years. As a result, it seems unlikely that there will be a sudden shift in focus to these important aspects in the near future.

Another obstacle to implementing the above is the insufficient recommendation of OTs as core to rehabilitation teams in policy documents (Department of Health, 2006; Department of Health, 2022). This is an oversight, because OTs are highly skilled at guiding individuals towards engaging in meaningful activities and developing a positive self-identity (Argentzell *et al.*, 2023), which can facilitate a reconnection to oneself and others (Carra *et al.*, 2023).

Chapter 10 – Conclusions and Recommendations

This chapter reviews the study's key findings and outlines evidence-based recommendations to guide practice and influence policy. The limitations of the research, as well as the recommendations for further research are also discussed. The chapter concludes with a discussion, highlighting how the research aims and objectives of the study (outlined in Chapter one) were achieved.

10.1 Key finding 1: Confusion over the Role of CRF

According to the information provided by residents on page 170, many lacked a clear understanding of the goals and purposes of the CRF. Although residents agreed that they are residing in a CRF in order to “*get better*”, they did not seem to fully understand the role the CRF plays in achieving this goal. As a result, some residents remained in CRFs for more than ten years.

Concerningly, neither the staff nor residents viewed the CRFs as temporary spaces, as transitioning on from the CRF was never broached with residents, [page 230]. Residents may not fully understand that the goal of the CRF is to help them improve their health and functioning to a point where they can eventually transition to living independently or with less support. As a result, this may cause residents to become overly dependent on the CRF and less motivated to work towards their own independence, thus perpetuating a culture of institutionalisation. The findings suggest that this lack of clarity may be due to the absence of clear policies, procedures or guidelines related to the overall aims, objectives and length of stay in the CRF.

In addition, there is an absence of structured formal waiting lists for admission to CRFs, which can create challenges for both residents and staff. For instance, without a structured formal waiting list, some residents may be admitted more quickly than others, leading to an unstructured and unfair approach to admissions. Furthermore, the lack of waiting lists may result in some residents remaining in CRFs for extended periods of time, potentially

beyond what is necessary or beneficial for their health and well-being. Moreover, without a waiting list of potential new residents, staff may not prioritise rehabilitation, if there is no time limit on the duration of stay and no new residents waiting to be admitted.

Findings thus suggest that confusion over the function of CRFs may have negative consequences for both residents and staff. CRFs must have defined policies, processes, and guidelines outlining their purposes, objectives, and goals, as well as a structured approach to admissions and duration of stay, to meet residents' needs effectively and efficiently (McPherson, Krotofil and Killaspy, 2018a).

10.1.1 Recommendation 1a: Provide clear communication regarding goals, purposes and length of stay in CRFs

Clear communication regarding the goals, purposes and length of stay in CRFs is necessary. The CRF should be clearly defined with regards to its intended model of care (McPherson, Krotofil and Killaspy (2018b), i.e., a recovery- and human rights-based approach to care, which aims to promote the well-being and independence of residents by focusing on their strengths and personal goals. There should be clear communication regarding the length of stay, goals and purposes of a CRF, which are defined as “achieving personal goals in social and occupational domains” (Lopes *et al.*, 2022 p. 117). Based on the findings of this study, it is proposed that when residents understand the aims and objectives of the CRF, they may be more likely to engage in their own care, thus potentially improving treatment outcomes at CRFs.

10.1.2 Recommendation 1b: Match residents with the appropriate level of support

Residents should be matched to the appropriate level of support (Wellesley Institute in Canada, 2015), so that they can receive the correct levels of support in order to achieve their personal goals and to prevent them from receiving more assistance than is required, which can occur in CRF environments (Kearns Murphy and Shiel, 2019). Receiving more support than

what is required can be counterproductive for residents as it may cause dependence on staff.

10.1.3 Recommendation 1c: Create formal waiting lists for any future admissions

Although it is not recommended that there are any new admissions to congregated settings, residents are still being admitted to these spaces (MHC, 2018; House of the Oireachtas, 2022). In this case, formal waiting lists should be created for any future admissions, to ensure a fair admissions criterion.

10.2 Key finding 2: Lack of Understanding Around the Role of Staff

Chapter six identified that precise communication regarding the scope of practice for staff was absent, which fostered confusion amongst residents regarding the actual role of staff. As a result, some residents perceived staff as “*not having much to do*”. Additionally, some residents expected staff to provide counselling, which may not be part of their duties and therefore staff may be unaware of these unmet needs. Furthermore, a lack of understanding and awareness of the roles of each member of the MDT was also identified, which may have contributed to the confusion surrounding the staff’s roles and responsibilities.

10.2.1 Recommendation 2a: Provide clarity on the role of staff within the CRF

Clarification is required regarding the role of staff within the CRF, so that both staff and resident expectations can be met, and to ensure that residents have a realistic understanding of how staff can best meet their needs. It is also important for residents to have a clear understanding of the role of individual members of the MTD, so that they are aware of the range of care that is available to them and know which team members are best suited to assist with specific issues they may be experiencing.

10.3 Key finding 3: Lack of Individualised Treatment Plans / Care Plans for Residents

A lack of individualised treatment plans/care plans for residents was identified by residents in this study. For example, residents did not know if they had a care plan and were not involved in developing or maintaining their care plan. This lack of evidence-based care resulted in an absence of care expectations and appropriate goals for residents and indicates that they do not participate in or have control over decisions around their own care (British Institute of Human Rights, 2016). Lack of individualised care planning may have a detrimental effect on recovery, as it may be challenging to identify residents' specific needs and provide appropriate treatment. In addition, if residents are not involved in decisions around their own care, this may lead to feelings of disempowerment and disengagement from the recovery process (Priebe *et al.*, 2011), which can impede progress (Joosten *et al.*, 2011). Therefore, the lack of individualised care planning for residents is a significant issue that needs to be rectified, to ensure that residents receive evidence-based care, as well as have input into their own treatment and care, as per national policy recommendation (Department of Health, 2006; Department of Health, 2020).

10.3.1 Recommendation 3a: Both staff and residents should collaborate on care planning

Both residents and staff (clinical and non-clinical) should collaborate on care planning, as this approach leads to more meaningful and integrated care planning with increased resident engagement (Dadich, Fisher and Muir, 2013). Care plans should be multidisciplinary and should be reviewed on a regular basis, rather than annually as reported by the MHC (2019).

10.3.2 Recommendation 3b: MHC regulation should be in place for all CRFs and not just medium and low support CRFs

Considering the positive impact the MHC has played in increasing compliance with care planning in acute mental health inpatient units (MHC, 2018), this study further recommends that medium and low support CRFs are

regulated by the MHC, as currently only high support CRFs are regulated by the MHC (MHC, 2019).

10.4 Key finding 4: Strict Rules and Regulations

Strict rules and regulations that limited residents' autonomy were identified in some CRFs and discussed in Chapter six. For instance, some residents were required to notify staff when they were leaving the CRF and were requested to check in with staff on a regular basis, indicating that they did not have the freedom to come and go at their own discretion. In addition, some residents were not permitted to lock their bedroom or bathroom doors, which is an invasion of privacy as people living independently in the community have the right to lock their bedroom and bathroom doors. Moreover, some residents were not permitted to use the kitchen autonomously, which may cause helplessness, given that they are not permitted to engage in everyday activities of daily living, such as cooking a meal without staff supervision.

Some residents also communicated that they were not allowed to socialise or consume alcohol, which may result in feelings of isolation or social exclusion. Residents perceived this restriction to have a negative impact on their possibility of meeting a partner, [page184]. In general, it appears that health and safety policies are overly restrictive and do not allow residents to live a normal life, which some residents seemed to be aware of, "*that's the way we have to live*". It is likely that staff are aware of the importance of resident autonomy, but they may also feel that they have a responsibility to protect residents and are possibly concerned about potential consequences if a significant incident were to happen while they are on duty. As a result, restrictive policies may have been created to reduce or prevent risk or harm to residents, but they may inadvertently cause residents to feel uncomfortable and controlled in terms of their behaviour and level of autonomy. This undermines the core principles of recovery and violates residents' human rights as it prevents them from engaging in normal activities and, for this reason, CRFs appear to emulate mini institutions rather than independent community living.

10.4.1 Recommendation 4a: Re-evaluate health and safety policies

All health and safety policies, procedures and guidelines should be re-evaluated and those that are in direct contravention of the main principles of Recovery and impinge on the rights and autonomy of residents need to be dissolved to ensure that residents live in a non-restrictive environment (The British Institute of Human Rights, 2016; United Nations, 2022). This will ensure that the CRF environment is both encouraging and conducive to recovery and the autonomy of residents is respected.

10.5 Key finding 5: Lack of Formal Assessments Prior to Admission

Chapter six identified a lack of formal assessments prior to admission, resulting in residents being matched with inappropriate levels of support. As a consequence, residents may not be receiving the appropriate level of care, leading to inadequate care and sub optimal recovery (Parker *et al.*, 2017). The role of OTs in this context is important, as they are highly trained to assess functioning (Hagelskjaer *et al.*, 2021). As a result, they can provide a significant and valuable contribution to ensuring that residents are matched to the appropriate level of supports.

However, a shortage of trained staff may be a contributing factor to the lack of formal assessments in CRFs, as the availability of OTs may be limited, as indicated by the recommendation of only two OTs per MDT in AVFC 2006 (Department of Health, 2006). In addition, the lack of OTs on committees that create governing policy documents needs to be highlighted and addressed, as Ireland's tradition of medicalising mental disorders has resulted in doctors' and nurses' significant decision making power (Department of Health, 2006; Gaffey and Evans, 2016; Jacob, 2015; Maddock, 2015). For example, in the work undertaken for AVFC (2006), only one OT was included among an expert group of 18 members, with the majority being doctors and nurses. Moreover, there was no formal OT representation on subsequent expert groups in the creation of *Sharing the Vision* (2020).

10.5.1 Recommendation 5a: Occupational therapists should perform

Formal assessments

Formal assessments should be carried out by OTs prior to admission. This recommendation is supported by virtue of them being highly trained in assessing a person's functioning and identifying barriers that may be preventing them from progressing (Hagelskjaer *et al.*, 2021)

10.5.2 Recommendation 5b: There is a need for government policies to support additional recruitment of occupational therapists

Government policies need to propose additional recruitment of 12-15 OTs per MDT, figures similar to that of nurses per MDT (Department of Health, 2006). Having an appropriate number of OTs may ensure that all residents receive appropriate rehabilitation to improve their functioning and QoL.

10.5.3 Recommendation 5c: Occupational therapists need to be involved in national policy developments

To promote the provision of evidence-based and recovery-focused care in clinical practice, it is essential to ensure that OTs are adequately represented on expert groups tasked with devising national policies. By establishing a firm presence within these groups, OTs can effectively advocate for additional OTs in clinical practice. This will result in better outcomes for people with mental disorders, including residents of CRFs. The reason for this is that OTs consider the physical, cognitive, psychological, and spiritual aspects of an individual's well-being through meaningful engagement in occupations (Cano Prieto, Simó Algado, and Prat Vigué, 2022). In addition, they hold specialised knowledge and skills in promoting recovery and undertaking psychosocial evaluations that include housing, social support networks, and community involvement (Swarbrick and Noyes, 2018), all of which are invaluable skills in supporting and guiding people with mental disorders.

10.6 Key finding 6: High Unemployment among Residents

Chapter six further identified that 91% of residents in this study were unemployed, which is consistent with national and international trends

regarding residents of CRFs and unemployment (Killaspy *et al.*, 2016; Roos *et al.*, 2016; Tedstone-Doherty, Walsh and Moran, 2007). Although residents want to work in mainstream paid employment, [page 189], they are encouraged to attend the local training centre that specifically caters for people with mental disorders (Grove, 2015). As highlighted on page 190, these centres often encourage residents to engage in meaningless occupations that are not relevant to the open job market (Drake, Becker and Bond, 2003; Grove, 2015). This lack of evidence-based rehabilitation is effectively maintaining residents in unemployment, which has various consequences, including financial limitations, social exclusion and marginalisation, lack of purpose and routine, reduced QoL and a lack of self-identity (Posel, Oyenubi and Kollamparambil, 2021).

Although this study highlights the high unemployment rate amongst residents and the inadequate rehabilitative approaches to occupational performance, it is important to note that Irish mental health services have recently made efforts to implement the IPS model for services users (MHC, 2019) given its evidence base (Drake, Becker and Bond, 2019; Marino and Dixon, 2014; Mueser, Drake and Bond, 2016) and OTs appear to have been tasked with the leading the development (Health Service Executive, 2019). OTs are well positioned to lead this service initiative given their training in occupational performance (Youngstrom, 2002), which will ensure that the IPS model is implemented effectively and that service users will receive evidence-based rehabilitation to gain and maintain meaningful employment.

10.6.1 Recommendation 6a: All residents of CRFs should have access to the IPS model of employment

This study is in agreement with the new *Sharing the Vision* (2020) policy recommendation that stipulates that individuals with complex mental health issues, which includes residents of CRFs, must have access to the IPS employment model, as is it proven to improve the employment outcomes of people with mental health disorders (Drake, Becker and Bond, 2019; Mueser, Drake and Bond, 2016). The implementation of this recommendation may also help to reduce the stigma associated with mental health issues, by

promoting the message that people with mental health issues are very capable of working.

10.6.2 Recommendation 6b: Occupational therapists should promote the IPS model at MDT meetings

OTs can positively influence the conversation around mental health and employment, by advocating for residents to utilise this evidence-based service. They can also champion and promote the IPS model at MDT meetings, documenting employment goals in care plans, and educating families on the significance of employment in the rehabilitation process (Health Service Executive, 2019). OTs should also advocate for the IPS model to be scaled up in order to meet residents' needs. Furthermore, training centres and sheltered workshops should be dissolved (Grove, 2015), and funding should be diverted toward the IPS model of employment, which would ensure that resources are aligned with evidence-based approaches.

10.7 Key finding 7: Impaired Social Functioning

This study revealed that residents are experiencing difficulties with social functioning, as indicated by the high percentage (57%) reporting challenges with participating in community activities. Chapter seven identified that residents had poor social networks, turbulent and estranged family relationships, and appeared to be more comfortable with meeting other residents or individuals with mental health disorders, rather than mixing with the wider society, which aligned with international research (Roos *et al.*, 2016; Ware *et al.*, 2007).

The reasons for residents' poor social functioning were not specifically investigated, but it is reasonable to assume that a combination of several potential factors, such as fear of stigmatisation [page 221], lack of finances [page 194] and a limited social network [page 194] are all contributing factors to residents' impaired social functioning. In addition, a lack of evidence-based approaches to improving social functioning, such as newspaper discussion groups, identified by the MHC (2016) and discussed on page 195, may be a further contributing factor. Furthermore, having a mental disorder,

such as schizophrenia, can significantly impair social functioning, due to negative symptoms and cognitive impairment (de Sousa *et al.*, 2019).

The above factors can make it challenging for residents to engage in social activities and form relationships, further contributing to social isolation. Therefore, improving social functioning in people with complex mental health disorders requires a multifaceted approach that targets stigmatisation, financial limitations, and limited social networks, as well as implementing evidence-based interventions that directly improve social functioning. The recommendations to improve social functioning focus on developing social networks in the community, as stigmatisation will be addressed in the section on **stigmatisation** and lack of finances has been addressed in the section on **unemployment**.

10.7.1 Recommendation 7a: Develop connections with local statutory and voluntary agencies

This study recommends that services develop connections with local statutory and voluntary agencies mentioned on page 242, such as Mental Health Ireland (<https://www.mentalhealthireland.ie>), Grow (<https://grow.ie>), Shine (<https://shine.ie>), and Aware (<https://www.aware.ie>). Residents should be encouraged to engage in these groups, as the benefits include an increased sense of belonging and emotional support, as well as advocacy support (Solomon, 2004). In addition, it has been determined that volunteering, where the emphasis is on belonging rather than productivity, is another effective means of achieving social inclusion (Simplican *et al.*, 2015).

10.7.2 Recommendation 7b: Multiple social skills training options should be available to all residents of CRFs

Improving social functioning should be addressed as one of the primary goals of rehabilitation for people with complex mental disorders, as discussed on page 195. Residents should have the option to engage in multiple evidence-based interventions to improve their social skills. In line with the recovery philosophy, it is important that residents are given the option of choosing which treatment option best suits their individual needs. For example, some

people may prefer engaging in individual social skills training (SST) over group SST, where the focus is role playing and structured teaching of social skills (Gates, Kang and Lerner, 2017). Others may prefer engaging in SST through technology-based interventions such as computer applications (Fulford *et al.*, 2020) or VR-based interventions (Schroeder *et al.*, 2022). OTs are ideally suited to lead evidence-based social skills interventions, given that social interaction and social skills have historically and traditionally been a focus of occupational therapy practitioners (Kauffman and Kinnealey, 2015). In addition, Ercan Doğu *et al.* (2021) noted that a combination of occupational therapy and SST interventions can improve and maintain functioning and well-being in individuals with complex mental health disorders.

10.8 Key finding 8: Dissatisfaction with Care

Chapter six further highlighted that some residents are unhappy with the care and treatment they are receiving. For instance, 43.5% felt that doctors were not informing them of their progress, which they perceived to be of minimal improvement over many years, as outlined on page 198. Doctors were also criticised for poor communication skills, such as not listening to residents, coming across as robotic and not providing enough information on the potential adverse effects of medications, [page 201]. In addition, residents perceived that they were not treated with dignity and respect and reported feeling infantilised by staff. Furthermore, residents were dissatisfied with the heavy focus on medication as the sole form of treatment. However, staff may not have been aware of residents' perceptions of their treatment and care, as no service evaluation procedures were in place.

Negative therapeutic relationships with staff, as described by residents in this study, can result in non-adherence to treatment (Chue, 2006) and lower satisfaction with care (Priebe and Miglieta, 2019). On the other hand, positive therapeutic relationships can increase patient satisfaction, adherence to treatment and improve QoL (Kornhaber *et al.*, 2016). Treating all individuals with mental health disorders with humanity and respect is a fundamental right (United Nations, 2022). Failure to do so does not align with recovery

principles and may result in low self-esteem and a diminished sense of self-worth. In addition, the WHO (2022) has demanded a rapid shift away from mental health services that primarily focus on medication, towards a comprehensive approach that prioritises individualised and person-centred care and treatment.

10.8.1 Recommendation 8a: There is a need for mandatory and continuous staff training on the concepts of recovery

Mandatory and continuous staff training on the concepts of recovery, including the human rights of individuals with mental disorders, should be introduced. The shared decision-making process between residents and staff should be promoted and emphasised, as it is a key element of the recovery model and will help to overcome difficulties such as poor communication between staff, and perceptions of not being treated with dignity and respect, [pages 199, 214, 215]. In addition, this can address residents' feelings of being infantilised by staff (Loman, 2017; Priebe *et al.*, 2011), as both residents and staff are on an equal playing field and power imbalances are removed (Shepherd, Shorthouse and Gask, 2014). As a result of the REFOCUS initiative, discussed on page 177, a manual was created to aid and support mental health teams in their transition to a recovery-focused approach. The manual is available for free [download](#), which can serve as a practical guidance tool for mental health teams in providing evidence-based practices to improve their knowledge and implementation of recovery and human rights based principles.

In addition, to ensure residents are aware of their rights and the standard of care they should receive, they should be given the option to participate in training sessions or workshops on recovery principles and their rights. Lack of awareness of their human rights could potentially lead to residents receiving substandard care that breaches their human rights. The suggestion to combine training for both staff and residents may work well, since everyone (staff and residents) will have a clear understanding of how recovery should be implemented in clinical practice, as well as the responsibilities on both sides (Salkeld, Wagstaff and Tew, 2013).

10.8.2 Recommendation 8b: There is a need to introduce a valid outcome measure assessing resident and family satisfaction

A validated outcome measure should be employed to investigate resident and family satisfaction with the service, so that any elements of residents' dissatisfaction or any unmet needs can be identified and addressed. Adaptation of the Client's Assessment of Treatment Scale (CAT) (Priebe and Gruyters, 1995) has produced a PROM, called the Client's Assessment of Treatment Scale – Supported Housing (CAT-SA) (Sandhu *et al.*, 2016), which is a valid and easy to use measure for residents in CRFs. In addition, the adaption of this scale from the CAT to the CAT-SA had input and involvement from residents of supported housing accommodation, which aligns with recovery. Implementation of this recommendation will provide residents with the opportunity to provide feedback to the service and will hopefully ensure that the views and opinions of residents are addressed, as well as inform the development of future services (Sandhu *et al.*, 2016).

10.9 Key finding 9: Stigmatisation

Chapter seven revealed that residents perceive family members to have a lack of understanding around their mental disorders. This results in family members' interactions being characterised by overprotectiveness, authoritarianism and dismissiveness, leading to residents feeling stigmatised by families. Some residents also described experiencing stigma from friends in the form of avoidance and negative comments related to possible unpredictable behaviour towards them [page 211]. Residents also perceived stigmatisation from neighbours in the form of unpleasant confrontations, where residents were accused of pacing up and down in front of their neighbour's house and throwing cigarette ends and empty beer cans on the footpath outside their house [page 212]. Residents felt wrongly accused of this antisocial behaviour and felt discriminated against by their neighbours, because they have a mental disorder. As a result, residents preferred to remain anonymous and avoid interacting with their neighbours.

Residents also experienced professional stigmatisation from mental health professionals, in the form of feeling dismissed and disrespected when denied permission to socialise, infantilising residents, and preferring to speak with relatives rather than the person themselves, [page 214]. In addition, residents experienced structural stigma through instructional practices, in the form of policies and procedures that restricted residents' opportunities to increase their independence, such as denying access to the kitchen [page 181]. Residents also reported feeling stigmatised by psychiatric labels through cultural norms and institutional practices and were aware of the negative connotations associated with schizophrenia. Given that internalised stigma is synergistically linked with social, professional and structural stigma (Sukhera *et al.*, 2017; Sukhera *et al.*, 2022), it is unsurprising that residents experienced internalised stigma in the form of attempting to conceal their diagnosis [page 221]. As a result, residents may feel excluded, socially isolated, marginalised and disrespected, all of which are paradoxical to recovery (Department of Health, 2006).

10.9.1 Recommendation 9a: Families should have access to individual or groups family interventions

Residents' families should have access to individual or group family intervention, if residents are willing to involve family members. However, as stated on page 243, some residents may not want family members involved. Family intervention will increase family awareness of the nature of their loved ones' mental disorder, providing families with a better understanding of the difficulties they may be experiencing (Ong, Fernandez and Kim, 2021). Family intervention will also help in refuting misconceptions about mental disorders, allow families to empathise with their loved ones and refrain from criticising them for their symptoms.

10.9.2 Recommendation 9b: Ensure continuous anti-stigma training for all health care staff

The successful and long-term implementation of recovery practice is contingent upon the staff's intrinsic belief in the ability of service users to lead improved and more fulfilling lives, despite ongoing limitations caused by

illness (Clarke *et al.*, 2020). Therefore, similar to recovery training, regular ongoing anti-stigma training for all health care staff should be implemented in order to remove/reduce unfavourable attitudes or perceptions held by health professionals (Friedrich *et al.*, 2013). In addition, service user involvement in the education and training of mental health professionals regarding the stigma of mental disorders is recommended (Sreeram, Cross and Townsin, 2022). Mental health services need to be aware of the impact of structural stigma on residents' lives. As previously recommended, all restrictive health and safety policies and procedures need to be re-evaluated. Moreover, those that are in direct contravention of the main principles of recovery and impinge on the rights and autonomy of residents need to be dissolved, to ensure that residents live in a non-restrictive environment (The British Institute of Human Rights, 2016; United Nations, 2022).

10.9.3 Recommendation 9c: Residents should have access to psychoeducational interventions that target internalised stigmatisation

In order to eliminate/reduce internalised stigma, psychoeducational interventions on stigma and multicomponent therapies, that incorporate psychoeducational, cognitive-behavioural, narrative, and motivational aspects that support and empower residents, should be employed (Alonso, Guillén and Munõz, 2019; Tsang *et al.*, 2016). Residents may be more equipped to deal with stigmatising attitudes in the community if they are supported in managing internalised stigma.

As a result, it is important to recognise the need for residents to have access to psychological therapies to help them cope with stigmatising attitudes, internalised stigma and any other challenges they may be experiencing. By providing such resources, staff can better support residents on their journey to recovery. For this to happen, additional posts for psychologists and counsellors need to be endorsed and recruited, as currently only two psychologists are recommended per community mental health team (Department of Health, 2006). This is not enough to adequately meet the needs of people with mental disorders (Psychological Society of Ireland, 2018).

10.10 Key finding 10: Loss of Autonomy and Independence

Residents are unable to live an independent life and are subject to strict rules and regulations, which deprive them of the same level of autonomy and independence as ordinary citizens. While most residents performed ADL and essential tasks, such as managing finances and medical appointments, only 24% expressed complete satisfaction with their level of independence and 63% of residents reported having moderate or little control over their own lives. This implied that strict rules and regulations and the inability to live independently may be contributing to their dissatisfaction. Thus, rules and regulations are limiting residents' ability to control their own behaviour and choices. Moreover, a lack of evidence-based care is excluding them from participating in decisions related to their own treatment. The inability to govern their own lives may result in a considerably diminished QoL, feelings of frustration, dissatisfaction, and a sense of helplessness. Furthermore, this culture of disregard for residents' autonomy may create an oppressive environment that is inconsistent with recovery-oriented care.

It is important to provide evidence-based care that empowers and encourages residents to make decisions around their treatment and care. A more person-centred recovery-orientated and human rights-based approach to care is required. As previously suggested, ongoing training for both staff and residents is recommended, as this approach will ensure that residents' opinions, and needs are the focus of their care plan and that they are involved in the decision-making processes. The implementation of this recommendation will also ensure that residents are treated with dignity and respect and that their right to autonomy is protected.

10.10.1 Recommendation 10a: Staff should increase resident awareness around advocacy and peer support services

The right to advocacy services and peer support needs to be emphasised and the challenges in accessing advocacy supports as highlighted in *Sharing the Vision* (2020) need to be addressed. Residents should have the option of having another person available to assist them in making decisions around

their care, in addition to other difficult decisions they may have to make. An added benefit of utilising advocacy or peer supports is that residents, who are unhappy with the care they are receiving, can be assisted and guided in making a complaint.

OTs play a key role in advocating for the rights of others and promoting occupational justice (Hammell and Iwama, 2012) and social inclusion. Consequently, OTs should continue to promote awareness of advocacy services and encourage self-advocacy. Promoting and encouraging awareness of advocacy services, through MDT meetings and occupational therapy interventions, can empower residents in the decision making process and enable them to take more responsibility and control over their own health (Hammell and Iwama, 2012; World Federation of Occupational Therapists, 2023).

10.11 Key finding 11: Loss

As previously mentioned, most residents (91%) were unemployed and 57% had not completed secondary school. Some residents expressed regret and disappointment for not completing their education and developing their careers. Moreover, they acknowledged that challenges they experienced as a result of their mental disorder were significant barriers to achieving their goals.

Other residents appeared to be grieving for a life that was no longer attainable to them. For instance, one resident communicated how she would have liked to have more children, but was concerned that her illness may be passed on to her children. Another resident expressed sadness around missing her child, who is in full-time care. Other residents spoke of missing their family members with whom they no longer have a relationship with, as their mental disorder impacted their ability to maintain close relationships.

A compounding issue is the feeling of hopelessness described by some residents regarding their current situation and circumstances, which can

negatively impact both physical and psychological health, as well as overall QoL (Farran, Herth and Popovich, 1995). Furthermore, the consistent and ongoing lack of access to psychological support possibly exacerbates their already difficult situation.

Without the necessary psychological support and a focus on instilling hope in service delivery, residents may struggle to cope with the trauma and loss experienced. Since hope is crucial to the recovery process and a core value of *Sharing the Vision* (2020), it is vital to place hope at the centre of all interactions with residents. By prioritising hope, and ensuring consistent access to psychological support, residents can be equipped with the tools to cope with their circumstances and overcome the challenges they face.

10.11.1 Recommendation 11a: Ensure that all staff interactions with residents are both positive and empowering

All staff members who provide services to residents should do so in a manner that is positive and empowering, and strengths-based, so that residents can live their best life. This is also a recommendation outlined in *Sharing the Vision* (2020). This approach may help instil a sense of hope in residents, which is a critical component of recovery, and a core value of *Sharing the Vision* (2020).

10.11.2 Recommendation 11b: Managers should ensure to conduct recruitment interviews using recovery-focused questions

In order to ensure appropriate selection of staff, it is essential that managers interview potential employees regarding their level of understanding, knowledge and perceptions towards recovery. This can be achieved by conducting interviews with recovery-focussed questions (Le Boutillier *et al.*, 2011).

10.12 Key finding 12: Evidence of Institutionalisation

The organisational cultures of the psychiatric institutions closed in the deinstitutionalisation process are often replicated in smaller congregated settings such as CRFs (Drake, 2014). Some residents in this study appeared

to have adapted and conformed to institutionalised care, as demonstrated by their complete acceptance of the possibility that they will likely not be permitted to have a barbecue without staff present, the inability to lock their bedroom or bathroom doors, or come and go as they please. Other residents have firmly placed themselves in the sick role by communicating that they are “*under the doctor’s care*”. Further examples include residents’ perception of themselves as only having relationships and socialising with other residents, referring to life outside the CRF as the “*outside*” word. Thus, they view the CRF as a safe environment or possible extension of the hospital, in that it allows them quick access to a doctor or admission to hospital.

In addition, although residents have a desire to move to more independent housing, they are also reasonably content with living in a CRF. This is since they are aware of some of the challenges facing them in terms of moving on from the CRF, such as unemployment, financial constraints, fear of not being able to manage independently, fear of potential stigmatisation, and lack of alternative housing. As residents are not being supported in navigating these challenges, they are further contributing to their institutionalisation, alongside other issues such as paternalistic care and lack of evidence-based rehabilitation.

10.12.1 Recommendation 12a: Formation of a formal committee with residents of CRFs, local offices of the Department of Health and the Department of Housing Planning and Local Government

Long-term residence in a CRF can lead to multiple challenges for residents, such as social isolation, lack of independence and institutionalisation (Krotofil, McPherson and Killaspy, 2018). Therefore, it is essential that the Department of Health and the Department of Housing, Planning and Local Government collaborate to develop a framework that specifically focuses on transitioning residents of CRFs to independent accommodation, as outlined in *Sharing the Vision* (2020). To achieve this recommendation, a committee should be formed that includes members from both departments, as well as residents of CRFs. The involvement of residents in the committee will ensure

that their perspectives are heard, and their needs are addressed, which is crucial for creating a successful transition.

10.13 Summary of Recommendations

The above recommendations are succinctly summarised in Table 10.1, in order to improve accessibility and clarity and increase the likelihood that they will be effectively disseminated and put into practice. Table 10.1 also clearly distinguishes which recommendations pertain to clinical practice and which recommendations are intended for policy implementation.

Recommendations	Recommendation for Clinical Practice	Recommendation for Policy
Clear communication regarding the goals, purposes and length of stay in CRFs is necessary.		Policy
The CRF should be clearly defined with its intended model of care.	Practice	
Residents should be matched to the appropriate level of support.	Practice	
Formal waiting lists should be created for any future admissions.		Policy
Clarification is required regarding the role of staff within the CRF.	Practice	
Clear communication should be provided to residents on the role of individual members of the MTD.	Practice	
Residents and staff (clinical and non-clinical) should collaborate on care planning.	Practice	Policy
Care plans should be multidisciplinary and should be reviewed on a regular basis.	Practice	Policy

Medium and low support CRFs should be regulated by the MHC.	Managerial	
Health and safety policies should be re-evaluated and ones that are in direct contravention of the main principles of Recovery and impinge on the rights and autonomy of residents need to be dissolved.		Policy
Formal assessments should be carried out by occupational therapists prior to admission.	Practice	Policy
Government policies need to support the additional recruitment of occupational therapists and propose 12 -15 occupational therapists per MDT.	Managerial	
Residents must have access to the IPS employment model.	Practice	Policy
Occupational therapists need to champion and promote the IPS model at MDT meetings, documenting employment goals in care plans, and educating families on the significance of employment in the rehabilitation process.	Practice	
Occupational therapists need to advocate for the IPS model to be scaled up in order to meet the needs of CRF residents.	Practice	
Training centres and sheltered workshops should be dissolved and funding should be diverted towards the IPS model of employment.		Policy
Services need to develop connections with local statutory and voluntary agencies and encourage residents to engage with these services.	Practice	Policy

Social skills training (SST) should be available for residents.	Practice	Policy
Mandatory and continuous training on the concepts of recovery for staff, including the human rights of individuals with mental disorders, should be implemented.	Practice	Policy
Residents should have the choice to participate in training on recovery principles and their rights.	Practice	Policy
Combining training for both staff and residents should be considered.	Practice	
A validated outcome measure should be employed to investigate resident and family satisfaction with the service and to identify elements of dissatisfaction or unmet needs amongst residents.	Practice	Policy
Families of residents should have access to individual or group family intervention if residents are willing to involve family members.	Practice	Policy
Regular ongoing anti-stigma training for all health care staff should be implemented by health care services.		Policy
Psychoeducational interventions on stigma and multicomponent therapies that incorporate psychoeducational, cognitive-behavioural, narrative, and motivational aspects that support and empower residents should be employed.	Practice	Policy

A more person-centred recovery orientated and human rights-based approach to care is required.	Practice	Policy
The right to advocacy and peer support services needs to be emphasised and the challenges in accessing these supports need to be addressed.	Practice	Policy
All staff members who provide services to residents do so in a manner that is positive and empowering, and strengths-based so that residents can live their best life.	Practice	Policy
Managers need to evaluate potential employees' recovery related competencies during the recruitment process.		Policy
The Department of Health and the Department of Housing, Planning and Local Government need to collaborate to develop a framework that specifically focuses on transitioning residents of CRFs to independent accommodation as outlined in <i>Sharing the Vision</i> (2020). To achieve this recommendation, a committee should be formed that includes members from both departments, as well as residents of CRFs themselves.	Practice	Policy

Table 10.1 Summary of recommendations for practice and policy

This chapter, and the preceding chapters, have demonstrated how mental health services have relied too heavily on institutional approaches, such as medication, paternalistic care and sometimes coercive interventions and how rehabilitation, including psychological supports, is largely absent. Consequently, this thesis has demonstrated that the current mental health

system is inadequate and has failed to improve the treatment and care provided to residents of mental health facilities in the past 200 years. Rather than making progress, health services have only succeeded in shifting individuals from one institution to another, without addressing their rehabilitative needs.

Mental health services need to prioritise a more person-centred service, which fosters hope and arms individuals with the tools and resources they need to take responsibility for their own recovery, and to develop confidence in people through empowering them. Self-determination, as in respecting autonomy and decision making are paramount, as well as protecting human rights. In addition to promoting social inclusion, access to community-oriented services, such as housing, education, employment and community support groups mentioned in Chapter six, must be achieved. Furthermore, challenging stigma and discrimination in health care, as well as the wider community, needs to be tackled. A lot of work still needs to be done, but most importantly, a human rights-based approach to service delivery must prevail.

To ensure that future mental health care policies are rooted in human rights and recovery-based approaches, the above changes to practice and policy must be implemented in a way that is meaningful and sustainable.

10.14 Strengths and Limitations of the Study

This is the first comprehensive study to be conducted in Ireland, employing a mixed-method approach to explore the lived experience of people residing in CRFs. One of the main strengths of the study is the qualitative approach, which accommodated residents in sharing their unique perspectives on living in a CRF. However, the study has a number of limitations. Firstly, due to the limited sample size, it was not possible to conduct a comparative quantitative statistical analysis. A larger sample size would have allowed sufficient statistical power to extrapolate the results to the overall population and afforded the opportunity to use more inferential statistical tests for significance, instead of relying solely on descriptive statistics. While the

inclusion of a larger sample size was initially considered, it was advised against by CSTAR, as it would have involved including residents from a rural geographical location, which would have been beyond the scope of one researcher. Even though a larger sample size can yield better results, practical constraints, such as resources, time, and scope of the study also needed to be taken into account. Moreover, the in-depth qualitative exploration of the lived experience provides a foundation for further, more extensive quantitative studies.

During the implementation of the study, it became apparent that certain scales employed were not ideal, mainly due to the response options provided. Specifically, when investigating residents' level of satisfaction with accommodation, response choices of *mostly satisfied*, *mostly dissatisfied* or *equally satisfied and dissatisfied* were utilised. This last option of feeling both satisfied and dissatisfied simultaneously can be challenging to interpret accurately and would have provided better results if a more discrete Likert scale (Likert, 1932) of one-to-ten had been employed instead. By using a one-to-ten Likert scale, where one represents extreme dissatisfaction and ten represents complete satisfaction, a clearer and more comprehensive understanding of residents' satisfaction with their accommodation could have been obtained. However, as previously highlighted in Chapter one, the initial purpose of this research was to provide residents of CRFs residing in an urban area in the West of Ireland an opportunity to express their opinions, as they were excluded from the national study conducted by the HRB. As a result, the measurement tools employed in the national study were used in this study.

Furthermore, as the researcher worked with some of the residents, they may have been reluctant to express dissatisfaction, leading to an underreporting of negative experiences and/or an overreporting of positive feedback. This could be viewed as a limitation. On the other hand, it may have made some residents feel more at ease sharing information, and rapport is an essential component for obtaining in-depth information (Lester, 1999).

In addition, the findings may have been limited by various factors that may have impeded residents' effective communication. Possible examples include sedation from medication, cognitive impairment or decline resulting from illness, poor rapport with the researcher, reluctance or embarrassment to share personal experiences within a group, or lack of confidence in speaking within a group setting. Despite efforts to allow each resident to express their views, it remains possible that the results represent the views of the more confident residents and the views of the more reserved or introverted may not be fully represented. To achieve a more balanced perspective, future studies could explore the use of both individual interviews, as well as focus groups.

Moreover, it would have been beneficial to have taken a more holistic approach to understanding the CRF environment by incorporating the views, opinions, and perspectives of staff working within the CRF environment. However, the researcher chose to prioritise gaining insights directly from residents, as the main purpose and focus of the study was to explore the lived experiences of the residents themselves, and a baseline of this understanding was successfully established.

Nonetheless, it is important to acknowledge that the findings may be limited in the absence of a proactive approach in overcoming the obstacles and challenges identified by residents. However, this limitation potentially provides an opportunity for further research that focuses on involving residents in effectively resolving these issues. For example, in contrast to the methodologies used in this study, an action research approach would have allowed the researcher to collaborate directly with residents and staff to create positive change (Coghlan, 2011). Action research provides a framework for implementing changes, and its iterative methodology would allow for the continuous evaluation of the outcomes to ensure they are effective, beneficial and contribute to policy change (Clark *et al.*, 2020).

Therefore, in order to cement change, this study recommends further research that looks at implementing, monitoring and evaluating the above recommendations through an action research approach. This would involve

residents and staff in co-developing interventions that are based on the needs of residents, as opposed to interventions that are based on the objective needs of residents. In addition, it would be of significant value to also involve staff in an action research approach that encourages them to continually evaluate and improve their practices and beliefs through critical thinking and reflection. This would result in staff becoming more responsible for their own thinking and professional practice, which would ultimately result in both improved personal and professional development and better outcomes for the individuals under their care (Clark *et al.*, 2020; McNiff, 2014). It is essential that research continues in this area and the findings of this study serve as a foundation for change. An action research approach could lead to a more holistic, recovery and human rights-based approach to care for people with complex mental disorders residing in CRFs.

10.15 Personal Reflection

Completing a PhD, while simultaneously raising a young family and working full-time, immigrating to a different country, moving back home again and dealing with family bereavements has been the most challenging experience of my life. The magnitude of responsibilities and obstacles that came with overseeing a research project of this scale often left me feeling overwhelmed and wanting to give up. However, my duty to my patients, and the service I was working with at the time kept me going.

On a more positive note, through the experience of completing this PhD I have learned to develop self-advocacy skills and resilience in myself, and these qualities have enabled me to succeed during challenging times. This process of completing a PhD has been a life-changing experience that has taught me the importance of perseverance. I am proud to have set an example for my children, that will inspire them to never give up on their own goals and aspirations.

As previously mentioned, my intention was always to ensure that the residents I worked with got the opportunity to have their voices heard and share their opinions, since they were excluded from the national study.

Having now completed the study, I would not have taken the approach that I did. As highlighted in the limitation section, I regret not considering conducting an action research study similar to that of Kidd, Kenny and McKinstry (2015), where they used participatory action research to explore the meaning of recovery-orientated care, through developing workshops to support change. If I had used an action research approach to develop recovery-orientated workshops, I believe I may have made more of a positive impact on the lives of residents in a timelier fashion. Although this study has clearly identified recommendations for both practice and policy, which will hopefully contribute to improving the lives of residents, ultimately, this is dependent on others to implement. This will be very challenging, as realistically the recommendations may not be implemented, given the health services history of failing to implement policy recommendations from policy documents as outlined in Chapter one.

In conclusion, this study aimed to investigate the experiences of individuals with mental disorders residing in CRFs located in an urban setting on the western coast of Ireland. The objectives of the study were achieved in that the quantitative measures provided a baseline to investigate the general functionality of CRFs. The subsequent qualitative exploration into residents' lives revealed the extent of insufficient rehabilitation and recovery principles, leading to the violation of human rights and institutionalisation. Furthermore, it brought to light the discrimination and stigmatisation experienced by residents from various perspectives, as well as the loss of meaningful family connections and opportunities. In addition, this study has presented evidence-based recommendations for practice, policy development, and future research, with the ultimate goal of promoting better care and support for individuals residing in CRFs. These recommendations will hopefully shed light on the care described by residents, that may not align with their human rights, desires, and future aspirations and goals. The substandard care provided to residents of CRF should no longer be accepted by CRF residents, their families, or society. Notably, the emphasis of care must shift from care that is imposed on patients, to care that is

tailored to their individual specific needs, in order for residents and people with mental disorders to live their best life.

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Appendices

Appendix 1: Permission to Reproduce Housing Model Table

From: Tim Aubry <Tim.Aubry@uottawa.ca>
Subject: Re: Supported Housing
Date: May 3, 2018 at 1:44:24 AM GMT+1
To: Lisa Maloney <lisalaloney4@gmail.com>

Hi Lisa,

Sorry for the delay. I am fine with your request but you will need to contact the University of Ottawa Press puo-uop@uottawa.ca since they have the copyright on the book. I am confident that they will give you permission. Good luck with your thesis research!

Best,

Tim

Dear Lisa Murray, dear Professor Aubry,

Thank you for your note.

I am happy to confirm permission for you to reproduce one of the tables included in Dr. Aubry's chapter, as this is an open access book with a Creative Commons licence. By virtue of this licence, you would need to ensure adequate attribution (something like « Published in.... Reproduced with permission by the University of Ottawa Press »).

With my best wishes,

Lara Mainville
Directrice | Director
Les Presses de l'Université d'Ottawa | University of Ottawa Press

Appendix 2: Participant Information Leaflet

Dear Sir / Madam

I am an occupational therapist working in the department of psychiatry in Galway University Hospital. I am writing to invite you to participate in a study called 'A Voice in My Own Home... A Survey and Evaluation of Community Residential Mental Health Services in Galway City'.

Participating in the study will involve completing a questionnaire about where you live and your opinion about the service you receive. Following this you may be invited to participate in a small focus group at a later stage. Also, your community mental health nurse will be asked to fill out a questionnaire on your occupational or social functioning.

All information received will be treated in the strictest confidence and any information you disclose will not be available to staff or other residents. No personal identifying information will be recorded and all information collected will be available to the research team only and data will be stored in a locked filing cabinet and destroyed 5 years after collection.

If you decide that you would like to participate in the study, I will arrange to meet with each resident individually to provide assistance with completing the questionnaire. Please note you are under no obligation to participate in this study and your current treatment will not be affected in any way.

Finally, if you do agree to participate please sign the enclosed consent form confirming that you have agreed to do so, and I will collect it shortly.

Please do not hesitate to contact me on the following number 087-6896599 should you require any further information.

I look forward to hearing from you.

Thank you

Lisa Maloney

Occupational Therapist, Department of Psychiatry, Galway University Hospital.

Date: _____

Appendix 3: Approval from Research Ethics Committee (amendment letter)



Appendix 4: Approval to Repeat the Happy Living Here Report



An Bord Taighde Sláinte
Teach Grattan
67-72 Sráid an Mhóta Íochtarach
Baile Átha Cliath 2
D02 H638
Éire

Health Research Board
Grattan House
67-72 Lower Mount Street
Dublin 2
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Ireland

t +353 1 234 5000
e hrb@hrb.ie
w www.hrb.ie

 [@hrbireland](https://twitter.com/hrbireland)

22 January 2021

To whom it may concern,

This is to confirm that Ms Lisa Maloney received permission from the HRB in November 2010 to repeat the Happy Living Here Report, A Survey and Evaluation of Community Residential Mental Health Services in Ireland (2007) for her own doctoral work with residents living in community residential facilities in Galway city.

Yours sincerely

A handwritten signature in black ink that reads 'Sarah Craig'.

Dr Sarah Craig,
Head of National Health Information Systems Uni

Taighde. Fianaise. Gníomh. Research. Evidence. Action.

Appendix 4: Consultant Letter

RE: Research Study Investigating Community Residential Facilities

Dear Dr. _____

I am writing to inform you that _____ has been asked to participate in a study called 'A Voice In My Own Home... a survey and evaluation of community residential mental health services in Galway City'. This study will evaluate the quality of community residential accommodation and the extent to which it meets the needs of the residents.

Please do not hesitate to contact me should you require any further information.

Regards

Lisa Maloney
Occupational Therapist

Appendix 5: Letter to ADON

RE: Research Study Investigating Community Residential Facilities

Dear _____

I am writing to request your participation in a study called 'A Voice In My Own Home... a survey and evaluation of community residential mental health services in Galway City'. This study will evaluate the quality of community residential accommodation and the extent to which it meets the needs of the residents.

Please find Facility Questionnaire attached, I would appreciate if you would meet with me to discuss this study further. Please note that your participation in this study is voluntary and you are free to decline participation.

Regards

Lisa Maloney
Occupational Therapist

Appendix 6: Facility Questionnaire Modifications

Questions used in the original study	Modified or Omitted Questions in this study	Reasons for Modifications or Omissions
Name of residence Name of Health Board	Health Board	The term 'Health Boards' had dissolved by the time data was collected
Date schedule completed Year residence opened?	Both	Not deemed to be relevant
Level of support; high, medium, low, other	'Other' was omitted	Only high, medium and low support were available in this service
Completed by: Job title Contact number	Both questions omitted	All questionnaires were completed by the ADON
Where is the building located (7 options were listed)	This question was omitted	All building were located in housing estates in an urban area
Description of the location of the building	This question was omitted	All building were located in an urban area
Is the building owned by Health Board, Voluntary or Private	No changes were made	N/A
Building Features		
Interior total (sqm) Exterior total (sqm)	These questions were omitted	Not deemed to be relevant
Number of bedrooms - single, double or triple? Number of bathrooms?	No changes were made	N/A
Number of bathrooms for residents use only?	This question was omitted	Residents were permitted to use all bathrooms
Number of living rooms? Are there any rooms for staff use only?	These questions remained unchanged	N/A
Is there a kitchen?	This question was omitted	All CRFs had a kitchen
Is there a designated visiting room? Is the building suitable for those with mobility problems? If no, what are the barriers?	These questions remained unchanged	N/A
Number of public phones?	This question was changed to 'is there a public phone?'	No CRF had more than one phone
Is there a smoking room? If yes, is it inside or outside	These questions remained unchanged	N/A
Access to Services		

<p>Time in minutes to reach shopping centre on foot? Time in minutes to reach shopping center by public transport? Time in minutes to reach post office on foot? Time in minutes to reach post office by public transport? Time in minutes to reach pup on foot? Time in minutes to reach primary care center on foot? Time in minutes to reach primary care center by public transport?</p>	<p>All of these questions were omitted</p>	<p>All CRFs were located in an urban area</p>
<p>Number of residents that have access to own transportation (e.g. bike or car)</p>	<p>This question remained unchanged</p>	<p>N/A</p>
<p>Questions used in the original study</p>	<p>Modified or Omitted Questions in this study</p>	<p>Reasons for Modifications or Omissions</p>
<p>Please enter a number of individuals with particular form of transport personal car () bike() motorcycle()</p>	<p>This question remains unchanged</p>	<p>N/A</p>
<p>Does the residence have a mini bus to transport residents? Is the transport shared with other residential facilities?</p>	<p>These questions remained unchanged</p>	<p>N/A</p>
<p>How long does it take to get to the day hospital / center by minibus/public transport?</p>	<p>This question was omitted</p>	<p>Not deemed to be relevant as all CRFs we are located in an urban area</p>
<p>Rules and Regulations</p>		
<p>Do residential staff supervise daytime comings and goings of residents? Are residents allowed to leave the units unsupervised? Do residents have a front door key?</p>	<p>These questions were omitted</p>	<p>The questions “when checking out - are residents required to notify staff where they go?” (Pg147) was deemed sufficient.</p>
<p>Can residents lock bathroom facilities? Are visiting hours scheduled? Our residence required to go to bed at a given time?</p>	<p>These questions remained unchanged</p>	<p>N/A</p>
<p>When checking out, are residents required to notify staff where they go? Are residents required to check in at a given time?</p>	<p>These questions remained unchanged</p>	<p>N/A</p>

Can residents stay in their bedrooms during the day? Can residents lock their bedrooms? Are residents allowed to smoke in their bedrooms?	These questions remained unchanged	N/A
Are there any areas where residents can be left on their own?	This question was omitted	Not deemed relevant
Can residents choose whom they share their bedrooms with?	This question remained unchanged	The majority of CRFs had single rooms
Can residents choose to stay in single rooms? Are the following items allowed: Razor, knife, scissors, matches, lighters, medication, money? Do staff run a check on residents' belongings? Are residents' belongings listed? Can residents administer their own finances?	These questions were omitted	These questions were deemed irrelevant as they did not apply to residents in medium and low supports CRFs
Meals		
Is the food prepared by the psychiatric hospital?	This question was omitted	The psychiatric hospital did not supply food to any of the CRFs
Who prepares the meals?	This question remained the same	N/A
Number of residents having their main meals outside the residence?	This question was omitted	Meals were cooked within the CRFs
Do staff have their meals in their residence?	This question was omitted	N/A
Can residents choose the menu?	This question remained unchanged	N/A
Can residents follow diet?	This question was omitted	It was difficult to interpret
Do residents purchase / shop for food? Do residents have unrestricted access to the kitchen?	The word 'unsupervised' was added to this question. This question remained unchanged.	N/A
Staff		
Number of daily working hours in residence? Number of staff for each scheduled shift- Nurses, Care Staff, Household, others?	These questions were changed to 'how many nurses are there per schedule shift'? How many hours do CRF supervisors work per schedule shift?	N/A

N/A	These questions were added to this section; Do other staff visit the residents daily? Do other staff visit this residence weekly?	This information would be beneficial to the study
Do named core staff, staff this residence? Do staff rotate at set intervals? If so, is it six months, yearly, two years?	These questions remained unchanged	N/A
Is there an emergency call Service in place during night shifts for the residence or group of residences? Does emergency call run for 24 hours including Saturdays? Does emergency call run for 24 hours on Sundays and public holidays? Are there volunteers and/ or trainees on placement?	These questions were omitted	All residents had 24-hour access to the Department of Psychiatry
Admission Procedures		
Is there a formal assessment prior to admission?	This question remained unchanged	N/A
How many places are there in the residence?	This question remained unchanged	N/A
Are there any designated; respite beds, crisis beds, beds for other uses?	This question remained unchanged	N/A
Is this residence ever used to accommodate transfers from the acute unit due to bed shortages?	This question remained unchanged	N/A
If applicable, is there a policy regarding the following admissions? Respite beds, crisis beds, transfers from acute units due to bed shortages?	This question was omitted	The ADON reported that the CRFs were for resident use only and not used in the case of bed shortages
Which, if any, criteria are used as exclusion criteria? Acute Psychotic disorders? Substance abuse? Alcohol abuse? Severe physical disease? Organic brain disorder? Intellectual disability? History of violent behaviours? Former residents of psychiatric hospitals? Former residents of criminal psychiatric hospital?	Alcohol abuse was omitted. Severe physical disease was change to 'condition'. History of violent behaviours was changed to 'risk of violent behaviours'. Former residents of psychiatric hospitals was omitted.	Some residents had a diagnosis of alcohol addiction N/A N/A The majority of residents had come from the Department of Psychiatry
Is there a waiting list? If yes, number of weeks? Number of applications?	This question remained the same.	N/A

Is there a specialised rehabilitation team for the service? If so, does it have ownership of beds? If not, who has ownership of beds?	These questions were omitted.	There was no specialised rehabilitation team in place.
Who decides on the placement, discharge or transfer of patients?	This question remained unchanged.	N/A
If there is a specialised rehabilitation team, is it multidisciplinary? If so, what professionals are included?	This question was omitted	No rehab team in place
Is there a provisional admitting diagnosis drawn up once a patient has been admitted?	This question was omitted.	This information was obtained from another question
Does each resident have an individual treatment plan with a clear aim?	This question remained unchanged.	N/A
If yes, does the treatment plan include the following? The specific medical treatment, the responsibilities of each member of the treatment team, adequate documentation to justify the diagnosis, the treatment and rehabilitation activities carried out?	These questions remained unchanged. One question was added to this section; 'Are residents involved in drawing up their treatment / care plan?'	N/A
Are treatment plans reviewed by those responsible for the care of the resident?	This question remained unchanged.	N/A
Is there an admission form to be signed by the resident or/and family members containing details on treatment goals and residential unit process and procedures?	This question remained unchanged.	N/A
Is there a qualified professional assigned to each resident that one can refer to throughout treatment?	This question remained unchanged.	N/A
Meetings		
Are there planned and regular meetings held by staff within the residence? If yes, how often are they held?	This question was omitted.	This information was obtained from another question

Are there meetings between the specialised rehabilitation team and residential staff? If so, how often are they held?	This question was changed to; 'Are there meetings between the multidisciplinary team and residential staff?	This information was deemed more important for this study
Are there meetings to discuss treatment and the resident's response to treatment?	This question was omitted.	This was covered in another question
Are there meetings open to residents to discuss the CRFs organisation and procedures? If yes, how often are they held?	This question remains unchanged	N/A
Are there meetings for relatives and families of each resident? If yes, how often are they held?	This question remains unchanged	N/A
Are there meetings where families of residents can attend together? If yes, how often are they held?	This question was changed to "are there scheduled meetings for relatives and families of each resident?"	N/A
Evaluation Process and Procedures		
Is an annual planning report compiled by the residential unit?	This question remained unchanged	N/A
Is there on evaluation plan underlining the CRFs quality services and controls? If yes please specify; Performance indicators monitoring system? Clinical evaluation of medical conditions examined by using designations evaluation tools? Surveillance of certain situations or problematic situations? Evaluating resident satisfaction? Evaluating residents family satisfaction? Integration evaluation within programs jointly coordinated with other services?	This question was abbreviated to; 'Is resident satisfaction with the CRF evaluated? Is the satisfaction of the residents' family with the CRF service evaluated'?	N/A
System Files and Regulation		
Are there guidelines or / and regulation in respect of dangerous situations staff may be dealing with?	This question remained unchanged.	N/A
Is there a Health and Safety policy in the workplace?	This question remained unchanged.	N/A
Is there an electronic fire alarm system in place?	This question remained unchanged.	N/A
Is there documentation on intervention programs offered by the CRF available for residents to consult?	This question was changed to 'Is there documentation on programs offered by the HSE / mental health service available for residents to consult'?	N/A

Is there a procedure to take into account residents and families feedback?	This question was omitted.	This information was obtained from another question
Is there an information protection act to safeguard confidentiality or/and a freedom of information act for administration staff when they may have to disclose information to her relative or a representative without prior patient consent?	This question was omitted.	Information was not deemed relevant for this study
Is an information pack given to residents on admission?	This question remained unchanged.	N/A
Are residents given information on emergency telephone numbers?	This question remained unchanged.	N/A
Are the emergency telephone numbers posted?	This question remained unchanged.	N/A
Are residents given information on rights?	This question remained unchanged.	N/A
Are residents provided with information on the complaints procedure?	This question remained unchanged.	N/A
Are residents told the name of the local complaints officer?	This question remained unchanged.	N/A
Are residents informed of the role and function of the Mental Health Commission?	This question remained unchanged.	N/A
Are notices concerning rights and complaints displayed on the walls?	This question remained unchanged.	N/A
Are residents asked if they wish to vote and assisted in voter registration and voting as necessary?	This question remained unchanged.	N/A
Are residents informed of national health initiatives such as breast screening and smoking cessation?	This questions remained unchanged.	N/A
Resident Characteristics		
Number of residents? Total Men 18 - 25, 26-35, 36-45, 46-55, 56-65, >65 Total Women 18 - 25, 26-35, 36-45, 46-55, 56-65, >65	This question remained unchanged.	N/A

No of residents that have been admitted since; <6 months, 6-12 months, 13-36 months, >36 months	This question remained unchanged.	N/A
Have any residents been discharged in the past 6 months?	This question was changed to; 'have any residents been discharged in the last 12 months'?	N/A
Please specify where residence went after discharge?	This question remained unchanged.	N/A
Have any residence been re-admitted after being discharged during the last year?	This question was omitted.	The ADON reported that no residents had been re-admitted since discharge
How many residents attended day center/Hospital? How many residents are in full-time sheltered employment? How many residents are in full-time supported paid employment? How many residents are in part-time supported paid employment in the community?	These questions were omitted.	This information was gathered from the residents questionnaire
Please complete the number of residents with a primary diagnosis of; Organic category? Schizophrenia? Other psychosis? Depressive disorders? Mania? Nuerosis? Personality disorder? Alcohol disorders? Drug dependence? Mental handicap?	This question was abbreviated to; Schizophrenia, Psychosis, Affective Disorders and Other Disorder.	All relevant information could be obtained from this revised question
Activities Does your service provide the following activities for residents? Organiser: Please Tick Nurse _ OT _ Social groups _ volunteers _ family _ Other (please specify)		
Vocational training	This question remained the same	N/A

Sheltered work	This question was omitted.	All residents either attended the day centres or the day hospital
Supported work in community	This question was omitted.	N/A
Cognitive behavioural therapies	This question remained the same	N/A
Practical living skills	Question was rephrased to activities of daily living	Rephrased into question re ADLs
Social skills	This question remained the same	N/A
Budgeting skills	Question was rephrased to activities of daily living	Rephrased into question re ADLs
Physical activities	This question remained the same	N/A
Family education / support counselling	This question remained the same	N/A
Leisure activities	This question remained the same	N/A
Other	This question was omitted.	Not relevant
Physiotherapy	This question was omitted.	Residents would need to be referred for physiotherapy

Appendix 7: Modified Version of Facility Questionnaire used in Current Study

Name of residence _____

Level of support
 High ()
 Medium ()
 Low ()

Is the building owned by:
 HSE () Voluntary () Private ()

Building Features
 Number of Bedrooms
 Single () double () triple ()
 Number of Bathrooms ()
 Number Living Rooms ()

Are there any rooms for staff use only
 (e.g. dressing room, bedroom, office, conference room, etc.) Yes () No ()
 Is there a designated visiting room (i.e. not TV room)? Yes () No ()
 Is the building suitable for those with mobility problems? Yes () No ()
 If no, what are the barriers? _____

Is there a public phone Yes () No ()
 Is there a smoking room / area? Yes () No ()
 If yes, is it Inside residence () Outside residence ()

ACCESS TO SERVICES
 Number of residents that have access to own transportation (e.g. car, bike) _____

Please enter number of individuals with particular form of transport in brackets
 Personal car () Bike () Motorcycle ()

Does the residence have minibus to transport residents? Yes () No ()
 Is the transport shared with other residence facility? Yes () No ()

Rules & Regulations
 Can residents lock bathroom facilities? Yes () No ()
 Are visiting hours scheduled? Yes () No ()
 Are residents required to go to bed at a given time? Yes () No ()
 Are residents required to be up at a given time?
 a) Weekdays Yes () No ()
 b) Weekends Yes () No ()
 When checking out - are residents required to notify staff where they go? Yes () No ()
 Are residents required to check in at a given time? Yes () No ()
 Can residents stay in their bedrooms during the day? Yes () No ()
 Can residents lock their bedrooms? Yes () No ()
 Are residents allowed to smoke in their bedrooms? Yes () No ()
 Can residents choose whom they share their bedrooms with? Yes () No ()

MEALS

Where do residents have their main meals during the week?

Residence ()
 Day Centre / Training Centre ()
 Restaurant ()

Where do residents have their main meals at weekends?

Residence ()
 Day Centre / Training Centre ()
 Restaurant ()

Who prepares the meals?

Residents ()
 Staff ()
 Residents and staff ()
 Kitchen staff ()

Can residents choose a daily menu? Yes () No ()
 Do residents purchase/ shop for the food unsupervised? Yes () No ()
 Do residents have unrestricted access to the kitchen? Yes () No ()

STAFF

How many nurses are there per scheduled shift? ()
 How many hours do hostel supervisors work per scheduled shift? ()
 How many hours do household staff work per scheduled shift? ()
 Do other staff visit this residence daily? Yes () No ()
 Do other staff visit this residence weekly? Yes () No ()

Do named core staff, staff this residence? Yes () No ()

Do staff rotate at set intervals? Yes () No ()
 If so, is it 6 Months () Yearly () 2 years ()

ADMISSION PROCEDURES

Is there a formal assessment referral procedure / form prior to admission? Yes () No ()
 Yes formally structured () Yes but not formally structured () No ()

Are there any designated;

Respite beds () Crisis beds () Bed for other uses ()

Is the residence ever used to accommodate transfers from the acute unit due to bed shortages?

Yes () No ()

How many places are there in the residence? ()

Which, if any, criteria are used as exclusion criteria?

Acute psychotic disorders	Yes ()	No ()	Substance abuse (history)	Yes ()	No ()
Severe physical conditions	Yes ()	No ()	Organic brain disorder	Yes ()	No ()
Intellectual disability	Yes ()	No ()	Risk of violent behaviours	Yes ()	No ()
Active Suicidal Ideation	Yes ()	No ()			
Former residents of forensic psychiatric hospital	Yes ()	No ()			

Is there a waiting list? Yes () No ()
If yes, Number of weeks () Number of applications ()

Which of the following decides on the placement, discharge or transfer of patients?
Individual's treating team Yes () No ()
Hostel management committee and individual's treating team? Yes () No ()
Other _____

Does each resident have an individual treatment plan with a clear aim? Yes () No ()

If yes, does the treatment plan include the following (please tick all appropriate boxes)
The specific medical treatment Yes () No ()
The responsibilities of each member of the treatment team yes () no ()
Adequate documentation to justify the diagnosis Yes () No ()
The treatment and rehabilitation activities carried out Yes () No ()
Are residents involved in drawing up their treatment / care plan? Yes () No ()

Are treatment plans reviewed by those responsible for the care of the resident? Yes () No ()

Is there an admission form to be signed by the resident or/and family members containing details on treatment goals? Yes () No ()

Is there a qualified professional assigned to each resident that one can refer to throughout treatment? Yes () No ()

MEETINGS

Are there meetings between the multidisciplinary team and residential staff? Yes () No ()
If so, how often are they held? Weekly () 1 – 3 months () 3 – 6 months () Other ()

Are there meetings open to residents to discuss the hostel's organisation and procedures? Yes () No ()
If yes, how often are they held? Weekly () 1- 3 months () 3 – 6 months () Other ()

Are there scheduled meetings for relatives and families of each resident? Yes () No ()
If yes how often are they held? Weekly () 1 – 3 months () 3 – 6 months () Other ()

EVALUATION PROCESS and PROCEDURES

Is an annual planning report compiled by the residential unit? Yes () No ()
Is resident satisfaction with the hostel service evaluated? Yes () No ()
Is the satisfaction of the residents' family with the hostel service evaluated? Yes () No ()

SYSTEM FILES and REGULATION

Are there guidelines or/and regulations in respect of dangerous situations staff may be dealing with, i.e. aggressive behaviour; harassment; etc.? Yes () No ()
Is there Health and Safety Policy in the workplace held in this particular residence? Yes () No ()
Is there an electronic fire alarm system in place? Yes () No ()

Is there documentation on programmes offered by the HSE / mental health service available for residents to consult? Yes () No ()

Is an information pack given to residents on admission (residence rules and

regulations of residence, policies and procedures booklet)? Yes () No ()
 Are residents given information on emergency telephone numbers? Yes () No ()
 Are the emergency telephone numbers posted? Yes () No ()
 Are residents given information on their rights? Yes () No ()
 Are residents provided with information on the complaints procedure? Yes () No ()
 Are residents told the name of the local complaints officer? Yes () No ()
 Are residents informed of the Mental Health Commission (including role and function in mental health services)? Yes () No ()
 Are notices concerning rights and complaints displayed on the walls? Yes () No ()
 Are residents asked if they wish to vote, and assisted in voter registration and voting, as necessary Yes () No ()
 Are residents informed of national health initiatives (e.g. cancer screening, health screening, smoking cessation) Yes () No ()
 If so, what information is provided (please specify) _____

Number of residents that have been admitted since...

< 6 months ()
 6-12 months ()
 13-36 months ()
 > 36 months ()

Have any residents been discharged in the last 12 months? Yes () No ()

Please specify where residents (number) went after discharge:

Other health unit with higher support ()
 Other health unit with same level support ()
 Other health unit with lower support ()
 Hospice ()
 Family ()
 Home ()
 Other, please specify.....

Please complete the number of residents with a primary diagnosis of:

Schizophrenia / Psychosis []
 Affective disorders []
 Other disorder []

Resident Characteristics

Total Men - 18-25 () 26-35 () 36-45 () 46-55 () 56-65 () <65 ()
 Total Women - 18-25 () 26-35 () 36-45 () 46-55 () 56-65 () <65 ()

Are the following services provided to residents living in the hostel? (you can tick more than one box if you wish)

Vocational training i.e. facilitation with seeking employment / voluntary work?

Yes [] No []
 If yes who facilitates the service? Nurse [] OT [] Social work [] Other _____

Cognitive behaviour therapies Yes [] No []
 If yes who facilitates the service? Nurse [] OT [] Social work [] Other _____

Activities of daily living skills i.e. self care, shopping, cooking, budgeting? Yes [] No []
 If yes who facilitates the service? Nurse [] OT [] Social work [] Other _____

Family education Yes [] No []

If yes who facilitates the service? Nurse OT Social work Other _____

Leisure activities Yes No
If yes who facilitates the service? Nurse OT Social work Other _____

Physical activities Yes No
If yes who facilitates the service? Nurse OT Social work Other _____

Social skills training and promote participation in social events within the community?
Yes No
If yes who facilitates the service? Nurse OT Social work Other _____

Facilitate re-housing yes No
If yes who facilitates the service? Nurse OT Social work Other _____

Appendix 8: Residents Questionnaire Modifications

Questions used in the original study	Modified or Omitted Questions in this study	Reasons for Modifications or Omissions
Site __ Resident ID number__ Gender Male __ Female__	Address - "Site" was replaced with "accommodation type"	This was more beneficial to the study
What is your present address?	Omitted	This was omitted for confidentiality reasons
How long have you lived here?	This question was omitted	This question was moved further down so it could be linked to other questions regarding accommodation
What age are you?	This question remain the same	N/A
Marital status: Single_ Married/Cohabiting_ Separated/Divorced_ Widowed_	Cohabiting was removed	None of the residents were currently living with their partners
Education: Some primary_ Completed primary_ Some secondary_ Completed secondary_ Some post secretary_ Certificate/diploma_ One or more university degrees_ Other_	The option "some post-secondary" was removed The option "one or more university degrees" was removed	This information could be collected under "other"
Current employment status: Employed full-time_ Employed part-time_ Unemployed_ Homemaker_ Study_ Retired Sheltered employment_ Training_ Other_	Sheltered employment was omitted Options such as 'study' and 'training' were omitted and replaced with 'student'. Employment options such as 'homemaker' and 'retired' were omitted and replaced with 'training centre' and 'day centre'	The service does not provide sheltered employment. These options were clinically relevant to this service and the researcher was looking for a tight and narrow focus of their experience inside the service.
This question was added _____ _____>	Are you happy with your current employment status?	This question was added in as the researcher felt this was important from a recovery perspective
Occupation_ (if unemployed or retired what was previous occupation)	This question remained the same	N/A

Do you wish to stay in your current accommodation?	This question remained the same	N/A
If you had a choice where would you like to live?	This question remained the same	N/A
Community integration		
Do you attend any of the following activities in the community? Social clubs_ Bingo_ Community centers_ Pubs/clubs/restaurants_ Leisure centers _ Library_ Cinema_ Religious worship_ Other please specify_	This question remained the same	N/A
Financial independence		
Do you know how much money you receive per week? Do you receive help with your finances? Do you vote? Do you visit your GP by yourself? Do you go out on your own?	These questions remained the same	N/A
Harassment		
Have you ever experienced harassment in the community (verbal abuse, physical abuse) If yes, Is the harassment continuing? Yes_No_Occasionally_	This question remained the same If yes, 'please describe' was added in	This question was added to gain more specific details on the individuals experience of harassment.
Did you experience any of the following feelings? Adverse effects on mental health_ anger and annoyance_ fear_	This question was omitted from this study	The previous question asked residence to describe their experience of harassment.
Treatment and Care Answer options: Yes_ Not_ Not sure_		
I know what my care plan is. I was involved in drawing up my care plan My care-plan has been explained to me I know what my medication is for I know about the possible side effects of my medication	These questions remained the same	N/A

I know when my care plan is going to be reviewed	This a question remained the same	
The term ‘key worker ‘has been explained to me I know the name of my key worker My key worker has explained to me their view of my problems My key worker is helping me to cope with my mental health problems If I have a problem, I can easily contact my key worker My key worker helps me with practical problems I can easily talk about my personal problems with my key worker My key worker lets my GP know how I am getting on I can always rely on my key worker to show up at arrange times My key worker helps make sure I keep my appointment with the psychiatrist My key worker makes sure I am alright if I don't turn up for an appointment	All of these questions were omitted	The service does not have key workers
My psychiatrist has explained my problems to me I can easily talk about my personal problems with my psychiatrist My psychiatrist is helping me with my mental health problems	Diagnosis was replaced with “problems” Personal problems were changed to ‘difficulties’ This question was omitted	N/A
My psychiatrist keeps me informed about my progress	This question remained the same	N/A
This question was added —>	I am aware of the role of each member of the multidisciplinary team	This question was added in as the researcher wanted to ascertain their understanding of the different professionals they encounter; this is important information from a recovery perspective

<p>How happy are you with the treatment and care you have received?</p> <p>Answer options: Very happy_ Quite happy_ Not very happy_ Not at all happy</p>	<p>This question remained the same</p>	<p>N/A</p>
<p>How much information have you received on your problems?</p> <p>Answer options: None_ A little_ Would like more_ Enough_</p>	<p>'Problems' was changed to 'diagnosis'</p>	<p>N/A</p>
<p>Perceptions of life in the Residence</p> <p>Answer options: Not good at all_ Good sometimes_ Good most of the times_ Great_</p>		<p>N</p>
<p>How good do you think it is to live here in this house?</p> <p>How good is the atmosphere around this house?</p> <p>How well did the people who live here get home with each other?</p> <p>How well do the people who live here get on with stuff?</p> <p>Do you ever feel bored during the weekdays or evenings?</p> <p>Do you ever feel bored as weekends?</p> <p>How much say do you have in the day-to- day today running of the house?</p> <p>How happy are you with your involvement in the running of the house?</p> <p>How much input do you have with regard to your treatment?</p> <p>How much control do you feel you have to lead your own life if you want?</p> <p>How happy are you with your level of independence?</p> <p>How happy are you with your involvement in the community?</p>	<p>These questions remained the same</p>	<p>N/A</p>

<p>Satisfaction for life Domains Scale -Quality of life</p> <p>Answer options: Mostly Dissatisfied_ Mixed- about equally satisfied and dissatisfied_ Mostly Satisfied_</p>		
<p>The place you live? The area they live in? Your food? Your health? People you live with? Your friends? Your love life? Relationship with your family? The way you get along with others? The way people in the community treat you? Your activities? The way you use your leisure time? What you do outside for your leisure? Services and facilities in your area? Your finances? Your drug treatment? Your life in general?</p>	<p>These questions remained the same</p>	<p>N/A</p>
<p>Disability Assessment Schedule (WHO)</p>	<p>These questions remained the same</p>	<p>N/A</p>
<p>Mannheim Interview On Social Support</p>	<p>These questions remained the same</p>	<p>N/A</p>
<p>Brief Psychiatric Rating Scale</p>	<p>These questions remained the same</p>	<p>N/A</p>
<p>Opened Ended Questions</p>		
<p>What are the best bits about living here? What are the worst bits about living here? What would improve living here? Where do you see yourself living in the future? What are your hopes for the future?</p>	<p>These questions remained the same</p>	<p>N/A</p>
<p>This question was added in — —></p>	<p>What difficulties do you think you might have with living independently?</p>	<p>This question was explored further in the focus group as a way of exploring how well the service equipped residents for discharge</p>

*Appendix 9: Modified Version of Residents Questionnaire used in
Current Study*

Residents questionnaire Patient ID No: _____

Accommodation Type: _____ Gender: Male () Female ()

What age are you? _____

Marital status: Single () Married ()
Separated / Divorced () Widowed ()

Education: Some primary () Completed primary ()
Some secondary () Completed secondary ()
Certificate / Diploma ()
Other _____

Current employment status: Employed full-time () Employed part-time ()
Unemployed () Student ()
Training centre () Day Centre ()
Other _____

Are you happy with your current employment status? Yes ___ No ___

Occupation (if unemployed or retired, what was previous occupation); _____

How long have you lived here? _____

Do you want to stay in your current accommodation? Yes ___ No ___

If you had a choice, where would you like to live? _____

Do you attend any of the following activities in the community?

Social clubs	Yes ___	No ___
Bingo	Yes ___	No ___
Community centres	Yes ___	No ___
Pubs / clubs / restaurants	Yes ___	No ___
Leisure centres	Yes ___	No ___
Library	Yes ___	No ___
Cinema	Yes ___	No ___
Religious worship	Yes ___	No ___

Do you know how much money you receive per week? Yes ___ No ___

Do you receive help with your finances? Yes ___ No ___

Do you vote? Yes ___ No ___

Do you visit the GP by yourself? Yes ___ No ___

Do you go out on your own? Yes ___ No ___

Have you ever experienced harassment
in the community (verbal abuse, physical abuse) Yes ___ No ___

If yes please describe; _____

If yes, is the harassment continuing?

Yes _____

No _____

Occasionally _____

YOUR TREATMENT AND CARE

Below are some statements about how you are getting on with psychiatrist and key worker and if you have all the information you need about your treatment and care. From these questions we will be able to gain an idea of how satisfied residents are with the care they receive. Your comments on this questionnaire and all others will be treated in the utmost confidence.

	Yes	No	Not sure
I know what my care plan is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was involved in drawing up my care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My care plan has been explained to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when my care plan is going to be reviewed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what my medication is for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know about the possible side effects of my medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My psychiatrist has explained my diagnosis to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can easily talk about my difficulties with my psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My psychiatrist keeps me informed about my progress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am aware of the role of each member of the multidisciplinary team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These are more general questions (read out responses and tick appropriate one)

How happy are you with the treatment and care you have received?

Very happy Quite happy Not very happy Not at all happy

How much information have you received on your diagnosis?

None A little Would like more Enough

PERCEPTIONS OF LIFE IN THE RESIDENCE

The following are a list of questions regarding various aspects of life in this house. When answering the question please think of how you feel generally. I will read you a number of options and you tell me how you usually feel (**show flashcard 1**).

How good do you think it is to live here in this house?

1 - Not good at all 2 - good sometimes 3 - good most of the time 4 - Great

How good is the atmosphere around the house?

1 - Not good at all 2 - good sometimes 3 - good most of the time 4 - Great

How well do the people who live here get on with each other?

1 - Not at all well 2 - well sometimes 3 - well most of the time 4 -Extremely well

How well do the people who live here get on with the staff?

1 - Not at all well 2 - well sometimes 3 - well most of the time 4 -Extremely well

Do you ever feel bored during the weekdays or evenings?

1 - All of the time 2 - sometimes 3 - most of the time 4 - Never

Do you ever feel bored at weekends?

1 - All of the time 2 - sometimes 3 - most of the time 4 - Never

How much say do you have in the day-to-day running of the house?

1 - None 2 - little 3 - moderate 4 - A lot

How happy are you with your involvement in the running of the house?

1 - Not at all happy 2 - slightly happy 3 - happy most of the time 4 -Very happy

How much input do you have with regard to your treatment?

1 - None at all 2 - little input 3 - moderate amount 4 - A lot of input

How much control do you feel you have to lead your own life as you want?

1 - None at all 2 - little control 3 - moderate control 4 - A lot

How happy are you with your level of independence?

1 - Not at all happy 2 - slightly happy 3 - happy most of the time 4 -Very happy

How happy are you with your involvement in the community?

1 - Not at all happy 2 - slightly happy 3 - happy most of the time 4 -Very happy

Satisfaction for Life Domains Scale - Quality of Life

The following questionnaire is designed to gather information on how satisfied you are with specific aspects of your life. You are to answer these questions using one of these answers (**show flashcard 2**) – mostly not satisfied, mixed feelings – about equally satisfied and not satisfied, mostly satisfied. Are you ready?

How do you feel about:

	Mostly dissatisfied	Mixed – about equally satisfied and dissatisfied	Mostly satisfied
The place you live?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The area you live in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People you live with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your love life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Relationship with your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way you get along with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way people in the community treat you?_	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way you use your leisure time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you do outside for your leisure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services and facilities in your area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your finances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your drug treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your life in general?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DISABILITY ASSESSMENT SCHEDULE (WHO DAS II)

This interview is about difficulties people have because of health conditions. (**show flashcard 3**). By health conditions I mean diseases or illnesses, other health problems that may be short or long lasting injuries, mental or emotional problems and problems with alcohol or drugs. Keep all your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about Increased effort, discomfort or pain, slowness or changes in the way you do the activity (**point to flashcard 3**). Think over the past 30 days when answering the questions and respond using the following scale (**show flashcard 4**).

In the last 30 days, how much difficulty did you have in:

Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme / cannot do
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme / cannot do
Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme / cannot do
How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme / cannot do
How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme / cannot do
Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme / cannot do
Walking a long distance such as a mile?	None	Mild	Moderate	Severe	Extreme / cannot do
Washing your whole body?	None	Mild	Moderate	Severe	Extreme / cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme / cannot do
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme / cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme / cannot do
Your day to day work / training?	None	Mild	Moderate	Severe	Extreme / cannot do

MANNHEIM INTERVIEW ON SOCIAL SUPPORT

The following are some questions about family and friends that you have in certain situations.

SECTION A. Everyday Psychological Support:

Whom do you like to do things with?

For example, go for a walk, go for a drink, play sport

With whom do you like to talk about things that interests you, such as everyday events, TV, family and son on?

Nursing/care staff Other residents Family/ friends outside hostel

SECTION B. Everyday Instrumental Support:

If you had to asked someone a small favour, for example to lend you something, to help out with small household repairs or do some shopping for you, whom could you turn to?

Nursing/care staff Other residents Family/ friends outside hostel

SECTION C. Instrumental Crisis Support:

If you had to make a very important personal decision, for example about moving to another house. With whom could you discuss your decision with?

Nursing/care staff Other residents Family/ friends outside hostel

SECTION D. Psychological Crisis Support:

Imagine a very close friend or relative is about to die or has died and you just need to talk about it to someone. Whom could you turn to?

Nursing/care staff Other residents Family/ friends outside hostel

Brief Psychiatric Rating Scale

Instructions: This form consists of 24 symptom constructs, each to be rated on a 7-point scale of severity ranging from not present to extremely severe. If a specific symptom is not rated, mark NA (not assessed). Circle the number headed by the term that best describes the patient's present condition. **The time frame for the interview questions is 2 weeks. The time frame for the observational questions is the interview period only.** Say to participant; I am going to ask you some questions to do with symptoms, that we ask everyone. When answering the questions, please think of your experiences over the over the last 2 weeks.

NA Not Assessed	1 Not present	2 mild	3 Very	4 Mild	5 Moderate Severe	6 Moderately Severe	7 Extremely Severe	
Somatic concern	NA	1	2	3	4	5	6	7
Anxiety	NA	1	2	3	4	5	6	7
Depression	NA	1	2	3	4	5	6	7
Guilt	NA	1	2	3	4	5	6	7
Hostility	NA	1	2	3	4	5	6	7
Suspiciousness	NA	1	2	3	4	5	6	7
Unusual thought content	NA	1	2	3	4	5	6	7
Grandiosity	NA	1	2	3	4	5	6	7
Hallucinations	NA	1	2	3	4	5	6	7
Disorientation	NA	1	2	3	4	5	6	7
Conceptual disorganization	NA	1	2	3	4	5	6	7
Excitement	NA	1	2	3	4	5	6	7
Motor Retardation	NA	1	2	3	4	5	6	7
Blunted Effect	NA	1	2	3	4	5	6	7
Tension	NA	1	2	3	4	5	6	7
Mannerisms & posturing	NA	1	2	3	4	5	6	7
Uncooperativeness	NA	1	2	3	4	5	6	7
Emotionally withdrawn	NA	1	2	3	4	5	6	7
Suicidality	NA	1	2	3	4	5	6	7
Self-neglect	NA	1	2	3	4	5	6	7
Bizarre behaviour	NA	1	2	3	4	5	6	7
Elated mood	NA	1	2	3	4	5	6	7
Motor hyperactivity	NA	1	2	3	4	5	6	7
Distractibility	NA	1	2	3	4	5	6	7

Can you tell me a bit about what it is like to live here?

What are the best bits about living here? _____

What are the worst bits about living here? _____

What would improve living here? _____

Where do you see yourself living in the future? _____

What are your hopes for the future? _____

What difficulties do you think you might have with living independently? _____

Appendix 10: Community Nurse Questionnaire Modifications

Questions used in Original Questionnaire	Modified or Omitted Questions in this study	Reasons for Modifications / Omissions
Former place of the residence immediately prior to admission to current residence: Home Medium support facility Psychiatric hospital Acute psychiatric unit No fixed dwelling High support facility Low support facility Central Psychiatric hospital Prison	All questions were omitted	The majority of residents came from the acute Psychiatric Unit
If answer 'Home' who was the person living with? Alone Partner and children Parents Friends Spouse / partner Children Other relatives	All questions were omitted	N/A
Income		
Disability pension Other Salary Specify	All questions were omitted	All residents were in receipt of a disability payment
Psychiatric History		
Date accepted / transferred to residence _____ Approximate duration of illness in years _____ Age of first contact with psychiatric services _____ Previous in-patient hospitalisation _____ Inpatient hospitalisation while a resident _____ Reason of last in-patient admission _____ Number of in-patient admissions in the past 5 years _____ Degree of symptoms in the past 5 years _____	All questions were omitted	This information was not relevant to the research question
Types of Symptoms in the last 5 years		

*Appendix 11: Modified Version of Community Nurse Questionnaire used
in Current Study*

Community Nurse Questionnaire

Patient ID _____

Appropriate placement

In your opinion, is the resident appropriately placed in this residential facility

Yes () No ()

If no, where do you think the resident would be more appropriately placed:

Low support home:

Medium support home:

High support home:

Rehabilitation unit:

Nursing home:

If the resident is inappropriately placed, what do you see are the barriers towards appropriate placement?

Mental state or behaviour precludes discharge / transfer

Resident refuses transfer

Relatives refuse transfer

Facility unavailable

Facility available, but will not accept

Facility available, but has waiting list

Other reason, please specify _____

Where do you see the resident living in six months time?

In the same residential facility?

In a higher support facility?

In a lower support facility?

In an independent setting?

With the family?

Nursing home?

Other?

Disability Assessment Schedule (WHO DAS II)

This questionnaire asks about difficulties due to health conditions. Health conditions include disease or illness, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the last 30 days and answer these questions thinking about how much difficulty the individual had doing the following activities. Difficulties refer to increased effort, discomfort or pain, slowness or changes in the way they do something. For each question, please circle only one response.

In the last 30 days, how much difficulty did this individual have in:

Standing for long periods such as 30 minutes?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Taking care of his / her household responsibilities?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Learning a new task, for example, learning how to get to a new place?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
How much of a problem did he / she have in joining in community <u>activities</u> (for example, festivities, religious or other activities) in the same way as anyone else can?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
How much has he /she been emotionally affected by his / her health problems?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Concentrating on doing something for ten minutes?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Walking a long distance such as a mile?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Washing his / her whole body?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Getting dressed?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Dealing with people he / she does not know?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
Maintaining a friendship?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do
His / her <u>day to day</u> work / training?	<u>None</u> <u>Mild</u>	Moderate	Severe	Extreme / cannot do

Appendix 12: Framework for Focus Groups

Group Facilitators: Lisa Maloney and Mary Geraghty

Introduction

I would like to start by thanking all of you for agreeing to participate in this focus group. The focus group is the second and final part of the study called "A Voice In My Own Home. A survey and evaluation of community residential mental health facilities in Galway city." The first part involved a one-to-one interview with myself where residents answered questions from a questionnaire.

The main aim of the study is to find out how satisfied residents are living in the hostels and how happy they are with the treatment and care they receive. This information will help to improve the service we provide to residents living in the hostels.

You are welcome to help yourself to the tea, coffee and cake provided for the group.

Confidentiality

All information provided by residents will be completely anonymous i.e. any information you give us will never be linked to your name. The information provided to us today will be written in a report however, there will be no way of linking people's names to their individual comments.

Consent for Taping

We would be very grateful if everyone would allow us to tape record today's discussion so that we can accurately interpret the information you provide us with.

Ground Rules

We ask that you do not talk about topics discussed within the focus group to staff or other residents who did not take part in the group.

You do not have to stay until the group is finished; you are free to leave at any stage.

You are not under any obligation to speak or participate in any way.

Your participation in the group will not affect your treatment and care in any way

Group Introductions

We will start by getting everybody to introduce themselves by saying their name and favourite food?

Section 1

Personal experiences of living in the CRF?

1. What do you think the community Residential Facility (CRF) should be called?
2. Why do you think you need to live in a CRF?
3. What is the role of the CRF? (? Rehabilitation)
4. Do you think residents should be allowed to live in the CRF permanently if they wish or do you think it should be a temporary living arrangement?
5. How would you feel if you were asked today to move out in 6 months' time?
6. Where do you see yourself living in 5 years' time?
7. What can staff do to help prepare you to move out of the CRF and live independently / alone / with family / friends etc.
8. How do you see the role of the CRF supervisors?
9. Do you think CRF supervisors should work more or less hours every day?
10. Do you think nursing staff and other staff should call more or less often?
11. What makes you feel comfortable about inviting friends and family to visit you in the CRF?
12. What makes you feel uncomfortable about inviting friends and family to visit?
13. How do you think you would feel about residents having their boyfriend / girlfriend / husband / wife stay overnight in the CRF occasionally?
14. Would you like to get to know your neighbours?
15. What is the best way to get to know your neighbours?

16. Is there anything else you would like to say about living in the CRF before we move to the next section? Food / Cooking / Rules /

Section 2

Personal experiences of living with a mental disorder?

1. How do you feel your illness has affected your life?
2. Are there any positive aspects to having a mental disorder?
3. Do people treat you differently because you have a mental disorder?
4. If so, how do they treat you differently?
5. What ideas do residents have on how to reduce stigma in the community around mental disorders?
6. Do you feel that your families have a good understanding of your disorder?
7. What kind of information should families be given that would help them to have a better understanding of mental disorder?
8. How do you feel about having to take medication?
9. What are the positives about taking medication?
10. What are the negatives about taking medication?
11. What have you heard about the recovery model?
12. What does recovery mean for you?
13. What can staff do to help you in your recovery?
14. Most of the residents in the CRF said they were unhappy with their love life (quantitative section), why do you think residents are unhappy with their love life?
15. Do you think residents get enough opportunities to socialise?
16. Is there anything else you would like to say before we move to the next section?

Section 3

What in your opinion helps to keep you well?

- Living in the CRF?
- Medication?
- Staff?
- Family/ friends?
- Religion?
- Social activities / groups?
- Physical activities/exercise?
- Have something to do everyday? Work / college / training centre / day centre/ voluntary work etc.
- Talking about things that are bothering you with someone?
- Drinking alcohol?
- Diet?
- Sleep?
- Financial independence

We have come to the end of the group, is there anything else anyone would like to say?

Appendix 13: Permission to use the Satisfaction for Life Domains Scale

Hi Lisa,

Yes you can use the other version. But, I wanted to let you know that we used a 20 items version which was validated. You can find the validation study in a journal called *Santé Mentale au Québec* by Caron J, Tempier R et al.

Also, I just want to let you know that I did upgrade this QOL instrument, SLDS in adding different items and adding an expectation scale. I called this instrument the Montreal Life Satisfaction Scale or MLSS to reflect better the priorities of patients with long term disorders such as schizophrenia living in the community. If you are interested, I could send you a copy and you could also do a validation work as for now, there is no publication on the validation of the MLSS.

Regards.

Pr Raymond Tempier MD, MSc, FRCPC, FCPA
Professor of Psychiatry, College of Medicine, University of Saskatchewan
Director of Continuous Professional Development
World Psychiatric Association Zone 1 (Canada) Representative
Subject: Satisfaction For Life Domains Scale

Appendix 14: Permission to use the BPRS

Dear Ms. Maloney:

Under the following conditions, we are pleased to grant permission to use the scale from the following article, in your master's dissertation at National University of Ireland. However, this is not permission to republish the Brief Psychiatric Rating Scale. Please write if you have any further questions that might be related to copyright. The citation must appear at the top of the reproduced copy and must read:

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Overall, J. E., & Gorham, D. R. The Brief Psychiatric Rating Scale.
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Sincerely,



S. A. Isbell, Ph.D
Editor

SAI:slp

Enclosure

cc: Dr. John E. Overall
Department of Psychiatry and Behavioral Science
University of Texas Mental Science Institute
1300 Moursund, Room 211
Houston, TX 77030

Appendix 15: Mannheim Interview on Social Support (Permission)

From: Lisa Maloney <lisamaloney4@gmail.com>

Subject: Re: Looking for contact details for DR. H.O.F. Veiel

To: Ray Koopman <koopman@sfu.ca>

Sounds good!!
Thanks for your help
Lisa

On Wed, Apr 13, 2011 at 7:46 PM, Ray Koopman <koopman@sfu.ca> wrote:

I have lost touch with Dr. Veiel. My last communication with him was in September 2001, via email at <hofv@interchange.ubc.ca>. In October 2001, and several times since then, I have received no replies to messages sent to that address. In January 2007 I heard third-hand that he had resigned from the College of Psychologists, bought a boat, and left to sail around the world. Sorry, but that's all I know.

----- Lisa Maloney <lisamaloney4@gmail.com> wrote:

> Dear Raymond

>

> I am trying to find an email address for Dr. H.O.F Veiel and came across
> your name on the internet connected to a study you did with him in 2001.
> If you have any contact details for him I would appreciate it if you could
> forward them to me.

>

> I just need to contact him to ask permission to use the Mannheim Interview
> on Social Support.

>

> Thank you

> Lisa Maloney

Appendix 16: Permission to use WHO DAS 11

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Washington, DC 20024
etuquabo@psych.org

Appendix 17: Quantitative Results – Facility Questionnaire

Rules & Regulations			
	High	Medium	Low
Can residents lock their bathroom doors	No - 1 (100%)	Yes - 2 (100%)	No - 1 (12.5%) Yes - 7 (87.5%)
Can residents lock their bedroom doors	No - 1 (100%)	Yes - 2 (100%)	No - 1 (12.5%) Yes - 7 (87.5%)
Are there restrictions on going to bed and getting up at certain times	Yes - 1 (100%) (weekdays only)	Yes - 2 (100%) (weekdays only)	No - 8 (100%)
Are residents required to notify staff of their comings and goings	Yes - 1 (100%) Residents had to check in at a given time	No - 2 (100%) Residents in 1 CRF had to check in at a given time	No - 8 (100%) Residents in 1 CRF had to check in at a given time
Are residents given an information pack on admission	Yes - 1 (100%)	Yes - 1 (50%) No - 1 (50%)	Yes - 7 (87.5%) No - 1 (12.5%)
Do residents have full access to the kitchen	Yes - 1 (100%)	Yes - 1 (50%) No - 1 (50%)	Yes - 7 (87.5%) No - 1 (12.5%)
Are residents allowed to smoke in their bedrooms	No - 1 (100%)	No - 2 (100%)	No - 7 Yes - 1

Table i outlines the rules and regulations in CRFs

Independence with Meal Preparation			
	X=no √=yes		
Independence with Meal Preparation	High - 1 CRF	Medium - 2 CRFs	Low - 8 CRFs
Meals are prepared by residents	X	X	√ (5)
Meals are prepared by staff	X	X	√ x 1
Meals are prepared by residents and staff	√	√ x 2	√ x 2
Do residents have an option to choose a daily menu	X	x (1) √ (1)	x (1) √ (7)

Table ii outlining independence with meals

Wait Times, Admission & Discharge Details			
	High	Medium	Low
Waiting List	√	2 = √	1=√ 7=X
Wait Time	25 weeks	4 weeks - 1 8 weeks - 1	1 - 20 weeks 7 - no waiting list
Resident Admission Numbers for past 6 months	3 admissions	No admissions in either CRF	7 = no admissions 1 - 1 admission
Resident Admission Numbers for past 12 months	1 admission	No admissions in either CRF	6 = no admission 2 = 1 admissions

Table iii outlining admissions and discharges

Treatment & Care			
	High	Medium	Low
Do residents have a treatment plan with a clear aim	1 = √	2 = √	1 = 8 √
Do treatment plans document specific medical treatment	1 = √	2 = X	8 = X
Are residents involved in drawing up their care plans	1 = √	2 = √	4 = X 4 = √
Do residents receive an admission form detailing treatment goals	1 = √	2 = X	8 = X
Do residents have a qualified professional assigned to them for the duration of their stay	1 = √	2 = √	8 = √

Table iv outlines key information reported by staff on the treatment and care of residents

Activities Offered by the Mental Health Services			
Activities offered by the HSE	High	Medium	Low
Vocational Rehabilitation	1 = √	2 = √	8 = √
Cognitive Behavioural Therapy	1 = X	2 = √	1 = X 7 = √
Activities of Daily Living	1 = √	2 = √	8 = √
Leisure activities	1 - √	2 = √	8 = √
Physical Activities	1 = √	2 = X	1 = √ 7 = X
Social skills training	1 = √	2 = X	1 = √ 7 = X
Family Education	1 = X	2 = X	8 = X
Re-housing	1 = √	2 = √	8 = √

Table v outlines all activities offered by the mental health services.

Hours Worked by CRF Supervisors	
Level of Support	Number of Hours
High Support	No supervisors (only Nurses) - household staff worked 9 hours per week
Medium Support - 1	70 hours per week
Medium Support - 2	70 hours per week
Low Support - 1	3 hours per week
Low Support - 2	3 hours per week
Low Support - 3	5 hours per week
Low Support - 4	15 hours per week
Low Support - 5	25 hours per week
Low Support - 6	No supervisors
Low Support - 7	No supervisors
Low Support - 8	No supervisors

Table vi highlighting hours worked by CRF supervisors

Diagnosis			
	High	Medium	Low
Primary diagnosis of schizophrenia	6	11	30
Primary diagnosis of affective disorders			3
Other Disorder	1	1	1

Table vii outlines the diagnosis of all 53 residents who resided in CRF accommodation

Exclusion Criteria KEY CODE: √ = YES X= NO			
	High	Medium	Low
Psychotic Disorders	X	2 = √	1 = X 7 = √
Risk of Violent Behaviours			
Organic Brain Disorders	√	√	√
Active Suicidal Ideation	√	√	√
Former Residents of Psychiatric Hospitals	X	X	X
Substance Misuse	X	X	X
Severe Physical Conditions	X	X	X
Intellectual Disabilities	X	X	X

Table viii outlining exclusion criteria for the study

Wait Times, Admission & Discharge Details			
	High	Medium	Low
Waiting List	√	2 = √	1=√ 7=X
Wait Time	25 weeks	4 weeks - 1 8 weeks - 1	1 - 20 weeks 7 - no waiting list
Resident Admission Numbers for past 6 months	3 admissions	No admissions in either CRF	7 = no admissions 1 - 1 admission
Resident Admission Numbers for past 12 months	1 admission	No admissions in either CRF	6 = no admission 2 = 1 admissions
Resident Discharge Numbers for the past 12 months	3 discharges lower support CRF	No discharges in either CRF	6 = no discharges 1=1 discharge to nursing home 1= 1discharge to higher support unit

Table ix outlines admission and discharge details

Appendix 18: Quantitative Results – Residents Questionnaire

Demographic Details of Residents (who participated in the study)	
Number of Residents	46
Gender	Male 28 (61%) Female 18 (39%)
Diagnosis	46 residents had a diagnosis of schizophrenia / psychosis
Age of Residents	18-30 n=7 31-60 n=32 Over 60 n=7
Marital Status	Single N=40 Separated/Divorced N=5 Married N=1
Education	Some Primary; n= 2 (4%) Some secondary; n= 22 (48%) Completed Secondary; n=14 (30%) Cert / Diploma; n= 4 (9%) Degree; n=2 (4%)
Employment Status	Employed; n=4 Unemployed; n=3 Student; n=5 Day Centre; n=12 Training Centre; n=19 Retired; n=3

Table i outlines resident demographic data

Brief Psychiatry Rating Scale

Brief Psychiatric Rating Scale (BPRS) - Symptom Constructs					
Somatic Concern	Anxiety	Depression	Guilt	Hostility	Suspiciousness
Unusual Thought Content	Grandiosity	Hallucinations	Disorientation	Conceptual Disorganisation (of thought)	Excitement
Motor Retardation	Blunted Effect	Tension	Mannerisms & Posturing	Uncooperativeness	Emotionally withdrawn
Suicidality	Self-neglect	Bizarre Behaviour	Elated behaviour	Motor Hyperactivity	Distractibility

Table ii outlines symptom constructs of the BPRS

Time in Current Accommodation				
	Less than 1 year	1-5 years	6-10 years	Over 10 years
High Support n=4	2	1	1	0
Medium Support n=11	6 (67%)	5 (21%)	0	0
Low Support n=31	1	18 (75%)	7 (88%)	5 (100)
Total Number of Residents	9 (20%)	24 (52%)	8 (17%)	5 (11%)

Satisfaction with Accommodation

Satisfaction with Accommodation	
Areas Assessed	Residents Responses
Satisfaction with Accommodation	Mostly Satisfied - 35 (76%) Mostly Dissatisfied - 3 (6.5%) Equally Satisfied & Dissatisfied - 8 (17%)
Satisfaction with the place you live	Mostly Satisfied - 35 (76%) Mostly Dissatisfied - 3 (6.5%) Equally Satisfied & Dissatisfied - 8 (17%)
Satisfaction with People you Live with	Mostly Satisfied - 36 (78%) Mostly Dissatisfied - 1 (2%) Equally Satisfied & Dissatisfied - 9 (20%)

Table iii outlines resident satisfaction with accommodation

Community Activities

Attendance at Community Activities	
Pubs, Clubs & Restaurants	N=30 (65%)
Religious worship	N=31 (67%)
Cinema	N=26 (56%)
Library	N=8 (17%)
Leisure Centres	N=8 (17%)
Social clubs, bingo	N=0 (0%)

Table iv: common community activities attended by residents

Independence

Independence			
Independence	Do you go out on your own	Do you visit your GP independently	How happy are you with your level of independence
	Yes - n=45 (98%) No - n=1 (2%)	Yes - n=41(89%) No - n=5 (11%)	n=23 (50%); Happy most of the time n=12 (26%); Slightly happy n=11 (24%); Very happy
Finances	Do you know how much money you receive per week	Do you receive help with your finances	How satisfied are you with your finances
	Yes - n=40 (87%) No - n=6 (13%)	Yes - n=5 (11%) No - n=41 (89%)	Mostly satisfied - n=29 (63%) Mostly dissatisfied n=11 (24%) Equally satisfied and dissatisfied n=6 (13%)
Voting	Do you vote	N/A	N/A
	Yes - n=28 (61%) No - n=18 (39%)	N/A	N/A
How much control do you have over your own life	A lot of Control 16 (35%) Moderate Control 16 (35%)	Little Control 13 (28%) None at all 1 (2%)	N/A

Table v: residents self-reported level of independence

Treatment and Care

Treatment & Care			
	Yes	No	Not Sure
I know what my care plan is	6 (13%)	39 (85%)	1 (2%)
I was involved in drawing up my care plan	6 (13%)	40 (87%)	0 (0%)
My care plan has been explained to me	7 (15%)	39 (85%)	0 (0%)
I know when my care plan is going to be reviewed	1 (2%)	45 (98%)	0 (0%)
I know what my medication is for	40 (87%)	4 (9%)	2 (4%)
I know about the possible side effects of my medication	24 (52%)	19 (41%)	3 (6.5%)
My Psychiatrist has explained my diagnosis to me	19 (41%)	21 (46%)	6 (13)
I can easily talk about my difficulties with my Psychiatrist	31 (67%)	11 (24%)	4 (9%)
My Psychiatrist keeps me informed about my progress	23 (50%)	20 (43.5%)	3 (6.5%)
I am aware of each member of the MDT	19 (41%)	24 (52%)	3 (6.5%)

Table vi: residents opinions on their treatment and care

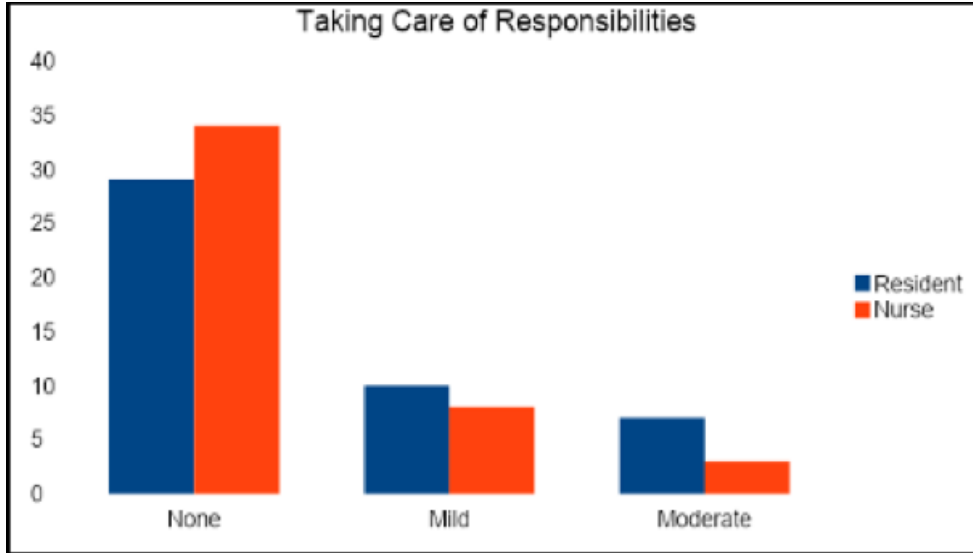
Satisfaction with Treatment and Care

Satisfaction with Treatment & Care			
Satisfaction with Treatment and care	Satisfaction with Information on Diagnosis	Residents Input with regard to Treatment	Satisfaction with Drug Treatment
Very Happy 8 (17%)	Received enough Information 16 (35%)	None at all 16 (35%)	Mostly Satisfied 29(63%)
Quite Happy 31 (67%)	Would like more information 17 (37%)	Moderate amount of Input 16 (35%)	Mostly Dissatisfied 10 (22%)
Not Very Happy 3 (7%)	Received little information 9 (20%)	Little Input 9 (20%)	Equally Satisfied and Dissatisfied 7 (15%)
Not happy at all 4 (9%)	Received no information 4 (9%)	A lot of Input 5 (11%)	

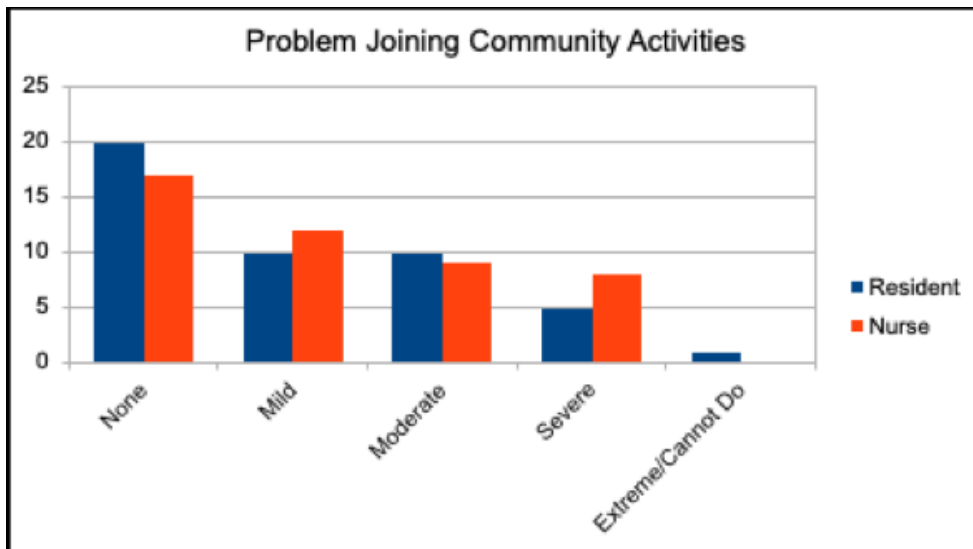
Table vii outlines residents self-reported satisfaction with treatment and care

Appendix 19: Quantitative Results – Community Nurse Questionnaire

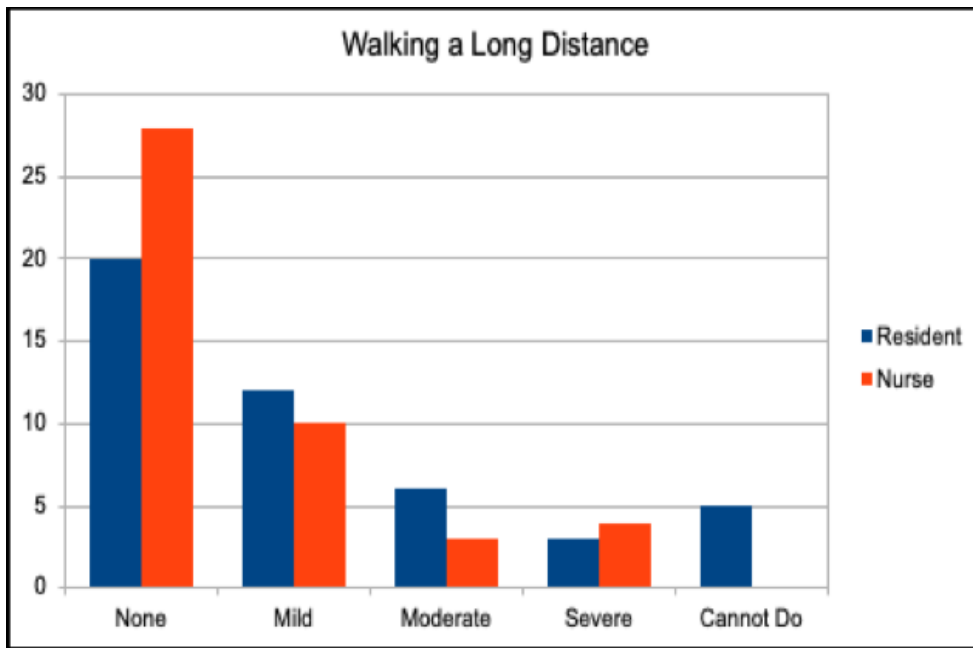
Graph i: Taking Care of Your Household Responsibilities



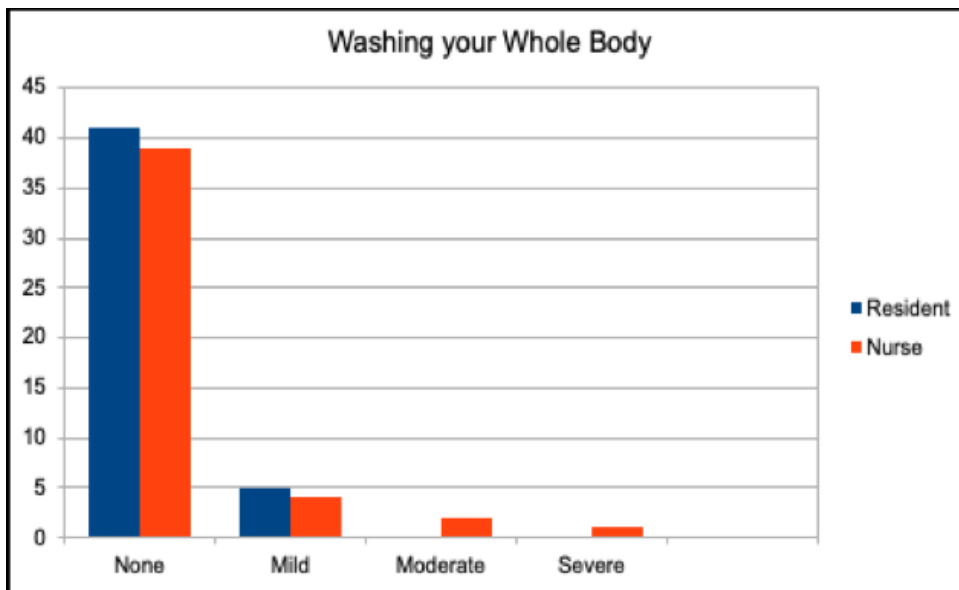
Graph ii: Difficulties with Joining Community Activities



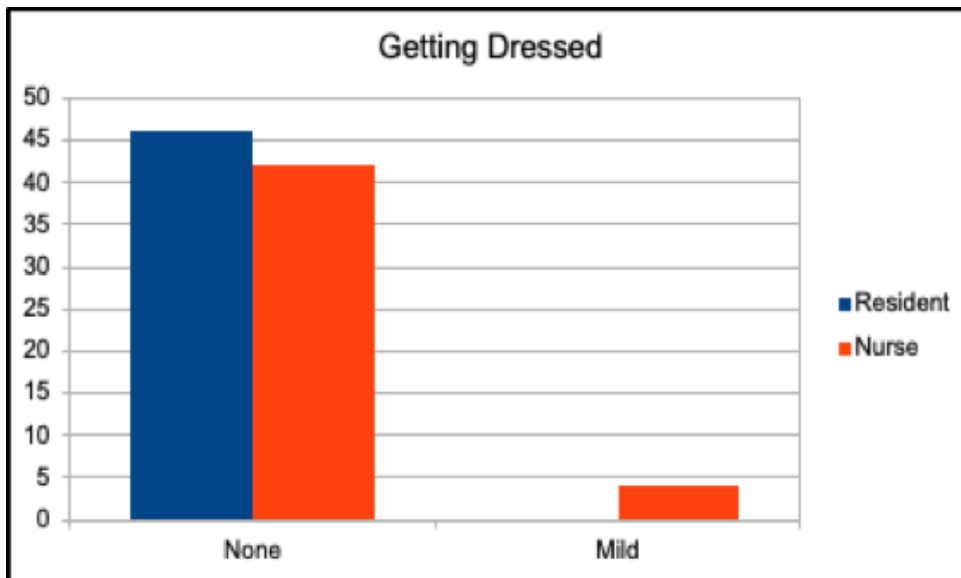
Graph iii: Walking A Long Distance (such as a mile)



Graph iv: Washing Your Whole Body



Graph v: Getting Dressed



Appendix 20: Individual Analysis of each House

Background Information

For the qualitative component of this study, a total of six focus groups, one for each residence, were conducted. In accordance with qualitative research norms and ethical standards, the identities of the community residential facilities (CRFs) and their residents were changed to protect the anonymity of the participants.

Throughout the focus groups, a variety of questions were asked to ascertain residents' perceptions and knowledge of recovery. In terms of specific knowledge, it was necessary to ascertain whether residents had ever heard of the recovery model and whether they could determine if this model was applied to their care. Additionally, residents were asked to describe their definition of recovery and what, in their opinion, helped them to remain well. Correspondingly, residents were asked to describe how they believed staff could assist them in their recovery journey. Certain questions (such as the latter), required rephrasing or probing for pertinent information, as it was difficult to filter responses in order to directly answer some questions. Additionally, data were gathered through indirect questions. Residents were asked to explain why they felt the need to live in a CRF, because the researcher needed to establish a baseline understanding of residents' self-awareness of their own needs and whether or not they understood why they were living in a separate and distinct environment from the general population. Residents were then asked about their perceptions of the CRF's role in order to ascertain whether or not they viewed the CRF as a rehabilitative facility. Residents were also asked to provide details about where they expected to live in five years. The purpose of this question was to ascertain residents' expectations for the future. In other words, did residents consider, or even express hope for, the possibility of increasing their independence?

Data from each focus group —that sought to understand the phenomena involved in “what is it like to live here now”—was analysed individually in the first phase of data analysis, following the underpinnings of phenomenology. The initial stage of data analysis involved the formation of theme clusters from each individual house. Phase Two data analysis (Chapter 5 – 9) involved the aggregation of theme clusters from Phase One to form a further exhaustive description of theme clusters so that the fundamental structure of the overall phenomenon being studied could be identified.

These qualitative findings represent a snapshot in the history of the residences. Although conditions in residences like those examined in this study can change over time, the rate of change is slow. Therefore, the applicability of these qualitative data remains. In addition, it is particularly relevant as a foundation for reflection for current staff and administrators in CRFs and is useful as a point of comparison when they consider 'what is it like to live here now?'

House 1

Profile of residents and house description

Three of the residents in H1 were male and one was female. Three residents had a diagnosis of schizophrenia and the diagnosis of the remaining resident was unspecified. Only three residents attended the interview as one resident had a prior engagement with family. However, one of these three residents had a severe speech impediment. This particular individual spoke on only three occasions. The first occasion was in response to the question “*Why do you think you need to live in a CRF?*” The second occasion was in response to “*How has your illness affected your life?*” The third occasion was during a discussion on stigma. Unfortunately, all data from this individual was rendered obsolete, as speech was mumbled with no clear enunciation.

H1 was a four-bedroom, low-support community residence situated in a quiet residential area in the suburbs of a city. The interview took place in the living room with furniture that consisted of a couch, two armchairs and a coffee

table. The floor had carpet that was threadbare and stained, and the walls were bare. The kitchen was not observed.

Residents were not attending the training centre or any other form of mental health day-support services at the time of interview, had total freedom to come and go as they pleased and were free to move out if they wished. Contact with staff involved community nurses calling approximately every three weeks and out-patient appointments with the local Department of Psychiatry. The researcher worked on a one-to-one basis with one of the residents in H1, however this particular individual did not attend the group interview. The researcher had not worked with the remaining three residents either individually or through occupational therapy in-patient groups.

Findings for House 1

Themes emerging from H1 are presented in the following table along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail.

Themes emerging from House 1	Resident Descriptive Phrases
Lack of recovery-oriented care	<i>control over your own life</i> <i>recovery doesn't seem to be an option</i> <i>no real communication</i> <i>don't feel any confidence in them</i> <i>ask the same questions</i> <i>feel like you are trapped</i> <i>there for life</i> <i>taking medicine that you don't want to take</i> <i>rather not have a routine</i> <i>the houses can be overcrowded</i> <i>meaningful occupation and activities</i>
Stigmatisation	<i>not quite as good as everyone else</i> <i>deficient</i> <i>try and help you out</i> <i>campaign to raise people's awareness</i>
Loss of hope	<i>scary going into rented accommodation</i> <i>financial worries</i> <i>stable income</i> <i>low self-esteem</i> <i>opportunities aren't there</i> <i>as much as I can do at the moment</i>

Table i: Lack of recovery-oriented care

Residents did not have any formal knowledge of recovery, and all three residents stated that they had not heard of the recovery model. However, residents expressed what helped to keep them well: “*diet*”, “*sleep*”, “*religion*”, “*friends*”, being in “*good company*”, engaging in “*hobbies and interests*” such as “*going to the gym*”, being financially stable and engaging in “*meaningful occupation*”.

Residents were also able to communicate what recovery would mean to them:

ELIZA: “*I suppose it would mean having a sense of well-being instead of being depressed and having more control over your own life, you know, as well.*”

Troy, who appeared quite shy, (i.e. poor eye contact) seemed to agree with Eliza by responding with “*Yeah.*”

INTERVIEWER: “*Do you feel you have control over your own life?*”

ELIZA: “*No not really, I feel like it’s been controlled by so many other factors, like you know, the psychiatric services and [...] lack of finance and things like that. I feel like I have very little control to be honest.*”

Eliza was then asked if having more control over her care would be of benefit:

ELIZA: “*I don’t know how that would work nobody has ever said to me you can have more control over your treatment*”

While further exploring the topic of recovery, Eliza was of the opinion that recovery within the psychiatric services was not an option:

ELIZA: “*I mean, when you are in a situation where you are told you have got a mental illness, then recovery seems, sometimes it seems like it’s not even an option, you know what I’m saying, it just doesn’t seem to be an option, you know*”

INTERVIEWER: “*That’s very interesting that recovery is not an option in the psychiatric services.*”

ELIZA: “*Yeah that’s how I feel.*”

TROY: “*Yeah.*”

Eliza provided a rationale for the above comments when asked how she could communicate her needs/concerns to staff:

ELIZA: “*I just find that they are not very communicative to be honest like, when I go and see a registrar or whatever, I’m talking to them and I feel that*

they are not really listening, they just want you to give the right answers to their questions you know, and they just ask you the main questions for about half an hour or so and you are just sitting there going 'yes, no' and there is no real communication, like. Maybe that's my fault, but I can't communicate with them and that's the way I feel."

INTERVIEWER: *"So you feel they are just asking you routine questions that they ask everybody just to tick the box?"*

ELIZA: *"Yeah, yeah that's it, and I don't feel any confidence in them that I could actually tell them how I really felt you know. If I really felt about something, I wouldn't say it to them like. I find it really difficult with them."*

Troy also agreed with Eliza's comments:

TROY: *"Yeah, I find they ask the same questions, like."*

Eliza began to cry at this point and was therefore offered the opportunity to speak to staff after the interview. However, she wished to continue with the interview and described feeling trapped by the services and finding it hard to escape their clutches:

ELIZA: *"I get sent a letter every so often saying go and see a psychiatrist you know, and I don't always do it because I was told that I should only go once a year but they keep on sending me letters every few months, and I know I don't need to go every few months. It's this sort of thing you know, it's like they won't let go of you and you just feel like you are trapped. I find it hard to see myself getting out of this situation [...] that I'm in. Once they get their clutches on you, you are there for life."*

Further evidence of an absent recovery service was identified by Troy when residents were asked if there was anything staff could do to help them in their recovery. Troy responded by suggesting that staff could actually ask residents how they were feeling and also offer them support. Overall,

residents did not have a positive opinion of staff (doctors and nurses) and seemed grateful that they only called every three weeks and were “*not too intrusive.*” Residents felt that staff did not contribute to keeping them well and preferred limited contact with staff:

ELIZA: “*I feel that the less they are in my life the better to be honest, you know? So, when it comes to nurses and doctors or whoever I just feel like, no I don't really want them in my life if I can help it, you know?*”

ELIZA: “*I feel like I am taking the medication, I'm living here and if I go and see a psychiatrist once a year then I'll be doing what they want me to do and I'll be living my life of sorts and that's as much as I can do at the moment, you know?*”

Eliza was asked if she felt the same way towards all staff or just nurses and doctors:

ELIZA: “*[...]not necessarily, I mean I think I've got a good counsellor there in [name] (member of the Occupational Therapy Department), he is very good, he would be one of the people in the services that I would say does a good job, you know?*”

When discussing the topic of how the residents' mental disorders have impacted their lives, it became apparent that Eliza had a negative view of her situation in general:

ELIZA: “*You can say in a very negative way you know, cause, you know, I don't think anybody's life is very positive, and I think in all different areas like it can affect your friendships, it can affect you know, your ability to see clearly obviously [...] It can have a very bad effect on your work situation even, it can affect all areas of your life very badly, you know, in a very negative way, so I would say, yeah, it's had a very bad effect on my life. I think it's a really grim thing, you know?*”

Troy also seemed to have a negative view of his situation, he appeared to look sad and defeated when stating the following:

TROY: "Same as that, yeah I find it hard enough trying to get back into the work environment, you were always with friends, like and you would have the bit of fun, like."

Further evidence of the absence of recovery-oriented care arose when residents disclosed that they did not have many opportunities to meet people in mainstream society:

ELIZA: "You see very few people, the people I know are actually within the services and I don't meet that many people outside the services."

Given the above responses, residents were asked if they would ever consider having a BBQ as a way of getting to know neighbours:

ELIZA: "Sounds like a good idea, I don't know how to do that but [Mr. X] (another resident) would probably know."

Residents had not thought of this idea before, but they stated that it was something they would consider in the future.

Eliza also felt that she didn't have any opportunity to meet a partner and she didn't know where she could go to meet people or what options were available to her and suggested the following:

ELIZA: "[...] maybe if there was some kind of information sheet or newsletter or something telling you what was going on or what was happening."

Eliza's comment indicates that she is not aware of different social groups in the community. Furthermore, both residents felt that they had a poor chance of meeting a partner because they were not currently employed:

ELIZA: *“You see, work might be one of the bigger factors in it, you know?”*

TROY: *“I’d say work, yeah ‘cause I met a lot of people now like being in the [place of work] and they have customers coming in and you get to know them.”*

Other critiques of the service included not enough information on the side effects of medication:

ELIZA: *“One of the negative things when you start taking it, is you don't get enough information about what it is you have been given, you don't get enough information about the side-effects. Then when you do take it, you feel like you are on it for life, so you feel like you are really trapped in this cycle of taking medicine that you don't want to take, but you feel like you have to take it, so it's a bit like being in a trap, for me anyway.”*

Finally, although residents felt that their families had a good understanding of their illness, they indicated that more information would be helpful, specifically around the symptoms that residents experienced:

TROY: *“Maybe understand that people might feel... [silence]...people might have different feelings, like.”*

INTERVIEWER: *“Could you say that again Troy? Are you saying that you might be feeling differently from time to time is it?”*

TROY: *“Yeah, that's right.”*

ELIZA: *“I suppose if they just had some insight into the symptoms of the illness so they would know what you are actually going through.”*

When residents were asked what kept them well, Eliza stated that *“going out and having something to do”* helped to keep her well. Troy agreed *“yes, yeah.”* However, Eliza further elaborated and stated that *“having something*

to do' must be of interest to the person:

ELIZA: *"But not just anything, some people make the mistake of thinking you know, a routine, we need a routine but if that routine is mind numbingly boring [...] it's deadly, I'd rather not have routine you know. So, I think when it comes to, if you got an interest in work or an interest in study, fair enough but otherwise, no. I don't think that having routine for routine sake is a good thing."*

INTERVIEWER: *"Would you say, 'meaningful' occupation?"*

ELIZA: *"Meaningful is a good word yeah, meaningful occupation and activities, absolutely, yeah."*

Eliza further communicated her concerns with how the mental health services viewed meaningful occupation:

ELIZA: *"[...] and I think that is something in the services that is quite bad, they seem to think routine for its own sake is good for people and I think that's quite a prevalent thing in the service, and I think it's really bad."*

In addition, residents felt that the CRF they were living in was not conducive to rehabilitation secondary to overcrowding:

ELIZA: *"I just think that in this house that there should only be three people, I've said that before, but I think that sometimes the houses can be overcrowded."*

Stigmatisation

Although residents did not disclose if they had been treated differently by people who were aware of their mental disorder, they seemed to be of the perception that members of society held negative perceptions towards people with mental disorders:

ELIZA: *"It's very hard to broach the subject [...] if you are just meeting*

people fresh or new. I think if they do view you as having a mental illness, they might treat you as if you are not quite as good as everyone else, like you know, you're in some way deficient, you know?"

In addition, Eliza stated that she would have liked to get to know her neighbours but was unsure if neighbours knew that the house was a CRF for people with mental disorders:

ELIZA: *"I don't know if they ever know our situation, to be honest."*

Troy perceived that people may treat him differently, in a positive way, if they were aware that he had a mental disorder:

TROY: *"Well, people might know you have, but they'll try and help you out like, talk to you and that, it could be a positive."*

Both residents agreed that stigmatisation towards people with mental disorders remains:

ELIZA: *"It's a big issue, isn't it? Like, it's a societal thing isn't it, you know like people feel this, I think there would need to be some kind of positive movement or campaign to raise people's awareness."*

Further comments were indicative of self-stigmatization. For example, when residents were asked if they should be allowed to keep pets in the CRF, Eliza seems surprised at the question:

ELIZA: *"In these situations?"*

Residents also reported not feeling comfortable inviting friends and family to the CRF:

TROY: *"If I had to meet up, I would go out 'cause I don't want to be bringing*

friends in, like.”

INTERVIEWER: *“Okay, in case that you disturb other residents?”*

TROY: *“Yeah.”*

ELIZA: *“Yeah, I feel like that as well. I would rather meet outside, because you just feel that you are disturbing other people in the house if you bring people back. I mean I have now and again brought my friend back, but I wouldn't do it too often, you know? Because you just don't want to get in other people's way, like.”*

Loss of hope

Comments from residents indicated that financial issues and a lack of alternative accommodation were contributing to a sense of hopelessness:

INTERVIEWER: *“Why do you feel that you need to live in a CRF?”*

ELIZA: *“Well the alternatives don't feel very safe apart from maybe council housing, but there is a big waiting list for the council housing and that is kind of off-putting, you know? I think for me personally it would be scary going into rented accommodation, you know?”*

INTERVIEWER: *“Right, would it be the financial worries?”*

ELIZA: *“Yeah, the financial worries would be the main thing, I think maybe everyone is down in the list for a council house. This seems the safest alternative apart from that, you know?”*

TROY: *“Yeah, I have applied for a place as well like, I would like to have my own place.”*

Residents stated that they did not need any rehabilitative training to prepare them for independent living but again mentioned that finances were an issue:

ELIZA: *“I think it comes down to finance with me anyway. If I had a stable income and I was assured of that for the future, I would be much more inclined to move out, you know, to go somewhere else?”*

Troy nodded his head in agreement with the above comment.

Finance issues arose again when residents were asked why people living in a CRF might be unhappy with their love life (as the quantitative section of this study indicated):

ELIZA: *“I think a lot of people with mental health problems have low self-esteem as well and financial opportunities aren't there to go out and socialise as much so the social life basically maybe isn't there for meeting people, you know?”*

Summary H1

Eliza perceives that she is being controlled rather than empowered by the mental health services and is critical of interactions with doctors as well as the ‘one size fits all’ approach to treatment and care rather than treatment and care tailored to individual needs. Self-stigmatization also seems to be an issue for Eliza as she is concerned about being viewed as “deficient” or inferior to others, which is possibly preventing her from engaging with her neighbours and her community. In addition, residents indicated a sense of hopelessness as they perceive themselves remaining in a CRF for the foreseeable future due to the long waiting lists for government housing.

The opinions and perceptions communicated from residents in house number one; lack of evidence-based rehabilitation, self-stigmatization and feelings of hopelessness, are not conducive to recovery. Without the implementation of individualised and evidence based to help residents resolve the challenges they are experiencing, residents may well remain in their current situation for the foreseeable future.

Summary H1

Eliza perceives her treatment and care as not conducive to recovery and instead of feeling empowered, she felt “*controlled*” by the mental health services. Residents were encouraged to attend the mental health services ‘one size fits all’ training centers, day hospital or day centers. In addition to the above, it is possible that other reasons were contributing to Eliza’s feelings of hopelessness regarding her future. As well as taking medication and going to see a psychiatrist once per year, Eliza also felt unable to help herself or move forward stating “*that is as much as I can do at the moment.*”

House No 2

Profile of residents and house description

There were a total of six residents residing in H2; five female, one male. Three participants, all females, took part in the focus group. Of the remainder, two were inpatients in the Department of Psychiatry (local hospital) at the time of data collection and one declined to participate.

This CRF was a medium support residence, with supervisors remaining in the building overnight. Routine staff hours were from 5pm to 11am the following day. The title of all staff working in the residence was 'supervisor.' Staff were not registered mental health nurses and did not have any formal training in mental health. The house was conveniently located in a housing estate within the city centre. The environment was clinical; chairs were lined up in the living room in a similar fashion to a medical waiting room. The living room was sparsely decorated and there was a nearby administration office for staff use only, which was kept locked when not in use.

Findings for House 2

Over-arching theme: Institutionalisation or 'The Perfect Patients.' Themes emerging from H2 are presented in table i along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail. The concept of deflection by residents will be discussed in a separate section as it has been identified as a response to the causal themes listed.

Themes Emerging from House 2	Resident Descriptive Phrases
Lack of recovery-oriented care	<p><i>make it happen more quicker</i></p> <p><i>make it a bit more positive for our minds</i></p> <p><i>don't really initiate counselling</i></p> <p><i>not much they have to do</i></p> <p><i>laughing with each other all day</i></p> <p><i>they just drug you up</i></p> <p><i>told I would never recover</i></p> <p><i>implementing the house rules</i></p> <p><i>just here to form atonement</i></p> <p><i>get you ready for adulthood in a childish way</i></p>
Institutionalisation	<p><i>lovely and near everything</i></p> <p><i>staff are nice</i></p> <p><i>nothing wrong with them at all</i></p> <p><i>all have been very helpful</i></p> <p><i>learned an awful lot</i></p> <p><i>want to improve myself</i></p> <p><i>happy enough</i></p> <p><i>very happy here</i></p> <p><i>staff might consider the BBQ a fire hazard</i></p> <p><i>they would help you</i></p> <p><i>we get in a pizza and it's great</i></p>

Table ii: Resident Descriptive phrases from House Number Two

Lack of recovery-oriented care

The first indication of lack of recovery emerged when residents were asked about the Recovery model:

INTERVIEWER: *“Has anybody heard of the recovery model?”*

DELIA: *“No.”*

ANGIE: *“What’s that?”*

SUZI: *>did not respond verbally, but shook her head to communicate that she had not heard of it either.<*

In addition, residents indicated that they have not made a lot of progress in terms of rehabilitation:

ANGIE: *“Like, we’ll say Delia is very good, she is here a year and a half and I’m here five years this year and Sarah they’re all doing pretty well. I’m not saying that I’m not, BUT there is a feeling that I’d love to be at home again, you see, you know?”*

Furthermore, while residents reported that staff provided education regarding their medication, further examination of the data revealed that residents had no individual control in that regard:

DELIA: *“They [the supervisors] know the time for everybody to get their medication, our tablets. The way it is with me anyhow, I get them morning, evening and night-time. They are always on the ball with that.”*

Finally, with regard to employment, it seemed that a co-resident was the main person who provided encouragement in this area:

ANGIE: *“Suzi (resident) is always on to me about getting a job, but I’m not ready for it yet.”*

Institutionalisation

Residents communicated that they were happy with both living in a CRF and the care they had received. For instance, when asked what made them comfortable about inviting friends and family to the CRF, responses towards both the CRF and staff were positive:

DELIA: *“It’s lovely and it’s near everything.”*

Without any hint of sarcasm, another participant added:

ANGIE: *“The staff are nice, oh there is nothing wrong with them at all.”*

The above question animated both residents, who were eager to respond with positivity. The word “*nothing*” was emphasised and the tone of voice from both residents was strong and confident.

Residents were asked if there was anything staff could do to help them move towards more independent living. Following a long silence, the researcher probed for answers by asking: “*Do staff help with education around medication or cooking?*” One resident reported:

DELIA: “*Yeah, they do, a lot.*”

Another resident followed with:

ANGIE: “*Oh definitely, the supervisors here [...] they all have been very helpful.*”

However, they did not illustrate any further.

The residents were asked to answer how they viewed the role of the CRF. One resident’s perception was that she had not learned a lot during her time at the CRF, and she communicated this in a measured way being particular and careful with her words:

ANGIE: “*Am... well hopefully I suppose, I know myself I’m here and everything, but definitely, I mean to say, well say from my experience anyhow, I don’t know if I have learned an awful lot since I’ve been here but I would definitely, I do want to improve myself so that I can live with my brother.*”

Despite the above resident feeling that she had not progressed as much as she would have liked during her time in the CRF, and the very careful way she expressed this, she confidently and promptly reported to be happy with the amount of hours that the supervisors worked.

INTERVIEWER: *“Do you think that CRF supervisors should work more or less hours every day?”*

ANGIE: *“Oh no the same, the same hours, yeah yeah.”*

A similar answer was given when residents were asked about the level of support from external nursing staff calling to the CRF. One resident stated emphatically:

DELIA: *“No, we are happy enough, they call every morning.”*

Another resident promptly supported the above comment by adding:

SUZI: *“Yeah, definitely happy enough.”*

When asked if there is anything else that anyone would like to add about living in the house, Delia responded:

DELIA: *“No, I’m very happy here, I’m much happier here than [house X] (another CRF the resident had previously resided in).”*

The same resident also included another resident (*Suzi*), by asking her if she was happy living in the house, as they had both previously lived together in a different CRF.

Suzi responded with *“yeah,”* but seemed guarded in both her verbal and non-verbal communication for the entire interview. Verbal communication was short and brief and information was only forthcoming with probing from either the researcher or other residents as indicated above. Non-verbal communications included poor eye contact, arms crossed and a sad facial expression.

Residents in H2 displayed institutionalised behaviour in various ways. Describing the house as *“lovely”* although it was bare and clinical looking,

and the staff as being “*very helpful*,” yet specifics on how they were helpful were not forthcoming. Another example, was when residents stated that they would like to have had a BBQ and invite neighbours as a way of getting to know them; one resident quickly realised that this may not be allowed by staff for Health and Safety reasons:

DELIA: “*The trouble is that staff might consider the BBQ a fire hazard so it would have to be in care of the supervisor.*”

However, another resident quickly deflected from the above comment by promptly informing the researcher that they were very happy to have pizza once a month:

ANGIE: “*Sometimes like now maybe once a month on a Friday we get in a pizza and it’s great, you know.*”

In addition to the above comments regarding restrictions on having a BBQ, residents usage of agreeable terms and body language suggested that residents were institutionalised in their thinking. It also demonstrated that they were speaking the language of institutionalised care. Consequently, residents believed that it was acceptable that they were not trusted enough to have a BBQ because they got pizza once a month instead—such comments indicated a true reflection of institutionalised care. Indeed, the residents’ comments supported the concept of needing permission to proceed with such an event and not feeling confident that this could have been granted.

Further comments supportive of institutionalised behaviour arose when residents were asked if people treated them differently if they knew that they had a mental disorder. One resident promptly responded:

DELIA: “*Not in the Unit.*” [*local Department of Psychiatry*]

INTERVIEWER: “*What about people that you don’t know?*”

DELIA: *“Well some people might laugh at you, you know.”*

Although residents didn't report experiencing stigma from society, they were aware that it was a possibility in society, but not in the local hospital (Department of Psychiatry). The local hospital was mentioned again during the interview around the role of the CRF supervisors:

ANGIE: *“If you needed to go the Unit, they would help you. They would ring [nurse X] or someone to bring you in [for admission].”*

Residents were asked how they would feel about their husband, wife, boyfriend or girlfriend staying overnight in the CRF. The residents answers were instantaneously “No,” with two of the three residents answering together:

ANGIE: *“No, No, No, Oh No!”* [followed by a slight giggle]

DELIA: *“I don't think so, no way.”*

With regard to the local hospital, some residents viewed it as a safe environment, and one in which they felt less stigmatised compared to the local community. This may also suggest that residents had developed a dependency on the local hospital and viewed admission as the primary option when unwell. If residents were versed in recovery principles, they might have seen admission to the local hospital as the last option instead of the primary option. In addition, they viewed staff as having an important role in supporting this treatment option (i.e. assisting with admission). It is possible therefore that residents viewed the CRF as an extension of the hospital, because they were surrounded by other residents with mental health disorders, medication was stored away and given in a regimented fashion, there were similar health and safety issues (e.g. BBQs would not be allowed in a hospital environment either) and nursing staff called every day. This helps in understanding the residents' attitudes towards the possibility of partners staying overnight. The idea sounded so absurd to residents that they considered it to be amusing—

possibly because they were applying hospital logic to the CRF space (i.e. partners are not allowed to stay overnight in a hospital). In other words, residents were not viewing it as their home where they would have the freedom to behave as they wished.

Deflection

Deflection was evident in the residents responses, however, it was not presented as a 'theme' but rather a response to the listed themes; residents deflected due to institutionalisation or in defense of their not really knowing any better when it comes to the lack of recovery-oriented treatment/care; hence, the separate section (and no segment in the introductory chart). There were many examples of obvious deflection from the residents throughout the interview.

The researcher specifically asked the residents the following question about their love life as there was a significant statistical finding in the quantitative data with regard to how residents felt about their love lives; eighty percent of residents indicated that they were unhappy with their love life.

Example 1

INTERVIEWER: *"Do you remember the questionnaires you filled out? There was a question asking 'how happy are you with your love life?'"*

The answers that I received, showed that most residents living in CRFs were unhappy with their love lives. A long silence followed this question. The researcher then asked the question again; *"Why do you think residents are unhappy with their love life?"* Another long silence followed and, finally, a resident responded with:

ANGIE: *"Hmm, yeah."*

ANGIE: *"The supervisors you mean, is it?"*

INTERVIEWER: *“No, the people in the CRF’s [...] I’m just wondering why such a large number of residents said they were unhappy with their love life?”*

ANGIE: *“There is another thing too, it’s kind of on my mind, I thought I might let it out and say it to you. Now I go to a day centre myself and usually they are on about my timing you know, getting out there at 10 in the morning...”*

INTERVIEWER: *“We will have a chat about that after the group, if that is okay? Because DELIA is in a rush to go.”*

When residents were asked for their opinion on why the majority of residents living in a CRF environment were unhappy with their love lives, they did not actually answer the question, even when probed. The first layer of deflection regarding this comment was a long silence. The second layer of deflection was asking the researcher if she mistakenly meant to ask about why staff were unhappy with *their* love lives, instead of the residents, despite the researcher making the question explicitly clear. The third layer of deflection became evident when the residents tried to completely change the direction of the conversation: *“[...]there is another thing too, it’s kind of on my mind, I thought I might let it out and say it to you. Now I go to a day centre myself [...]”*

It is possible that the residents did not want to think about the impact that their mental disorder may have had on their love life, or did not want to realise that they may be too unwell to have a relationship. It is also possible that the residents simply just did not have the skills required to talk about personal aspects of their lives. Whatever the reasons are for deflection of this question, they remain unknown.

Example 2

INTERVIEWER: *“How would you feel about residents having their boyfriend, girlfriend, husband, or wife stay overnight in the CRF? Do you think they should be allowed?”*

All three participants promptly responded together with a robust no, following probing by the researcher and a long silence, residents then gave the following response:

ANGIE: *“Well, I suppose that might not be for us to say, there is probably enough in the house already, is there? There is six here, but there is two in the hospital at the moment. But as far as I can see...everybody is trying to do their bit and all that like, you know?”*

When the residents were asked how they would feel about their partners staying overnight in the CRF, a similar pattern arose again where the residents attempted to deflect the researcher by trying to change the subject: *“[...] there are six here, but there are two in the hospital at the moment, but as far as I can see...everybody is trying to do their bit and all that like you know?”* The last part of this comment is not relevant to the actual question (dignity in relationships). It is about the number of bodies in the house and the physical capacity of the house. This is an attempt to deflect the researcher, possibly because they could not contemplate having a relationship while living in a CRF. Furthermore, the intensity of the manner in which residents answered the question did not match their reasoning in how they answered the question. It seemed that the participant was trying to communicate ‘everything is fine here, so let's move on’ in order that they would not have to speak about themselves on private aspects of their lives. Instead, they resorted to intellectualising negative topics (that they did not wish to talk about) into more acceptable ones.

Example 3

INTERVIEWER: *“Has anyone heard of the recovery model?”*

DELIA: *“No.”*

ANGIE: *“What's that?”*

ANGIE: *“Did you say you are doing your masters?”*

INTERVIEWER: "Yes"

ANGIE: *"Masters in what Lisa?"*

ANGIE: *"Oh no Lisa and when are you starting it?"*

INTERVIEWER: *"Well I have started it already...but can we move on?"*

ANGIE: *Masters in what Lisa?"*

INTERVIEWER: *"Masters in Occupational Therapy,"*

ANGIE: *"And how long will that go on for and will you be qualified after your masters then is it?"*

INTERVIEWER: *"Well I'm qualified already; this is just something extra I am doing. Can we move on?" >interrupted by ANGIE<*

ANGIE: *"How is your husband?"*

INTERVIEWER: *"Great, thanks but can we move on to the next question?"*

Residents stated that they had not heard of the recovery model, and made a concerted effort to deflect the researcher away from the interview question by getting her to talk about herself. Again, the reasons for this were unclear. It is possible that the residents felt disinterested in this question or that they felt it was an irrelevant question. Another possibility could be that residents felt embarrassed by not knowing what the recovery model was, and therefore tried to deflect the researcher by asking her to talk about herself. Another reason could be that they simply felt that asking the researcher to talk about herself was more interesting than talking about a concept they had never encountered.

Example 4

INTERVIEWER: *“Can you tell me if there is anything else that staff can be doing to help you in your recovery?”*

Once again, the researcher was met with a long silence and therefore probed residents for information; *“Is there anything else that staff could do to help?”*

ANGIE: *“Are you based in the Unit (local psychiatric ward) now?”*

INTERVIEWER: *“Yes.”*

ANGIE: *“All the time? How many years are you over there now?”*

INTERVIEWER: *“Four or five anyway but...” >interrupted by ANGIE<*

ANGIE: *“Five! Oh my God, it’s a long time alright!”*

INTERVIEWER: *“I’ll read the question again.”*

Residents were asked if there was anything that staff could do to help residents in their recovery journey; the researcher was again met with silence. The question was then asked again in a more direct and specific way. The residents used a repeat of the same deflecting technique by asking the researcher a question in return. Possible reasons for this obvious deflection could be that residents simply did not know ways in how staff could help them in their recovery. Another possibility could be that residents felt that if they were forthcoming with ideas, that this might indicate that staff were currently not helping them in their recovery and they possibly did not wish to portray staff in this manner.

Summary H2

Overall, residents seemed reluctant to detail specifics of the staff-resident interactions, and were also reluctant to criticise any aspect of their care and

surroundings. They reported positive perceptions towards living in a CRF. This also made it difficult to extract and filter detailed responses from the residents, which in turn made it difficult to gain a sense of what it was really like for residents to live in this particular CRF. In addition, one resident indicated that she did not make a lot of progress in terms of functioning, despite living in the house for five years. The last part of her comment was worded in a way that did not implicate staff in her perceived lack of progression: *“I do want to improve myself.”* Although Suzi did not contribute significantly to the group, she reported that she was happy living in the house. However, her verbal and non-verbal communications (as described above) indicated that she did not feel comfortable enough in the house to be able to talk about living there.

This lack of detail and limited responses to prompts did not correspond with the residents’ self-reports of being ‘happy,’ as illustrative stories were not told. This rendered the descriptor ‘happy’ empty and devoid of meaning. It is possible the residents felt that they may lose their place in the CRF if they complained about the staff or the house itself. However, the more plausible reason is that residents were institutionalised in their thinking and behaviour. This was particularly evident in residents comments around having a BBQ as it demonstrated that they were speaking the language of institutionalised care. Consequently, residents believed that it was acceptable that they were not trusted enough to have a BBQ because they got pizza once a month instead—such comments indicated a true reflection of institutionalised care. Indeed, the residents’ comments supported the concept of needing permission to proceed with such an event and not feeling confident that this could have been granted.

House No 3

Profile of residents and house description

H3 had six residents residing there, of which five took part in the focus group interview. One resident in particular, Anna, overpowered the conversation of the focus group. The four remaining residents were not as forthcoming with information and required probing questions by the researcher. Diagnoses of residents varied from schizophrenia to alcoholism. The researcher had not previously worked with any of the residents in this house.

H3 was situated on the outskirts of the city with good access to bus services. The house had six bedrooms and provided medium support care to residents. Nursing staff from the high support CRF were responsible for management of the house and residents and called on a daily basis. The main goal was to provide rehabilitation and recovery to residents to enable them to transfer to lower support CRFs, with the overall goal being full independent living. Residents left the CRF during the day to attend the local workshop (also referred to as the ‘training centre’) in the community. The environment inside the CRF can be described as dark with poor natural light, the walls looked as though the paint had faded in colour, especially the small room nearest to the front door (formerly known as the ‘smoking room’). The living room was spacious and had comfortable seating, as well a fireplace. Although the researcher did not have access to the kitchen, residents described it as spacious.

Findings for House No 3

Themes emerging from H3 are presented in the following table along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail. It is important to note the relationship between the descriptive evidence and the themes identified, as comments often reflected more than one theme.

Themes Emerging from House 3	Resident Descriptive Phrases
Lack of recovery-oriented care	<p><i>on medication and cannot come off it</i></p> <p><i>well enough to leave here now</i></p> <p><i>wouldn't be without a nurse</i></p> <p><i>should be here more permanently</i></p> <p><i>we all have our own jobs</i></p> <p><i>if I'm allowed</i></p> <p><i>if I got the chance</i></p> <p><i>never be moved from here</i></p>
Institutionalisation	<p><i>nice and relaxed</i></p> <p><i>structured environment for medication</i></p> <p><i>involvement</i></p> <p><i>I accept it</i></p> <p><i>very convenient</i></p> <p><i>I need somebody to check up on me</i></p> <p><i>we need this house</i></p> <p><i>nurse is always on call</i></p> <p><i>under the doctor's care</i></p> <p><i>staff do their very best</i></p> <p><i>they look after you so well</i></p> <p><i>that's the way we have to live</i></p> <p><i>nothing to complain about</i></p> <p><i>cooks are fantastic</i></p> <p><i>I'm much happier</i></p> <p><i>I have improved</i></p>
Stigmatisation	<p><i>house like this place</i></p> <p><i>not being treated with respect</i></p> <p><i>know you have an illness</i></p> <p><i>makes me hurt</i></p> <p><i>own bedroom</i></p> <p><i>privacy</i></p>

Table iii: Themes and descriptive phrases from house number three

Lack of recovery-oriented care

Residents were specifically asked if they were familiar with the Recovery Model, to which they all responded strongly with a "No." Nonetheless, residents demonstrated a rudimentary understanding of recovery, through the

direct and indirect questions, which manifested itself in desires to return home to family life and to work, as well as a desire for medication to be discontinued:

SIMON: *“I’d like to be at home [...] getting on with work, like.”*

BRIAN: *“I was hoping, well there was a recent improvement [...] to be kept on in the workshop but I think I’m well enough to leave here now.”*

ANNA: *“To leave here [...] to come off the medication and be very well and to be able to go home on the bus [...] and be there to meet the family, cook a dinner for them.”*

CARMEL: *“To leave here.”*

Carmel did not elaborate on what recovery meant to her, but she did state that she wished to leave the CRF but was unable to do so because she was *“on medication and cannot come off it.”* Her remark indicated a sense of defeat, as she appeared to look sad (i.e. not smiling and looking down to the ground).

Another resident, Tom, stated that he would like to move to more independent living and expressed a desire to live in rented accommodation:

TOM: *“Oh, I’m on my last leg, I’d like to leave here I suppose [...] I’d like to get a house [...] start renting, you know”.*

When residents were asked to discuss what helped to keep them well, only one resident, Anna, responded:

ANNA: *“[...] happiness, enjoyment, socialising, cooking [...]”*

Other residents did not make eye contact while the above question was being discussed.

It is clear from the above data that residents had no formal understanding of the recovery model or what constituted recovery-oriented care. Despite the residents' limited understanding of recovery, the majority of residents were able to express their personal desires and wishes for the future.

Tom's contribution to this section was significant, given that he spoke only once or twice during the interview and demonstrated how important it was for him to transition to more independent living. However, comments from residents did not appear to indicate that staff were encouraging, supporting, or providing life skills training to residents, in order to aid in achieving these goals.

Carmel's comment about having to *"take medication and being unable to come off it"* when combined with her non-verbal communication (as discussed previously) gave the researcher the impression that she was pessimistic about her future. Residents appeared to lack a general understanding of recovery and how they might go about achieving their expressed wishes or goals. A reasonable underlying assumption in recovery-oriented care is that the individual understands key tenets of the recovery model, and that recovery occurs in collaborative with staff and residents.

It was evident throughout the interview that there was minimal to no training on recovery given to residents in this CRF. Some residents were even unsure of the role of the CRF:

CARMEL: *>Long delay< "Ah... to give you experience with making up your own medication and things like that, I suppose."*

ANNA: *"I wouldn't be without a nurse, if I moved house, I might need a nurse overnight, if something happened, like."*

The researcher probed residents for information and rephrased the question:

INTERVIEWER: *“Would anybody feel that it helps with rehabilitation in any way, would you say there is rehabilitation going on here?”*

ANNA: *“We all work as a team here, we all do our own jobs, go to work in the morning, come home, do the different jobs we have to do, watch some TV maybe [...] that’s me, the rest of them are the same.”*

INTERVIEWER: *“Alright, so you would say it has a rehabilitative role or function to it?”*

ANNA: *“Yeah.”*

CARMEL: *“Yeah.”*

No further details were provided. However, when residents were asked if staff could do anything to help them prepare to move on, Anna’s response shed some light on the limited recovery training residents receive:

ANNA: *“Oh there is, what they do is they put you to a role of thing [...] They would have me in charge of the tea, maybe a fry some evenings to do and they would stand back. The nurses would be there, but they would let you off on your own with what you have to do. I’m a devil for the kitchen [...] I can do my own cooking when one of the cooks supervises. There has to be a supervisor here, like one of the girls (cooks) or a nurse here for insurance if a fire started.”*

However, Anna and other residents do not get to cook every evening:

ANNA: *“The girls come in here (cooks)...they cook in [House 1] and bring it down to us here, and sometimes they would cook it here themselves.”*

Furthermore, residents reported that the last meal of the day is at 5 p.m., and if they get hungry after this time they either go out to a service station to buy

fast food, have tea and biscuits or possibly make a sandwich if there is ham or cheese in the fridge.

In addition to the above, residents reported that staff helped them to prepare for independent living by taking them to view other CRFs as possible future living options:

ANNA: "Oh they are good to us, like they take you out to see hostels and if you are not happy with the hostel, they are not going to throw you out the door. They are going to say 'well make up your mind, we will give you two weeks to a month to make up your mind what you want to do' and that's being honest, like."

However, when residents were asked how they would feel if they were asked to move out in six months' time, responses indicated that residents would not be happy:

ANNA: "Well, I would be upset [...] I think I'm 4 years here in this hostel but ah, 5 or 6 more years here and I will improve myself, maybe I would be able to move back home full-time, but at the minute I should be here more permanently than anybody else, according to [Dr X], this is my home and I will never be moved from here."

Other evidence gathered throughout the interview to highlight the absence of recovery-oriented care was discovered when residents were asked what helped them to remain well:

ANNA: "Well, I have a good friend Carmel, that will come in once a week to talk to me and I tell her everything that's going on and she helps me, and whatever I want to know then she will ask my nurse and have a chat and ring her and tell her."

ANNA: "I get to go set dancing too, if I'm allowed."

In addition to the above evidence, Brian repeated himself many times throughout the interview and communicated that he would prefer to move to a higher support facility:

BRIAN: *“As I said about [higher support facility], I would go there if I got the chance or maybe [psychiatric ward at long-stay hospital] if I got the chance, but I don't think that's in the cards.”*

However, what was more concerning to the researcher was the fact that Brian seemed to be still grieving for his father who died in 1978:

BRIAN: *“My father passed away in '78 and I was admitted the same year and I find it, I found it hard to cry at his death, that kind of way. But I'm beginning to feel more relieved in recent times. Looking back at that time, he might not have had a happy funeral or that I could have done more for him before he passed away.”*

Carmel appeared to guess the CRF's purpose and only responded after a lengthy delay, stating that its primary objective was to provide her with *“experience with making her own medication and things like that [...]”* If recovery-oriented thinking were the norm, it is reasonable to assume that the CRF's role in her care would have been described in greater detail and with more positive language. Carmel's response, on the other hand, demonstrated that this was not the case and corroborated the notion that recovery thinking is limited or nonexistent in her care.

Additional evidence of the absence of recovery-oriented care was found in Anna's statement that she *“wouldn't be without a nurse”* and *“might need a nurse overnight.”* These statements implied a more dependent and hierarchical relationship with staff, as opposed to the collaborative relationship encouraged in recovery-oriented care.

Likewise, when the researcher specifically inquired about whether rehabilitation was occurring in the CRF, the majority of residents did not

respond, indicating that recovery-oriented care was limited. Additionally, Anna stated that *"we all have our own jobs"* but did not elaborate. This response indicated that residents have basic daily house chores to complete rather than engaging in meaningful and purposeful rehabilitation. If recovery-oriented care had been implemented in the CRF, Anna and the other residents could have detailed their rehabilitation when discussing the CRF's role.

Anna's responses indicated that she was passionate about cooking (e.g. the statement, *"I'm a devil for the kitchen,"*) but she described being permitted to cook only in the presence of staff and only on *"some evenings."* Residents had apparently been informed that access to the kitchen was restricted due to health and safety regulations. However, given that residents reported eating their final meal of the day at 5 p.m., one might wonder if this regulation was in place to accommodate staff working hours. Whatever the reason or reasons, restricting access to a kitchen in a medium-support CRF is unacceptable and demonstrated a more custodial and paternalistic model of care rather than a recovery-oriented one.

Striving towards more independent living is a central tenant of the recover model. As evidenced by several of the residents' responses, no structured approach to this issue appeared to exist. Anna stated that, while staff took residents out to view potential CRFs, the final decision to relocate appeared to be haphazard and left to the residents, who were given between two to four weeks to decide. There was no evidence that staff prepared or even encouraged residents to make this transition to more independent living. On the contrary, Anna stated that *Dr. X* referred to the CRF as her home and assured her that she would *"never be moved."* Anna, as well as staff, may have interpreted this message from *Dr. X* as *'I don't see you ever recovering'*. *Dr. X's* remark was anti-recovery, even if Anna's wish was to remain in the CRF indefinitely.

Additional evidence demonstrating the absence of recovery-oriented care was provided by Anna's statement that she had been living in the CRF for four years, but felt she needed another five or six years to improve herself. She did

not state that she required additional time to also receive further rehabilitation training. Additionally, it appeared as though staff were not communicating with residents about their recovery, as Anna stated that she had a friend (another resident) who acted as a liaison between her and nursing staff. This is not how recovery-focused care operates. Additionally, Anna stated that she enjoyed going set dancing *"if [she is] allowed."* Residents of a medium-support CRF should be able to pursue their hobbies in the community and there should be no reason why they cannot. Indeed, community involvement is a central tenet of the recovery model.

Furthermore, Brian's continued grief for his father following his 1978 death indicated that he had never received grief counseling. Brian's grief could have been impeding his recovery, but rehabilitation and holistic recovery-oriented care would almost certainly address this issue. In addition, Brian's repeated mention of his desire to live in a higher support facility was additional evidence of custodial care. He clearly felt more secure in a more structured and constrained environment, most likely because it was more familiar to him.

Despite the above evidence, it was encouraging to note that all residents expressed a desire to improve upon their individual circumstances. Simon wished to be at home and work, Tom wished to live independently in rented housing, and Brian, despite his desire to move to a higher level of support, stated that he believed he was well enough to leave the workshop. Anna stated that she wished to discontinue her medication, return to her family, and cook for them. If the recovery model of care were implemented here rather than the paternalistic model, it is highly likely that residents' desires and wishes for the future could have become a reality instead of residents continuing to have lived their lives in accordance with health and safety regulations.

Residents showed signs of being 'stuck in the past,' unable to move on from trauma and grief. Brian talked about how difficult it was for him to grieve at his father's death and how concerned he was that he had not done enough for him before he died. These thoughts are all part of the normal grieving process,

but they become abnormal when they are not resolved over 30 years later. Recovery-oriented care should address these matters as they may be instrumental in preventing or inhibiting progress.

Institutionalisation

When residents were asked whether or not they should be allowed to live in H3 permanently, the majority agreed that it should be a permanent arrangement, which was reflective of institutionalisation. Additional examples of institutionalisation were evident, when residents were asked to give examples of what, in their opinion, helped to keep them well. Answers were mainly centered around aspects of the service such as medication and structured environments:

BRIAN: *“I don't know if we are all on medication here, but I am, and places like this kind of keep me reminded when I get up in the morning and to take them at night, it's helpful in that line.”*

CARMEL: *“My medication.”*

BRIAN: *“Going into the workshop, I go in every morning [...] I have my chores in the workshop, and I found recently they are helpful.”*

ANNA: *“It's nice and relaxed [...] for most of us here, this offers a structured environment for medication involvement.”*

The above comment indicated that Anna was using medical terminology that was possibly learned from listening to staff. Furthermore, when residents were asked to express how they felt about having to take medication, nobody reported any negative effects. Indeed, all residents had a passive attitude towards medication in general:

CARMEL: *“There are side effects to all medication, I don't know what they are, but that's what they say.”*

INTERVIEWER: *“Do you mind having to take medication, Carmel?”*

CARMEL: *"I accept it."*

TOM: *"I don't mind."*

Medication arose again when residents were asked why they thought they needed to live in a CRF and what the role of the CRF was:

ANNA: *"My illness, the medication I'm on, I would need a nurse if something went wrong with my medication or if I took the wrong medication. It's very convenient cause if you wanted a doctor there is a doctor there, they have a number on call, like if someone gets sick in the house, they ring the unit [local psychiatry hospital] and they come out. We need this house."*

BRIAN: *"Medication helps, structure helps me to keep taking the medication [...] I need somebody to check up on me."*

CARMEL: *"Ah... to give you experience with making up your own medication and things like that, I suppose."*

The above comment suggested that Carmel was unsure what the role of the CRF was, and when explored further by the interviewer, Carmel was unable to express what the benefits of living in the house were:

CARMEL: *"I don't know [...] I'm in the workshop and I work in woodwork [...] you can get a bus easily [to the training centre]."*

However, Anna reiterated once again the importance of living in a CRF:

ANNA: *"He could have a fall, or I could have a fall, if you got a fall or he got a fall >pointing to other residents< The nurse is always on call for that, isn't that right?" >looking to the other residents for reassurance<*

Simon agreed with Anna by responding with a "yeah" and Anna quickly ordered him to "speak up". Anna believed that she "need[ed] this house" for

the above reasons, a view that others agreed with as it also allowed for staff to “*check up*” on them given the fact that they were “*under the doctor’s care*” and “*on tablets*”.

SIMON: “*I’m under the doctor’s care, so I don’t mind living in here, like, I’m on tablets you know?*”

This dependency on the service may explain why all residents agreed that nursing staff should call more often instead of less often.

Further examples of institutional thinking were identified when residents were asked for their opinion on whether or not their husband, wife, boyfriend or girlfriend should be allowed to stay overnight in the CRF:

CARMEL: “*There wouldn’t be room in the house, would there?*”

Carmel’s response to the above question suggested that her level of institutionalisation was affecting her thinking process. She answered the question in an unsatisfactory and practical manner, and in the absence of any emotional impact on her current living situation (in a CRF).

CARMEL: “*They shouldn’t be allowed to stay...it might be too much for the house.*”

Simon’s comment indicated that he liked structure and letting partners of residents stay overnight might disrupt the structured environment that he believed he required.

In addition, residents were asked for their thoughts on why the majority of residents indicated that they were unhappy with their love life in the quantitative section of the study. Answers demonstrated either a lack of insight or denial of their current situation, as Anna suggested that residents “*may not have met the right person*”. When probed, the other residents all agreed with Anna’s comment.

Furthermore, when residents were asked if there was anything staff could do to help them to live more independently, Anna seemed both eager (quick to respond) and anxious (pressured speech) to answer the question, she communicated that she was happy with how staff treated her and that residents had their own role which was rehabilitative in nature:

ANNA: *“Staff do their very best for all of us here, and they will give us as much help as you need or as you want, and I’m happy with the staff here because they look after you so well. They take you out to see hostels and if you are not happy with the hostel, they are not going to throw you out the door, like.”*

INTERVIEWER: *“Would you say that this house is rehabilitative in nature?”*

ANNA: *“What they do is they put you to a role of things, right, a role they call it. That’s a [Nurse X] or [Nurse Y]. There would be no bother to me cause I’m well able to go, I’m well able to cook, I’m well able to do everything myself. They would have me in charge of the tea, maybe a fry some evenings to do and they would stand back, the nurses would be there, but they would let you off on your own with what you have to do. I’m able to do all the housework, I’m able to do all the cooking, I’m able to do every bill in the house cause [Nurse X] gives me training here[...] she makes me go out and pay whatever it is and so on.”*

However, when residents were asked how they liked the food, answers revealed that residents were not actually allowed to cook in the absence of staff:

ANNA: *“I can do my own cooking when one of the cooks supervises, I can do my own cooking, there has to be a supervisor here like one of the girls (cooks) or a nurse here for insurance wise if a fire started. That’s the way we have to live.”*

Brian reported that he would like if staff spoke to the nursing staff on his behalf regarding a move to a higher dependency CRF:

BRIAN: "Have a chat with some nurse about the possibility whether or not I'm repeating myself about [House 2], if I got the chance, then I'd give it a chance. I mentioned it to [Nurse X] she is in the community and she said it's hard to get into [House 2] now [...] but it's more my cup of tea, the area is more relaxing and the place itself is more relaxing [...] it's very close to the bus stop for the workshop."

At the conclusion of this section, residents stated that there was nothing else required from the staff to help them live independently. However, Brian reiterated his desire to move to a higher supported CRF or a long-stay ward in another hospital in the city:

BRIAN: "I might be repeating myself about the accommodation, places like [high-support CRF] or maybe getting an update or are they sure or not yet, but you see, even if I were to get either [high-support CRF or long-stay ward] I'd still be going to the workshop and I might be on computers there."

Further examples of institutionalised thinking were observed when residents were asked if people treated them differently if they knew that they had a mental illness:

BRIAN: "There is little discrimination here or in the workshop, but outside that there might be, not that I think it, but other people might."

BRIAN: "My mother passed away in 1999 the same way, 10 years ago, 11 years ago. I have a sister married, she teaches in (city), that's the only immediate family I have. I have relations outside (city), it's a different world since '78."

The specific mention of the word “*outside*” in the above comments indicated that Brian perceived living in a CRF as different to the outside world. In fact, the word “*outside*” can arguably be considered prison language.

Carmel’s response to the same question was:

CARMEL: *“They say people with mental illness are treated differently, that’s what is said anyway.”*

INTERVIEWER: *“Have you ever experienced that yourself, Carmel?”*

CARMEL: *“I don’t know.”*

It is unclear here who Carmel was referring to by “*they*”—she may have meant staff or society in general. When Carmel responded by stating she did not know whether or not she had ever experienced stigma, it led the researcher to consider that she possibly had experienced stigma and might not have had the confidence to discuss that in a group situation.

For Anna, it seemed that the pattern of institutionalisation had extended to her family:

INTERVIEWER: *“How has your illness affected your life?”*

ANNA: *“I have my family reared now and [Nurse X] is in charge of me now. [David] will meet me at home [...] he is going to college and he would always be home at the weekends to make sure I’m alright and that I get my medication, am I doing well, I have to have bloods done [...] and he checks in to everything for me, he is very good.”*

Before finishing the first section of the interview, the researcher asked if anyone would like to comment on the rules of the CRF. Answers indicated that residents were happy with their structured environment:

ANNA: *“We should have a few more rules in the house I think, and this house would be perfect.”*

CARMEL: *“We have nothing to complain about.”*

Residents' responses to what kept them well focused primarily on medication and structured environments like the CRF and workshop. If this question were asked of people who did not live in a CRF, but were receiving mental health treatment, it is reasonable to anticipate that answers would contain information about family, friends, and activities. Furthermore, none of the residents expressed any negative opinions towards taking medication, notably antipsychotics used to treat schizophrenia which can have potentially undesirable side effects.

Residents' persuasiveness in demonstrating their reasons for living in a CRF illustrated dependency on mental health services, which can be a common feature of people living in institutionalised settings. Anna's choice of the word *“need”* is informative. It is possible that she equated the need to live in a CRF with a means of maintaining health or preventing relapse. Another possibility was that Anna incorrectly or suspiciously believed the researcher was there to determine whether residents needed to live there, despite the fact that the purpose of the interview was made clear to residents by the interviewer herself.

Furthermore, some residents lacked an understanding of the CRF's role, and one resident (Brian), felt he needed to be constantly monitored. Brian may not have expressed a need for constant monitoring if the CRF system was functioning properly. Brian was either not receiving the assistance he believed he required, or he had become so de-skilled and institutionalised in his thinking, that he believed he required constant contact from staff. Brian's repeated request to transfer to a higher-support CRF indicated that he was regressing rather than progressing in terms of independent living. Another possibility was that the service cultivated a sense of dependency and need in some residents.

In keeping with the preceding reflections on institutionalised thinking, all residents agreed that their partners should not be permitted to spend the night in the CRF and communicated that residents might be unhappy with their love lives (as indicated by the quantitative data) because they "*may not have met the right person.*" Residents appeared to be in denial about the possibility that their love life would suffer as a result of having a severe mental disorder and living in a CRF, or perhaps residents were too institutionalised to have the appropriate insight into their current situation.

When asked if staff could do anything to prepare residents to live more independently, responses indicated broad support for staff, but lacked specifics. When questioned, Anna stated that staff assigned roles to residents, and that she was occasionally responsible for cooking evening meals. However, staff prepared the meals for residents in this particular house. Combined with the fact that residents were not permitted to use the cooker unless staff were present, it is possible that Anna's (and other residents') cooking experiences may have been quite limited, reinforcing institutionalisation.

Further examples of institutionalised thinking were reflected in the choice of the word "*outside*" used by Brian when referring to discrimination and family relations. The term is not further elaborated upon, but it likely represented a world far removed from his own experience, which reflected a further example of institutionalisation.

When residents were asked how their illness had affected their lives, Anna stated that *Nurse X* was now in charge of her and her, and that her family members ensured that she received her medication. This implied that Anna had comfortably abdicated all responsibility for her own recovery to others and had developed a strong reliance on others to remain well.

Furthermore, residents' assertions that they "*should have a few more rules in the house*" also reflected institutionalised thinking and demonstrated that residents had adhered to structure and order. Carmel's remark during a

discussion of the house rules, *"we have nothing to complain about,"* implied that the residents were appreciative of their institutionalised, ordered, and restricted lives.

Gratitude emerged as a primary response among the residents. Data indicated that residents were grateful for the location of the house, the staff, their health and getting to home at the weekends:

CARMEL: *"It's convenient to many things around here, you can go out for walks and just go down the road and get a bus into town and get a bus up to the training centre."*

ANNA: *"You can go home and do your own thing, go shopping."*

CARMEL: *"You can even go home at the weekends."*

ANNA: *"The food is good here [...] and the cooks are very good to us, the cooks are fantastic, no complaints."*

CARMEL: *"The staff are very good here to us."*

In addition, when residents were asked how their illness has affected their lives, data revealed that most residents were grateful for their health:

SIMON: *"I have improved, I feel a lot better today."*

BRIAN: *"I look forward to things more, well I used to anyway [...] improved health I'm taking medication now."*

ANNA: *"Oh I'm much happier and jollier and I'm first up in the morning and out to work, out the door and I might even see my sons every evening. Look at all the places I'm able to go now in the last few years!"*

Anna also disclosed the information below of how her illness affected her life in the past and communicated that she was grateful to be alive:

ANNA: “Well I was very sick [with my eldest] when I came into hospital and [Nurse X] got me to [Dr X] and then I was on bed rest for 3 months. I was in hospital for eight months. I couldn't get out of the bed until they tried to figure out what medication was going to be best for me to make me better right [...] thanks be to God, [Dr X] got the right medication for me, and then they put me on shock treatment to clear out the head so I had three shots of shock treatment and thanks be to God that I came through. I'm very lucky to have come out of my illness.”

It appeared from the comments above that the residents' institutionalisation was primarily coming out as gratitude. Residents were grateful to be able to go for walks, go shopping and go home at the weekends. The fact that residents expressed such gratitude for independence and freedom indicated that this sense of freedom was precious or perhaps taken less for granted, than by the general population. In addition, residents, despite not being allowed to cook unsupervised, remained grateful for the staff, the cooks and the food they received, particularly Anna, who loved to cook.

Additionally, all residents expressed gratitude for their health, despite the fact that they had a chronic illness that required medication and, in some cases, prolonged hospitalisation. Both Simon and Brian endorsed feeling better and more optimistic about the future and expressed gratitude for their medication's beneficial role in this regard. Anna's detailed account of a prolonged period of illness and the measures required to recover, including “shock treatment to clear out the head,” was particularly noteworthy. While it is not unreasonable to be thankful to have come through that ordeal, it was possible that this gratitude was a coping mechanism used to mitigate any associated trauma. Finally, when residents were asked if the house was too strict, Carmel responded that they had “nothing to complain about” indicating an overall sense of gratitude.

Stigmatisation

Residents were asked whether they felt comfortable inviting friends and family to the CRF, having romantic partners stay overnight, whether they

were treated differently as a result of having a mental disorder, and whether they would like to get to know their neighbours. However, the majority of data on stigma were revealed in questions unrelated to stigma.

For example, when residents were asked why they thought they needed to live in a CRF, some responses were surprising:

CARMEL: *“I don’t know, I have lived in different places and they change every so often.”*

TOM: *“Because there was no room at home for me.”*

CARMEL: *“I don’t suppose there was much room for me at home either.”*

Given the above responses, the researcher considered the possibility that residents might have lacked awareness of their mental illness. To ascertain this, the researcher directly asked residents, and all agreed that they had a mental disorder.

CARMEL: *“Oh I wouldn’t be here otherwise.”*

Given that the additional probe question ruled out the possibility that the above responses were the result of a lack of insight, a reasonable hypothesis is that residents experienced self-stigmatisation and thus answered the question logically rather than truthfully.

Another indicator of self-stigmatisation occurred when residents were asked whether they believed pets should be permitted in the CRF:

CARMEL: *“How would they manage to keep them in a house like this place?”*

Despite the above, residents did not describe experiencing stigma in the community:

BRIAN: *“There is little discrimination here or in the workshop, but outside that there might be, not that I think it, but other people might.”*

Carmel was less positive in her response when asked if people treated residents differently when they knew they had a mental disorder; *“sometimes they can.”* Also, residents were asked if they felt that their families had a good understanding of their mental disorder, Carmel’s response was again negative with some perceived sarcasm:

CARMEL: *“They accept me all right, I’ll say that much.”*

Self-stigmatisation may have influenced residents' responses to why they believed they were living in a CRF, particularly given that a probing question ruled out a lack of insight. Additionally, residents may have experienced embarrassment or shame as a result of discussing their diagnosis and living situation, particularly in a group setting.

Additionally, Carmel's response to the question about pets in the CRF was revealing given her reference to the CRF as *“a house like this place.”* Although we do not know exactly what Carmel meant by this comment, its negative connotation suggested that she viewed the CRF as distinct from 'normal' people's living environments. In addition, when Carmel added that people can sometimes treat residents differently when they became aware of the residents’ mental disorders, this appeared to include her family as well. Carmel did not convey the impression that her family was accepting of her *illness*; rather, she stated that *“they accept me”*. This statement was consistent with stigma's concepts of difference, shame, and abandonment.

Brian, for the most part, concurred with Carmel's assessment but used more diplomatic language. While he claimed not to face discrimination at the CRF or workshop as a result of his mental disorder, he believed that people may face stigma outside of those settings.

Stigmatisation by the mental health services was particularly dominant in this house. Anna revealed in her response to the question about whether society should have a better understanding of mental disorders that she had encountered stigma from the system:

ANNA: "Well, I'm sure that it would be nice to know that your doctor would be concerned if you weren't taking the medication for the illness you have. You would be back in hospital again just as quick as you would be out, and you would be put on high risk after that maybe the clothes would be taken off you and you might not get out for three months. That happened to me cause I wouldn't take my medication."

Data from Brian's response to the probe question regarding insight into illness ("*Do residents think that they have a mental disorder?*") also revealed that he had felt stigmatised by the system:

BRIAN: "I do at times like, depression, but its schizophrenia they are treating me for, they have me on Clozaril."

However, more robust data was uncovered by Anna when asked if people treated residents differently because they had a mental disorder:

ANNA: "Sometimes I feel myself that I'm not being treated with respect half the times, and they don't want to know you 'Oh we are sick of talking to you, we'll talk to you today and you tomorrow and you the next day' that's the kind of thing that goes on, I don't like that. It makes me hurt, to be honest."

ANNA: "If they know you have an illness, like, they don't want to know you and they will say 'Oh I want to talk to [husband] or I want to talk to such a person' and they will be gone out the door. That's the way I see it and that's been honest, like."

The researcher clarified with Anna if she was specifically speaking about the nurses:

ANNA: *"Yeah, yeah, that's been fair."*

Anna added a further comment about her perceived treatment by the nurses:

ANNA: *"Well if they don't talk to me, I'll walk off and leave them there and let them make up their own minds what they want to do."*

Brian also added a similar comment however, he did not clarify who 'they' were, one can only assume he meant staff working in the CRF:

BRIAN: *"Yeah, at times I feel they are stopping myself from being with other people like."*

Anna recalled an incident in which she was involuntary admitted to hospital for three months where she was constantly observed by staff and had her clothes removed due to medication non-adherence. Anna's comments implied that she felt she was being punished by the system for failing to take her medication. Anna may have also felt stigmatised by this admission, as having one's clothes forcibly removed is extremely stigmatizing and is frequently interpreted as dehumanizing by the individual (Department of Health, 1966).

Additionally, and possibly compounding the traumatic experience described above, Anna believed she was not respected by staff. She sometimes felt that staff *"don't want to know"* her and that they were *"sick of talking"* to her. Anna may also have believed that staff regarded her as inferior to them because she was convinced that staff would rather speak with her husband than with her. According to the evidence presented above, Anna was experiencing emotional distress (e.g. the statement, *"it makes me hurt"*) as a direct result of her perceived treatment by staff. Anna was clearly upset about this issue, as when the researcher moved on to the next topic, Anna interrupted by stating that she *"will walk away and leave them"* if staff refused to speak with her.

Brian provided additional evidence of stigma by the system by stating that he had a diagnosis of depression but was being treated for schizophrenia. The diagnosis of schizophrenia carries a great deal of stigma, and individuals with schizophrenia are frequently viewed as bizarre, unpredictable, or violent (see chapter 2 for details). As a result, given the perceptual differences between the two diagnoses, it was entirely understandable why an individual would prefer to believe they were being treated for depression rather than schizophrenia. Brian may view depression as a disease that can strike anyone and individuals with schizophrenia as possibly 'crazy.' Brian was more than likely to feel stigmatized by the label of schizophrenia. In addition to the above, Brian believed that "*they*" were preventing him from socializing. Although Brian did not specify who '*they*' were, one can only assume '*they*' are CRF staff. If this was the case, it was possible that Brian may have had strange mannerisms or issues with personal hygiene (both of which are common in schizophrenia), and that staff were attempting to shield him from potential abuse/stigma in the community. However, during the interview, the researcher did not observe any issues with behaviors or hygiene from Brian.

Throughout the interview, residents attempted to demonstrate that 'everything was fine' and that their living environment was 'normal.' When residents were asked if they felt uneasy inviting friends and family to the CRF, an example of this was given:

ANNA: *"All the people come here cause [...] you get the cup of tea which is nice, they can just turn off the TV and have a chat."*

However, Brian disclosed that he felt uncomfortable at times:

BRIAN: *"At times, yeah [...] the television might be on and the radio might be on so you would go up to the bedroom."*

Anna, following on from Brian's response, quickly tried to minimise his concerns:

ANNA: *"He has his own room."* >pointing to Brian<

ANNA: “*You can bring them in here or the sitting room the choice is there, and you can close the door there and there is not a bother, isn't that right guys?*”

ANNA: “*If there is anybody here when my visitors come in, I have my own room upstairs, I can have privacy up there and I have the TV and everything up there so there is nothing to be missed. The radio is up there everything is up there*”

Simon also agreed when probed that he did not mind inviting family and friends to the residence.

Finally, Anna communicated how she “*looks after*” a neighbour next door:

ANNA: “*There is an old lady next door and I do be looking after her like, and she got a bit of a fall this time last year. She has to go in to have surgery on her hip, her husband is in hospital too, he has Alzheimers [...] and I do be looking after her like and looking out for her and helping her bring in the shopping to the house.*”

The above comment suggested that Anna was trying to normalise her situation with neighbours in the community.

Residents' attempts to demonstrate that living in a CRF was 'normal' may be a result of institutionalisation; in other words, living in a CRF had *become* a normality for them. Brian admitted that he occasionally felt uneasy inviting friends and family members to the CRF, but his reasoning was appropriate and may have reflected the views of people living in shared housing in mainstream society—fear of disrupting other residents.

However, Anna quickly attempted to alleviate Brian's concerns by emphasizing that “*he has his own room.*” She continued to emphasise how normal living in a CRF was by revealing that she had “*her own room*” with “*privacy,*” a “*TV,*” and “*everything up there,*” including the radio. The fact

that she looked to other residents to support her theory (e.g. the statement “*isn't that right guys?*”) further demonstrated her attempt to normalise living in a CRF.

Another indication that Anna was attempting to normalise stigma came from her description of her interactions with a neighbor. Generally, caring for elderly neighbors in the community is regarded as 'normal' behavior, and Anna may have been attempting to convey this to the researcher. This comment, however, appeared to contradict a previous statement made by Anna in which she stated that *she* required the assistance of a nurse to look after *her*.

Summary

Residents may feel more at ease in organised and structured environments and the majority of residents had taken on the 'sick role,' relinquishing all responsibility for themselves to staff, believing that they were "*in the doctor's care*" and requiring nurses to "*check up*" on them.

Residents were also using medical jargon, referring to the term "*medicine involvement*" and citing health and safety rules as the basis for restricted access to the kitchen. In addition to the above evidence, the majority of residents believed they should be permitted to remain in the CRF indefinitely, showing that they were content with their situation. Residents expressed gratitude for the staff, their food, their health, and their independence which consisted of being allowed to go home at the weekends and get the bus into town or the training centre.

Furthermore, residents did not mention care plans and were unable to articulate how staff were assisting them or could assist them in preparing for more independent living (which is the overall goal of living in a medium support CRF). Additionally, Anna seemed eager for the researcher to move on from the topic of rehabilitation and began speaking on behalf of other residents, concluding her remarks with questions such as "*is that all right?*" and "*is that a good enough answer?*"

Overall responses from residents indicate that recovery orientated care is not even been discussed with residents and some staff were giving counter-recovery messages to residents. Indeed, staff may have been impeding residents' integration into the community by occasionally refusing to allow Anna to attend her regular dancing classes. Brian also indicated that staff occasionally prevented him from socializing with other people. Additionally, evidence of unaddressed trauma and grief in people dating back over 30 years, was discovered.

Despite the fact that residents confirmed a need for the service and expressed gratitude for it, they acknowledged feeling stigmatised by mental health professionals. Anna, for example, felt stigmatized when her clothing was removed during a hospitalisation many years ago; she also believed her admission and the treatment which followed (including clothing removal) were a punishment for failing to take her medication.

Anna felt inferior to staff and believed that they did not respect her. Despite these experiences, residents attempted to 'normalize' living in a CRF by attempting to convey to the researcher the idea that everything was good—*"we are a happy little bunch here"* and recounted examples of assisting neighbours and going to work (i.e. training centre). Residents appeared to be in denial about their actual situation; for example, residents believed that people living in CRFs were unhappy with their love lives in general because they did not have the opportunity to meet the right person, not because they were living in a CRF as a direct result of having a chronic mental disorder.

A probable explanation for the residents' responses is that they appeared to be institutionalised in both their thoughts and behaviours in the absence of recovery-oriented care. Residents lacked formal awareness of the recovery model, lacked a clear understanding of the CRF's function, associated regular domestic duties with rehabilitation, and lacked purposeful occupation by instead attending a training center that was not evidence-based. Given the above information, it was logical to believe that staff facilitated the above experiences for residents through the use of custodial and paternalistic forms

of care, resulting in residents developing a dependency on staff and the service in general. For example, residents were able to convey clearly that they needed to live in the CRF and would prefer that nursing staff contact them more frequently than once per day.

Despite their circumstances and prior experiences, residents expressed a desire for recovery-oriented care by stating their future goals. It would be far more helpful for residents to live their lives through recovery than it would be to live their lives through custodial care and compliance with health and safety rules.

House No 4

Profile of residents and house description

Three males and one female ranging in age from 18 to 65 took part in the focus group for H4. Two females were unable to take part in the group due to prior engagements.

H4 is a 24-hour nurse staffed residence with six beds located on the outskirts of a city. It caters to people with severe and enduring mental disorders and complex needs. The main goal was to provide rehabilitation and recovery to residents so that they could transfer to lower support CRFs when ready, with the overall goal being full independent living. Residents left the CRF during the day to attend activities in the community, and they cooked meals on a daily basis. The environment was warm and welcoming as it was nicely painted and decorated. It had comfortable furniture, a spacious living room, a relaxation room. There was a resident pet dog living there who was loved by both residents and staff. This particular residence was more luxurious than the others, possibly because it had originally operated as a private bed and breakfast.

Findings for House 4

Themes emerging from H4 are presented in the following table along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail.

Themes Emerging from House 4	Resident Descriptive Phrases
Lack of Recovery-oriented Care	<p><i>make it happen more quicker</i></p> <p><i>make it a bit more positive for our minds</i></p> <p><i>don't really initiate counselling</i></p> <p><i>not much they have to do</i></p> <p><i>laughing with each other all day</i></p> <p><i>they just drug you up</i></p> <p><i>told I would never recover</i></p> <p><i>implementing the house rules</i></p> <p><i>just here to form atonement</i></p> <p><i>get you ready for adulthood in a childish way</i></p>
Stigmatisation	<p><i>make them socially accepted</i></p> <p><i>call them social centres</i></p> <p><i>mental illness, it's not a nice name</i></p> <p><i>prove to them that you can be the same person without drugs</i></p> <p><i>trying to go around undetected</i></p> <p><i>need something to keep me locked away</i></p> <p><i>they haven't enough research</i></p> <p><i>they write about us everyday</i></p>
Loss of Normal Life	<p><i>looking forward to getting home</i></p> <p><i>taken away my life and given me a new one</i></p> <p><i>you have to stay</i></p> <p><i>preferred my old life</i></p> <p><i>feel like I'm being poisoned</i></p> <p><i>it's the medication</i></p>
Loss of Autonomy	<p><i>awful strict</i></p> <p><i>love doesn't come around all that often</i></p> <p><i>not allowed to drink</i></p> <p><i>could give us more freedom</i></p> <p><i>should let me drink</i></p> <p><i>should let me do what I want</i></p>
Loss of Hope	<p><i>I could move on and feel better about myself</i></p> <p><i>have something definite to look forward to</i></p> <p><i>at home with family</i></p>

Table iv: Themes and descriptive phrases from house number four

Lack of recovery-oriented care

Residents were asked to describe the role of staff working in the CRF, responses indicated that residents were not completely satisfied with the level of input from staff:

JOE: *“They could push the button a bit, they could make it happen more quicker and make it a bit more positive for our minds.”*

Although it is not absolutely clear what this resident meant by the above comment, a plausible explanation might be that he felt that staff do not discuss future options or goals regarding moving on from the CRF. Given the above comment, residents were asked if they find staff approachable and feel comfortable talking to them, all residents communicated that they did *“oh yeah.”* However, they highlighted that *“counselling”* does not happen on a regular basis:

HARRY: *“[...staff] don't really initiate counselling; they wait for you to come to them.”*

Residents held the perception that staff were not assisting them with moving forward and were not initiating counselling. In addition, when residents were asked how they would feel if they were asked to move out in six months' time, one resident implied that this would motivate him to get better:

JOHNATHON: *“Yeah, well I'd try and get myself better within that six months.”*

This comment indicated that the application of the recovery model appeared limited, as it did not sound like there was a structured care plan with attainable goals in place regarding future accommodation options.

Residents did not specifically state that staff did not engage in rehabilitation with them, but gave the impression that staff were able to afford the time to engage in rehabilitation:

HARRY: *“There is not much they have to do, except be there for us if we need a bit of counselling or something to say, or to take your medication.”*

JOE: *“They’re there laughing with each other all day, ya know, to be honest, sitting around drinking tea and coffee.”*

To further support the argument that rehabilitation was limited in H4, residents perceived staff to have the opinion that residents did not have the ability to recover:

JOE: *“They just drug you up, once you are drugged up, they see the case as closed and it’s finished.”*

The above comment was communicated in a distinctive sarcastic tone. In keeping with the above, none of the residents had heard of the recovery model, and one resident reported that he was given unhelpful and counter-recovery model information regarding his diagnosis:

HARRY: *“I was told I would never recover by Dr. [X] and his team.”*

Finally, residents perceived the role of staff in the CRF to be authoritative rather than rehabilitative:

SELENA: *“[The role of staff is] implementing the house rules [...] and the house law”*

JOHNATHON: *“They have to teach the patient how to be on the ball, like you know, with their own chores, kind of thing.”*

Data from residents indicated that staff were not engaging residents in recovery-oriented care and one comment indicated that residents perceived staff to have a punitive role in their treatment and care:

HARRY: *“They are just here to form atonement, kind of thing, you know.”*

Despite the above, one resident described a sense of gratitude for the rehabilitation opportunities they were receiving, despite the fact that this 'rehabilitation' seemed to be delivered in a way that may have been disrespectful to some residents:

HARRY: *"It's a sanctuary for moving on, ya know, to get yourself ready and I'm thankful for that because I've never been in a place where I've had to cook food for six heads, right, and then afterwards clean up after them, clean the floor. It does stuff for you that your mother did for you when you were between nought and ten, but on a different scale. Things your mother did for you when you were between nought and ten were mainly maternal. This here [the CRF] seems to be maternal in a way, they get you ready for adulthood in a childish way."*

From the data above, it would seem that there is a disconnect between residents and staff. Residents described an unmet need by expressing the opinion that staff were not doing enough to speed up their discharge process to more independent accommodation *"they could push the button a bit."* They also felt that staff should be more forthcoming with regard to offering counselling instead of residents having to approach them. By counselling, it is possible that residents meant regular discussions on goals for the future, including accommodation goals.

In addition, residents perceived staff as not having any form of structure to their day as they *"sit around," "laughing,"* and *"drinking tea."* Compounding the above is the fact that residents perceived that staff viewed them as incurable because *"they say, you will never be cured"* and therefore, the preferred option is to *"drug [them up ...] case closed."* Residents were not hopeful about the future because staff did not seem to be discussing goals or options regarding moving on from the CRF. Residents felt that they would be motivated to get better if they knew they would be moving to more independent accommodation in six months' time.

The only ‘rehabilitation’ that residents described seemed to focus on house chores, “*having to cook,*” “*clean up after them,*” and “*clean the floor.*” In general, residents from H1 were dissatisfied with the level of input from staff regarding moving forward with their goals. This, in conjunction with the fact that residents perceived staff as having a largely punitive role in their treatment, suggested that residents were receiving custodial care rather than recovery-oriented care. It is difficult to see how recovery can take place in this type of environment.

Stigmatisation

At the time of data collection, CRFs were referred to as ‘hostels’ within the mental health service. All residents felt that this term was stigmatising and agreed that they should not be called ‘hostels’ and that this term should be changed.

SELENA: “*They should change the laws to make them socially accepted.*”

JOHNATHON: “*They should call them social centres.*”

Further evidence of stigma arose when residents were asked if people treated them differently if they knew they had a mental disorder:

JOE: “*I don’t believe in mental illness, it’s not a nice name.*”

HARRY: “*I don’t believe in it either, people are born equally like animals, you don’t see mental illness on a Jaguar that’s running through the forest.*”

Residents also communicated that they felt the need to “*prove*” to people that they were the same person with and with without medication:

JOE: “*You might be acting differently; you need to prove to them that you can be the same person without the drugs and as well with the drugs.*”

Another resident, described the possibility of people talking about him “*behind the scenes.*” However, in contrast to this, some residents felt that people may have viewed and treated them in a more positive light secondary to their mental disorder:

JOHNATHON: “*They talk about you in a more comforting way.*”

INTERVIEWER: “*In a nice way you mean?*”

JOHNATHON: “*Yeah, they know you have had a rough time.*”

When residents were asked if they would like to get to know their neighbours, they communicated that they already knew their neighbours but possibly from a distance:

HARRY: “*Our neighbours, oh we know our neighbours, don’t we Joe? Mr. [X] is his name, the others [neighbours] have grandchildren playing in the garden.*”

However, this comment was said in a sarcastic tone, followed by laughter. The sarcasm in the above comment implicated the possibility of tension between the residents and their neighbours and highlighted that residents were very aware that they were not part of normal socialising within the community. The following comment supported this theory:

HARRY: “*We are trying to go around undetected, like.*”

The above comment may be an indication of self-stigmatisation. Further evidence of possible self-stigmatisation emerged when residents were asked to describe why they thought they needed to live in a CRF:

JOE: “*I need something to keep me locked away, it keeps me occupied and on the straight and narrow.*”

In addition to the above, residents felt that they were being stigmatised by staff:

JOE: *“I think the balloon is going to burst, they haven’t enough research, they don’t know enough to be able to apply a label to you, like schizophrenia.”*

INTERVIEWER: *“Do you feel that people attach labels to you?”*

JOE: *“No, except the doctor.”*

Residents also described feeling scrutinised by staff on a daily basis:

HARRY: *“They take notes every day, they write about us every day and every morning and every night, they know exactly what’s going on, what you had for dinner, do you know what I mean, everything, everything.”*

Residents appeared to be acutely aware of stigma from the mental health services and staff. For example, they were aware that the term ‘hostel’ was stigmatising and communicated that they would like to see this changed. They also felt that the word ‘schizophrenia’ was weighted with stigma and that doctors could possibly have applied this label to them without having enough evidence. They obviously felt that there were negative consequences attached to that label. Residents did not specifically state that they felt stigmatised by staff recording their every move, but this behaviour may have made residents feel uncomfortable. The level of recording seemed unnecessary. However, it may have been done because the service viewed people with psychiatric disorders as unpredictable, with this opinion having been common in the past, as outlined in chapter one. Monitoring residents for signs of unpredictable behaviour aligns more with custodial care rather than recovery-based care.

In keeping with the above, residents also felt that the term ‘mental illness’ was stigmatizing, *“it’s not a nice name.”* Residents queried why this term

needed to be used by concluding that animals didn't stigmatise each other, so why did humans stigmatise each other?

Regarding stigma from society, residents had mixed opinions. Some had never experienced stigma, and in fact, some felt that people may have treated them in a *more* caring way as a direct result of their mental disorder. Others felt that they needed to prove themselves to people to show that they can be 'normal' without medication. However, residents gave the impression that they did not have a close or good relationship with the neighbours to H4 and responses with sarcastic tones indicated that there might have even been tension between the residents and these neighbours. Residents stated that they were trying to go around "*undetected*." This may have been a direct result of negative interactions with their neighbours, but it could also have been an indication of self-stigmatisation. Residents may have also been trying to hide themselves from society. In fact, one resident stated that he needed to be "*locked away*" in a CRF to keep him on the "*straight and narrow*." Residents may possibly have been picking up indirect messages from staff, neighbours and society in general that 'if they were not well enough to blend in then it was better to be invisible.'

Loss of a normal life

Residents felt that having a mental illness had negatively impacted their lives. A significant impact being that they had to reside in a CRF:

JOHNATHON: "*Yeah, staying here, yeah, you would be looking forward to getting home like, ya know.*"

Some residents gave the impression that they did not have a choice with regard to living in a CRF:

SELENA: "*You have to stay in [House No 4].*"

Both of these comments were expressed in a noticeably sad tone. In fact, there seemed to be a sense of defeat behind the above words. Another resident described a sense of loss for his old life:

JOE: *"It has taken away my life and given me a new one."*

INTERVIEWER: *"...Which is a good thing, is it?"*

JOE: *"No, it's very bad, I much preferred my old life compared to my new one."*

It is possible that this resident was speaking about his life before he became ill. In addition to the above, residents were also enduring unpleasant side effects of medication:

JOE: *"I feel like I'm being poisoned, it's poison, if you take too much of it you die. I nearly died from an overdose, well I'm not sure if I was dying, but I would say I was close enough to it."*

HARRY: *"I put on four stone and they keep saying 'you eat too much,' but that's rubbish, it's the medication, there is no doubt about it, like. The doctor said it to me, different people say it to me that I've put on four stone, but I can't do much about it."*

Although there is no definition of a normal life, it is reasonable to assume that such would include choices within an independent living environment. The fact that residents perceived living in a CRF as not a choice of their own likely acted to undermine any feeling of normalcy in this regard. The fact that this message was delivered in a sad tone, also indicated that the resident felt a sense of defeat and seem resigned to living there. Whether this was the case or not, the residents' overall perceptions of their situation were not positive. Therefore, the impact of having a mental disorder, for this particular resident, was that they could not live where they wanted to live, the way any other 'normal' citizen would be able to make that choice. This theme also illustrated

that residents had a sense of loss for a normal life, whether it was their life before they became unwell or a life which they had anticipated having.

Weight gain is a common side effect of some psychiatric medications, particularly anti-psychotic medication. Four stone for one resident was a significant weight gain (56 lbs) that could have brought about other issues such as low self-esteem and poor physical health. The question that the latter raised, was why a person would continue to take medication that contributed to such weight gain? It may have been that there was a threat of re-hospitalisation if the medication was refused. For example, individuals diagnosed with schizophrenia can uncommonly be at risk to themselves (including significant deterioration) or others, which accounts for different approaches to care; including legislation which enforces hospital admissions and treatment (Mental Health Act, 2001). This legislation is only applicable to people with mental disorders, which re-enforces the fact that they are different from the general population and not living a 'normal' life.

Loss of autonomy

Residents spoke about the strict rules of the house and felt that the house they were residing in was particularly strict compared to other CRFs:

JOHNATHON: *"The house is awful strict."*

HARRY: *"Well that's just the house, if you were up in House [number X], you could go out if you wanted to."*

Some residents seemed discontented at the fact they were not allowed to drink alcohol (like 'normal' people) and repeatedly used this point throughout the interview to illustrate how restrictive and abnormal their living environment was:

JOE: *"You're not supposed to be drinking, you're not allowed to drink [...] If I touch a drop of alcohol I'll be locked away in a hospital."*

When residents were asked if they felt that they had enough opportunities to socialise, responses were *“no I don’t think so.”* They again highlighted the fact that they were not allowed to drink alcohol and felt that this was affecting their chances of meeting a partner:

HARRY: *“You’re not supposed to be drinking, you’re not allowed to drink [...] love doesn’t come around all that often”*

Residents were significantly aware that they were living in an abnormal environment with strict rules and regulations that were completely different from the living environments of most ordinary citizens. For example, when the researcher asked residents how they would feel about having their romantic partner stay overnight in the CRF, they seemed shocked that the researcher would even ask that question. Their response was one of shock followed by laughing out loud:

HARRY: *“Oh my God!”*

In fact, one resident thought it was so absurd that he compared it to the apparent and perceived intractability of the house’s ‘no drinking’ rule:

JOE: *“That’s like saying we are allowed to bring a crate of beer into the house.”*

When asked if there was anything that staff could do to help residents, again most of the answers were around increasing autonomy:

HARRY: *“They could give us more freedom.”*

JOE: *“They should let me drink.”*

JOHNATHON: *“They should let me do what I want to do.”*

It is quite possible that residents were not allowed to drink for medical reasons, such as interference with medications, or risk of triggering a relapse. However, it seemed unfair that there would be an outright ban on alcohol use for all residents living in this particular CRF. Of course, it is possible that staff may have been of the opinion that it was easier to manage risk by having all residents refrain from alcohol (in case people become violent when drinking). Whatever the reason, residents perceived that this particular rule was more for punitive reasons than medical reasons.

Not only did residents connect this rule to a lack of autonomy, but they also felt that it was affecting their social life and their chances of meeting a partner by loss of social opportunity. It may be more difficult for people living in a CRF type of environment to find a partner because of rules and regulations which limit autonomy. It would seem that barriers were in place that may have prevented the development of friendships and relationships, which in turn prevented community integration.

Residents described a sense of not having control over their own lives and they were fully aware of the fact that they did not have the same rights as ordinary citizens. More specifically, in that they did not have the freedom to go out and socialise when they wished or have their partner stay overnight in the CRF.

Loss of hope

Responses from residents indicated that there was a sense of hopelessness amongst the residents. Although residents did not speak directly about hopelessness, it was communicated through their non-verbal communications (e.g. downward gaze, diminished tone and slumped posture) and neutral to negative comments about the future. For example, when asked what does recovery mean for residents, they described the following:

JOE: *“It would mean I could move on and feel better about myself, life would be pretty different.”*

The above comment was a subtle comment, but the language used implied a sense of hopelessness about the future. To emphasise, the resident did not say “*it will mean,*” which implies an active process and confidence in that process. As a result, when this comment was matched with negative nonverbal communication, as the participant looked defeated (i.e. his voice was quiet and was physically listless), the researcher observed a distinct feeling of hopelessness. Other comments had a similar tone:

JOHNATHON: “*I’d have something definite to look forward to.*”

Residents did not give the researcher any indication that they expected their situation to improve. Even when residents were asked where they saw themselves living in five years’ time, all of the participants gave short, dismissive answers devoid of detail:

JOHNATHON: “*At home.*”

SELENA: “*With family.*”

HARRY: “*Somewhere in Europe.*”

JOE: “*At home with my family.*”

Although hopelessness is common in people with mental disorders, particularly schizophrenia, it is possible that residents would feel less hopeless if they were living elsewhere. However, living in a restrictive CRF was compounding matters and residents seemed to have learned to accept their situation. Residents did not visualise or even talk about the future, which is another indicator of hopelessness.

Summary H4

The overarching theme within H4 was loss. Residents felt a deep sense of loss in their lives given the fact they had an enduring mental disorder and were

living in a restrictive CRF environment. Consequently, they had the added burden of unemployment, possible fractious relationships with family and friends, and experiences of stigmatisation, secondary to their mental disorder.

Residents were exceptionally aware that they were not living similar lives to ordinary citizens. They lived in an environment with strict rules and regulations and seem to be longing for a more 'normal' life. They had to endure unpleasant side effects of medication, which caused one resident in particular to gain four stone. They had lost their independence and autonomy and were dissatisfied with the rules imposed on them. There was a definite sense of hopelessness amongst residents, possibly because the future was not being discussed or addressed in any form, they were not receiving adequate rehabilitation and some residents were even told that they would "*never recover.*"

In fact, the message being picked up by residents was that staff did not expect them to recover and would prefer to drug them up rather than focus on rehabilitation. Residents were also of the opinion that staff did not "*have much to do*" and were only there for authoritative purposes. Furthermore, residents felt that they were being treated like children, as the 'rehabilitation' they received was described as having been delivered in a "*childish way.*"

Compounding matters were that residents experienced stigma from many angles; self-stigmatisation, stigma from the system, stigma from staff and stigma from society. In fact, they described themselves as trying "*to go around undetected.*"

It would be practical to assume from the above data that this CRF was enacting the recommendation of the previous policy document (*Planning for the Future*, 1984) (discussed in chapter one), rather than the current one. This document recommended the creation of CRFs (loss of normal living environment) where the culture of staff dictated how residents were treated. In this instance, treatment involved limiting residents' freedom and choices (loss of autonomy) and disempowering them from moving forward with their

lives (loss of hope). It is clear how the culture of the system has a corollary adverse effect on residents. If the system put less energy into policing the residence and more energy into promoting recovery, residents would possibly be more positive about the future and happier in general.

House No 5

Profile of residents and house description

House 5 had seven residents in total, four females and three males. Five residents had a diagnosis of schizophrenia, and two residents had a diagnosis of affective disorders. All residents were between the ages of 18 and 55 years. One resident had a prior engagement, one resident did not wish to attend, and one resident forgot about the group and joined the group half-way through. Therefore, four residents attended the first part of the group and five residents were present for the second part of the group.

House 5 was a seven-bedroom, low-support community residence, situated in a quiet residential area in the suburbs of a city. This particular house was the newest CRF in the locality. The focus group interview took place in the living room. Furniture consisted of a couch, four armchairs and a coffee table. This particular house was purposely refurbished house for use as a CRF and was first opened approximately one year prior to the focus group taking place. There was an office for staff on the ground floor which was kept locked. The kitchen was not observed. A small number of residents were attending the local training centre (also known as the local workshop). Residents had total freedom to come and go as they pleased and were free to move out if they wished. Staff supervisors were present from 5 p.m. until 11 a.m. the following day. Community nursing staff called on a weekly basis, and residents attended regular out-patient appointments at the local Department of Psychiatry.

The researcher had worked on a one-to-one basis with two of the residents when they were living in a different CRF. However, only one of these residents attended the interview. The researcher had not worked with the remaining three residents either individually or through occupational therapy in-patient groups.

Findings for House 5

Themes emerging from H5 are presented in the following table along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail.

Themes Emerging from House 5	Resident Descriptive Phrases
Lack of Recovery-oriented Care from staff	<p><i>my own independence</i></p> <p><i>a place of my own</i></p> <p><i>should move on...when they are ready</i></p> <p><i>they don't talk to us about that</i></p> <p><i>everyone gets on</i></p> <p><i>give us plenty of leniency</i></p> <p><i>no arguments</i></p> <p><i>roof over your head and a place to sleep</i></p> <p><i>that's the rules</i></p> <p><i>hard to live on my own</i></p> <p><i>family are overprotective</i></p>
Institutionalisation	<p><i>a lot of stress if you were in your own house</i></p> <p><i>free to do what I want</i></p> <p><i>it's up to ourselves</i></p> <p><i>we are very happy</i></p> <p><i>trying to stay positive</i></p> <p><i>make the most of what I have</i></p> <p><i>we tend to look out for each other</i></p>
Stigmatisation	<p><i>mental asylums</i></p> <p><i>we're not mental</i></p> <p><i>she complained</i></p> <p><i>keep your distance</i></p> <p><i>some are scared</i></p> <p><i>still a bit of stigma</i></p> <p><i>I don't tell anybody</i></p> <p><i>I don't have anyone calling here</i></p>
Loss of Normal Life	<p><i>not really allowed to socialise</i></p> <p><i>stopped every move we make to go out</i></p> <p><i>told not to drink</i></p> <p><i>treated like children</i></p> <p><i>not able to be a full-time mom anymore</i></p> <p><i>would like to have more children</i></p> <p><i>I lost it all</i></p> <p><i>[the medication] destroyed me</i></p>

Table v: Themes and descriptive phrases from house number five

Lack of recovery-oriented care

Although all residents stated that they had not heard of the recovery model, one resident acknowledged that she had heard of the Wellness Recovery Action Plan (WRAP), however she did not seem to realise that the WRAP was actually part of the recovery model. Despite this, when residents were asked to list or describe what, in their opinion helped them to remain well, responses demonstrated a firm knowledge base of the principles required for recovery. For example, financial independence was described as being “*very important,*” as well as, “*good diet, sleep, exercise, religion, medication*” and the ability to “*manage stress.*” The importance of “*routine*” (e.g. “*employment and training courses*”) was also identified. Having good supports, such as family and friends, and being able “*to give love and receive it*” were also described. “*Living in shared accommodation*” (i.e. CRF) and “*having the freedom to do what you want*” were also noted. Residents did not, however, mention that staff or engaging in rehabilitation helped them to remain well.

When residents were asked where they saw themselves living in five years’ time, all residents expressed a desire to be living independently in either bought, rented or council owned accommodation:

THOMAS: “*I’ll be in a place of my own, my own independence yeah [...] rented or bought, yeah.*”

DAVID: “*Five years’ time? The plan for me like, I was hoping to move to London as soon as I [...] get a bit better.*”

CAROL: “*I’d like to have a place of my own, yeah in five years’ time [...] I would never buy, I don’t think in five years’ time I will have the money to buy.*”

One resident implied that independent accommodation is the goal for everyone:

BARBARA: *“I think that’s everyone’s wish that they would like to have a place of their own, council house or a flat or something.”*

Residents expressed a uniform desire to live independently, although, how this goal might be achieved was not discussed. Residents did not state that they planned on finding employment in the near future to facilitate this goal or that they were on the waiting list for government housing. For residents living in low-support CRFs, a discussion between staff and residents on how to achieve the goal of independent accommodation should be a regular one. Without a structured plan in place, this goal may never materialise.

The fact that all residents, with the exception of one, were unfamiliar with the recovery model and felt that six months was insufficient to prepare for independent living (despite living in a low-support CRF) suggests that rehabilitation was minimal to nonexistent in this residence. For instance, David and Carol provided the following responses when asked how they would feel if they were asked to move out in six months:

DAVID: *“Six months? Oh, I'd like to stay here.”*

INTERVIEWER: *“You would like to stay longer?”*

DAVID: *“Yeah, right now, you know the way I feel now like?”*

CAROL: *“Yeah, I would feel the same, I would feel that I need to be stable for a period of time before I move on. A good period of time, you know? I would love to be able to move out on my own and be independent, but I feel six months is too little time, too little time.”*

When residents were further asked for their opinions on whether or not residents should be allowed to live in a CRF permanently, responses indicated that people should move on but only when it was the right time for the person:

CAROL: *“If you are well enough and stable enough for a period of time and*

have a place to go.”

DAVID: *“Yeah, I guess so, yeah I think they should move on yeah, but when they are ready like, no deadline or nothing.”*

BARBARA: *“They should move on, if they could at all and if they have a place to go.”*

Although residents expressed a desire to live independently, responses indicated that despite living in a low support CRF, independent living remained more of an aspirational than an attainable goal. Furthermore, residents felt that they should not be put under pressure to “*move on*” from the CRF. Although they did not elaborate on why six months was “*not enough time*” to move out of the CRF, or why they should not be pressured to move out, possible reasons may be that residents did not feel ready from a rehabilitative point of view.

However, more plausible explanations may have been that residents had limited options for alternative housing, and that residents did not receive guidance and support in this area. In addition, staff did not appear to have meaningful conversations with residents about this matter. Possibly, residents' reluctance to relocate in the near future was also attributable to financial concerns and transitional stress. Residents may have received emotional and practical support (assistance with activities of daily living) from staff and felt a sense of security from living in a CRF, which would have made the transition to independent living unappealing. Residents may have also appreciated the social aspect of living with other residents in similar circumstances. Consequently, it is reasonable to assume that residents were fearful and anxious about their housing prospects in the future. However, unless staff addressed these anxieties and concerns (which did not appear to be the case in this particular CRF), independent living would remain an aspirational goal for residents. This may have had a significant impact on the CRF system's overall functionality and led to the system becoming saturated. When residents were asked if there was anything staff could do to assist them

in their journey toward independent living, their responses confirmed that staff did not address this issue with them. However, this information was only revealed after probing:

THOMAS: *“Ah they are good here you know, you know they don't bother you too much, they let you do your own thing.”*

DAVID: *“I think they are good as well.”*

BARBARA: *“They let us do our own thing, I agree with you.”*

INTERVIEWER: *“Okay, but what can staff do to help you move out of the house and live independently or with friends or family or wherever it is you want to live?”*

BARBARA: *“They don't talk to us about that.”*

INTERVIEWER: *“About moving on, is it?”*

BARBARA: *“Yeah they could talk a bit more maybe about it or we could talk to them about it and get them started then to talk to us about it.”*

Following the above comment Barbara was concerned that she may have been critical of staff:

BARBARA: *“Was it any harm to say that?”*

Similar responses were provided by residents when they were asked what they perceived the role of the CRF supervisors to be:

THOMAS: *“Ah they are friendly, you know”*

BARBARA: *“Very friendly, as SIMON says, ‘They give us our own way’ and plenty of leniency, they are very good.”*

BARBARA: *“They are good, they are quite good.”*

Given the above responses, the researcher asked the following probe question:

INTERVIEWER: *“Yes. Yeah, I'm wondering if people think they need more experience with shopping, cooking, paying bills, laundry, etc?”*

BARBARA: *“Not at all, we are all okay with that.”*

THOMAS: *“Well, I find everyone gets on you know, there is no arguments, everyone is good at the shopping, everyone is good.”*

Furthermore, when residents were asked for their view on the role of the CRF in general, some responses indicated that residents were either not aware of the role of the CRF:

THOMAS: *“It gives you a roof over your head and a place to sleep. We all live together and get on with each other, cook together, right, living in a community, living in an environment and fitting into society.”*

BARBARA: *“We all get on very well, it's a close group in this house, and we keep out of each other's way as well, some of us might be in our rooms and some in the dining room and someone else might be in the sitting room and you know, we all have our own interests. We watch television and other interests, reading and different other things as well.”*

Lack of recovery was further suggested by residents indicating that there was a regimented system in place with regard to taking medication:

THOMAS: *“If you're in another house, it's up to yourself. You're not told to come in at certain times to take it. But that's all part of it if you're staying here, that's the rules.”*

In addition to the above, when residents were discussing how illness had impacted their lives, David indicated that he would find it difficult going from a CRF to independent living because of his living environment at the time:

DAVID: *“It is hard to live on my own, I get everything done like, you know?”*

Furthermore, residents felt that their families did not have a good understanding of their illness:

SARAH: *“Yeah, they don't realise how seriously ill I can be.”*

DAVID: *“My family, they make a big thing out of things, you know? They are overprotective and they are on your case ringing you and I'd prefer if they would just let me live my life and I come and see them on the weekends and that, but I don't want them interfering.”*

CAROL: *“It has taken them nearly over 15 years to understand, I suppose over the last two years now they are more understanding and accepting, it was hard, you know? There was a lot of bullying going on for a long time with them, but now they are understanding.”*

However, residents felt families were reluctant to participate in family education:

CAROL: *“Yeah it was brought up to have a family meeting with my family, but my family they don't want it anymore, they are just not keen on it at the moment”*

Residents were not forthcoming with any information with regard to staff except the fact that they were “good,” “very good,” “quite good,” “friendly,” and that they allowed residents to do their “own thing.” They seemed to appreciate whatever autonomy was present, “they give us plenty of leniency, they are very good,” and did not mention that they engaged with staff in terms of any form of rehabilitation.

The fact that staff did not discuss the next step for residents in terms of accommodation was only disclosed when residents were directly asked “*what can staff do to help you move out of the house and live independently?*” A possible reason for the lack of information regarding staff may have been that they were fearful of repercussions for criticising staff. Barbara’s comment (“*was that any harm?*”) indicated that she was concerned that she might get into trouble within the system for criticising staff. However, a more logical explanation for the above may be the fact the residents felt they did not need any assistance with activities of daily living (ADL) (e.g. the statement, “*not at all, we are all okay with that.*”). Staff may have felt that they did not need to provide assistance to residents with regard to ADL, if residents were already confident in this area.

It seemed from the above data that residents were unsure of both the role of staff and the role of the CRF itself. Thomas did not see the CRF as anything other than a “*place to sleep*” and Barbara spoke about how well residents got on together and how they spent their time rather than directly answering the question regarding the role of the CRF. Possible reasons for these answers may have been the fact that this question was asked in the early stages of the group, and since Thomas and Barbara were not familiar with the researcher, they may not have felt comfortable answering these questions. Furthermore, Thomas’s comments suggested that he may have been trying to please the interviewer with his textbook answer: “*We all live together and get on with each other, cook together, right, living in a community, living in an environment and fitting into society.*”

Additional evidence of lack of rehabilitation can be gleaned from Thomas’s comment regarding the regimented medication system in the CRF as he indicated that residents had to “*come in at certain times*” to take their medication. For residents living in a low-support CRF, self-management of medication is a basic requirement, which did not seem to be occurring in this CRF. Furthermore, the treatment and care residents are receiving appear to be fostering independence as residents anticipated that living independently would be difficult as a result of “*getting everything done*” for them. In

addition, residents expressed dissatisfaction with their perceived treatment from families including perceived bullying and high-expressed emotion, if families were engaging in family education, residents may have had a more positive experience in terms of familial relationships.

Institutionalisation (emerging through gratitude)

Despite having a chronic mental disorder and living in a CRF, residents displayed a sense of gratitude for what they had, whether it was the staff, food or the ability to think positively. For example, it was evident that residents had a general appreciation for staff as they described them as being “*lovely, very good, friendly.*” Residents were also appreciative of the fact that staff provided assistance with household chores:

DAVID: “*They help with the cooking and cleaning, keeping the house, maintenance and that. It would be a lot of stress if you were in your own house and you had to do the cooking and cleaning and keep the place tidy all the time.*”

Residents also expressed gratitude for the fact that staff allowed them to spend their time in the CRF as they wished:

BARBARA: “*If we want to sit there for 10 hours no one bothers anyone else. I could sit out there for 10 hours and no one would say, ‘Get up Barbara do this, do that.’ It’s up to myself, you know, I’m free to do what I want, and I think that’s great*”

An appreciation for freedom of choice regarding food was also expressed by residents:

INTERVIEWER: “*What about the food in the house? Can you choose a daily menu? Is it a certain meal on a Monday, certain meal on a Tuesday?*”

BARBARA: “*We can have it the same or we can have it different, isn't that right Carol (other resident)? It’s up to ourselves. We talk between ourselves*

you know and we talk to the supervisors and we tell them what we would like [...] we are very happy.”

In addition to the above, Carol, expressed that she found it very difficult having a mental disorder, and was unable to view her situation in a positive light:

CAROL: “I find it hard to see a positive, you know? At the moment I still find it hard to manage my mental illness and I'm trying to stay positive and things, but I feel it's stopping me from having the quality of life that I want.”

In response to Carol's negative comment, Sarah provided information on her own coping mechanisms, including gratitude:

SARAH: “At first I was like that, very much like that, and I said to myself either I stay that way or I find another avenue 'cause I didn't like the place I was in at the time, so I told myself that I might as well make the most of what I have, no matter how little it is.”

Thomas appeared to hold a similar opinion with regard to his own situation:

Thomas: “I know, but you got to kick yourself in the ass too and that's what I did. Now I don't get down anymore and I don't get high and I'm ready to move on and put it beyond me. You can be all the time complaining that this is wrong and that is wrong, but it's up to yourself on how you want to view life, you know? And if you know what's going on around ya ,you're doing okay, and you move on from there.”

In addition to the above, one resident in particular, Sarah, appeared to have a sense of gratitude that her brother was willing to learn about her condition and that her medication was working:

SARAH: “I find my brother has a very good [understanding]. He has been reading about it but the rest [...] don't, no. I'm lucky that my medication

works well with me so I have enough insight to talk to them to know that they don't fully understand. Yeah, they don't realise how seriously ill I can be, even my friends, you know?"

Finally, the majority of residents stated that they did not have any family or friends calling to the CRF, and therefore had a sense of gratitude for each other:

BARBARA: "Well, if your family are not near I feel your friends in the house could be closer to you. I've got so used to Carol and Sarah and SIMON and David now, that they are like family to me, and I get up and see a smile on one of their faces or they might say 'Good morning, Barbara how are you?' and I feel good."

SARAH: >agreeing with Barbara< "We tend to look out for each other."

Residents appreciated the fact that staff were not intrusive and gave them freedom to do as they wished. It is reasonable to assume from this comment that residents may not have had this experience in previous accommodation—whether living with family or in another CRF. As a result, being left in peace is precious to residents. Some CRFs have a policy where residents must attend day centres, day hospitals or workshops. Residents were possibly aware of this and grateful, that staff did not enforce this upon them. Even though residents were unhappy with the fact that they were not allowed out to drink alcohol, they recognised that this restriction was coming from staff higher up in managerial positions. Residents also appreciated the fact that staff provided assistance with household chores and the general upkeep of the house, because they realised that having to do this with a chronic mental disorder could be challenging. Gratitude for the freedom to choose their own their meals was also expressed by residents. Residents also appreciated having the insight and ability to think positively about their situations, and appeared to have a sense of appreciation for each other.

Stigmatisation

Residents appeared to enjoy brainstorming suitable names for CRFs in general. For example, David suggested that the collective term for CRF's should be "*homes*," instead of 'hostels', however, Barbara was quick to disagree:

BARBARA: "*Ah Jesus, it's not in a nursing home we are in David, we might as well put down geriatric home.*"

Residents (including David) began to laugh at Barbara's comment. Barbara suggested a couple of names (unfortunately the first half of the name included the current name of this particular CRF and, therefore, will not be disclosed). SIMON then suggested the following:

THOMAS: "*Mental asylums.*"

It was obvious that Thomas was joking and once again, all residents began to laugh at the above comment. However, Barbara spoke quite assertively and again mentioned the name she had previously suggested, as well as her general thoughts on the issue:

BARBARA: "*I'm going to have a big plaque out there someday that says [name of CRF] now I'll say no more on that, mental this, mental health this. We're not mental, nobody in this room is mental.*"

In addition to the above, residents stated that they did not wish to get to know their neighbours and laughed out loud when this question was asked by the researcher. Barbara stated that they had got to know them once, "*but not anymore*". Thomas elaborated further:

THOMAS: "*They are complaining about smoke being on their clothes on the line from where we were out the back, it's virtually impossible for that to happen, but and she [neighbour] has given her [supervisor] a lot of complaints*"

Barbara agreed with the above comment (“*She did,*”) and clarified that the neighbor had made the complaints to *Supervisor X*. Residents had a lot to say on this topic and felt wrongly accused of the above:

CAROL: “*She said that we were pacing out the front and there was drink bottles and everything outside, alcoholic cans, everything outside and there wasn’t.*”

THOMAS: “*They weren’t ours, the cigarette butts and she complained, she said someone was pacing up and down and there was no one pacing.*”

BARBARA: “*Cause we go into the gazebo (to smoke), but I think she is sick in the head.*”

THOMAS: “*So we know them now whether we like it or not.*”

Barbara provided further evidence of tension between the residents and their neighbour:

BARBARA: “*I walked over the last day, she complained to [Supervisor I ...] I walked over and I said ‘Excuse me,’ I said, ‘I always mind my own business, I go up and down to the shop and I don’t look left or right and that’s the way I intend to have it’. And I turned on my heel and I walked back into the smoking area and I finished my cigarette. I don’t bother with anybody along this estate or I don’t intend to [...] They are lovely neighbours all down along there and everything, but just keep to yourself and do your own thing [...] Did ye ever here it said, ye didn’t probably, ye are younger than me, ‘Good fences makes good friends,’ keep your distance.*”

Given the fact that Barbara stated that the neighbours on the other side were “*lovely neighbours*”, the researcher asked if residents would have liked to get to know them:

BARBARA: “*We don’t want to know them the other side either, but if we did*

we would, but they don't want to get to know us either because they keep their distance.”

Despite the difficulties described above with neighbours, Thomas was of the opinion that stigma towards people with mental disorders had reduced:

THOMAS: *“I don't think people are prejudice over it anymore like they used to be, you know? If you can get out of the situation you are in and make a new life for yourself again, people tend to accept it, you know? There is no stigma anymore as much as there used to be.”*

However, Sarah disagreed with Thomas's theory and described her own experience of trying to navigate a mental disorder in society:

SARAH: *“Some are scared I find. Yeah, they don't know what your next move will be, 'cause my friend told me the last time, 'I hope you won't make a karate move on me.'”*

Sarah began to laugh at what she had just disclosed, and therefore the researcher asked if she was of the opinion that her friend was joking:

SARAH: *“She was joking but she was serious at the same time.”*

Furthermore, Sarah described how she lost friends when she disclosed that she had a mental disorder:

SARAH: *“You know on Facebook I have found my old friends from before, all of them I have told them my situation and none of them have called me again, so the next person I won't say anything, so there is still a bit of stigma.”*

Sarah also felt that disclosing her mental disorder would have a negative effect on romantic relationships:

SARAH: *“If I go and talk to a man they will say 'What have you been doing?’*

'I've been in hospital. I've spent all my time in hospital.' The man will run.'

Although Barbara, David and Carol did not disclose that they had been treated differently by people because of their mental disorders, they indicated that they preferred to keep this issue private:

BARBARA: *"I don't tell anybody [...] nobody knows what I have or what is inside of me, they don't know everything about me, that's the good of living in a city."*

DAVID: *"I just prefer not to tell anybody, if I can you know"*

CAROL: *"I'm quite open, no like I do hide things, like sometimes I would tell them I have post-natal depression after my daughter, I don't tell them the full story"*

Finally, residents disclosed that they did not feel comfortable inviting friends and family to the CRF:

BARBARA: *"You don't feel comfortable inviting people in. If a friend calls, you go to the door and they don't want to come in, right? You would want them to come in and make a nice cup of tea and a biscuit for them, but they don't want to come in because they feel they would be invading on your privacy [...] so, you go somewhere else to have a cup of tea or coffee."*

However, the above topic also uncovered the fact the residents did not have good external supports as family and friends did not actually call to the CRF to visit residents:

BARBARA: *"I don't have anyone calling here; only one person, that's all, and he won't come in."*

THOMAS: *"I don't have anyone either."*

DAVID: *“No one really comes round to see me.”*

Stigmatisation may be the reason for this. However, it is also possible that family relationships have broken down secondary to the resident’s mental disorders.

Although residents had some fun when discussing names for the collective term *“hostels”*, there was also a seriousness about the fact that residents did not like names that were associated with institutions (e.g. hostels or mental asylums). It was very clear that residents did not want to be stigmatised. However, it is noteworthy, that while residents did not want to be stigmatised with labels themselves, they seemed to think that it was okay to label their neighbour as *“sick in the head.”* In other words, they saw it as unacceptable for them to be labeled, but they did not see it as unacceptable for them to label someone else. It is possible that the comment merely reflected feelings of injustice, frustration and anger towards their neighbour. This experience may help explain why residents did not want to get to know their other neighbours.

Although residents did not disclose that they had been treated differently by people once they found out that they had a mental disorder, comments indicated they were fearful and hesitant of disclosing their mental disorder. Furthermore, all residents agreed that they did not feel comfortable inviting friends and family to the CRF and it was further discovered that family and friends did not actually call to see residents. This may reflect fractious family relationships or all parties may feel stigmatised by being associated with a CRF.

Loss of normal life

Residents felt that their opportunities to socialise were restricted. This issue first arose when residents were asked why the majority of residents who responded to the quantitative section of this study indicated that they were unhappy with their love lives:

THOMAS: *“Well, we are not really allowed to socialise, a nurse said it to*

me.”

BARBARA: *“And she said that goes for us all.”*

Residents perceived the imposed restrictions were limiting their chances of meeting a partner:

THOMAS: *“Well, you can go to a pub and have a few drinks, you might meet someone. If you go to a bowling alley or somewhere, you are not going to pick somebody up there, that’s all been tried and tested. It just happens when you are out, you meet someone and you can’t deny that, you know?”*

BARBARA: *“Exactly, that would be nice, but we are not allowed anymore. We are stopped every move we make to go out, and if we go out we are told not to drink—only the limit of a pint or two, sure you would only starting that time you want three or four at least to enjoy the night.”*

Other residents found this comment humorous and began to laugh, however, Barbara appeared un-phased by their reaction and raised her voice to make the following point:

BARBARA: *“I’m saying how I feel, I’m talking about myself!”*

Barbara further expressed her dissatisfaction with the no alcohol policy:

BARBARA: *“We feel that when those people stops us, right, we feel like lower down children again. Well, personally I’m speaking on my own behalf, I feel like a five-year-old again. Like mammy telling me to go into bed and get up and don’t do this and don’t do that [...] we should be allowed to socialize, and I’ll say it at the next meeting when she is here herself, I intend to speak up. I’ll be speaking up for everybody in the house, we should be allowed to socialise. And another thing, we are not animals in a cage. And we do not want to be treated like animals and we do not want to be treated like children, is that fair enough?”*

Offering a solution to the difficulties described above, Barbara made the following statement:

BARBARA: *“But, I think what is really wrong down deep inside is that we haven't got our own places. If we had our own places, we would have more freedom. Do you get me Lisa? and I think that goes for everyone else in the room, as well as myself [...] you could go out then, whatever night you want to go out or maybe two nights you could go as you please and go out what ever weekend you want or every second weekend or every weekend there is no one to stop you.”*

Interview data indicated that residents found it difficult to comprehend the rationale behind the no-alcohol/socialising policy:

BARBARA: *“Anyone here that has been out or did go out a weekend, come in and they don't make a sound around the house, you wouldn't even know they were in.”*

Residents felt that going out and having a few drinks was a big part of socialising:

THOMAS: *“If you can't go out and have a few drinks, where can you go? There is nowhere else you can go.”*

Residents felt that this imposed rule, coming from staff outside of the residence was unnecessary and unfair—unnecessary, because if residents were out socialising and drinking, they *“come in and they don't make a sound around the house,”* and unfair because residents stated that they were *“not lower down children”* or *“animals in a cage,”* which is how they perceived being treated. These responses shed light on the hierarchical relationships between staff and residents which may be the result of long-standing cultural practices.

Each resident also provided a moving account of the negative impact that

mental illness had on their respective lives and identities.

CAROL: *“[I am] not able to be a full-time mom anymore.”*

Carol then silently showed the researcher a photograph of her child who was in full-time care. Sarah stated that she would like to extend her family, but was concerned that her illness may be genetic:

SARAH: *“I would like to have more children, but I am kind of scared because I'm scared of passing on the gene that made me unwell, Yeah I'm scared of passing that gene.”*

Thomas further corroborated a deep sense of loss secondary to the impact of mental illness on his life:

THOMAS: *“It has changed it unbelievably yeah, I had my own business and I was married and I had children and I lost it all you know? It was my fault really. You can't blame anyone [else] for mental illness, you know.”*

Barbara also described a deep sense of loss and began to cry when disclosing the following:

BARBARA: *“I'm a very capable person and a very independent person, but ye all know my past and I won't go through it again okay because it upsets me emotionally. I have three grown up daughters that I love a lot, but I don't see them much, but that's my own business and I keep that in my heart, and I keep it to myself. I won't talk about it 'cause it only upsets my feelings, but I love them very much, and all I have is their photographs up in the room and their letters and little bits and pieces belonging to them.”*

In addition to the above, residents described that significant side-effects from drug treatments had impacted their lives in a negative way. For example, Barbara stated that medication had damaged her kidneys:

BARBARA: *“Well [the medication] destroyed me, one particular one of*

them anyway, Priadel that has caused me to be on dialysis today [...] it affects your kidneys.”

Further side effects experienced by residents included the following:

“breathlessness, bloating, dizziness, weight gain, memory disruptions, difficulty concentrating, blurred vision, difficulty waking in the morning, drowsiness and tiredness.”

There was no indication that the experiences of trauma described by residents were being addressed by psychological therapies.

Summary

Although residents had an excellent understanding and knowledge of the principles of recovery, residents did not detail specifics on exactly how staff are assisting them in their rehabilitation and recovery. As the interview progress, it became clear, that the focus in this particular house needed to be on psychological rehabilitation rather than rehabilitation with ADL. The ongoing and unresolved emotional consequences from trauma may be complicating recovery for these residents. In addition, residents perceive themselves as having received stigmatization and discrimination from neighbours and staff which may be another complicating factor in terms of their recovery. A united desire to live independently was expressed by all residents, but this appeared to be a long-term aspirational goal rather than a goal they had been working towards as no discussions towards independent living were taking place, and there was no indication that residents were encouraged to register for government housing.

House No 6

Profile of residents and house description

House six (H6) was a five-bedroom low-support community residence situated in a quiet residential area in the suburbs of a city. The interview took place in the living room. There was an office for staff on the ground floor which was kept locked. All residents were attending the local training centre (also known as the local workshop). Residents had freedom to come and go as they pleased and were free to move out if they wished. Staff supervisors were present from 5 p.m. until 11 a.m. the following day. Community nursing staff called on a weekly basis, and residents attended regular out-patient appointments at the local Department of Psychiatry.

All residents had a diagnosis of schizophrenia and were between the ages of 26 and 65 years. Two male residents did not attend the interview, one resident was not in the CRF at the time of interview, the other resident did not wish to take part, as a result, one male and two females participated in the interview.

Findings for House 6

Themes emerging from H6 are presented in the following table along with descriptive phrases from residents appearing within the context of these themes, all of which will be discussed individually in further detail.

Themes Emerging from House 6	Resident Descriptive Phrases
Lack of Recovery-oriented Care	<p><i>support from the hospital</i></p> <p><i>living independently</i></p> <p><i>having a routine</i></p> <p><i>need to have a goal</i></p> <p><i>getting on with everybody</i></p> <p><i>feel a bit isolated</i></p> <p><i>would have rather'd a different life</i></p> <p><i>a big mess</i></p> <p><i>fight to stay better</i></p> <p><i>get rid of the voices</i></p> <p><i>you could do anything</i></p> <p><i>mother blames it all on the drink</i></p> <p><i>drooling, I find that the worst</i></p> <p><i>put on a lot of weight</i></p>
Institutionalisation	<p><i>HSE houses</i></p> <p><i>we are all settled here</i></p> <p><i>we have the social group</i></p> <p><i>keep our rooms spotless</i></p> <p><i>we all get on</i></p> <p><i>great house for that</i></p> <p><i>I just thank God an awful lot</i></p> <p><i>if you need them, that you know they are there</i></p> <p><i>I have a suite upstairs</i></p> <p><i>I don't want to move out</i></p> <p><i>feels like a home</i></p> <p><i>comfort</i></p> <p><i>sense of security</i></p> <p><i>I would like to stay here</i></p>
Stigmatisation	<p><i>it's a clean home</i></p> <p><i>cleaning yourself</i></p> <p><i>dressing nicely</i></p> <p><i>keeping yourself clean and tidy and neat</i></p> <p><i>people around here look down on you</i></p> <p><i>see you going in here</i></p> <p><i>I felt uncomfortable</i></p> <p><i>stray away from you</i></p> <p><i>a bit weary of you</i></p> <p><i>feel different to other people</i></p> <p><i>nice area</i></p> <p><i>meet different people</i></p>

Table vi: Emerging themes and descriptive phrases from house six

Lack of recovery-oriented care

Although none of the residents had heard of the recovery model, they seemed to have a good understanding and holistic view of what helped to keep them well. Residents described having received “*support from the hospital*” and “*living independently*,” (presumably they meant living in a CRF) as good supports. Medication and routine was also mentioned:

JACKSON: “*You feel your life is going to run good again if you take your tablets, you are more positive about the future, I think.*”

LANA: “[...] *Having a routine and getting up in the morning.*”

LANA: “*I don't think though the training centre [...] I don't always intend to stay there, but at the moment I find it good between the classes and the training centre, I feel it's getting me out of the house. It's doing something, I'm not idle or slouching around, you know? I'm out and doing things. I think you have to have that in life, you need to have a goal, think of what you want to achieve in the future.*”

Lana's comment suggests that may be attending the training centre for the sake of having a routine, rather than having a meaningful routine.

When residents were asked how their illness itself had impacted their lives, Grace revealed that she felt different to other people:

GRACE: “*I suppose you feel different to other people and you feel a bit isolated, I suppose.*”

Data from Lana suggested an absence of a recovery process as she lingered on how her illness had left her somewhat trapped:

LANA: “*I would have rathered have not ever got involved with the unit (Department of Psychiatry) and would have rathered that I never got sick like, you know? I wish my life would have gone down another road, you*

know? I would loved to have lived and had a good job and got myself educated, and I would have rathered a different life, you know?"

Responding to the above question, Jackson indicated that it was a constant struggle for him to remain well:

JACKSON: *"It has a real mess made out of it, a real mess, a big mess."*

INTERVIEWER: *"Do you think your life would have been different if you didn't have a mental disorder?"*

JACKSON: *"Yeah, it's coming back slowly but surely, but I don't know how far it's going to go, like. I fight every day of my life like, I fight to stay better. It's a pure fight like, it's a fight every day."*

When residents were asked what recovery would mean to them, Jackson gave the following response which helped explain why he felt that it was a constant struggle to remain well:

JACKSON: *"To get rid of the voices. They are like a nerve inside my head, you know? I feel my teeth, it's done to me like, it's not a natural thing. It's not a natural thing, I don't know why or what's the cause of it, I don't know."*

Jackson, however, also perceived his future full of limitless opportunities if he was to recover from his mental disorder:

INTERVIEWER: *"But, what would it mean, what kind of things do you think you would be able to do if you were well?"*

JACKSON: *"Oh I don't know, sure you could do anything like you know? You know what I mean? You could do anything."*

Further comments from residents revealed significant breakdowns in family relationships secondary to their mental disorder:

INTERVIEWER: *“Do you feel your families have a good understanding?”*

JACKSON: *“Not really, they don't think there is anything wrong with me at all, my sister said to me, ‘You are fine Jackson there is nothing wrong with you, get your mind off things, go wash your hair, go do things.’”*

Lana communicated that she had similar experiences with her family:

LANA: *“That’s the way my family think too, you know? Just get out there [...]”*

Although Jackson disclosed that he had not drunk for *“10 or 12 years,”* he explained how his mother used to blame everything on his drinking habits:

JACKSON: *“You know the mother blames it all on the drink anything that happens to you, ‘It's the drink doing it to you,’ she says [...] You know, I was supposed to go to Medjugorje [once] and my mother was going with me, but I couldn't go because my blood pressure got high and it went high because they put me on olanzapine so I couldn't go that year anyway and my mother still said to me, ‘It was the drink now that did that to you.’”*

INTERVIEWER: *“Right, so your mother was blaming it on the drink when in fact it was the medication?”*

JACKSON: *“Yeah.”*

Jackson then went on to describe an unsupportive relationship with his father:

JACKSON: *“I bite my nails right, I was biting my nails in the car last Friday [my father] said, ‘What’s wrong with you?’ He said biting your nails, and I said, ‘It's a bad habit I have,’ I said. He said, ‘You are on tablets for it,’ he said [...] ‘Are you on tablets for it?’ for biting my nails, like. I mean how ignorant could he be? I told my mother about it and she said, ‘That's unbelievable Jackson. Say nothing.’”*

Residents also disclosed having to deal with adverse side effects from their medications:

LANA: *“Drooling, I find that the worst, drooling, you wake up in the morning and your pillow is wet and you go through the day and people are looking at you and they don't understand and you're drooling and you're trying to get the tissue to wipe your mouth. And you wake up in the morning and your pillow is wet.”*

However, Jackson stated that the drooling did not bother him:

JACKSON: *“I put a towel down, so I don't mind.”*

Other side effects mentioned included the following:

LANA: *“I used to have blurred vision, and that used to vex me. I don't have it anymore, but when I had it, it was awful, awful uncomfortable, and I have put on a lot of weight as well.”*

Institutionalisation

It was evident throughout the interview that residents were displaying institutionalised thinking. One example being, when residents were asked to come up with a collective name for the CRFs, they were unable to think of names other than *“HSE Houses”* or *“something independent, maybe like independent accommodation.”* Further evidence of institutionalised thinking emerged during a discussion about medication. When residents were asked how they felt about having to take medication, Grace had a vague response:

GRACE: *“I suppose, if it helps, like.”*

It would seem that Grace had become resigned to the fact that she had to take medication, whether it helped her or not. Although Jackson did not answer this particular question, it seemed as though it may have caused him to consider how he would manage his medication, if he was living in independent accommodation:

JACKSON: *“We have our own tablets, there is a problem with tablets (supervisor) found tablets under my bed, there was two tablets under my bed there for a long, long time, and I just couldn't be bothered picking them up, do you know what I mean, like? (Supervisor) saw them and she went down to the pharmacy and told them about it and he said (Pharmacist) ‘We will have to do something about it.’”*

Given the above comment, the interviewer attempted to encourage Jackson to focus on the future by stating that we could discuss this issue after the group finished:

INTERVIEWER: *“Well I'll tell you what, we might come back to that after the group because I know that...” >interrupted by Jackson<*

JACKSON: *“I have to take my tablets now.”*

INTERVIEWER: *“Can you wait a few minutes until after the group, is that alright?”*

JACKSON: *“Yeah.”*

Jackson may have been directed to take his tablets at a specific time or he may have perceived the interviewer as representing the system and, therefore, must be seen to take his medication. Institutionalised thinking emerged again when residents were asked how they would feel about having their boyfriend/girlfriend/partner stay overnight in the residence:

LANA: *“I wouldn't like it.”*

GRACE: *“We are all settled here, like.”*

Also, when residents were asked for their thoughts on why a large number of the residents indicated that they were unhappy with their love life (in the

quantitative section of this study), answers again reflected institutionalised thinking:

JACKSON: *“It’s something to do with tablets anyway.”*

LANA: *“Because when they are up you are down or when they are down you are up or they might not be supported.”*

It is not clear what Jackson meant by this comment, Lana’s comment was also not easy to interpret, however, it can be assumed that by the last part of her comment she meant that one partner may not feel supported by the other partner around their mental health issues. Institutionalised thinking arose again when residents were asked if they are getting enough opportunities to socialise:

LANA: *“Well, we have the social group, but that is only on every two weeks or every so often, I feel there should be more of that kind of stuff. I don't know why we are waiting for the hospital. I don't know why we couldn't get together ourselves. Bring people around like and meet up with the other residents in the hostels, and not to be waiting for the hospital to put on another social outing to go out.”*

Although the above comments reflected a desire for independence, they also reflected institutionalised thinking as Lana only viewed herself mixing with other residents in the services.

Further comments indicated that residents perceive the CRF as having a major role in training residents on how to do house chores:

LANA: *“To do chores.”*

LANA: *“Yeah, keep our rooms spotless and keep the bathroom and kitchen all parts of the house spotless.”*

Residents agreed that the CRF itself provides support but responses also indicate that residents may also be a form of support to each other:

JACKSON: *“The fact we, we are lucky in a way, the way we all get on with everybody in the house. It’s a great house for that like, you know?”*

Residents also displayed a great deal of affection for their supervisor:

JACKSON: *“I love (Ms. X). She is off sick, she will be out another three weeks and she will be back then to us. (Ms. X) is lovely.”*

Faith in God was also described as a form of support. For example, when residents were asked why they thought they needed to live in a CRF, Jackson’s response indicated that he had a strong trust in God:

JACKSON: *“I just thank God an awful lot, I believe God does things for me, you know?”*

Evidence of a strong faith in God emerged again when residents were asked if there was anything positive about having a mental disorder:

JACKSON: *“I really feel I have God on my side, you know?”*

INTERVIEWER: *“You feel that, because of your illness, you have a closer relationship with God?”*

JACKSON: *“Yeah [...] God says to me, ‘Jackson don’t ever drink again,’ I said, ‘I won’t God.’ Every day I wake up I think of that, you know? I can’t drink again like, you know? And I love drink so much, but I’ve learned to live 10 or 12 years without it now.”*

Although it was difficult to extract any information from Grace regarding her mental disorder, she did hint that the CRF prevented her from isolating herself:

INTERVIEWER: *“Can you tell me some reasons as to why you think you need to live in a CRF?”*

GRACE: *“To meet different people of different walks of life I suppose, meeting people, I suppose.”*

In addition to this, Grace felt that the CRF should have been a *“temporary arrangement”* until people felt that *“they don’t need it.”*

Residents were asked if nursing staff should call more or less often than once per week, responses indicated that having nurses on-call when needed may be a better option:

LANA: *“I suppose if you weren't well that they would call a bit more, but if you are well that they would stay away, if you need them that you know they are there, like. [...] If you are trying to get independent, you don't want nurses you know? If you are all right and you are getting independent and if you are not, you know, to call upon them.”*

Jackson explained why he thought that he did not need to live in a CRF anymore:

JACKSON: *“I don't feel I need it anymore, you know?”*

INTERVIEWER: *“You don't feel you need it anymore, but there was a time you did, is it?”*

JACKSON: *“Yeah, I have a suite upstairs and I don't want to lose it, you know? I have my name in for a counsel flat and I have a TD working on it. (Nurse X) said before she left, ‘Put your name in for county counsel housing, you will have to move out one day anyway.’ It may take 6, 7 or 8 years but it will come, like, you know?”*

However, when residents were asked how they would feel if they were asked to move out in six-months’ time, Jackson’s response contradicted his previous comment above:

JACKSON: *"I went through that with (Nurse X), I said, '(Nurse X) I don't want to move out (Nurse X).' I said, 'In case anything happens or anything like that,' I wouldn't be happy about it."*

Grace hinted that she would be living in isolation if she were not living in a CRF. Residents were of the opinion that the CRF was for people who were struggling in life secondary to their mental disorder, and they felt that people should only stay for as long as they needed it. When residents were doing well, they preferred to be left to their own devices and preferred if nursing staff were available on-call only during times of need.

Jackson stated that he did not need to live in a CRF anymore and that he was basically waiting for government accommodation. He realised this would be a lengthy wait and was happy with his *"suite upstairs."* However, later in the interview when residents were asked how they would feel if they were asked to move out in six-months' time, Jackson's response was quite the opposite. Although Jackson did agree that there was a time when he did need it, he feared moving out in case *"anything happens"* in the future. Therefore, it is possible that Jackson and the other residents viewed the CRF as a place of safety and support, particularly during times of need.

However, additional comments indicated that residents were also comfortable with continuing to live in the CRF long-term. For example, when residents were asked where they saw themselves living in five-years' time, responses indicated that living in independent accommodation was not a priority:

JACKSON: *"I don't know."*

GRACE: *"I suppose I could move out and get a place near home."*

LANA: *"I wouldn't like to move out yet, but if I was, I would like to get an apartment in the village of (x)."*

To further support this theory, residents communicated that they would not be happy if they were asked to move out in six-months' time:

GRACE: *"I suppose it would be a case if you have to go you would have to deal with it, I wouldn't be very happy about it, yeah."*

LANA: *"I don't know what to say, I wouldn't like it anyway, not for a while anyway."*

LANA: *"I would like to stay here"*

JACKSON: *"It would take me about a year to get out here anyway. From what I can get is that this is as far as you go like, after that it's your own place, like."*

It is easy to understand why residents could not prioritise moving on from the CRF, as residents disclosed that they had already been living there for a long period of time—Grace, one year and Lana, three years. Furthermore, residents stated that they *"have fun between us,"* that the CRF *"feels like a home,"* and it that it gave them *"comfort"* as well as a *"sense of security."*

Stigmatisation

As mentioned above, residents felt that they needed to keep the CRF *"spotless,"* and this was mentioned a second time when residents were asked what benefits they received from living in a CRF:

LANA: *"I feel if you keep the house and have respect for the house and look after it and keep it clean and tidy and so that when people come in they will say 'it's a lovely home' and 'it's a clean home.'"*

Jackson supported Lana's theory by responding *"that's what people do say about it like."* Also, when residents were asked what staff could do to help them prepare for independent living, all responses again pointed towards keeping the CRF clean and keeping themselves clean:

GRACE: *"They help you like, they are very good helping us with I suppose the general run of the house, allocating work to us."*

INTERVIEWER: *"Yeah, yes okay. What do ye see as the role of the CRF supervisors? what do you think their job is?"*

LANA: *"They are there to see that you do your chores and that you take your medication and that you are cleaning yourself and that you are dressing nicely. I'm able to do it myself, but am keep the house clean, and keep yourself clean, yeah and your clothes, if you dress nicely it shows."*

GRACE: *"I suppose just to make sure that the house is clean and that you are motivated and that you are up and about and all that like, you know."*

The above desire with keeping oneself "clean" arose again when residents were asked to list or describe what helped them to keep well:

LANA: *"Keeping yourself clean and tidy and neat."*

The above comments may suggest that self-stigmatisation is an issue which may help explain why residents stated that they would prefer if CRF supervisors worked "less hours," as they may have felt stigmatised by staff. The following comments also indicate the possibility of self-stigmatisation:

INTERVIEWER: *"Would you like to get to know your neighbours?"*

LANA: *"I talk to them next door, I just feel that people around here look down on you when they see you going in here."*

JACKSON: *"You don't still think that do you?"*

LANA: *"Sometimes I do yeah. It doesn't bother me now but when I first came, I felt that way a bit, but they have their own lives now. At first I felt uncomfortable you know."*

In addition to the above, there doesn't seem to be any interaction between residents and their neighbours:

INTERVIEWER: *"What do you feel is the best way to get to know your neighbours?"*

JACKSON: *"We meet them going out to their cars and that?"*

Furthermore, residents felt that people treat them differently if they know that they have a mental disorder:

LANA: *"Well, I think that if you had a broken hand or a broken leg, people have more. But when it's the mind, people are kind of, stray away from you like, they don't want to know you, they are a bit weary of you. But, if you had a broken arm they're like 'Oh God, I have to meet you,' and all this."*

GRACE: *"I suppose you feel different to other people and you feel a bit isolated, I suppose."*

Grace, for whatever reason, did not feel comfortable talking about her mental disorder:

INTERVIEWER: *"What would recovery mean for you?"*

After a long silence, Grace stated the following:

GRACE: *"Well, I suppose at the moment it would be to keep my blood sugar level and watch my diet so that it doesn't get out of control."*

Grace's response to the next question, *"Why do you feel you need to live in a CRF?"* further supported the about theory that she did not feel comfortable talking about her illness:

GRACE: *"To meet different people of different walks of life, I suppose."*

Grace also seemed to view the CRF in an idealistic manner. For example, when asked what makes residents feel comfortable about inviting friends and family into the house, Grace attempted to make everything seem “normal”:

GRACE: *“It’s a nice house like, and a nice area.”*

INTERVIEWER: *“Okay, is there anything that makes you feel uncomfortable about inviting friends and family to the house?”*

GRACE: *“No, I don’t think so, my sister-in-law and my brother have been here a few times, and said it was lovely, it’s a lovely home you know, and I have met all of Lana’s family, she has met my family, yeah and Jackson’s family.”*

The residents placed a strong emphasis on keeping the housing “*clean and tidy*.” A possible reason for this could have been that residents perceived that they had to work for their place in the CRF as residents referenced staff “*allocating chores*” to them more than once. However, the fact that residents paid a monthly rent to the mental health services to secure their place in the CRF, makes this theory unlikely.

A more persuasive argument emerging may be that residents were either self-stigmatising or trying to protect themselves from stigmas within society. It is possible that residents had a preconceived idea that people with mental disorders looked disheveled and lived in messy and dirty accommodation. It may have been for this reason also, that residents perceived the role of CRF supervisors as ensuring that residents looked ‘normal’ to society by ensuring that they took their “*medication and [were] cleaning themselves and [were] dressing nicely*.” Therefore, by placing a strong emphasis on cleanliness and orderliness with regard to the house, as well as themselves, they ensured that the house and everyone in it, looked ‘normal’ from the outside looking in.

Summary

Residents in House six displayed institutionalised thinking in that their responses focused on supports within the service, such as support from the hospital, living in a CRF and medications, and only viewed themselves getting into relationships and socialising with other residents or other people within the mental health services. In addition, given the residents' repeated focus on cleanliness and tidiness, with both themselves, and the CRF; it can be argued that there is an over-arching presence of preconceived ideas, reflective of previous centuries where people with mental disorders were often viewed as 'crazy and disheveled'. Although residents did not give specific examples of experiencing stigma from society, they perceived that they would be treated differently and viewed in a more positive light, if they had a physical illness of some kind, rather than a mental disorder.

In addition, family relationships seemed fractious, and there was little to no contact with neighbours. Understandably, residents had formed close bonds with one another and were generally comfortable living in the CRF. They were aware that this was a temporary living arrangement, yet they did not see themselves moving out within the next five years. They cited a shortage of government accommodation and high private rents. Residents' lives could be tenuous and chaotic at times, and they realised that once they left the CRF that support from the mental health services would be significantly reduced. Therefore, residents felt more comfortable and secure living in a CRF, than living in independent accommodation.

Residents also perceived that they missed out on education and employment opportunities. They also felt misunderstood by family members and self-professed to "*fight*" every day, to stay well and perceived that they could only dream of what life would be like, should they recover from their mental disorder. Finally, residents had to cope with significant side-effects from medications, such as drooling, which was possibly further adding to their self-stigmatisation. In general, residents appeared to be living a lonely life where they felt judged by society. They did not seem to have a lot of hope for the

future, and while they were living in a safe and secure environment, they were aware that could change at any time at the behest of the mental health services.