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Transitioning into the Community: Outcomes of a Pilot Housing Program for Forensic Patients

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The Transitional Rehabilitation Housing Pilot (TRHP) was designed to transition hospitalized forensic patients to the community. Twenty clients and their clinicians in two Ontario cities completed measures on functioning, substance use, recovery, social support, and quality of life at admission to the program and then every 6 months until 18 months post-admission. Clients also responded to open-ended questions on the impact of the program and living in the community on their recovery. Three (15%) clients re-offended. Eleven clients (55%) experienced rehospitalization; however, brief rehospitalization was seen as part of the recovery process. Level of community functioning was stable across time and 35% of clients had a decrease in the restrictiveness of their disposition order. Clients described numerous characteristics of community living that contributed to improvements in functioning, such as integration into the community, social contact, and newfound independence. Some aspects of TRHP that encouraged recovery included developing new skills and knowledge, staff support, and the programming that engaged clients in treatment and recovery-oriented activities. Findings suggest that forensic patients can transition successfully into the community with appropriate support and housing.

Keywords: community-based rehabilitation, mental illness, offender rehabilitation, program evaluation, reintegration

Community-based treatment programs have been developed for forensic patients, offering services such as medication management, psychotherapy, and case management in a community, rather than institutional, setting. However, patient outcomes with respect to re-arrest range drastically from 26% of parolees with mental illness returning to prison within 12 months (Farabee & Shen, 2004) to reconviction of 53% of forensic patients receiving care from specialized community forensic services over the longer term (Sahota, Davies, Duggan, & Clarke, 2009). Given the risk of recidivism, the development of effective community support programs for forensic patients is important to reduce recidivism and facilitate independent living in the community. Programs for individuals with severe mental illness discharged to the community from correctional facilities have been described in the literature (Hammett, Roberts, & Kennedy, 2001; Hartwell & Orr, 1999; Solomon & Draine, 1995). However, there is a paucity of research on the outcomes of transitional housing programs for forensic patients discharged from psychiatric hospitals into the community.

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Transitional Relationship Model

The limited extant research supports a transitional model for a general population of psychiatric patients moving from hospital to the community. The Transitional Relationship Model (formerly called the Transitional Discharge Model; Forchuk et al., 2013) described by Forchuk, Martin, Chan, and Jensen (2005) involves: (1) overlapping contact with inpatient and community support providers until the client develops a working relationship with community support providers and (2) peer support. Psychiatric (including forensic) patients who received this overlapping contact with support providers and peer support were discharged after a shorter time in hospital and, a year post-discharge, reported improved quality of life in terms of social relations compared to patients receiving treatment as usual, although there was no group difference in global quality of life (Forchuk et al., 2005). Another small study using this model reported that, after 5 months, two of nine intervention group participants were rehospitalized compared to five of ten who received treatment as usual (Reynolds et al., 2004).

Re-Entry and Discharge Preparation Programs

The importance of targeted interventions focusing on community re-entry for individuals with serious mental illness moving from inpatient psychiatric care to the community has been documented (Kopelowicz, Wallace, & Zarate, 1998). In a study of 59 patients with schizophrenia or schizoaffective disorder randomly assigned to a community re-entry program or occupational therapy, those in the re-entry program increased their knowledge and skills on the material addressed in the program and were more likely to attend their first aftercare appointment post-discharge (Kopelowicz et al., 1998). The discharge preparation program of a psychiatric hospital forensic service has also been evaluated. Patients found Not Criminally Responsible (NCR) who were in a discharge preparation program were found to have a low rate of recidivism, with a re-offense rate of 7.3% after 11 years of following patients in the community (Luettgen, Chrapko, & Reddon, 1998). There was no comparison group of patients in this study.

Case Management and Assertive Community Treatment Programs

Case management and appropriate housing, including transitional housing, were cited as critical ingredients of effective care in a review of community treatment programs for offenders with severe mental illness (Lamb, Weinberger, & Gross, 1999). Case management has been shown to reduce the likelihood of re-arrest for individuals with severe mental illness leaving jail 3 years post-release (Ventura, Cassel, Jacoby, & Huang, 1998). Assertive Community Treatment (ACT) teams have also been developed to work with forensic patients (Lamberti, Weisman, & Faden, 2004). In a review of ACT programs for forensic patients, some programs were identified as offering a supervised residential component, usually to support treatment for substance abuse (Lamberti et al., 2004).

The review identified three ACT programs that had published outcomes for forensic patients (Lamberti et al., 2004). One program adopted a progressive treatment model; clients moved from hospital to residential treatment facility followed by a move to the community and ACT support. Findings indicated that 94% of clients remained in the community, and none had recidivated or abused substances after an average of 508 days in the community (Cimino & Jennings, 2002).

The second program, Project Link, offers services to individuals with severe mental illness, and a history of criminal justice system involvement and non-adherence with outpatient treatment (Lamberti et al., 2001). Staff supported clients and linked them to diverse services in the community including residential treatment for individuals who abuse substances. After a year of involvement in the program, clients had a decreased frequency and duration of arrests, incarcerations, and hospitalizations compared to the year prior to admission to Project Link and their functioning was improved.

The third ACT program, Thresholds Jail Project, reported more than an 80% decrease in jail days and 85% drop in psychiatric hospital days for the group during the first year of admission compared to the year prior to admission ("Helping Mentally Ill People," 2001). Together, these results are promising, suggesting that support from an ACT team can lead to improved outcomes for adults with mental illness and a history of criminal justice system involvement.

Transitional Housing for Forensic Patients

No research to date has examined the outcomes of forensic patients who moved from hospital to transitional housing in the community, followed by supported housing (i.e., housing with support off-site rather on-site). Cimino and Jennings (2002) reported positive outcomes for forensic patients who moved from hospital to an interim facility before moving to the community, as described above. However, the transitional step was described as a residential treatment facility, rather than transitional housing. Also, this specialized program was designed for patients with chronic mental illness and substance abuse disorders, rather than a more general population of forensic patients.

Casper and Clark (2004) described the outcomes of supportive housing for forensic participants. However, participants in the study were considered forensic if they had ever been incarcerated, thus, this housing was likely not transitional housing between hospital and community living. In another study, 13 forensic patients on conditional release moved from a psychiatric hospital to one of nine residential facilities (Heilbrun, Lawson, Spier, & Libby, 1994). Three participants were rehospitalized within 6 months. It was

suggested that lack of fit in terms of patients' needs and the facilities' monitoring and treatment may have contributed to re-admission. Given the lack of literature on transitional housing outcomes for forensic patients discharged from hospital into the community, there is a need for research in this area in order to identify the types of programs that can reduce recidivism and rehospitalization.

Current Study

This article presents the findings from research on the outcomes of the Transitional Rehabilitation Housing Pilot (TRHP) programs in two metropolitan Ontario cities. In addition to evaluating client outcomes, an evaluation of implementation was also conducted as part of the research on the pilot program. The results of the implementation evaluation, with a more in-depth description of the program including its structure and delivered services, are presented in a previously published article (Cherner, Nandlal, Ecker, Aubry, & Pettey, 2013). The initial placements occurred in 2007 and data collection for the study ended in September 2010.

Description of the TRHPs

Each Canadian province has a review board that is responsible for overseeing individuals found unfit to stand trial or Not Criminally Responsible (NCR) on account of mental disorder (Ontario Review Board [ORB], 2011). Individuals who are NCR committed an act while "suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong" (Ontario Review Board, 2011, The Population section, para. 4). The ORB creates and reviews dispositions for the individuals under its jurisdiction. The TRHPs were established to support the transition to the community for individuals who were declared NCR. Reintegration into the community was to be supported through the transitional housing and eventual move into regular housing or other accommodation.

Each TRHP involved a partnership between a hospital with a designated forensic unit and one or more community agencies. The clients are individuals with an ORB disposition that allows for community placement at the discretion of the hospital in charge. Clients are referred while an inpatient in a secure forensic bed. TRHP staff focus on daily living skills training and community integration activities within a recovery-oriented psychosocial rehabilitation approach. Because clients are under the purview of the ORB, the hospital has ultimate accountability for the care, treatment, support, and supervision of TRHP clients. Accordingly, TRHP housing provided by community partner agencies must be configured to ensure compliance with ORB supervision requirements.

At the time of the evaluation, TRHPs existed in Cities A and B located in Ontario with room for supporting 10 patients in each city. Clients of the City A TRHP moved directly from hospital into a one- or (shared) two-bedroom apartment in a building that housed TRHP as well as clients from a Mental Health and Justice program. Upon completion of the program, they moved to other housing (although some joined the Mental Health and Justice program and remained in the residence). In contrast, City B clients typically moved from hospital into the four-bedroom residence shared with other TRHP clients before moving to a satellite apartment. They remained in the same apartment upon completion of the program. As such, most TRHP clients in both cities shifted from transitional housing, wherein supports are tied to TRHP housing, to supported housing in which they continue to be offered support, but this support is not located on-site. Initially, support is from TRHP and then through generic services and to the extent required.

Study Objective

While transitional programs have been established to facilitate the integration of forensic patients from the hospital into the community in Canada and other countries, very few have been described in the literature and studied in a systematic way. Thus, there is little information on the outcomes of clients who have been served by such programs. This article describes the outcomes for 20 clients who were involved in the TRHP program in two cities. The study was intended to answer four questions: (1) Are clients discharged into the community re-offending? (2) To what extent are clients in TRHP requiring re-hospitalization? (3) Are there improvements in functioning over the course of participation in TRHP? and (4) What was the status of the clients at the end of data collection?

METHOD

A series of measures were completed by clients and their clinicians at admission to the program, then at 6, 12, and 18 months post-admission. The measures assessed community functioning, substance use, social support, recovery, and quality of life. Clients also answered open-ended questions regarding the impact of the program and living in the community on their recovery. The research was integrated into the program design.

Participants

Twenty-four clients were admitted to TRHP during data collection. Nine of 10 (90%) clients in City A and 11 of 14 (79%) clients in City B consented to participate in the study. Data were available for 18 clients at baseline, 18 clients at 6 months, 18 clients at 12 months, and 15 clients at 18 months. Four clients had been in TRHP for less than 18 months by the end of data collection, so their 18-month outcomes could not be assessed. Each TRHP had one female client. The mean

age of clients was 33.56 ($SD = 7.14$) in City A and 33.27 ($SD = 10.69$) in City B.

In City A, the number of hospitalizations before admission into TRHP ranged from one to 13 ($M = 4.89$, $SD = 4.88$). The length of clients' last inpatient stay prior to admission to TRHP ranged from 17 to 66 months ($M = 34.67$, $SD = 14.37$). The mean score on the Historical, Clinical, Risk-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) was 19.50 ($SD = 6.75$). Based on clinical information provided by hospitals, the mental health diagnoses of City A clients included schizophrenia ($n = 8$), co-occurring substance use disorder ($n = 5$), personality disorder ($n = 4$), anxiety disorder ($n = 1$), psychosis not otherwise specified ($n = 1$), and developmental disability ($n = 1$). The most common index offenses committed by City A clients were assault and weapons charges. Other offenses included attempted murder, theft, robbery, mischief, and breach of probation.

The number of hospitalizations before admission into the TRHP for City B clients ranged from two to 13 ($M = 6.09$, $SD = 3.42$). The length of the most recent inpatient hospitalization prior to admission to TRHP ranged from 6 to 21 months ($M = 15.09$, $SD = 8.73$). Mean score on the HCR-20 was 20.00 ($SD = 5.29$). Ten of the City B clients had been diagnosed with schizophrenia or schizoaffective disorder. Other diagnoses included co-occurring substance use disorder ($n = 8$), personality disorder ($n = 4$), and mood disorder ($n = 1$). The majority of the index offenses involved assault and/or weapons offenses. Other offenses included attempted murder and criminal harassment.

Clinician Measures

Case managers completed measures on the demographic characteristics, community functioning, and substance use of their clients at baseline, 6, 12, and 18 months. Interrater reliability was not assessed in our study as only one clinician was available to complete the measures with respect to each client.

Toolkit for Measuring PsychoSocial Rehabilitation Outcomes (PSR Toolkit)

The PSR Toolkit (Caminar, 2001) is measure of historical and current data on clients in various domains including diagnosis; hospitalizations; residential situation; employment status; participation in educational programs; legal involvement; and other demographic characteristics. The PSR Toolkit was completed by a TRHP service provider who had regular contact with the client and access to their file information. Reliability data were not available on the sections of the PSR Toolkit that were used in this study.

Multnomah Community Ability Scale (MCAS)

The MCAS is a 17-item measure assessing the level of community functioning among individuals with psychiatric disability in the areas of health, adaptation, social skills, and behaviour (Barker, Barron, McFarland, & Bigelow, 1994). Response options can range from 1, which indicates difficulties (e.g., *extreme health impairment*), to 5, which represents no difficulties (e.g., *no health impairment)*. A higher score indicates a higher level of functioning (low level of functioning: 17 to 47; moderate: 48 to 62; high: 63 to 85). The interrater reliability (.85) and the test-retest reliability (.83) have been shown to be very good in a previous study (Barker, Barron, McFarland, Bigelow, & Carnahan, 1994). The interrater reliability was found to be .97 for the total score in a more recent study and to range from .84 to .97 for the subscales; however, the four-subscale structure of the MCAS was found to vary over time and to not be reliable (Bassani et al., 2009).

Alcohol Use Scale-Revised (AUS-R) and Drug Use Scale-Revised (DUS-R)

The AUS-R and DUS-R measure alcohol use and drug use, respectively (Mueser, Noordsy, Drake, & Fox, 2003). These one-item scales are completed by clinicians according to a client's problematic substance use in the previous 6 months. Ratings are based on all available sources of information, such as client self-report, clinician observations, laboratory tests, or reports from others. Ratings range from 1 (*no use*) to 5 (*use resulting in institutionalization*).

Client Measures

Client interviews occurred at baseline, 6, 12, and 18 months in order to collect client self-report outcome and open-ended responses on how TRHP impacted functioning and recovery.

Social Provisions Scale (SPS)

The 24-item SPS (Cutrona & Russell, 1987) measures the degree to which individuals perceive their social relationships as providing support. Items are rated from 1 (*strongly disagree*) to 4 (*strongly agree*). Total scores range from 24 to 96 and a higher score indicates greater perceived support. Test-retest reliability was found to range from .37 to .66 in other research, and the SPS correlates with other measures of social networks (Cutrona & Russell, 1987).

Recovery Assessment Scale (RAS)

This 41-item measure assesses perceived level of recovery (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995). It explores overall empowerment, coping ability, and quality of life. Ratings range from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores range from 41 to 205 and a higher score is related to lower levels of psychiatric symptoms and a higher level of psychosocial functioning. The RAS demonstrated very

good 2-week test-retest reliability (.88) in previous research (Corrigan et al., 1999).

Quality of Life Interview (QOLI)

The QOLI was designed to assess the objective and subjective quality of life of individuals with severe mental illness across eight domains and their general satisfaction with life (Lehman, 1988). The eight domains include living situation, daily activities and functioning, family, social relations, finances, work or school, personal safety, and health. Each subjective item was rated from 1 (*terrible*) to 7 (*delighted*). The 1-week test-retest reliability of general life satisfaction was .71 in a previous study (Lehman, 1988). The findings on the general life satisfaction subscale will be presented.

Open-ended questions on functioning and recovery

Client interviews included five open-ended questions about how the program contributed to better functioning and recovery (i.e., "Do you think that your functioning has improved because of your living in the community?", "If not, why not? If so, why?", "Do you think this transitional rehabilitative housing contributes to recovery from mental illness?", "Why or why not?", and "(If yes) What about it helps with recovery?").

Chart Data

Information on length of hospital stay and disposition order was obtained from each client's program chart.

Hospital Measure

Historical, Clinical, Risk-20 (HCR-20)

Hospital staff rated clients on the HCR-20 prior to discharge to TRHP. The HCR-20 (Webster et al., 1997) is a violence risk assessment instrument that examines historical (10 items), clinical (five items), and risk management factors (five items). Items are rated on a scale of 0 (*not present*) to 2 (*definitely present*) and scores range from 0 to 40. HCR-20 scores are predictive of recidivism (Douglas, Yeomans, & Boer, 2005). Interrater reliability of the risk judgments from the HCR-20 has been found to be acceptable in a previous study (weighted kappa = .61; Douglas, Ogloff, & Hart, 2003).

Procedures

Service providers initially approached TRHP clients to provide information about study participation. Clients who wished to participate completed four interviews (compensation was $30 per interview) and allowed researchers to access clinician data. A case manager for each client completed the clinician measures at baseline, and 6, 12, and 18 months after admission to TRHP. Clients also completed interviews at these time points that included standardized measures and open-ended questions on functioning and recovery. The client interviews were conducted at the residence in City A and the researchers' institution in City B. Responses to open-ended questions were audio-recorded. Interviews took approximately 30 to 60 minutes. The interviews were conducted by independent researchers whose sole relationship with TRHP was to evaluate the implementation and outcomes of the program.

Ethical approval was obtained from the researchers' institutional research ethics boards. Clients were informed of their right to decline study participation and that their decision regarding participation would not affect their involvement in TRHP. These points were raised by the service providers when they first informed clients about the study and again by the researchers at the initial telephone contact with clients and at the beginning of the interviews prior to consenting to participation. Participants provided their written consent and also provided permission for the researchers to access the clinician data.

Data Analysis

Descriptive statistics are presented for quantitative data. Statistical analyses were not conducted due to the small sample size and limited power to detect significant differences. The interviews were audio-recorded and detailed notes were produced. The recordings were used to confirm the interviewers' detailed notes, and in City B, transcripts were produced for the open-ended questions addressed in this paper. Two researchers independently coded the open-ended responses. The researchers then compared their themes for consistency. When discrepancies emerged, these were discussed by the researchers until a consensus was reached. The open-ended responses were analyzed using a modified *grounded theory* approach (Berg, 1989; Patton, 1990; Ryan & Bernard, 2000) to identify emergent themes in relation to the questions that guided the implementation evaluation. This approach was thought to best suit the analysis because, although there was a set of evaluation questions to answer and hypotheses present, all the interviews involved open-ended questions.

The data analysis took place in stages. The first step involved the open coding of data. Each transcript was read line-by-line and codes were then developed for segments of the data. As initial codes should stick closely to the data (Charmaz, 2006), in vivo coding was used as often as possible. During open coding, a constant comparison technique was used. Within this, codes were compared within each individual transcript and then across all the open-ended responses. Seeking out disconfirming data also continuously occurred throughout the coding process in order to increase validity (Maxwell, 1998).

Following open coding, focused coding was completed. This type of coding allows for data to be synthesized and

placed into meaningful themes and subthemes. From this stage, the frequency at which each theme occurred across the data was determined.

Since a modified grounded theory approach was used, the more traditional follow-up steps of axial and selective coding were not employed. The research team decided to eliminate these latter stages of coding due to the nature of the data and the evaluation questions. Since data collection involved a mixed-methods interview and the open-ended component occurred during the latter stages of the interview, the opportunity to engage the participants in an in-depth manner was limited. Also, as mentioned above, there were a set of evaluation questions to be answered and therefore a truly inductive approach to data analysis was limited. Despite the impracticality of engaging in axial and selective coding, the open-ended responses were important to explore due to their richness and meaningfulness, and they provided an understanding of the program that was not captured by the quantitative data.

RESULTS

Are Clients Discharged in the Community Re-offending?

Three clients (15%) re-offended during their participation in TRHP. One client was convicted of robbery with possession of a weapon for the purpose of committing an offense and declared Not Criminally Responsible. Another was charged with arson by negligence, mischief, and arrest without warrant for contravention of disposition. The third client was convicted of possession of cocaine.

To What Extent are Clients Requiring Hospitalizations?

Eleven (55%) clients were rehospitalized during their participation in TRHP. Reasons for rehospitalization according to TRHP staff (and documented in client charts in City B) included substance use ($n = 7$), re-offense ($n = 3$), elopement ($n = 3$), medication non-compliance ($n = 3$), change in medication leading to functioning difficulties ($n = 2$), destructive behaviors ($n = 1$), and mental health deterioration ($n = 1$). In City A, all clients were living at the TRHP residence at the time of rehospitalization. In City B, one rehospitalization occurred after the client had completed the TRHP program. Once rehospitalized in City A, the majority of clients had short-stay admissions lasting less than 3 weeks. One client had a longer hospitalization of 3 months, while another client remained in hospital indefinitely. The majority of City B clients had long-stay admissions upon rehospitalization, with the exception of one client who had four short-stay admissions lasting approximately 4 to 10 days.

Are There Improvements in Functioning Over the Course of Participation in TRHP?

Community Ability

The mean scores of clients in both cities on the MCAS remained similar across time points (baseline: $M = 68.83$, $SD = 8.88$; 18 months: $M = 68.86$, $SD = 10.73$). At the initial rating, six clients were within the moderate range and 14 were in the high range. At the final rating (in some cases the 12-month time point), 14 clients remained in the same range as at baseline (moderate: $n = 3$; high: $n = 12$). Three clients who had initially been rated within the moderate range were now within the high range, and two clients had a decrease in rating from the high to moderate range.

Disposition Order

Within the Ontario system, individuals who are declared NCR can have a *detention disposition* that may allow living in the community in an accommodation that is approved by the person in charge; a *conditional disposition* that allows the individual to live in the community subject to conditions (e.g., reporting to a hospital, attending before the ORB as required, or notifying the ORB of changes of address or telephone number); or an *absolute discharge*, in which case the individual is no longer subject to the ORB (Ontario Review Board, 2011). All 20 clients were initially detained with community access (i.e., permitted to reside in the community with hospital approval), although one had to live in supervised accommodation (i.e., a residence with staff providing daily supervision). By the end of data collection, four had received absolute discharges, two received a conditional discharge, one had received a conditional discharge prior to rehospitalization, and 13 remained under a detention order.

Substance Abuse

Of 18 clients (data were not available for two clients), 16 abstained from alcohol and drug use at baseline. Two used alcohol without impairment, one of whom did not use drugs and one of whom abused drugs. At 6 months, 13 clients were abstinent from drugs and alcohol. Two clients used alcohol without impairment and no drugs. One client used drugs without impairment, but did not consume alcohol. One client used both alcohol and drugs without impairment. One client abused alcohol and was dependent on drugs. Data were missing for two clients. At 12 months, 12 clients were abstinent from drugs and alcohol. One client used alcohol without impairment and abstained from drugs. Another used drugs without impairment and no alcohol. One client abused drugs, but did not consume alcohol. Three clients were dependent on drugs, two who abstained from alcohol and one client who used alcohol without impairment. Data were missing for two clients. By 18 months, nine clients were abstinent from alcohol and drugs. One client used alcohol without

impairment and no drugs. One client used drugs without impairment and abstained from alcohol. One abused drugs and did not consume alcohol. Two were dependent on drugs, but did not consume alcohol. Data were not available for six clients.

Employment and Education

At baseline, three clients were employed in assisted/supportive settings; one had casual employment; two were involved in a non-paid work experience; four were not employed, but were involved in other activities; and six were not working. The employment status of the other four clients was not available at baseline. At 18 months, six clients were employed (independent job [$n = 4$], assisted/supportive setting [$n = 1$], or alternative business [$n = 1$]). An additional two clients had casual employment, one was involved in other activity (school), six were unemployed, and data were not available for five clients. Over the course of their involvement in TRHP, nine clients participated in educational programs (English classes, $n = 1$; community college, $n = 3$; adult education, $n = 3$; secondary school, $n = 3$; vocational program, $n = 1$), and one client was waiting for a student placement.

Clients' Perceptions of Social Support, Recovery, and Quality of Life

As can be seen in Table 1, clients reported a fairly consistent level of social support, as assessed by the SPS with a slight decrease at 18 months. Clients' perceptions of their level of recovery (RAS) were also quite consistent across time, with a slight decrease at the 18-month time point. General life satisfaction was also fairly stable across time with a slight decrease at 18 months.

TABLE 1
Client Self-Report Data on Social Support, Recovery and Overall Quality of Life

Measures and time points	Both cities *M* (SD)
Social Provisions Scale	
Baseline	70.06 (7.14)
6 months	70.82 (7.42)
12 months	72.86 (5.19)
18 months	66.83 (9.84)
Recovery Assessment Scale	
Baseline	168.59 (19.46)
6 months	169.76 (13.53)
12 months	171.64 (13.61)
18 months	166.67 (15.08)
Quality of Life–general life satisfaction	
Baseline	5.47 (1.81)
6 months	5.50 (1.21)
12 months	5.43 (0.76)
18 months	4.08 (1.73)

TABLE 2
Factors of How Living in Community Affects Functioning

Theme	Number of interviews in which theme was mentioned ($N = 35$)	City
Improvement in functioning		
Independence	11	A, B
Social contact	7	A, B
Integration	3	A, B
Self-confidence/self-esteem	3	B
Future-oriented	3	B
New skills (social, independent activities of daily living, coping, decision making)	3	B
Emotional health changes/mental health improvement	3	A
Building characteristics (e.g., location)	2	A
New activities (community programming)	2	B
Motivated to change	1	B
Privacy	1	A
Sleep	1	A
Health improvement	1	A
Comfort	1	A
Following disposition order	1	B
No change in functioning		
Inactivity	2	B
No change	2	A, B
Vocational goals unmet	1	B

Clients' Perceptions of Factors That Improved Functioning

Clients were asked at each follow-up interview whether their functioning had improved because of living in the community. In 86% of the follow-up interviews, clients responded in the affirmative. Table 2 lists the themes and the number of interviews in which each theme was discussed.

A range of factors related to living in the community were thought to contribute to improvements in functioning. Independence was frequently cited, and clients reported that living on their own allowed them to regain their independence:

> Because I've been given back my independence. I feel free as a person, free as a bird. I am able to spread my wings and fly where I want to, I mean, just the fact that I have my independence. For me, that's the most important thing.

Clients liked having their own space. They also enjoyed the opportunity to perform daily tasks independently (e.g., grocery shopping, paying bills, cooking, cleaning, and dishwashing) and to take care of themselves. Living in the community, clients also felt that they lived a

more "natural" life in which they were not controlled by others, could make decisions about how to spend their time, and had more freedom of movement. Independence also entailed responsibility, such as taking medications without supervision. For one client, living in the community and the experience of previous relapses emphasized the importance of following the disposition order. In addition to independence, clients reported that they had increased privacy compared to when hospitalized.

Another benefit of community living that contributed to improvement in functioning was regaining social contacts. Clients reported enjoying the opportunity to have varied social interactions with new people, including those outside of the mental health system, and to re-establish contact with friends and family they had not seen as frequently when in hospital. One client reported benefiting from becoming more extroverted. The importance of social contact was described in the following way:

> I guess mental illness is difficult because you have to beat the nothingness, the lonesomeness of being on your own, so having people to do things with, who you enjoy being with, is a big help. And it seems through [TRHP] that you develop a social network that helps you and hopefully will help you when you leave the program.

Integration was also identified as beneficial to functioning and was described as a process. For example, watching others' behaviour and seeing others leading active lives provided a model for clients, ". . .seeing the way people dress, people act, try to blend in." Integration also entailed being active in the community, for example, playing sports or socializing, which reduced loneliness. This involvement in community activities (e.g., sports, support groups, and other social activities) and being active were reported to contribute to improved functioning. Living in the community reportedly increased motivation for one client. Another described developing a future-oriented focus related to staying well, for example, abstaining from drugs.

Clients felt that they were moving forward with their lives and reported hope for the future:

> I'm kind of more motivated. Not susceptible to want to use drugs or smoke cannabis because I know it's detrimental to my future and I'm feeling good because I'm making advancements in life. I'm not where I want to be yet, but I know I'm on my way there.

Increased sleep was of benefit, as were housing characteristics, such as quietness, convenience, and location. Clients identified the development of new skills as contributing to functioning in relation to community integration, social skills, independent living skills (e.g., cooking, cleaning), coping, and decision-making. Clients noted several improvements in their self-perception, including increased self-esteem, as exemplified in the following comments, "I feel more positive about myself" and "My self-confidence, my self-esteem certainly have risen." Clients also noted improved emotional health (e.g., feeling calmer, "less paranoid," happier), and feeling generally more comfortable. Recovery from physical and mental health problems was also reported as improvements resulting from living in the community.

One client who did not think that living in the community improved functioning noted that he was inactive and did not work as much recently, "Now I've got this job things are going to change, but for the past month or so I've just been sitting around watching TV, so I've gotta work on that." Two clients did not perceive improvements in their functioning since leaving the hospital, one indicating that, "I think it's the same. I don't know. It's just what I notice. They think that it has improved, but I don't see that."

Client Perceptions of How TRHP Contributes to Recovery

Clients were asked at each follow-up interview whether the rehabilitative housing contributed to recovery. Clients responded in the affirmative during 83% of the follow up interviews. The themes and the number of interviews in which they were mentioned are reported in Table 3.

TRHP was described as an "innovative," "one-of-a-kind" program by several clients:

> I think it's a step in the right direction. I am not saying it's the end all and everything. It's just that there's been nothing like that before. You know what I mean? Here at the hospital they talk about holistic, patient-centered care, but that's actually put into practice here, you know what I mean?

The programming was noted frequently as a helpful aspect of TRHP, including the provision of cognitive behaviour therapy and a concurrent disorders treatment group, as was being active and engaged in recovery-oriented activities, such as recreational programming. The structure of the program was described as supporting recovery, as it helped in developing a routine and "encouraged healthy lifestyles." It was described as well-structured and as being an appropriate length. The programming also kept clients active and engaged in a range of activities:

> You couldn't just get up when you wanted. You had to get up at a certain time, you had to go to programs, . . . it was well-structured and it promoted active living, so you had to go out and do stuff, you couldn't just stick around, and you had to report in, so it wasn't just going out and doing nothing, you had to actually go do what you said you were going to do.

The supportive housing model of the residences contributed to recovery, according to clients. TRHP gave clients a

TABLE 3
Factors of Rehabilitative Housing That Affect Recovery from Mental Illness

Theme	Number of interviews in which theme was mentioned ($N = 35$)	City
Factors that contributed to recovery		
New skills/knowledge (mind frame)	8	A, B
Staff (supportive, directive)	5	A, B
Programming (content)	4	B
Independence	4	A, B
Activity	3	B
Self-reflection	2	A, B
Integration	2	A, B
Structure of programming	2	B
Housing	2	A,B
Social contact	2	A, B
Relaxation	2	A, B
Motivation	2	A, B
Privacy	2	A
Medication	2	A
Improved self-concept and self-empowerment	1	B
Innovative program	1	B
Focus on recovery	1	B
TRHP one of many parts of recovery	1	B
Peer support	1	B
Security	1	A
Financial	1	A
Location of program	1	A
Transition	1	A
Factors that negatively affect recovery		
Difficulties with housing	1	B
Restrictions	1	A

secure place to live, while also providing the chance to develop more positive perceptions of the community. The staff members were described as supportive. Clients indicated that staff provided assistance with integrating into the community, guidance, and feedback. In addition to the staff, clients developed social networks with others in the program and received peer support. For one client, privacy was important; without the perception of being constantly supervised, he could focus mental resources on other activities and felt a sense of peace. Clients appreciated opportunities for relaxation.

Ways in which clients recovered included developing a new outlook on life, improving their self-concept, and experiencing an increased sense of empowerment:

> It gives you a new outlook on life. Instead of thinking that you have a mental illness and that you're sick and that you can't do anything for yourself, they completely change your way of thinking that you can do something for yourself. So that's what I believe recovery is, that you empower yourself to do things for yourself, that you're self-empowered, and no one's going to do it for you, so you have to learn these basic skills to do things for yourself.

Clients were provided with the opportunity to focus on a new direction in life and redevelop their independence. As one client indicated, living in the satellite apartment gave him a "chance to get what I need in life to have my own life." Clients noted that they developed new skills (e.g., cooking, time management, relapse prevention, coping strategies, medication management, maintaining "positive mind frame," social skills), new knowledge (about symptoms, mental illness, living in the community, medication), as well as insight into their mental health. TRHP was also described as providing an opportunity for self-reflection.

> The program keeps us honest. It forces you to get out and do stuff. And not just any stuff, stuff that's geared to recovery. So you either go out to [a] recreational program or... you get involved with a positive atmosphere ... and it teaches [you] to stay away from old habits and old friends so pretty much it forces you into a positive mind frame, things that are important in your life. Stay away from things that hurt you in the past. That's what they teach you.

> First of all, it helps people lose the institutionalization that they kind of accept, learn to cook for themselves, organize their own time, without having someone tell them to wash their clothes or time to eat or whatever. I think it gives people the opportunity to find out who they might actually be.

Although TRHP was generally described as a helpful program, some clients noted that it was one piece of the recovery process, not the whole. Individual traits, such as self-motivation, were also thought to be important to recovery. This motivation was present more often when living in the community, compared to during hospitalization. Of the clients who did not think that TRHP contributed to recovery, one reported difficulties with the housing, such as challenges in getting along with others. Two clients indicated that medication was the most important contributor to recovery. Another did not feel that living at TRHP was sufficient to support recovery. One client was ambivalent, stating that the support from the housing was beneficial, but this client did not like the curfew, which was due to restrictions imposed by the disposition order:

> The support from the housing helped, but I don't want to live in housing where there's so many rules. This is not too bad, but I can't spend the night out. I go to visit my brother in [nearby city] and get in trouble because I spent the night there.

What Is the Status of Clients at the End of Data Collection?

At the end of data collection, five (56%) City A clients had completed TRHP and were living in their own apartment.

Three (33%) clients were still in TRHP and were residing at the residence. One client remained in hospital and was not returning to TRHP. In City B, three (27%) clients had completed the program and were living in the community, one client had also completed TRHP and was later hospitalized, two clients continued to be involved with TRHP and were living in satellite apartments, and one client was living in the TRHP residence. Four (36%) other clients were in hospital; one client would not be returning to TRHP, one client might be readmitted to TRHP, and two clients were expected to return to TRHP shortly.

DISCUSSION

Overall, a majority of clients achieved high functioning during participation in TRHP and did not experience major setbacks, despite the need for some to be rehospitalized as part of the transition process. Transition to the community and rehabilitation are challenging, and most clients were able to meet this challenge. Clients generally perceived their functioning as improving because of living in the community and described TRHP as contributing to recovery. The clients described a variety of aspects of community life and of the TRHPs that supported their recovery.

While the improvements in functioning and recovery reported by clients were not reflected in the measure of community ability completed by staff (i.e., MCAS), clients were rated at a high level of community ability at baseline and were in fact referred to the program as they were considered likely to succeed in living independently. These high ratings of community ability upon admission to TRHP limited the possibility for higher ratings at subsequent time points.

The clients' stable scores of self-reported level of recovery on the RAS over the course of the study were also at odds with the level of perceived recovery reported in response to the open-ended questions. Part of this inconsistency may have occurred because, at baseline, clients were optimistic about their recovery after being discharged from hospital and being in transitional housing. This optimism remained with them as they moved into their own apartment. As well, the self-reported levels of social support were relatively high on the scale at entry into TRHP and these levels remain throughout the study. These results are consistent with clients noting in the open-ended portion of the interviews that they perceived themselves as being supported by the program. It appears that the available support is viewed as continuous for TRHP clients even after moving into their own apartment. Similarly, clients assess their quality of life generally as being positive throughout their participation in TRHP and after completing the program. However, it was lower at 18 months, and close to the mid-point on the scale, which could be due to challenges in living independently after leaving the TRHP residence.

Clients generally did not reoffend during their participation in TRHP. Only three (15%) clients re-offended during the course of the program. However, a majority (55%) of clients did require at least one rehospitalization after their admission to TRHP. The fact that many clients required rehospitalization suggests that the transition to the community is challenging and a return to the hospital may be an appropriate course for some clients, especially as four of the five City A clients who experienced rehospitalization had successfully returned to the community by the end of data collection, and, in City B, most of the rehospitalized clients had or were expected to return to the community. Past research with forensic patients has noted that rehospitalization is a proactive approach to manage symptoms and prevent further difficulties, and does not reflect failure (Heilbrun & Griffin, 1993; Luettgen et al., 1998; Viljoen, Nicholls, Greaves, de Ruiter, & Brink, 2011).

Medication non-compliance and substance use were commonly thought to contribute to rehospitalization, according to TRHP staff. Other research supports the role of these factors in subsequent difficulties (e.g., recidivism, return to hospital). Medication non-compliance and cocaine use were found to predict recidivism 12 months post-release in a group of parolees with mental health problems who were prescribed antipsychotic medication (Farabee & Shen, 2004). Medication adherence was particularly important in preventing recidivism for consumers of cocaine, reducing the risk of recidivism by 26% (Farabee & Shen, 2004). Compliance to a treatment regimen was also greater in forensic patients who successfully reintegrated compared to those still in recovery 3 years post-discharge (Viljoen et al., 2011). Substance abuse was also found to lead to revocation of conditional release for individuals found not guilty by reason of insanity or NCR who were discharged from hospital (Luettgen et al., 1998; Vitacco et al., 2008).

Clients described a process of integration into the community that contributed to improvement in functioning. One example of community integration is the increase in paid and volunteer work by clients during their participation in TRHP. The finding that TRHP clients were in the process of integrating into the community is interesting in light of another study that followed 15 forensic patients who were released to the community and received monitoring and support by nurses from the psychiatric hospital (Gerber et al., 2003). After living in the community for an average of 2.5 years, patients reported being generally satisfied with their lives and feeling a sense of community; however, their integration into the community was limited (Gerber et al., 2003). That TRHP clients had at least begun to integrate and had community involvement (e.g., employment, recreational activities) suggests that the services offered by TRHP are supporting clients with integration into the community. Community integration was a particular focus in City B and staff sought to encourage clients to participate in activities outside of the residence and of the hospital.

Clients described a range of factors associated with the TRHPs that contributed to improvements in functioning,

including increased independence, privacy in their living situation, acquiring social contacts, and developing new skills and perspectives. These factors could be relevant to other programs offering transitional housing to a forensic population. Similar to TRHP clients, hospitalized forensic patients in another study endorsed increased understanding of their illness through education as contributing toward recovery as patients developed strategies to monitor and manage their mental health (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). However, TRHP was also described as only one of the sources contributing to recovery with other factors (e.g., medications) also identified as important. The descriptions of recovery and increased functioning reported by the TRHP clients fit with the findings of a study in which forensic outpatients reported on changes in quality of life over a 6-month period (Bouman, de Ruiter, & Schene, 2010). In that study, patients were more likely to report having a "helping" friend at the 6-month time point. Self-esteem and overall subjective quality of life also improved in the Bouman et al. study. Higher treatment intensity was positively related to gaining a helping friend and improvements in self-esteem.

A qualitative study was conducted to explore how three groups of hospitalized patients (i.e., eating disorders, dual diagnosis, and forensic) described the concept of recovery (Turton et al., 2011). Numerous themes discussed in that study were consistent with factors that TRHP clients identified as contributing to recovery. The theme of social inclusion was endorsed as part of the recovery process in the Turton et al. study. Social inclusion entailed developing and working on relationships, employment, and other activities in the community, such as recreation or education. This idea is consistent with the themes of social contact and integration described by the TRHP clients. Having respectful interactions with staff were important to the Turton et al. participants, as were positive staff relationships for the TRHP clients. In the Turton et al. study, aspects of self-concept were important to recovery, such as developing a more positive self-concept in place of a negative self-perception. Recovery also involved improved self-esteem and a new sense of identity. TRHP clients endorsed improved self-concept, self-esteem, and self-confidence as contributing to recovery. Thus, several factors that were perceived as contributing to recovery by TRHP clients appear to apply to individuals in other forensic settings or individuals with other mental health concerns.

Similar to previous research examining the perceptions of clients and service providers concerning aftercare (Coffey, 2012), the TRHP clients found the community support provided by the program helpful. However, in contrast to the perceptions of other clients who spoke of limited freedom due to monitoring (Coffey, 2012), the TRHP clients did not describe the care they received as restricting their integration into the community, with the exception of one client who expressed frustration with the rules associated with the TRHP housing. TRHP clients spoke about the importance of their newfound independence. These results suggest that post-discharge support is important, but there is a need to foster independence even in the context of supervision.

Limitations and Future Research

This study had several limitations. As the studied program was a pilot serving a small number of clients, the sample size was limited. Future studies examining transitional housing for forensic populations should include more participants. The study also followed clients for only 18 months and future studies should include a longer follow-up period to better understand client outcomes. Another limitation is the fact that participants were program clients during at least some of the interviews, and it is possible that their responses were biased if clients felt pressure to present their functioning and their impressions of the program in an overly positive light. There was no control group with which to compare outcomes (e.g., recidivism), so it is unclear whether TRHP clients have better outcomes than those receiving treatment as usual. Future research on transitional housing for a forensic population should include a control group of individuals receiving treatment as usual.

Conclusion

Overall, transitional housing in combination with targeted, individualized support, followed by a transition to supported housing appears to be an appropriate treatment option for forensic clients discharged from hospital. Although many clients struggled at times and experienced rehospitalization, with appropriate support, many of these clients were able to return to the community. One potentially important aspect of a transitional program for forensic clients is an understanding that short-term rehospitalization can be part of the recovery process. Other factors include support around medication adherence and substance use, and the fostering of independence and community integration. These findings support the development of housing programs designed to assist the transition of forensic clients from hospital to the community.

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