

**EXPERIENCES OF STIGMA AND COMPULSORY
TREATMENT IN THE FORENSIC AND CIVIL MENTAL
HEALTH SYSTEMS OF BRITISH COLUMBIA**

by

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ABSTRACT

A small proportion of people with mental illness use community mental health services involuntarily – either as a consequence of civil commitment or criminal justice sanctions. Compulsory community treatment is intended to protect the welfare and safety of people with mental illness; however, it may also reinforce stereotypes about the mental health system and about people who use the services. Self-stigma refers to a complex, subjective process – embedded within a socio-cultural context – characterized by negative feelings, maladaptive behaviour, identity transformation, and adverse outcomes resulting from an individual’s experience, perception, and anticipation of adverse social reactions on the basis of their mental illness. This dissertation describes a prospective, mixed-methods, longitudinal study that examined the experiences and consequences of self-stigma for people with mental illness who receive compulsory community treatment in the forensic (N = 52) and civil (N = 39) mental health systems of British Columbia. The quantitative findings indicate that compulsory community treatment does not engender additive self-stigmatizing effects beyond that which is produced by mental illness itself. As well, the notion that ‘forensic’ labelling, or receiving compulsory treatment in a specialized forensic mental health system, is associated with increased levels of self-stigma was not supported by the data. Finally, the study revealed that level of self-stigma at baseline was not a significant predictor of quality of life one year later. The qualitative data that was collected for this study provides some evidence that compulsory community treatment has the potential to create barriers that ultimately prevent people with mental illness from

emerging out of stereotyped social roles. Regardless of whether they actively use treatment services on an involuntary basis, people with mental illness share a common struggle for choice, autonomy, respect, fairness, inclusion, and equality – especially in relation to how their services should be delivered. The present study indicates that these issues are interwoven into the stigmatizing experiences related to living with mental illness.

Keywords: Stigma; Mental Illness; Civil Commitment, Forensic Psychiatry; Labelling; Community Mental Health

DEDICATION

To Mom, Joanne, Sharon, and Elijah:

Four people to whom I owe everything that I am.

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CHAPTER 1: INTRODUCTION

Implicit in labeling theory is the argument that conditions need not and should not be the way they are. (Scheff, 1975, p. 2)

Stigma is a complex, multifaceted monster. It is conceptually indiscriminate, theoretically amorphous, and experientially pernicious. Stigma has been associated with an endless number of attributes, circumstances, health conditions, and social groups, with the literature primarily concentrated on the topics of race, sexuality, HIV/AIDS, and mental illness (Manzo, 2004). The focus of this dissertation is on the stigma that is associated with mental illness. More specifically, it describes the experiences and consequences of self-stigma for people living with severe mental illness who are legally mandated to receive community mental health treatment in British Columbia, Canada.

Factors that influence research decisions have been described as intersecting within a “four-cornered relationship” between scientific paradigm, theoretical preference, practical need, and methodological bias (McNeill & Chapman, 2005, p. 27). In addition to these factors, the choice to pursue a particular research topic is influenced by an individual’s motivation to solve a particular problem, their basic curiosity and interest, and their desire to build upon previous research (Marczyk, DeMatteo, & Festinger, 2005). Decisions pertaining to the topic of this dissertation, and the approach that was undertaken to study it, have been shaped by multiple considerations that are scientific, pragmatic, and professional in nature. These considerations supply the rationale for

decisions that were made about every element of this dissertation and, as such, are briefly discussed below.

Three seminal works were highly influential in the development of this dissertation; including Szasz's *The Myth of Mental Illness* (1960), Becker's *Outsiders* (1973), and Link and colleagues' *A Modified Labeling Theory Approach to Mental Disorders* (1989). Thomas Szasz focused critical attention on the actors and processes that are implicated in the social construction of disease – in particular, mental illness – which planted the theoretical seeds for this dissertation. Howard Becker's critical work laid the theoretical foundation for understanding deviance through the lens of the labelling perspective, with a criminological twist. The policy-perspective that was embedded within this dissertation was highly influenced by Becker's thoughts about how an individual's status and identity can be affected by power differentials that are created and perpetuated by social structures. Lastly, the contemporary writings of Bruce Link renewed the ideas of labelling theory and connected them with empirical research relating to subjective experiences of stigma for people with mental illness. Important for this dissertation was the fact that Link and his contemporaries situated labelling theory in such a way that it was made accessible to those who do not question the validity or existence of mental disorder: "even if labeling does not directly produce mental disorder, it can lead to negative outcomes" (Link, Struening, Cullen, Shrout, & Dohrenwend, 1989, p. 400).

The choice of topic for this dissertation was also influenced by the professional context in which the investigator was operating and the desire to connect research activities with the policy objectives of the British Columbia Forensic Psychiatric Services Commission (FPSC). This can be best elucidated by describing two converging

experiences that occurred during a period of employment with the FPSC. The first involved a recurring conversation with clinical colleagues at FPSC in relation to the inequity and adversity that their clients faced during the process of reintegrating into the community. The inequities were routinely attributed to the prevalence of negative attitudes and discriminatory practices throughout the health system – commonly referred to as the effect of the ‘forensic’ label. The second experience involved a request from senior management for a briefing note that outlined the relative strengths and weaknesses of the forensic mental health service delivery model in British Columbia. This request was made within the context of proposed reforms to the BC mental health system which called for better, “integration of forensic psychiatric services with other elements of the mental health system to provide better community support...” (British Columbia, 1998, p. iii), which potentially would diminish the specialized nature of forensic mental health services in the province.

While no published research had examined the relative effectiveness of different forensic mental health service delivery models (e.g., integrated versus specialized), several commentary articles identified ‘stigma’ as a potentially negative element of a highly-specialized forensic mental health system, since it, in effect, creates a separate subgroup of mental health service recipients. These overlapping experiences led to the development of a working hypothesis that, in addition to positive outcomes, service recipients of a specialized forensic mental health system would likely experience a host of adverse consequences, such as a high level of stigma, which may result from structural-level factors such as how services are organized and funded. A comprehensive literature review uncovered no studies that had examined the effects of the ‘forensic’ label, and

certainly none that had drawn connections between individual subjective experiences (e.g., stigma) and structural-level factors (e.g., policy, service delivery model). The research that was carried out for this dissertation was designed to address this gap in the empirical literature.

This dissertation has been organized into seven chapters. Chapter Two provides a thorough review of stigma, including an in-depth discussion regarding the relevant conceptual, theoretical, and empirical literature. This chapter also identifies the underlying epistemological approach that guides this dissertation. Chapter Three articulates the policy frameworks that supply the architecture for: the design of mental health service systems in British Columbia, the practice of compulsory community treatment, and the definition of mental health service recipients. Chapters Two and Three, together, provide the context and rationale for studying self-stigma among people with mental illness who receive compulsory community-based treatment in the forensic and civil mental health systems of British Columbia. Chapter Four highlights the main objectives of the research, which were broadened beyond the scope of the original hypothesis described above. As well, this chapter provides details concerning the methodological approach and analytic strategy that were used within the research study. The research findings are presented in Chapter Five. Chapter Six outlines the major strengths and methodological limitations of the present study. In Chapter Seven, the research findings are interpreted in the context of previous research and theory, and their implications for policy, practice and future research are discussed.

CHAPTER 2: STIGMA

As early as 1939, Dr. Winfred Overholser – in his call for the humane treatment of individuals with mental illness – discussed the shame, secrecy and stigma surrounding mental illness (Overholser, 1939). His discussion of the etiology of stigma astutely identified several factors that are deeply rooted in historical context and social structures, including the separation of psychiatry from the general medical community and the “barbaric and antiquated treatment of those with mental disease”(Overholser, 1939, p. 204). These ideas simmered silently for almost twenty-years, until the 1960s ushered in the labelling perspective as a dominant paradigm for understanding deviance. In the past ten years, there has, once again, been an explosion of research and theory regarding the labelling and stigma associated with health conditions, such as mental illness. This chapter provides an in-depth discussion of the extant literature on stigma, including the construct itself, related theories, and relevant research.

2.1 CONCEPTUAL REVIEW

Conceptual clarity regarding ‘stigma’ is lagging behind the burgeoning body of research regarding its effects. Too often, social scientists study ‘stigma’ without an apparent understanding, or explicit articulation, of its conceptual ingredients and boundary (Link & Phelan, 2001; Parker & Aggleton, 2003). Manzo (2004) asserted that stigma is consistently “underdefined and overused” (p. 401). Other authors have also been critical of using stigma as an all-encompassing concept: “Stigma, we suggest, is creaking

under the burden of explaining a series of disparate, complex and unrelated processes to such an extent that use of the term is in danger of obscuring as much as it enlightens” (Prior, Wood, Lewis, & Pill, 2003, p. 2192). This is particularly problematic as governments and professional organizations mobilize resources toward preventing and managing “this thing called stigma” (Manzo, 2004, p. 413). This section seeks conceptual clarification of the ‘stigma’ construct by reviewing leading definitions and by identifying its distinctive characteristics.

Erving Goffman’s conceptualization of ‘stigma’ has influenced over 40 years of a blossoming body of theory and research. In his seminal work, *Stigma: Notes on the Management of Spoiled Identity*, Goffman (1963) referred to stigma as: “an attribute that is deeply discrediting” (p. 3), “an undesired differentness” (p. 5), and something that reduces the bearer “from a whole and usual person to a tainted, discounted one” (p. 3). Goffman (1963) developed a taxonomy of stigma, including: abominations of the body (e.g., physical deformities), blemishes of individual character (e.g., mental disorder, unemployment), and tribal stigma (e.g., race, religion). Variations on the definition articulated by Goffman continue to be widely cited in contemporary stigma literature; however, his ideas tend to be over-simplified and the crux of his conceptualization is often ignored. Goffman (1963) primarily conceived stigma as a dynamic process unfolding in the social world rather than a static attribute occurring within an individual: “A stigma...is really a special kind of relationship between attribute and stereotype...” (p. 4). According to Goffman, stigma manifests through a socialization process involving routine face-to-face interactions, which affects how those with discrediting attributes perceive themselves, anticipate being treated by others, and relate to others.

The utility of Goffman's conceptualization for understanding health-related stigma within the context of contemporary society has been challenged (Sayce, 1998; Scambler, 2006; Weiss, Ramakrishna, & Somma, 2006). For example, Weiss and colleagues (2006) have outlined several shortcomings in Goffman's formulation, including: the outdated language and concepts, the over-generalized application of stigma to an array of circumstances unrelated to health, the failure to account for variability in stigma experiences, the incompatibility of his analytic framework with today's multicultural or pluralistic societies, and the over-emphasis of dyadic social interactions at the expense of structural considerations (Weiss et al., 2006). Drawing on relevant parts of Goffman's conceptualization, Weiss and colleagues offered the following definition:

Stigma is...a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted. In addition to its application to persons or a group, the discriminatory social judgment may also be applied to the disease or designated health problem itself with repercussions in social and health policy. (Weiss et al., 2006, p. 280)

Through this definition of stigma, Weiss and colleagues (2006) reformulated and reframed the concept to improve its relevance for studying the social dimensions of public health problems in the context of modern globalization and multiculturalism.

Herek (2007) conceived of stigma as a cultural phenomenon that, "creates the social context in which such attitudes are formed, maintained, expressed, and changed" (907). Drawing from the works of several stigma theorists (e.g., Goffman, 1963; Jones et al., 1985; Link & Phelan, 2001), Herek (2004, 2007) discussed stigma in relation to sexuality and delineates it into the following five principal features. First, stigma

necessitates the identification of an enduring condition, attribute, or mark that is symbolic of difference or deviance. Second, an attribute's meaning is acquired and negotiated through social interaction. Third, negative meaning is attached to the attribute, signalling that the bearer is socially devalued and discredited. Fourth, the stigmatized status engulfs the bearer's entire identity. Fifth, relative powerlessness is essential for stigma – those who occupy 'stigmatized' social roles have less power and have access to fewer resources than do those with 'normal' social status. The key ideas within Herek and colleagues' conceptual framework of stigma include the following: (a) that it should be understood as a cultural ideology manifest in socially shared knowledge of the negative regard for certain community members, (b) that it legitimates a dominant belief system and justifies the resulting social response (e.g., hostility, oppression), and (c) that it simultaneously expresses and perpetuates hierarchical relations within society (Herek, 2004, 2007; Herek, Gillis, & Cogan, 2009).

In a critical review of the way in which the concept of stigma is being handled by contemporary social scientists, Manzo (2004) explored the rationale for studying certain statuses or conditions as 'stigmatizing'. Conditions that have been constructed as 'stigmatizing' within the research literature share one or more of the following qualities: the condition is visually notable, it is fatal or debilitating, it is perceived as contagious, it implies blame or negligence, it is relatively rare, it reflects frailty and incompetence, and it points to an alternative lifestyle. Furthermore, Manzo (2004) added four additional qualifications for conditions that are construed as stigmatizing by social scientists: the condition is known or knowable, the stigma is actively managed by those who are stigmatized, the negative outcomes of the condition are exacerbated by stigma, and stigmatized individuals are relatively powerless and marginalized. The main point argued

by Manzo (2004) was that ‘stigma’ has been constructed by social scientists in such a manner that its meaning is no longer grounded in the actual discourse or lived experiences of social actors; therefore, the concept provides an inadequate framework for explaining these subjective phenomena and processes.

In addition to its features or qualities, stigma may also be understood in terms of the different ways in which it is experienced and manifested. The literature articulates three interacting levels of stigma: self, social, and structural (Corrigan, Kerr, & Knudsen, 2005; Herek, 2007; Herek et al., 2009). Self-stigma, also referred to as *internalized* or *felt* stigma, exists at the individual (i.e., micro) level and is defined as “the loss of self-esteem and self-efficacy that occurs when people internalize the public stigma” (Corrigan, Kerr et al., 2005, p. 179). In the context of mental illness, self-stigma describes a process whereby affected individuals endorse stereotypes about mental illness, anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society (Corrigan, Kerr et al., 2005; Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006a). Further distinctions are made between *felt* and *self* stigma (Herek, 2007; Herek et al., 2009). Whereas *felt* stigma describes negative consequences resulting from an individual’s awareness of how society perceives, and will likely act toward, the group to which they belong (e.g., homosexual, mentally ill, etc.), *self*-stigma refers to the process of an individual accepting society’s negative evaluation and incorporating it into their own personal value system and sense of self. Similarly, Corrigan and colleagues (2006a) distinguished between *perceived* stigma (awareness of stereotypes) and *self*-stigma, and defined the latter as: “when the person internalizes the stigma and applies it to people with mental illness in general (stereotype agreement) or to him or herself (self-

concurrency)” (p. 882). The concept of self-stigma is crucial for understanding how cultural ideology can negatively affect an individual’s self-concept and well-being even in the absence of any overt stigmatizing behaviour.

Social stigma, also known as *public* or *enacted* stigma, exists at the group (i.e., meso) level and describes “the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group” (Corrigan, Kerr et al., 2005, p. 179). While the concept of *social* stigma encompasses negative societal attitudes (i.e., prejudice), the term *enacted* stigma specifically refers to overt behaviours, including exclusion, discrimination, and violence (Herek, 2007; Herek et al., 2009). Structural stigma, also called *institutional* stigma, exists at the system (i.e., macro) level and refers to the rules, policies, and procedures of private and public entities in positions of power that restrict the rights and opportunities of people with mental illness (Corrigan, Kerr et al., 2005; Corrigan, Watson et al., 2005). In this form of stigma, “cultural ideology [is] embodied in institutional practices” (Herek, 2007, p. 907) so that differentials in power and status are legitimated, and disadvantage and social exclusion are perpetuated (Corrigan, Kerr et al., 2005; Herek, 2007; Herek et al., 2009). Corrigan and colleagues (2005) differentiated *institutional* from *structural* discrimination, in that the former refers to a conscious intent by social actors to create inequality while the later involves unintentionally diminishing opportunities for people with mental illness.

Link and Phelan (2001) offered a “revised conceptualizing” of stigma by delineating it into core components: “we apply the term stigma when the elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (p. 367). Labelling is the social

process of constructing and applying oversimplified, socially salient categories of human difference. Through this process, labelled persons are believed to be distinctly different. Stereotyping involves cultural endorsement of the association between social labels and undesirable characteristics. In the next component, separating ‘us’ from ‘them’, persons bearing a stereotyped label are set apart and isolated from the rest of society. Thus, a “stigmatized them” (Link & Phelan, 2001, p. 375) is created. The preceding components then lead to devaluation, rejection, and exclusion of certain groups, which creates social disadvantage and loss of social status. Link and Phelan (2001) recognized that the social production of stigma is dependent on power differences: “Stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination” (p. 367). Addressing criticisms of the concept, Link and Phelan (2001) also clarified that stigma is: (a) a continuum in terms of how it is experienced, (b) actively resisted by its recipients, (c) a persistent predicament for those with relative powerlessness, (d) a key determinant of an array of life changes, and (e) amenable to change.

Corrigan and colleagues conceptualized stigma in a similar manner as Link and Phelan (2001); however, they tended toward a more individualistic, social-cognitive approach (Corrigan, 2000; Corrigan, Larson, & Rusch, 2009; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Corrigan & Watson, 2002; Corrigan, Watson, & Ottati, 2003). Social stigma is conceived as the interrelationship between stereotypes, prejudice (operating at the cognitive and affective levels), and discrimination. These three

components are framed within attribution theory to understand the interrelationship between signalling events (e.g., symptoms of mental illness), knowledge structures (e.g., stereotypes), cognitive mediators (e.g., attribution of controllability or dangerousness), affective responses (e.g., pity, fear, or anger), and behavioural reactions (e.g., benevolence, social distance) (Corrigan, 2000). Self-stigma is conceptualized in the same terms: people with mental illness who are aware of, and agree with, stereotypes may experience negative emotional reactions (e.g., devaluation) and behavioural responses (e.g., social withdrawal) (Corrigan & Watson, 2002). Corrigan and colleagues (2009) described self-stigma as the hierarchical relationship between awareness, agreement, and application: “a person with mental illness must first be aware of corresponding stereotypes before agreeing with them and applying self-stigma to one’s self” (pp. 75-76).

A central analytic debate in the literature concerns the relationship between stigma and discrimination. Link and Phelan (2001) contended that analytic frameworks which seek to reflect a common understanding of the term ‘stigma’ must include both beliefs and behaviour: “the term stigma cannot hold the meaning we commonly assign to it when this aspect [status loss and discrimination] is left out” (p. 370). Diverging from this perspective, Deacon (2006) argued that behavioural responses (i.e., discrimination) should not be subsumed within definitions of stigma. The primary reason for advocating for the analytic separation between stigma and discrimination is that the conceptual conflation creates an over-simplistic depiction of the effects of stigma and fails to account for existing forms of social power and disadvantage: “Defining stigma as something that results in discrimination reduces analytic clarity about the relationship between stigma and its effect” (Deacon, 2006, p. 421). To support his position, Deacon asserted the

following arguments: (a) stigma is not dependent on social position, (b) adverse effects of stigma can occur in the absence of overt discrimination, (c) stigma may result in positive outcomes (i.e., increased social status), and (d) stigma is only one factor that causes social disadvantage. Sayce (1998) also described the advantages of maintaining an analytic distinction between stigma and discrimination: “If we had to use only one word, we should choose one rooted in notions of unfair treatment, such as ‘discrimination’. That way we do not compound discrimination through our choice of terms” (p. 333).

Clearly, stigma is a socially constructed concept that means many different things to many different people. Variability in the definition of stigma is, in part, a consequence of the fundamental epistemological and ontological differences of those who seek to define the term. Link and Phelan (2001) pointed out that conceptual variability also results from the complexity of the phenomenon and the array of circumstances to which stigma has been applied. Campbell and Deacon (2006) emphasized the complexity of stigma by describing it as “a phenomenon rooted in the individuals psyche, yet constantly mediated by the material, political, institutional and symbolic contexts” (p. 416). Though numerous definitions of stigma have been published, fewer definitional examples of self-stigma exist in the literature. Borrowing from several of the aforementioned conceptualizations, particularly from Weiss and colleagues (2006), this dissertation adopts the following definition:

Self-stigmatization is a complex, subjective process – embedded within a socio-cultural context – characterized by negative feelings, maladaptive behaviour, identity transformation, and adverse outcomes resulting from an individual’s experience, perception, and anticipation of adverse social reactions on the basis of their mental illness.

This definition recognizes the macro-socio-cultural forces that influence this subjective, individualized process. As well, this conceptualization pays attention to the multi-faceted dimensions of self-stigma (Link & Phelan, 2001), which involves interacting processes at the individual and societal levels.

2.2 THEORETICAL PERSPECTIVE

Humans label and categorize in an effort to simplify and understand complexity. Theorists from functionalist (e.g., Dentler & Erikson, 1979; Durkheim, 1979; Erikson, 1964) or evolutionary (Kurzban & Leary, 2001) perspectives would argue that the social process of labelling deviance serves an integral – even beneficial – societal utility or function: “There can be no ‘normal/acceptable’ in the absence of tangible exemplars of the ‘abnormal/unacceptable’” (Scambler, 2009, p. 442). A single label can quickly communicate a myriad of features and attributes. Labels that are attached to people suggest the type of person they are, including whether they are normal or deviant (Phelan & Link, 1999). Every professional specialty has developed complex systems of categorization; it appears that none have been so heavily criticized as those used by criminal justice and mental health professionals. Because these disciplines are, arguably, the largest agencies of social control in Western society – both striving to identify, classify, and remedy deviance – the manner in which they categorize and label individuals and social groups has powerful consequences (positive and negative) for society (Cohen, 1985; Szasz, 1963).

For this dissertation, a social constructionist perspective, using a labelling theoretical approach, has been adopted as the principal lens through which the

phenomenon of stigma is examined and understood. More specifically, a ‘soft labelling’ approach (Mechanic, 1999) is being used to identify the social structures and processes that shape the understanding and management of mental illness, and, in turn, affect the subjective experiences of people who live with mental illnesses. Whereas a ‘hard’ version of the labelling perspective (Scheff, 1966) would position social processes/reactions as the etiology of mental illness, a ‘soft’ version emphasizes labelling processes as being important for, “the course of the disorder and how persons with mental illness respond to their situations over time” (Mechanic, 1999, p. 26).

The central tenets of classical and contemporary perspectives in regard to labelling and stigmatization are considered below. The discussion of the classical labelling perspective begins with a cursory consideration of its conceptual and theoretical foundation: symbolic interactionism. This follows with an overview of the core ideas of classical labelling theory. The theoretical discussion concludes with a consideration of the manner in which contemporary theorists conceive of labelling and stigma.

2.2.1 Symbolic Interactionist Theoretical Roots

‘Objects’ in the world around us do not have intrinsic meaning; rather, it is only through social interaction with these ‘objects’ that meaning emerges for, and about, ourselves (see Blumer, 1971; Cooley, 1902; Mead, 1917). This fundamental principle of the symbolic interactionist perspective emphasizes the social process and the situational nature by which people define their environments, each other, and themselves, as Mead (1917) articulates: “The individual in his experience is continually creating a world which becomes real through his discovery” (p. 225). In order to understand the meaning of a

social object, we must inquire about the processes involved in generating social definitions and formulating meaning (Denzin, 1969). Of particular importance to the foundations of the labelling theoretical perspective, is how symbolic interactionism conceptualizes an individual's development of sense of self and society's construction of social problems.

On the sense of self, key ideas stem from the reflected appraisal process or the looking-glass self concept which draws attention to the social nature of self-concept/identity (Cooley, 1902; Mead, 1934). According to the theory, an individual derives his or her sense of self by interacting with others, actively interpreting how one is appraised and perceived by others, filtering through the information, and internalizing what one imagines others think of them (Felson, 1985; Kaufman & Johnson, 2004; Wells, 1978). An individual's sense of self is maintained and shaped by this continual social process, as is explained by Davis (1980): "Symbolic interactionism emphasizes the self as social object, an entity which is formed, sustained, weakened, and transformed in its interaction with others" (p. 204). The social structures and institutions that surround an individual are key to the development of self (Denzin, 1969), as was articulated by Singlemann (1972):

...society is historically prior to the individual member: the individual is born into an already existing society which sets the institutional parameters for his self-development. Self and society thus develop together and because of each other in a dialectical process of mutual transformation. (p. 415)

Indeed, the basic symbolic interactionist idea that the self is a social product provides the theoretical foundation for labelling perspective's concept of secondary deviance.

Moreover, theorizing by interactionists (i.e., Mead and Cooley) influenced the subsequent

work of labelling theorists, particularly Goffman (on the presentation of self) and Scheff (on shame) (Adams, Robertson, Gray-Ray, & Ray, 2003).

Regarding social problems, Blumer's (1971) essay 'Social Problems as Collective Behavior' offers a clear postulation of the symbolic interactionist perspective. Like the self, deviance is conceptualized as a social product: "Social problems do not lie in the objective areas to which they point but in the process of being seen and defined in the society" (Blumer, 1971, p. 306). Under this theoretical perspective, particular attention is paid to the process of how social problems are identified and collectively defined, as well as the structures that solidify power differentials and influence this process (Becker, 1973). According to Blumer (1971), collective definitions of social problems progress through five stages that seek to: (i) identify the problem, (ii) legitimate the problem, (iii) mobilize action toward the problem, (iv) formulate an official definition and response plan to address the problem, and (v) implement a plan against the social problem:

It is this process which determines whether social problems are recognized to exist, whether they qualify for consideration, how they are to be considered, what is to be done about them, and how they are reconstituted in the efforts undertaken to control them. (p. 305)

The interactionist approach regarding social problems sheds light on taken-for-granted social processes that define and influence the "drama of deviance" (Becker, 1973, p. 175). As such, Blumer and other interactionists questioned the conventional perspective toward social problems and supplied labelling theorists, such as Becker, with the fundamental roots needed to advance their perspective.

2.2.2 Classical Labelling Perspective

Describing ‘classical labelling’ as a *theory* is inherently flawed (Becker, 1973; Goode, 1975). Goode (1975) went so far as to suggest that the labelling approach, “...isn’t even as grandiose an edifice as a general perspective” (p. 581). Rather than referring to a unitary theory, ‘classical labelling’ is more aptly characterized as a theoretical perspective or a collection of profound ideas rooted in symbolic interactionism (Blumer, 1969; Cooley, 1902; Mead, 1917, 1934) and centered on the notion that neither individuals nor behaviour are inherently deviant; rather, deviance is a social construction.

In the early 1960s, the labelling perspective became the dominant sociological approach to understanding deviance. Classical labelling perspective is often attributed to the work of Becker (1973), the so-called ideological “chief spokesman” (Davis, 1972, p. 451). Interestingly, Becker refuted the notion that he intended to propose an actual theory:

Labelling theory...is neither a theory, with all the achievements and obligations that go with the title, nor focused so exclusively on the act of labelling as some have thought. It is, rather, a way of looking at a general area of human activity; a perspective whose value will appear, if at all, in increased understanding of things formerly obscure. (Becker, 1973, p. 181)

Becker (1973) suggested that what he sought to do was to understand deviance as a form of collective action. That is, how people collectively work together to define deviant behaviour. Other sociological seminal contributions to the classical labelling perspective include, but are not limited to, Edwin Lemert’s *Social Pathology* (1951), Kai Erikson’s *Notes on the Sociology of Deviance* (1962), and John Kitsuse’s *Societal Reaction to Deviant Behavior* (1962). Erving Goffman’s *Stigma* (1963) and *Asylums* (1961), and Thomas Scheff’s *Being Mentally Ill* (1966; 1984) are the most relevant works for

understanding mental illness through the lens of the labelling perspective and will be considered at the end of this section.

While the labelling perspective defies simple synthesis, Thoits (1999) managed succinctly to articulate the basic premise: “People who are labelled as deviant and treated as deviant become deviant” (p. 134). Building on the work of the symbolic interactionists, the founders of the labelling perspective, also known as social reaction theory, rallied for a paradigm shift away from the conventional considerations of deviance as being a property of individuals and of their behaviours (Becker, 1973; Erikson, 1962; Kitsuse, 1968; Major & O'Brien, 2005). Labelling theorists argued that the common-sense sociological conceptualization of rule-breaking activities (as inherently deviant) ignores the symbolic socio-cultural processes implicated in formulating these judgements and, consequently, misses critical variables in the deviance equation (Becker, 1973; Kitsuse, 1968; Schrag, 1971). Through the labelling perspective, the emphasis was shifted from the individual actor to the social audience (Becker, 1973; Erikson, 1962); the moral burden was moved from those who break the rules to those who make them (Davis, 1972); and the focus of inquiry was transferred to the social processes and contextual factors involved in defining and responding to primary deviance (Davis, 1972; Phelan & Link, 1999; Schrag, 1971).

Deviance is conceptualized as a process by which society interprets certain behaviours as deviant, defines individuals who perform such behaviours as deviant, and treats them in accordance with the socio-cultural convention for handling deviants (Kitsuse, 1968). ‘Deviant’ labels are attached to certain violations of norms by official

social control agencies in order to define a society's normal standards and to institute authority over 'deviance', as was articulated by Becker (1973):

...social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label. (p. 9)

Society reacts to violations against social norms by applying labels; persons that violate legal rules are defined as criminals and those who violate certain cognitive, affective, or behavioural rules are identified as mentally ill. Mental illness is conceptualized as 'deviance' in that it violates normative rules for how people should think, feel, and behave (Thoits, 1999). Accordingly, rather than focusing on mental illness as an inherent problem of an individual, the labelling perspective focuses on the social forces, processes, and institutions that influence how and why particular behaviours come to be defined as such (Brown, 1995; Rosenberg, 1984).

Not all rule-breaking behaviours are selected for formal social definition and response (Erikson, 1962). Labelling theorists recognized that everyone, in some manner, violates normative rules that either go undetected or are handled through informal social sanctions (i.e., parenting, peer pressure). Moreover, definitions of deviance vary across time, situations, context, and culture: "it is easily observable that different groups judge different things to be deviant" (Becker, 1973, p. 4). 'Macro-social structural forces' influence the rule-breaking activities that are selected for formal labelling and social response (Yang et al., 2007). Indeed, power differentials affect who is able to make and apply rules (Becker, 1973). This is confirmed by the fact that the ability to attain the

social positions needed to make rules for others is affected by socially relevant characteristics, such as age, socioeconomic class, ethnicity, and gender (Becker, 1973). Because definitions of deviance serve the interests of the powerful, activities that are considered contrary to their interests become defined as deviance.

The characteristics that prevent individuals from acquiring powerful social positions (i.e., class, race, gender) also influence the differential application of formal labels (Becker, 1973; Davis, 1972; Erikson, 1962; Schrag, 1971):

The distribution of power, legal definitions, and controlling activities are central issues that provide analytic starting points for delineating those structural conditions that create the basis for generating a body of rule-breakers. Labeling in this sense, is a consequence and symbol of power (Davis, 1972, p. 468).

Those who are not able to acquire rule-making social positions become the targets of those who are privileged to possess this ability. Groups that lack power and status relative to institutions of social control ultimately become formally labelled as deviant (Schrag, 1971; Thoits, 1999). Features of rule-breaking behaviour may have some influence on the labelling process, with those that are frequent, severe, or highly visible being prioritized for formal labelling (Lemert, 1979; Thoits, 1999). However, in relation to the criminal justice context, labelling theorists emphasized that the characteristics of offenders, rather than the features of offences, ultimately determine who gets caught and what happens to those who are caught (Erikson, 1962; Schrag, 1971).

Social systems maintain norms by applying social pressures and rewards in order to encourage behaviour that is consistent with the core values of society. Any behaviour that deviates from the nucleus of the normative system is considered deviant (Erikson, 1962). Any individual who operates beyond the proscribed boundaries of the group is

considered a candidate for deviant sanctions. Erikson (1962) compared the creation of social norms to the development of articles of common law: “it is an accumulation of decisions made by the community over a long period of time which gradually gathers enough moral influence to serve as a precedent for future decisions” (p. 310). The purpose of a social norm is to “promote a high level of uniformity among human actors and a high degree of symmetry within human institutions” (Erikson, 1962, p. 309). Labelling theorists recognized the importance of, and paid some attention to, macro-sociological factors (i.e., economic, political) that influence the structure and formation of normative social systems. However, the labelling perspective primarily remains at the micro-sociological level (Davis, 1972), with most of the theorizing taking place after a person is “caught and publicly labeled as deviant” (Becker, 1973, p. 31).

The labelling perspective emphasizes the “independence of act and reaction” (Becker, 1973, p. 196). Primary deviation, or initial rule violations (e.g., psychiatric symptoms, immoral acts, illegal behaviour), play a relatively minor role in this perspective (Davis, 1972; Gove, 1982; Thoits, 1999). Lemert (1979) argued that primary deviations are unimportant until they are defined as socially unacceptable, are transformed into social roles, and become criteria for assigning social status. This process is responsible for creating secondary deviance, which Lemert (1979) conceived as a process whereby “a person begins to employ his deviant behavior or a role based upon it as a means of defense, attack, or adjustment to the overt and covert problems created by the consequent societal reaction to him” (p. 169). Lemert’s secondary deviance hypothesis asserted that social reactions to initial acts of deviance are responsible for placing a person into a deviant social role, and transforming their identity and behaviour

into that of a deviant. In other words, the collateral consequences of formal labelling are a self-fulfilling prophecy since these processes “stabilize and deepen deviant behaviour” (Link, Mirotnik, & Cullen, 1991, p. 302).

The first collateral consequence of formal labelling is described as “structural impediments to conventional life” (Chiricos, Barrick, Bales, & Bontrager, 2007, p. 548). Because of differential treatment based on their deviant label, individuals are restricted from participating in social activities (e.g., work, school, relationships) that are required for social advancement, such as acquiring material wealth, achieving respectable social roles, and developing meaningful relationships (Becker, 1973; Link et al., 1991; Thoits, 1999; Ulmer, 1994; Yang et al., 2007). Label carriers are isolated and segregated away from normal society and consequently, their involvement in regular social activities and networks becomes restricted. Negative societal reactions toward deviant labels ultimately hinder a person’s ability to integrate into, and be a part of, society. Therefore, the social processes and institutions that are created to control deviance in actuality contribute to its continuance through oppression, discrimination, and marginalization (Erikson, 1962). It is through this differential treatment that the individual begins to identify with the deviant role (Thoits, 1999).

The second consequence of formal labelling processes is the transformation of status or identity (Chiricos et al., 2007). For the labelling perspective, the passage from ‘doing deviance’ to ‘being deviant’ is key. The pernicious effects of labelling and stigma include changing the way that individuals perceive themselves (Davis, 1972, 1980; Goode, 1975). Borrowing directly from symbolic interactionism, labelling theorists suggested that individuals will develop a deviant self-concept if they believe that society

views them in that manner (Cumming & Cumming, 1968; Ulmer, 1994). And, this deviant self-concept is continuously reinforced through social interaction. Moreover, Schur (1971) indicated that individuals undergo a process of ‘retrospective interpretation’ in which their former identity (prior to being labelled ‘deviant’) is erased and ignored by society. This process, in turn, denies individuals access to their former identity.

Similarly, the concepts of ‘role engulfment’ (Schur, 1971) and ‘master status’ (Becker, 1973) suggest the powerful implications that result from moving individuals into deviant social roles. Role engulfment describes a process by which individuals who find themselves in deviant roles begin to relate to their deviant identity and organize their behaviour in accordance with their new social role (Schur, 1971). As time passes, individuals place increasing amounts of significance on their deviant role, which ultimately causes their identity to become engulfed by that role. The concept of ‘master status’ also refers to a process whereby an individual’s deviant social status becomes prioritized and dictates how they are perceived and treated by society regardless of the other subordinate social roles the person may occupy, as was articulated by Becker (1973):

Some statuses, in our society as in others, override all other statuses and have a certain priority... The status of deviant (depending on the kind of deviance) is this kind of master status. One receives the status as a result of breaking a rule, and the identification proves to be more important than most others. (p. 33)

Erikson (1962) also noted how a brief brush with a deviant social role can potentially create an overriding and everlasting stain on an individual’s character:

...a person may be jailed or hospitalized for a few scattered moments of misbehavior, defined as a fulltime deviant despite the fact that he had supplied the community with countless other indications that he was a decent, moral citizen. The screening

device which sifts these telling details out of the individual's overall performance, then, is a sensitive instrument of social control. (p. 308)

Deviant labels are associated with an array of stereotypes and carry a “generalized symbolic value” (Becker, 1973, p. 33). Individuals who break specific social rules (i.e., commit an illegal act, exhibit signs of mental illness) and are formally labelled may be considered generally deviant in all aspects of character and life (Becker, 1973). Thus, a person labelled *mentally ill* is perceived as possessing the stereotypical attributes and images that are associated with the label. Some authors consider the labelling process to be dehumanizing since it reduces a complex human being to an abstraction (Goffman, 1961; Scheff, 1975).

Transformation of an individual’s identity into that of a deviant is most fully achieved by processing them through social institutions that have been given authority by a particular culture to uphold normative standards. Formal labels are acquired through contact with monolithic social control agencies, such as the police, courts, or mental health services (Davis, 1972). At the same time, individuals go through a formal status degradation ceremony (e.g., incarceration, involuntary hospitalization) that strips away their previous status and imposes a socially constructed deviant identity on them (Davis, 1980; Garfinkel, 1956; Gove, 1982). Erikson (1962) described these status transformation ceremonies as occurring in three phases: (a) confrontation between the alleged deviant and the community, (b) public proclamation of the individual’s deviance, and (c) social relocation of the individual and redefinition of their position in society. Erikson (1962) further said that process manifests in an irreversible “sharp rite of transition” that

transfers an individual from a normal position in society into a distinct deviant role (p. 311).

Erving Goffman's sociological theorizing and research provides a detailed elucidation of the effects of labelling and stigma for individuals who are, on account of differentness, disqualified from full social acceptance. Goffman's seminal work, *Stigma: Notes on the Management of Spoiled Identity* (1963), described the ways in which people that have a discrediting attribute or condition navigate social interactions, negotiate relationships, and manage their personal and social identities. Goffman examined the exchanges that occur during face-to-face interactions (i.e., rule-breaking and rule-adherence) in order to highlight the social structures that regulate and control social behaviour. For Goffman, the structure and organization of routine interactions was what "steadies and sustains social order" (Scambler, 2009, p. 443). In his writings, Goffman rapidly skipped between profoundly complex concepts and ideas; however, a dominant theme emerging from the biographical accounts in *Stigma* concerns the structure of interaction between the 'stigmatized' and the 'normals':

When the normals and stigmatized do in fact enter one another's immediate presence, especially when they there attempt to sustain a joint conversational encounter, there occurs one of the primal scenes of sociology; for, in many cases, these moments will be the ones when the causes and effects of stigma must be directly confronted by both sides. (Goffman, 1963, p. 13)

Stigma is conceptualized as a dynamic social process in which every member of society plays a role, rather than "a set of concrete individuals who can be separated into two piles" (Goffman, 1963, p. 137). Therefore, an individual may occupy the role of either the stigmatized or the stigmatizer at different points of time and in different situations.

Moreover, it is emphasized that those who occupy 'normal' and 'stigmatized' roles are figuratively cut from the same cloth (i.e., products of the same norms).

The concept of 'moral career' was used by Goffman to describe a socialization process whereby stigmatized individuals shift between the socially constructed statuses of 'normal' to 'discreditable' to 'discredited'. Through this process, the individual's conception of the world, of others, and of self is transformed. The career process starts with an individual learning about the perspective of 'normal' society regarding how a particular stigma is viewed, which Goffman (1961) referred to as "culturally derived and socially ingrained stereotypes" (p. 132). In their moral career, the individual then proceeds through the stages of learning that they possess a particular stigma and then realizing that they will be rejected and disqualified by society. The term 'discreditable' is used to describe a status in which individuals possess a stigma that is unknown and unapparent to others. For the 'discreditable' individual, a primary task during routine social interaction is to manage information about their stigma so as to avoid being exposed: "To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where" (Goffman, 1963, p. 42). In contrast, for the 'discredited' individual who possesses a stigma that is known or obvious to others, a core issue is managing the tensions and impressions that arise during face-to-face interactions with others.

In *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961), Goffman narrowed his focus to discuss the influence of social institutions on the moral careers of 'the mental patient', which he conceptualizes as unfolding in three phases: (a) the pre-patient phase, (b) the in-patient phase, and (c) the ex-patient phase.

Drawing on his ethnographic fieldwork in an American psychiatric institution, Goffman (1961) argued that the experience of being admitted to a psychiatric hospital is a pivotal event in shaping “the person’s self and in his framework of imagery for judging himself and others” (p. 128). Of particular interest is the manner in which contact with psychiatric hospitals, which Goffman considered a form of ‘total institution’, systematically strips away an individual’s rights, liberties, and sense of self. A primary feature of total institutions, such as asylums, prisons, army barracks, or convents, is that they prevent interaction between their inhabitants and the outside world. As well, total institutions force their inhabitants to perform all spheres of life (e.g., sleeping, eating, playing, and working) within the same place, controlled by highly structured rules and routines, alongside a cohort of other inhabitants, under the direction of a single authority, and for the purpose of achieving an institutional goal.

Upon entry to a total institution, individuals go through a “process of mortification” (Goffman, 1961, p. 43) by being forced to surrender their autonomy, freedom, self-determination, social roles, relationships, personal effects, and previous way of life that has, thus far, sustained their formulation of self-identity. Within the total institution, individuals are required to submit to a stigmatized status and engage in activities “whose symbolic implications are incompatible with his sense of self” (Goffman, 1961, p. 23). According to Goffman (1961), a person has limited ability to sustain their self-conception after being removed from natural supports and settings. Through institutional pressures, manifest in rules and standardized processes such as a system for granting ‘privileges’ to patients, the self becomes unsettled and reorganized:

The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members. The

self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it. (Goffman, 1961, p. 168)

Thus, a stigmatized individual's social identity is profoundly shaped by the power imbalances that are supported and sustained by social structures, manifest routinely as face-to-face interactions and, in the extreme form, as total institutions.

Building on Goffman's work, Thomas Scheff (1966) offered a more complete and explicit labelling theory of mental illness. In his original writings, Scheff (1966) claimed that labelling was the single most important cause of stabilizing residual rule-breaking (i.e., symptoms of mental illness), but he later downgraded 'labelling' to among the most importance causes (Scheff, 1984). One of the main ideas stemming from Scheff's theory is that mental illness can be conceptualized as a form of 'residual rule-breaking' or deviance, in which individuals are labelled mentally ill because they violate unspoken rules that cannot be classified by other existing cultural categories. Similar to other labelling theorists, Scheff's primary focus was on the social reaction to residual deviance, and how this reaction stabilizes deviance and causes secondary deviance. According to Scheff, labelling someone 'mentally ill' triggers a sequence of powerful social events.

Scheff articulated the main points of his theory in the following statement:

In a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and at times the deviant himself. When societal agents and people around the deviant react to him uniformly in terms of the traditional stereotypes of insanity, his amorphous and unstructured rule breaking tends to crystallize in conformity to those expectations, thus becoming similar to the behavior of other deviants classified as mentally ill, and stable over time. The process of becoming uniform and stable is completed when the traditional imagery

becomes a part of the deviant's orientation for guiding his own behaviour. (Scheff, 1966, 82)

Stereotypes of mental illness are learned at an early age and are constantly reaffirmed through social interaction (Scheff, 1968). Negative stereotypes about mental illness (e.g., dangerousness, incompetence) become the guided imagery for action. Therefore, the treatment of anyone who is labelled 'mentally ill' will be consistent with the stereotyped imagery of mental illness.

Scheff (1968) described a social system in which labelled deviants are rewarded for playing the stereotyped role and blocked from attempting to return to their conventional role. For example, individuals with mental illness are praised when they acknowledge their illness and accept the help of professionals, and are punished if they deny that they are mentally ill (Link & Phelan, 1999). This system of reward and punishment is responsible for: restricting individuals to the role of the mentally ill person; transforming their self-concept; and creating a stable pattern, or career, of secondary deviance (Link et al., 1989). Moreover, the optimal pathway that society expects those who are labelled 'mentally ill' to follow – which includes contacting agents of social control (i.e., mental health professionals), being assigned a formal label (i.e., diagnosis), and receiving psychiatric treatment – also serves the purpose of creating and reinforcing the individual's deviant identity and social role.

As is evident from the discussion above, the classical labelling perspective is much more complex than its popularized distillation of 'attaching labels to people'. However, the sheer number of diverse ideas that were stuffed within the 'classical labelling' envelope, and the resulting lack of clarity in several areas, perhaps led to its demise. By the 1970s, the classical labelling perspective became unfashionable. Persistent

critics (e.g., Gove, 1970, 2004) refuted the position of classical labelling theorists that labelling-induced stigma has significant and enduring adverse effects on the lives of people with mental illness.

The critics argued that serious problems related to functioning and psychiatric symptoms, not stigma, are the principal barriers that prevent people with mental illness from regaining a normative social role (Gove, 1970). They also contested the characterizations of stigmatized individuals as being passive receptors of deviant careers, and of authority figures as being victimizers with “Leviathan qualities of social control” (Davis, 1980, p. 206). Moreover, it was asserted that the labelling perspective is only applicable to the minority of individuals with mental illness who are involuntarily hospitalized (Thoits, 1999). Critics contended that the overwhelmingly positive aspects of labelling for the majority of individuals with mental illness (i.e., attaining appropriate treatment) were overlooked by labelling theorists (Gove, 1970). As will be discussed in the next section, contemporary labelling theorists have tried to address some of these critiques by being more specific about their concepts, by repositioning their focus, and by offering research evidence to confirm their ideas.

2.2.3 Contemporary Perspectives toward Stigma

Contemporary theorizing about labelling and stigma is led by Link and colleagues (Link et al., 1991; Link & Phelan, 1999; Link et al., 1989), Scambler and colleagues (Scambler, 2004, 2006, 2009; Scambler & Paoli, 2008), and Parker and Aggleton (2003), who focused their writings on the health conditions of mental illness, epilepsy, and HIV/AIDS, respectively.

Drawing on the work of classical labelling theorists, particularly Scheff's labelling theory, Link and colleagues employed a social psychological perspective in their 'modified labelling approach' to mental disorder. Similar to Goffman's description of 'moral career', Link and colleagues indicated that culturally endorsed negative beliefs, or stereotypes, about mental illness influence the behaviour of those who are (and those who are not) labelled as such. Because of these stereotypes, society tends to devalue, dismiss, and discriminate against people who are labelled mentally ill. Consequently, when people are diagnosed with a mental illness, stereotypes become personally salient, they anticipate social rejection, and their sense of self is negatively affected. Official labels, rather than informal labels, are of particular relevance to the modified labelling approach, since they are more potent (Phelan & Link, 1999). As Link and Phelan (1999) pointed out in their formulation of labelling theory, the label of mental illness can have adverse effects in the absence of overt or direct harm by others.

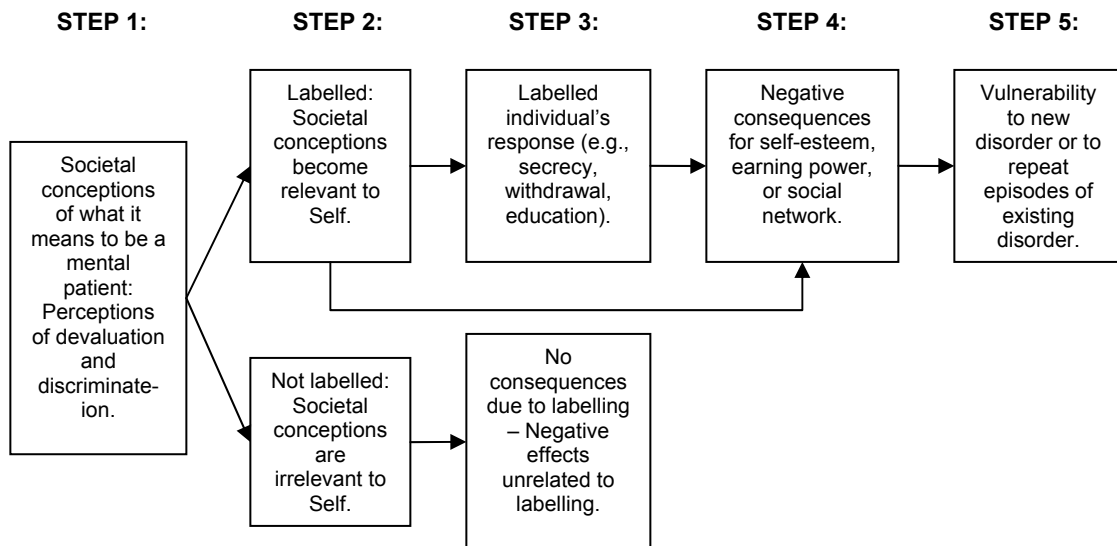
The original contribution offered by the modified labelling theory is the idea that people use maladaptive coping strategies to deal with anticipated social reaction to their mental illness label or status. To avoid rejection, people with mental illness may respond by socially withdrawing or by engaging in other defensive behaviours that have deleterious impacts on other life domains:

In the course of being socialized, individuals develop negative conceptions of what it means to be a mental patient and thus form beliefs about how others will view and then treat someone in that status. Typically this array of beliefs is fully in place before an individual enters treatment. As a result, when patients enter treatment for the first time, they are likely to confront the effects of stigma immediately because often they have internalized a generally negative view about what it means to be a mental patient. ... With time, their beliefs about the implications of the label they

carry and their way of dealing with it shape the nature of their social connectedness. (Link et al., 1989, p. 419)

The modified labelling approach proposed that people with mental illness who are most concerned about society's perceptions will most strongly identify with the negative role and, consequently, will suffer the most from the labelling process. The stigma that they anticipate and experience may result in a lowering of self-esteem and life satisfaction as well as increases in social withdrawal and psychiatric symptom severity, as is illustrated below in Figure 1.

Figure 1. Modified labelling approach (reproduced from Link et al., 1989)



The negative outcomes can be caused directly from a person's beliefs about how society perceives mental illness or from a person's attempts to protect against stigmatization, such as by withdrawing (Link et al., 1989). This modified approach is supported by research (Kroska & Harkness, 2006; Wright, Gronfein, & Owens, 2000), though some evidence suggests that the approach is less applicable in some cultures

(Freidl, Lang, & Scherer, 2003). Research has yet to determine whether it is actual or anticipated social rejection that are most strongly associated with negative outcomes (Camp, Finlay, & Lyons, 2002; Wright et al., 2000). The modified labelling approach differs from Scheff's 'original' theory in the following ways: (a) greater emphasis is placed on the diversity of societal beliefs about mental illness; (b) the perception and response of the labelled person, rather than society, is of particular importance; and (c) labelling and stigma are viewed as risk factors that exacerbate or prolong, rather than cause, the problems associated with mental illness (Link et al., 1989).

Diverging from the tradition for labelling theorists to remain rooted in symbolic interactionism at an individualistic level, Parker and Aggleton (2003) leaned on the writings of Foucault and other philosophers/sociologists in their "post-individualist" (Scambler, 2009, p. 450) analysis of stigma. Labelling and stigmatization were conceptualized within the macro-sociological processes of culture and power. They argued that the current ways of understanding stigma through behavioural and psychological approaches are overly narrow and limited – in that, stigma tends to be conceptualized as a fixed attribute rather than something produced through constantly changing socio-cultural processes. According to this framework, stigma is a phenomenon that manifests at the intersection of culture, power, and difference:

...the construction of stigma (or, more simply, stigmatization) involves the marking of significant differences between categories of people, and through such marking, their insertion in systems or structures of power. Stigma and stigmatization function, quite literally, at the point of intersection between culture, power and difference – and it is only by exploring the relationships between these different categories that it becomes possible to understand stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultural values, but as

central to the constitution of the social order. (Parker & Aggleton, 2003, p. 17)

Actors in positions of power symbolically wield labelling and stigma to produce and reproduce social inequality and exclusion so that their dominant social positions are maintained. Therefore, “culturally constituted stigma” is an instrumental tool for individuals, communities, and the state to establish and maintain hegemony, hierarchies, control, and order (Parker & Aggleton, 2003, p. 17).

Scambler (2006) similarly called for a reframing and deepening of the sociological approach toward stigma. He highlighted the need for greater attention to social structure of cultural norms and individual choice, which he asserts is neglected and overlooked by present explanatory models of health-related stigma. Scambler suggested that disability theorists and researchers have tended to conceptualize stigmatization in an individualistic sense to describe the personal disadvantage that is experienced by individuals with stigmatizing health conditions. He argued that oppressive social barriers should be added to stigmatization as causal factors of ‘disablism’, or disadvantage enacted upon people with a disability who are deemed socially unacceptable: “stigma relations need to be studied as part of a nexus of structures... stigmatization is rarely the sole ingredient of disadvantage, other notable companions being exploitation and oppression” (Scambler, 2006, p. 294). Thus, modes of oppression, such as exploitation, marginalization, powerlessness, cultural imperialism, and systemic violence, must be included in the equation to fully understand how social structure and stigmatization relate to social disadvantage.

Scambler and colleagues also took on the task of refining sociological constructs that, he argued, had been conflated by labelling theorists and researchers. Several works

have examined the distinction between ‘stigma’ and ‘deviance’ (Scambler, 2004, 2006; Scambler & Paoli, 2008). Stigma is defined as the possession of an ‘ascribed’ or ‘ontological’ deficit for which people are considered imperfect beings and are shamed for having an intrinsic flaw for which they have no corrective control. Those who possess a stigmatizing attribute are not held personally responsible for being socially unacceptable. In contrast, deviance is the possession of an ‘achieved’ or ‘moral’ deficit that is within a person’s control to correct, and, therefore, they are blamed for the deficit and are held morally culpable. For Scambler, the analytic distinction between the logic of shame and stigma, on the one hand, and the logic of blame and deviance, on the other hand, was pivotal to his framework. Individuals with an ascribed or achieved deficit can be recipients of ‘enacted’ or ‘felt’ stigma and deviance. Whereas enacted stigma and deviance refers to actual experiences of discrimination, felt stigma and deviance denote problems that are created either by internalizing shame/blame or by the anticipation of social rejection and devaluation.

2.3 EMPIRICAL KNOWLEDGE

An expansive body of research has investigated the social stigma of mental illness; however, the present review of extant research knowledge will focus on self-stigma. Firstly, a review of the self-stigma literature will be discussed. This will be followed by an in-depth consideration of other relevant research findings.

2.3.1 Literature Review

In order to achieve a comprehensive understanding of the self-stigma research, a review was performed on empirical literature pertaining to the correlates and predictors of self-stigma for people with mental illness. This review enables the present study (discussed in Chapters 4 and 5) to be considered within the larger body of empirical literature pertaining to self-stigma. The methods and procedures used in the literature review, as well as the limitations, are described in the endnote at the end of this chapter.

The review was guided by the following conceptualization of self-stigma:

Self-stigmatization is a complex, subjective process – embedded within a socio-cultural context – characterized by negative feelings, maladaptive behaviour, identity transformation, and adverse outcomes resulting from an individual’s experience, perception, and anticipation of adverse social reactions on the basis of their mental illness.

As such, this definition encompasses the various conceptualizations of self-stigma embodied in the studies – and their measures – that were included in the present review. It should be noted that methodological quality of the studies was not formally assessed and, therefore, was not used to exclude articles. This approach was guided by the intent of the review, which was to provide a broad overview of the extant literature. In total, 127 studies were selected and reviewed. The references of all included studies are listed separately in Appendix A.

2.3.1.1 Research Characteristics

Indicative of the growing interest in the topic of self-stigma for people living with mental illness, 89.8% (k = 114) of the included studies were published in 2000 or later. Most of the studies used a cross-sectional design (82.7%, k = 105), with 17.3% (k = 22)

of studies reporting longitudinal designs. Six (4.7%) studies provided data on the effectiveness of interventions that are aimed at addressing various aspects of self-stigma; the remaining 121 (95.3%) studies used naturalistic designs. The median sample size of the included studies was 131 participants, ranging from 20 to 1827 participants. While most of the studies (58.3%, $k = 74$) were carried out with more than 100 participants, 41.7% ($k = 53$) of the included studies used relatively small sample sizes of 100 participants or fewer.

The included studies represent findings from 35 different countries. Most of the studies were carried out in a single country (96.9%, $k = 123$). North American studies, mostly from the United States, accounted for 45.7% ($k = 58$) of all included studies. Research conducted in European countries accounted for 33.1% ($k = 42$) of total studies, with slightly more English-language research generated by the United Kingdom ($k = 9$) than any other European country. Nineteen (15.0%) of the included studies were from Asian regions, primarily Taiwan and Hong Kong. The remaining studies came from the Middle East (5.5%, $k = 7$), Africa (1.6%, $k = 2$), South America (1.6%, $k = 2$), and Australia (0.8%, $k = 1$).

2.3.1.2 Sample Characteristics

There was substantial variability between the studies concerning the level of detail they each provided about sample characteristics. It is recognized that finer-level detail about the sample characteristics is desirable; however, for this section, broad categories are relied on for this section in order to maximize the number of studies contributing to the data reported below. The average age of participants across the studies was 41.4 years

of age ($SD = 7.0$). Males (49.4%, $N = 12,202$) and females (50.6%, $N = 12,496$) were equally represented. Fifty-five studies (43.3%) provided details on the ethnic diversity of their samples, with participants representing 58.9% ($N = 7,475$) Caucasian and 41.1% ($N = 5,210$) non-Caucasian ethnic backgrounds.

In the 31 (24.4%) studies that reported education level using a secondary/high-school scheme, the majority of participants (64.9%, $N = 5,681$) had at least a high school level of education. The 42 (33.1%) studies that reported the employment status of participants indicated that the majority (61.9%, $N = 4,763$) were unemployed. Marital status was reported in 40.9% ($k = 52$) of the studies, with most participants (71.5%, $N = 8,392$) reported to be unmarried. While the majority of study participants (88.4%, $N = 22,844$, $k = 105$) lived in the community, 11.6% ($N = 3,008$, $k = 27$) of participants were hospital inpatients. It is worth mentioning that not all of the participants in the included studies were currently receiving mental health services.

The psychiatric diagnoses of participants were indicated in 111 (87.4%) of the studies, with almost half of the participants (47.8%, $N = 11,484$, $k = 67$) diagnosed with a mood or anxiety disorder and 38.7% ($N = 9,284$, $k = 87$) of the participants diagnosed with a schizophrenia spectrum disorder. For the 40 (31.5%) studies that provide data on illness duration, the average time that participants had been living with a mental illness or had received mental health treatment was 13.6 years ($SD = 5.9$).

2.3.2.3 Self-Stigma Measures

Self-stigma is a socially constructed concept that carries many different meanings. Consequently, it was measured in slightly different ways across the studies that were

reviewed. Variability in the definition of stigma is, in part, a function of the fundamental epistemological and ontological differences of those who seek to define the term.

Conceptual variability also results from the complexity of the phenomenon and the array of circumstances to which stigma has been applied (Link & Phelan, 2001). Because of their nebulous nature, psychosocial variables sometimes overlap with one another, which is apparent in how self-stigma has been defined and measured in the research literature.

In their recent narrative review, Brohan and colleagues (2010) categorized the Consumer Experiences of Stigma Questionnaire (CESQ) and the Devaluation-Discrimination Scale (DDS) as measures of ‘experienced’ and ‘perceived’ stigma, respectively, rather than ‘self’ stigma. While ‘experienced’ stigma was interpreted as actual encounters with discrimination, ‘perceived’ stigma was referred to as an individual’s beliefs about how they, and people who carry a similar stigmatizing condition, are viewed by society. In contrast, ‘self’ stigma was defined as the internalization of stigmatized social values and beliefs. From a symbolic interactionist and labelling perspective, this analytic distinction between ‘self’, ‘experienced’, and ‘perceived’ stigma is problematic. The self is a social product and, as such, the constructs of perceived, experienced, and self stigma are conceptually intersecting and experientially intertwined. Measuring these subjective processes as though they unfold in isolation is inconsistent with the lived experience of stigma. Indeed, Brohan and colleagues (2010) recognize the limitations with how they have categorized the measures: “Throughout the review, stigma was categorised as perceived, experienced or self stigma. These distinctions were useful for organising the review, however many inter-connections exist between the concepts.”

Several of the measures included in the present review, such as the DDS and CESQ, do not neatly fit the self-stigma construct; however, consistent with the leading definitions of stigma (Link & Phelan, 2001; Weiss et al., 2006), the present review adopted a broad conceptualization of self-stigma, which includes “an individual’s experiences, perceptions, or negative social reactions on the basis of their mental illness.” As such, the operational definition encompasses the degree to which a person perceives and responds to stigmatizing experiences (including labelling, stereotyping, separation, status loss, discrimination). These subjective processes are encapsulated by the instruments, such as the CESQ and DDS, included in the present review.

Almost a quarter of the studies (22.8%, $k = 29$) used multiple measures of self-stigma. Sixteen (12.6%) studies measured self-stigma using self-developed scales or significantly modified versions of existing standardized instruments. Nine (7.1%) studies measured self-stigma using fewer than 5 items or questions, which were often stigma-related items extracted from larger instruments, such as the World Health Organization Disability Assessment Schedule (version 2). Several standardized measures pertaining to the self-stigma of mental illness are reported in the literature, with six scales (described below) representing the most commonly used within the included studies. The numbers reported below include translated versions and slightly modified versions of the measures that were identified in the English-language articles. Further detail about these measures may be found in a recently published narrative review (Brohan et al., 2010).

The most frequently used self-stigma measure was the Devaluation-Discrimination Scale (DDS) (Link et al., 1991), which was used in 36.2% ($k = 46$) of the included studies. It is also the oldest measure of self-stigma for persons with mental illness. The DDS is a 12-item measure that assesses the extent to which respondents

believe that people with mental illness will be devalued or discriminated against. The second most commonly used measure was the Internalized Stigma of Mental Illness scale (ISMI) (Ritsher, Otilingam, & Grajales, 2003), which was used in 11.8% (k = 15) of the included studies.

The ISMI is a 29-item questionnaire that assesses subjective experiences of stigma using a total score and five subscale scores, including alienation, stereotype endorsement, discrimination experiences, social withdrawal, and stigma resistance. The Self-Stigma of Mental Illness Scale (SSMIS) (Corrigan, Watson, & Barr, 2006b) was used in 7.1% (k = 9) of the studies. The SSMIS contains 40 items and includes four subscales, including stereotype awareness, stereotype agreement, stereotype self-concurrence, and self-esteem decrement. A Chinese version of the SSMIS has been developed and used in several studies (Fung, Tsang, Corrigan, Lam, & Cheung, 2007).

Six (4.7%) studies measured self-stigma using the Consumer Experiences of Stigma Questionnaire (CESQ) (Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Wahl, 1999), which has 21 items and 2 subscales (experienced stigma and experienced discrimination). The CESQ is a self-report measure that assesses the degree to which an individual has subjectively perceived negative social reactions (e.g., stigma experiences and discrimination experiences) on the basis of their mental illness in the past month. Items of the CESQ go beyond simply assessing actual experiences by asking about subjective internalized processes (e.g., “Over the past month, how often...have you worried that others will view you unfavourably because you received psychiatric treatment?”) and anticipation/avoidance of negative social reactions (e.g., “...have you avoided telling others outside your immediate family that you have received psychiatric treatment?” or “...have you avoided indicating on written applications that you received

psychiatric treatment for fear that information would be used against you?”). Such processes are encompassed by the concept of self-stigma as defined within this review.

The Depression Stigma Scale (DSS) (Kanter, Rusch, & Brondino, 2008) and the Taiwanese Self Stigma Assessment Scale (SASS) (Yen et al., 2005) were each used in 3.1% (k = 4) of the included studies. The DSS measures the stigma of depression using 32 items and five subscales, including general self-stigma, secrecy, public stigma, treatment stigma, and stigmatizing experiences. The Taiwanese-SASS includes eight items to measure self-stigma in Taiwanese populations with mental illness (Yen et al., 2005).

2.3.2.4 Correlates of Self-Stigma

The table below provides an overview of the relationship between self-stigma and other variables that were commonly studied.

Table 1. Literature review – Relationship between self-stigma and other variables

Variables	A.		B.		C.		D.		E.	
	Number of studies (k = 127)		Non-significant relationship (p > .05)		Significant relationship (p < .05)		Positive relationship (p < .05)		Negative relationship (p < .05)	
	k	%	k	%	k	%	k	%	k	%
Sociodemographic	47	37.0								
Gender (Male=1)	38	29.9	31	81.6	7	18.4	4	57.1	3	42.9
Age	35	27.6	24	68.6	11	31.4	4	36.4	7	63.6
Education	27	21.3	22	81.5	5	18.5	1	20.0	4	80.0
Employment (Employed=1)	14	11.0	10	71.4	4	28.6	0	0.0	4	100.0
Marital status (Married=1)	11	8.7	9	81.8	2	18.2	1	50.0	1	50.0
Income	10	7.9	8	80.0	2	20.0	0	0.0	2	100.0
Ethnicity (Non-Caucasian=1)	9	7.1	5	55.6	4	44.4	4	100.0	0	0.0
Psychosocial	86	67.7								
Hope	5	3.9	0	0.0	5	100.0	0	0.0	5	100.0
Self-esteem	34	26.8	4	11.8	30	88.2	0	0.0	30	100.0
Empowerment	12	9.4	1	8.3	11	91.7	0	0.0	11	100.0
Self-efficacy	8	6.3	0	0.0	8	100.0	0	0.0	8	100.0
Quality of life	24	18.9	1	4.2	23	95.8	0	0.0	23	100.0
Social support	12	9.4	5	41.7	7	58.3	0	0.0	7	100.0
Psychiatric	99	78.0								
Symptom severity	60	47.2	10	16.7	50	83.3	50	100.0	0	0.0
Diagnosis (Schizophrenia=1)	25	19.7	15	60.0	10	40.0	3	75.0	1	25.0
Hospitalizations	12	9.4	7	58.3	5	41.7	4	80.0	1	20.0
Illness duration	14	11.0	9	64.3	5	35.7	1	20.0	4	80.0
Insight	12	9.4	10	83.3	2	16.7	1	50.0	1	50.0
Treatment adherence	11	8.7	4	36.4	7	63.6	0	0.0	7	100.0
Treatment setting (Inpatient=1)	10	7.9	7	70.0	3	30.0	2	66.7	1	33.3
Functioning	8	6.3	4	50.0	4	50.0	0	0.0	4	100.0
Medication side effects	2	1.6	2	100.0	0	0.0	na	na	na	na

The association between self-stigma and psychiatric variables had been examined in 78.0% (k = 99) of the included studies. Sociodemographic and psychosocial variables had been examined in 37.0% (k = 47) and 67.7% (k = 86) of the included self-stigma studies, respectively.

Sociodemographic Variables

As is delineated in Table 1, none of the sociodemographic variables – including, gender, age, education, employment, marital status, income, and ethnicity – have, within the body of included studies, demonstrated consistently significant relationships with self-stigma for people with mental illness. For example, the association between gender and self-stigma was evaluated in 38 (29.9%) studies, with non-significance ($p > 0.05$) established in 81.6% (k = 31) of those studies. Age was the sociodemographic variable with the highest number of studies that had significant findings (31.4%, k = 11); however, the direction of the relationship is mixed in the studies with statistically significant relationships, with higher levels of self-stigma associated with being older in 36.4% (k = 4) studies and being younger in 63.6% (k = 7) studies. Overall, the findings suggest that sociodemographic variables are neither consistently nor strongly correlated with levels of self-stigma.

Psychosocial Variables

All of the psychosocial variables included in this review – including hope, self-esteem, empowerment/mastery, self-efficacy, quality of life, and social support/integration – were significantly associated with self-stigma in the majority of

studies, ranging from 58% to 100%, within which they were examined (see Table 1). For example, self-esteem had been examined in 34 (26.8%) of the included studies, and was significantly associated with self-stigma in 30 (88.2%) of those studies. In addition, the direction of these relationships was consistently negative in all of the studies with significant findings. This consistent pattern indicates that self-stigma is negatively associated with a range of psychosocial variables.

Psychiatric Variables

Findings concerning the relationship between self-stigma and a range of psychiatric variables – including psychiatric symptom severity, psychiatric diagnosis, psychiatric hospitalizations, illness duration, insight, treatment adherence, treatment setting, functioning, and medication side effects – were mixed. The relationship between psychiatric symptom severity and self-stigma was examined in 47.2% ($k = 60$) of the studies, making it the most frequently researched relationship in this body of research literature. Symptom severity had significant, positive associations with self-stigma in 50 (83.3%) studies, and there were no studies that found a significant negative relationship. Treatment adherence was examined in eleven (8.7%) studies, with 63.6% ($k = 7$) of those studies demonstrating a significant, negative correlation with self-stigma. As is indicated in Table 1, none of the other psychiatric variables were significantly related with self-stigma in the majority of studies.

Longitudinal Findings

As was mentioned previously, 22 (17.3%) of the included studies had longitudinal research designs. The median follow-up period was six months, ranging from 1.25 months to 24 months. These studies attempted to address questions such as: To what extent is self-stigma dynamic (i.e., changeable) or static (i.e., unchangeable)? Which outcomes does self-stigma predict? Which variables predict self-stigma? Regarding the first question, only two of the longitudinal studies included in this review explicitly report significant changes in self-stigma over time – both following an intervention. Griffiths and colleagues (2004) found small but significant reductions in self-stigma following an internet-based intervention for people with depression. MacInnes and Lewis (2008) also detected significant reduction in self-stigma following the implementation of a structured, group-based, cognitive therapeutic intervention.

In relation to the second question, four studies have found that baseline levels of self-stigma predict follow-up levels of self-esteem. Self-stigma was found to predict service utilization/needs in two studies. As well, the following variables have been determined by single studies to be predicted by baseline levels of self-stigma: emotional discomfort, social adjustment, depressive symptoms, and treatment discontinuation. Finally, single studies have found that the following variables at baseline significantly predict levels of self-stigma at follow-up: coercion, self-esteem, diagnosis, positive symptoms, recent onset of illness combined with level of social support, and shame-related negative associations of mental illness.

2.3.2.5 Summary of Literature Review Findings

The review uncovered a large body of research that has examined associations between self-stigma and other sociodemographic, psychosocial, and clinical variables. The most striking finding is the robust relationship between self-stigma and a range of psychosocial variables; however, this should be interpreted with caution given the dearth of longitudinal research in this area. Longitudinal research is critically important for assessing change and temporal order between the variables. Longitudinal designs also have the benefit of allowing researchers to collect and statistically control for potential confounding variables throughout the duration of the study. It is also of interest that a significant, negative relationship between self-stigma and quality of life has been established in 23 cross-sectional studies to date. The significance of this relationship over time has not yet been demonstrated in any longitudinal studies, which limits the conclusions and inferences that can be drawn about the association between self-stigma and quality of life. Several limitations (see endnote belowⁱ) need to be considered when interpreting the findings of this review.

2.3.2 Research with Specific Relevance

This section concentrates on research studies that have specific relevance to the research questions that are examined within this dissertation. The first series of studies describes research that specifically examined how the experiences of self-stigma for people with mental illness are affected by other social categories. The second batch of studies provides a brief overview of findings relating to the subjective experience of coercion for people who receive mental health services. Criminological research findings

pertaining to labelling theory are considered in the third group of studies. Finally, research that has examined the relationship between self-stigma and structural-level factors is discussed.

2.3.2.1 Layers of Stigma

Despite the fact that individuals exist on multiple, intersecting axes of difference (e.g., race, gender, class, disability), the self-stigma research has primarily focused on how a single factor or status, such as being diagnosed with a mental illness, influences and shapes peoples' subjective experiences. A major weakness of such a research approach is that it excludes important social categories at the expense of over-simplifying the complexity of a person's lived experience. As was mentioned earlier, this critique has been levelled against early labelling theorists (e.g., Goffman, Becker) who had a tendency to theory-build based on unitary dimensions (e.g., sexuality, race, illness). Furthermore, essentialism has plagued the work of labelling theorists. Essentialism describes a phenomenon whereby there is a failure to acknowledge differences within social categories and, therefore, an individual is assumed to possess the attributes that characterize the social group to which they belong: "This 'essentialist' assumption ascribes a fixed, underlying nature to members of a category, which is understood to determine their identity, explain their observable properties, render them fundamentally alike, and allow many inferences to be drawn about them" (Haslam, Bastian, Bain, & Kashima, 2006, p. 64). The ideas embedded within an emerging research paradigm, called 'intersectionality', are well positioned to address these limitations (Burgess-Proctor, 2006; Davis, 2008; Hancock, 2007; Hankivsky & Cormier, 2009).

Intersectionality describes a model that seeks to understand how the intersection and interaction between multiple axes of oppression/domination influence and shape an individual's lived experience. As was articulated by Hankivsky and Cormier (2009), "At the core of an intersectional model is the understanding that individuals occupy complex and dynamic social locations, where specific identities can be more or less salient depending on the historical or situational context" (p. 5). From an intersectional perspective, multiple social locations produce interlocking, rather than additive, effects in relation to an individual's experience of disempowerment and marginalization (Collins, von Unger, & Armbrister, 2008; Hankivsky & Cormier, 2009; Simien, 2007). While not explicitly adopting an intersectional analytic approach, *per se*, several studies have attempted to understand how multiple social dimensions affect the experiences of self-stigma for people with mental illness.

Corrigan and colleagues (2003) tested the presumption that the discrimination that people with mental illness face directly results from their 'mental illness' status by examining their perceived reasons for having been discriminated against. While 73.3% of the study participants reported discrimination on account of psychiatric disability, they also endorsed several other factors contributed to their discrimination including: poverty (51.5%), physical disability (36.4%), age (30.2%), gender (27.4%), race (27.0%), homelessness status (21.5%), and arrests with jail time (14.7%). This finding confirms that there are likely numerous overlapping factors that contribute toward the subjective stigmatizing experiences for people with mental illness. Bahm and colleagues (2009) examined the effect of comorbid physical disability on experiences of self-stigma for people who live with mental illness. They found that people with both conditions

(physical and psychiatric disability) experienced significantly higher levels of stigma compared with those with only a psychiatric disability, which suggests an additive stigmatizing effect of multiple social categories of marginalization. In a literature review, Thomas and Shute (2006) considered the ‘double stigma’ of being elderly and mentally ill, and concluded that: “When we look at old age and mental illness the effects of stigma and discrimination appear cumulative” (p. 189). As well, a literature review concerning mental illness stigma in Asian countries identified ‘double stigmatization’ as a problem for persons living with mental illness who also occupy other oppressed social categories (e.g., minority background, marital separation or divorce, being a woman) that are highly salient for their cultural context (Lauber & Rossler, 2007).

Other authors have also discussed the deleterious effect of minority group status on the burden of mental illness (e.g., Gary, 2005). Collins and colleagues (2008) offer one of the best examples of intersectional analysis within the body of stigma research. Their qualitative study examined the intersections of race/ethnicity, gender, class, status and mental illness stigma among Latina women with serious mental illness living in New York City. The findings indicated that mental illness and sexuality are interwoven with the experiences of immigration, poverty, race, and gender: “...living with a mental illness amplifies existing power inequalities in the intersection of gender, race/ethnicity and class and weakens the status of the women within their families and relationships” (Collins et al., 2008, p. 396).

Of particular relevance for this dissertation is research relating to the intersection of crime and mental illness. In a qualitative study with mentally ill offenders, Roskes and colleagues (1999) identified ‘double stigma’ – the co-occurring statuses of being mentally

ill and being a convicted criminal – as a barrier to community reintegration. Similarly, in a study with mentally ill ex-offenders who had co-occurring substance use problems, Hartwell (2004) provided evidence to suggest that problematic community reintegration is compounded by the intersection of these three statuses (mentally ill, addicted, ex-con) – termed “triple stigma.” The effect of ‘forensic’ labelling and stigma – that is, a person who has a mental illness, has been involved with the criminal justice system, and receives forensic mental health services – has been alluded to in a number of publications (Draine, Blank, Kottsieper, & Solomon, 2005; Ontario, 2002); however it has rarely been studied. The findings of a study on family burden among the family members of forensic patients in Hong Kong, suggested that they carry some additional shame and stigma (Pearson & Tsang, 2004). Only one study has been published to date on the effects of self-stigma for people with mental illness who receive forensic mental health services (Margetic, Aukst-Margetic, Ivanec, & Filipcic, 2008). The study, which involved 62 male patients diagnosed with schizophrenia who were receiving services in the Croatian forensic psychiatric system, detected a few variables that were correlated with stigma experiences (e.g., psychiatric symptoms, age, and non-violent offence). The study had several methodological limitations, including a non-comparative, cross-sectional design, and a weak measure of stigma that only consisted of three items.

The labelling/stigma theoretical approach and intersectionality have common and distinct characteristics. Similar to contemporary stigma theories, a core feature of intersectionality is that lived experiences are understood within the context of macro-socio-political forces, sometimes referred to as ‘systems of domination’, that create and perpetuate power differentials and inequality. As well, social justice is a central pursuit of

both stigma and intersectionality research approaches (Burgess-Proctor, 2006). A key difference between the two approaches is that the labelling/stigma theories and research have a tendency to refer to a layering effect for individuals that carry multiple labels or who occupy multiple social categories of difference. The terms ‘double’ and ‘triple’ stigma imply that adding several oppressive labels together (e.g., mentally ill, addict, HIV-positive) will have a cumulative adverse effect on an individual’s experience; individuals who have multiple labels are expected to experience more stigma and greater marginalization. In contrast, the intersectional approach is designed to examine how multiple social categories of difference fuse together and shift an individual’s experiences: “Intersectionality research...places special emphasis on the simultaneity of oppression and stresses the need to move beyond simple, additive models” (Simien, 2007, pp. 265-266). This distinction between these two approaches is particularly relevant for the research described within this dissertation.

2.3.2.2 Subjective Experiences of Coercion

Several studies have assessed the subjective experiences of legal (e.g., mandated treatment) and extra-legal (e.g., peer persuasion) coercion regarding the use of mental health services (Bindman et al., 2005; Broner, Mayrl, & Landberg, 2005; Canvin, Bartlett, & Pinfold, 2002; Gibbs, Dawson, & Mullen, 2006; Iversen, Høyer, & Sexton, 2007; Pescosolido, Gardner, & Lubell, 1998; Robbins, Callahan, & Monahan, 2009; Tan, Stewart, Fitzpatrick, & Hope, 2010; Tarrier, Khan, Cater, & Picken, 2007; Van Dorn et al., 2006). Overall, the findings indicate that the subjective experiences of coercion and compulsory treatment are complex and diverse, as was suggested by a qualitative study of

people with mental illness living in Saskatchewan and receiving compulsory community treatment (O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006):

This study confirms that there are negative aspects of mandatory outpatient treatment, particularly the common experience of coercion. However, the degree of reported coercion appears to be much less than suggested during policy debates. It was also apparent that there is a diverse range of opinions amongst patient (sic) on CTOs [community treatment orders]. (p. 523)

One literature review found that while involuntary hospitalization leads to significant clinical improvement for people with mental illness, it is regarded negatively by a significant proportion of patients (Katsakou & Priebe, 2006). Another systematic review by Kisely and colleagues (2005) on the outcomes of compulsory community treatment, which included a range of interventions (e.g., community treatment orders, extended leave provisions, involuntary outpatient commitment), concluded the following: "This review revealed little evidence for the effectiveness of compulsory community treatment in any of the main outcome indices: health service use, costs, social functioning, mental state, quality of life or satisfaction with care" (p. 9). While some research indicated that compulsory treatment is associated with increased perceived coercion (Bindman et al., 2005; McKenna, Simpson, & Coverdale, 2006), other research suggested that outpatient commitment does not lead to elevated perceptions of coercion (Steadman et al., 2001).

With regard to self-stigma, a study by Link and colleagues (2008) has the most direct relevance. This longitudinal study compared the experiences of individuals who received community mental health services either voluntarily (N = 108) or involuntarily (N = 86) on a number of variables, including: symptoms, self-stigma, perceived coercion, insight, social functioning, and self-esteem. One of the main findings was that group membership (e.g., compulsory versus voluntary treatment) was unrelated to perceptions

of coercion, self-stigma, or quality of life. The study found that perceived coercion was significantly higher amongst those with a history of multiple involuntary hospitalizations. Another main finding was that self-stigma was significantly associated with perceived coercion. The results suggest that higher perceptions of coercion lead to more self-stigma as well as poorer quality of life. The authors concluded that: “This evidence suggests that if we can address the reasons people feel coerced and effectively reduce such perceptions we can reduce perceptions of devaluation-discrimination [stigma] and improve quality of life” (p. 417).

2.3.2.3 Criminological Findings about Labelling Theory

A key question that has occupied the field of criminology since its inception is the degree to which official criminal justice sanctions have a “deterrent, criminogenic, or null effect on subsequent criminal activity” (Bhati & Piquero, 2007, p. 249). In contrast to the deterrence perspective, which indicates that criminal justice sanctions (e.g., sentencing, incarceration) will decrease criminal behaviour, the labelling perspective suggests that formal criminal justice processes may actually increase subsequent criminal and delinquent behaviour. Over the past 30 years, numerous studies have examined whether official labelling is directly associated with subsequent crime and delinquency – with mixed results (Chiricos et al., 2007; Wellford, 1975). A comprehensive review of this body of research suggested that while there is some supportive evidence, “...much of the available empirical literature is inconsistent with labeling theory’s two central hypothesis” (Paternoster & Iovanni, 1989, p. 389). These authors argue the methodological and conceptual limitations of prior labelling research, rather than the

propositions of the theory itself, have limited the empirical support for labelling theory to date (Paternoster & Iovanni, 1989). However, academics continue to question the empirical validity of the ‘deviance-enhancing’ effects of official labelling: “The preponderance of research finds no or very weak evidence of labeling effects...The soundest conclusion is that official sanctions by themselves have neither a strong deterrent nor substantial labeling effect” (Akers & Sellers, 2004, p. 142).

More recently, the labelling theoretical approach has been used in criminological research to examine the influence of criminal justice interventions (e.g., convictions, incarceration) on exclusionary processes – also called “structural impediments to conventional life” (Chiricos et al., 2007, p. 548) – and on deviant social interactions (Bernburg, Krohn, & Rivera, 2006). The object of inquiry for contemporary labelling researchers has shifted away from examining the direct effects of official labelling on subsequent delinquent behaviour; instead, the central concern for this body of research is on the impact of official labelling processes for creating conditions and situations that are conducive to criminality. Research that examines the intermediary processes between labelling and criminality is not new (Becker, 1973; Farrington, 1977); however, this shift in empirical emphasis and revitalized interest in the labelling perspective has been referred to as a revised ‘structural’ version of labelling theory (Bernburg & Krohn, 2003; Bernburg et al., 2006). Concomitantly, a developmental labelling perspective has been created to serve as a framework to examine the restriction of social opportunities (e.g., employment, education, prosocial relationships) for young offenders and the degree to which this is associated with offending in adulthood (Lanctot, Cernkovich, & Giordano, 2007). Empirical support for the ‘structural’ labelling perspective is beginning to emerge, with research indicating that official criminal justice interventions may have important

influences on peer networks (Bernburg et al., 2006) and life chances (Bernburg & Krohn, 2003) that may increase the probability of involvement in criminal behaviour: “The exclusionary processes triggered by deviant labeling may, in many cases, explain the individual’s movement into a deviant group, as well as the isolation of deviant groups from mainstream social life” (Bernburg et al., 2006, p. 83). While the focus on social exclusion offers a promising direction for labelling research in criminology, the field will continue to be challenged with ascertaining the role of deviant labelling, relative to other risk factors, for creating conditions that perpetuate crime and delinquency.

2.3.2.4 Association between Structural Factors and Self-Stigma

The topic of structural factors that influence the subjective experience of self-stigma for people with mental illness has rarely been studied. Most studies in the area of self-stigma have used psychological approaches to understanding the phenomenon and have, therefore, remained at the individual level. This is in spite of the recognition that structural factors are important for the creation and perpetuation of stigma: “The policies and institutional practices we create to address social problems are critical for stigma – they can induce it or they can minimize or even block it” (Link et al., 2008, p. 409).

A series of Belgian studies by Verhaeghe and colleagues have examined the organizational characteristics that are related to stigma experiences for people with mental illness (Verhaeghe & Bracke, 2007, 2008; Verhaeghe, Bracke, & Bruynooghe, 2007; Verhaeghe, Bracke, & Christiaens, 2008). One study (Verhaeghe & Bracke, 2007) evaluated the degree to which individual experiences of self-stigma are related to service level characteristics, such as overall composition of the client population (e.g., psychiatric

symptom severity), selectivity of the service, the importance of vocational and psychotherapeutic activities, the size of the client population, and the composition of the staff population. In describing the rationale for their study, the authors indicated the following: "...the reasons for stigma may lie in the nature of the users of the service, rather than the service itself. The services are tainted with the reputation of the people they service..." (p. 382). The study found that while service level characteristics, as an overall variable, explained a small percentage (4%) of the variance in self-stigma, certain service characteristics (e.g., organization size, vocational orientation) had significant, yet weak, relationships with self-stigma. Overall, the researchers indicate that they were unable to detect service-level determinants of stigma experiences that were not attributable to the clients themselves.

Other studies have examined the stigmatizing effects of receiving mental health services in different settings (e.g., psychiatric versus general hospitals, university versus traditional institutions). Angermeyer and colleagues (1987) found that in comparison to university hospital patients, state hospital patients were significantly less likely to endorse stigmatizing attitudes. Another study found that people with mental illness who received services in general hospitals (i.e., psychiatric wards) reported less stigma than those receiving care in psychiatric hospitals (Verhaeghe et al., 2007). A similar study resulted in a different conclusion: the stigmatizing effects of the hospital setting were dependant on psychiatric diagnosis (Chee, Ng, & Kua, 2005). The results indicated that patients diagnosed with schizophrenia who received services in a state psychiatric hospital actually had lower stigma scores compared to patients with schizophrenia in general hospitals. The opposite trend was found for individuals with other psychiatric diagnoses,

leading the authors conclude that, "...there are disease-specific and institution-specific aspects of stigma that deserves to be borne out by further investigation" (p. 653).

2.4 SUMMARY

Subjective experiences are shaped by macro-level social and structural factors. Indeed, the manner in which society decides to deal with mental illness – reflected in and enshrined by mental health policy and legislation – has both direct and indirect effects on those who live with mental illness. Social reactions toward mental illness not only affect how people are treated, but symbolic interactionist and labelling theories also suggest that they have the profound effect of transforming the way in which people with mental illness perceive themselves. This, in turn, has the potential to reinforce, perpetuate, and exacerbate adverse outcomes, including social exclusion, for people with mental illness. Confirmatory evidence is provided by a large body of research, which indicates that a high level of self-stigma is associated with a host of problems for people with mental illness, such as hopelessness, disempowerment, poor self-esteem, low self-efficacy, and decreased quality of life.

ⁱ **Procedure for Systematic Literature Review**

Study Selection: The search strategy included locating relevant articles by searching several electronic databases, including PsychINFO, PubMed, and Web of Science. Web of Science includes the Arts & Humanities Citation Index (1975-present), the Social Citation Index Expanded (1900 to present), and the Social Sciences Citation Index (1956-present). An inclusive search strategy that used broad keywords was purposely chosen in order to ensure a comprehensive scan of the literature. In January 2010, the key words ‘stigma’ AND ‘mental illness’ were entered into the aforementioned databases, and English language titles were obtained. Additional titles were retrieved by manually searching the references of all included full-text articles.

Inclusion Criteria: An article was included for a full review if it met all of the following criteria: (i) constituted primary research published in a scholarly or professional journal, (ii) focused on the perspective of adults diagnosed with a mental illness, (iii) included quantitative measures pertaining to internalized stigma or self-stigma and at least one other variable (such as an outcome or demographic variable), (iv) reported on the statistical relationship between the two variables, (v) could be retrieved by contacting the author or through university library services, and (vi) was written in English. For the purpose of this review, ‘mental illness’ was defined as an Axis I clinical disorder as specified by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Articles were excluded if their sample consisted of adults diagnosed with substance-related disorders, but without any other comorbid Axis I mental illnesses. Articles were also excluded if they were purely descriptive; that is, they did not examine associations between self-stigma and any other variable. The inclusion criteria did not contain restrictions on publication date or methodological rigour. The initial search generated 3,127 titles that were reviewed by one author for relevance. The large number of titles that were initially retrieved was a consequence of the comprehensive search strategy. A total of 2,777 titles were excluded, primarily because they did not constitute primary research or they pertained to other forms of stigma (e.g., social stigma). The abstracts and full-text articles of the remaining 350 titles were thoroughly reviewed and 242 titles were excluded for failing to meet one of the aforementioned inclusion criteria. The references of the remaining 108 titles were hand inspected, which generated an additional 19 articles that were included in the review. In total, 127 articles were included in the systematic review. A reference management software program was used to facilitate the search and filtering processes.

Data Extraction: Data on the following variables were coded and entered into a spreadsheet: author, publication date, country, sample size, study design, utilization of self-stigma intervention, length of follow-up period, treatment status, gender, psychiatric diagnoses, average age in years, marital status, employment status, average illness duration in years,

ethnicity, education, self-stigma measures, and main findings. Several studies used multiple subscales or measures of a single variable (e.g., self-stigma, quality of life), which often resulted in mixed findings regarding the relationship (e.g., significance, strength, direction) between the two variables. In such cases, data on the variable's total score was used. This approach is consistent with that which was employed in the meta-analysis of HIV internalized stigma (Logie & Gadalla, 2009). If a total score was not reported, then the findings relating to the dominant subscale or measure – that is, the one that most closely resembled the construct and contained the most items – were used. If a dominant subscale or measure of a particular variable could not be determined, then any subscale that was significantly related to the variable of interest was selected.

Data Analysis: The first step of the analysis involved selecting variables that were commonly assessed across the 127 included studies. For each variable that was selected, descriptive analyses were performed to examine the proportion of studies that detected a relationship between self-stigma and another variable at a .05 significance level. The direction (positive or negative) of each statistically significant relationship was ascertained. Dummy variables, as are indicated in Table 9, were used to determine the direction of a relationship; however, they were not used to ascertain the existence of a significant relationship.

Limitations: First, although a diverse set of countries and populations were represented in the review, the review did not include published research in languages other than English. This restricts the cross-cultural generalizability of these findings. Second, the review excluded qualitative research studies, which means that self-stigma in this study has been approached and understood using a quantitative research paradigm. Third is the potential for null or negative findings to be under-represented on account of publication bias, since researchers and academic journals have traditionally minimized the importance of these findings. The review did not include unpublished studies that met all other the inclusion criteria, which may limit the accuracy of this synthesis of extant findings on account of 'file drawer' effects. It is also possible that the data extraction process introduced biases toward statistically significant findings; consequently, non-significant findings may be underreported. Fourth, the review was largely exploratory, primarily based on observational studies, and focused on bivariate correlation data. As such, causal inferences should not be drawn between self-stigma and the other variables that were examined. The fifth limitation is that the included studies measured self-stigma and other variables (e.g., quality of life, self-esteem, symptom severity) using a variety of instruments. As a result, conclusions drawn from the systematic review are limited by the fact that the studies may have assessed somewhat different constructs, or different domains of the same construct. The use of a more narrow operational definition of self-stigma may have resulted in excluding the CESQ or the DDS from the review. Lastly,

because the methodological quality of the articles was not assessed, the review includes studies with a range of methodological limitations, such as small sample sizes and use of self-developed (not validated) measures. Consequently, many of the included studies are underpowered which could create a bias toward type II errors (e.g., non-significant findings).

CHAPTER 3: STRUCTURAL CONSIDERATIONS

This chapter provides a detailed discussion of the structural factors that influence the formation of the two study groups. As such, the different policy frameworks that shape the delivery of compulsory community treatment within the forensic and civil mental health systems are reviewed. Policy can be considered an articulation of societal values and beliefs toward particular social problems; therefore, significant space is devoted to analyzing policies that enable the compulsory treatment of people with mental illness.

3.1 FORENSIC MENTAL HEALTH POLICY

The forensic mental health system contains both criminal justice and mental health elements and is, therefore, often characterized as a hybrid of these two systems. In British Columbia, and elsewhere in Canada, the policy framework for the forensic mental health system consists of federal and provincial/territorial, health and criminal justice legislation. The merger of these seemingly incompatible policies creates a system that is complex and filled with contradiction. The forensic mental health system faces many challenges with balancing the treatment needs of the individual with the protective needs of the state. As well, the system is continuously challenged with providing effective, integrated services despite the competing and fragmented nature of the policies that support the system.

Generally, the mental health system consists of a civil system and a forensic

system. In contrast to the civil system, which provides services to all persons with mental illness, the forensic system offers services to persons with co-occurring mental health and legal problems who are in need of specialized inpatient and community services. In Canada, the forensic mental health population consists of two legally distinct subgroups: mentally disordered offenders and mentally disordered accused. The mentally disordered offender subgroup is comprised of persons who are charged or convicted of crimes and are also suffering from a mental illness, including persons living in the community (i.e., probation, parole, bail) as well as those in custodial settings (i.e., jail, prison, remand centres). Mentally disordered offenders have not been provided with a special legal designation by the Courts on account of their mental illness. The other legal subgroup – mentally disordered accused – consists of persons who have engaged in, or have been accused of engaging in, unlawful behaviours and have been provided with a special legal designation on account of their mental illness. The mentally disordered accused subgroup includes persons subsumed under the mental disorder provisions of the Canadian *Criminal Code* (1985, s. 672) [hereinafter the *Criminal Code*], such as persons who are court-ordered to receive forensic psychiatric assessments on issues of criminal responsibility or fitness to stand trial, as well as persons who are adjudicated ‘Not Criminally Responsible on account of Mental Disorder’ (NCR-MD) or Unfit to Stand Trial. The scope of this section is limited to the policies that are applicable to the mentally disordered accused subgroup.

The *Criminal Code* (1985) provides the federal criminal justice framework for the forensic mental health system; the *Canada Health Act* (1985) provides the federal health framework for the forensic mental health system. The interpretation of law by the

Supreme Court of Canada has a national impact on the delivery and structure of forensic mental health services. At a provincial/territorial level, the various health and mental health policies of each province/territory supply the local health framework for the forensic mental health system. The discussion below will begin with a brief review of the federal and provincial/territorial health policies that surround the forensic mental health system, which is then followed by an overview of relevant criminal justice policies. The tensions that result from merging health and criminal justice policies and creating a system that is framed by both federal and provincial/territorial legislation are also discussed. Throughout the discussion, comparisons are made between the forensic and non-forensic (or civil) mental health systems. This section ends by considering the potential implications that the policy framework, and resulting organization of forensic systems, has on individuals who receive forensic mental health services.

3.1.1 Health Framework

The forensic mental health system is structured by virtually the same set of health policies as those found in all other Canadian healthcare systems. Health policies significantly impact the organization and delivery of forensic mental health services; therefore, an overview of the most influential health-related policies, including the *Canadian Constitution Act* (1982) [hereinafter the *Constitution*], the *Canada Health Act* (1985), and provincial/territorial health statutes are discussed below. For the purposes of this section, the health elements, rather than the criminal justice elements, of the forensic mental health system will be emphasized.

The *Constitution* (1982) and *Canadian Charter of Rights and Freedoms* (1982) [hereinafter the *Charter*] are considered to be the “supreme law of Canada” and every law in Canada must act in accordance with the *Constitution* and *Charter*. The *Constitution* (1982) is the principal policy that guides matters pertaining to the division of legislative powers between the provincial/territorial and federal governments. In Canada, it is generally understood that healthcare is primarily under the jurisdiction of the provinces and territories, rather than the federal government. The federal government does have some health-related legislative powers, including the authority to deal with matters pertaining to quarantine, marine hospitals and supplying health services to specific populations (e.g., First Nations and Inuit peoples, federal penitentiary inmates). In addition, the *Constitution* (1982) states that the Parliament of Canada has the authority to “make Laws for the Peace, Order, and good Government of Canada” (s. 91). The federal government may exert control over matters that are of national concern and ‘beyond the reach’ of provincial/territorial governments (Gibson, 1996; Jackman, 2000). In relation to health matters, these powers are exercised through federal health agencies (e.g., Health Canada, Public Health Agency of Canada) and through national public health policy (e.g., *Food and Drugs Act*, 1985; *Canada Health Act*, 1985).

The federal government provides significant financial support for healthcare; however, each of the ten provinces and three territories has the authority to spend the money according to their own priorities and organize health services according to their own needs. The provinces and territories receive the full share of financial support from the federal government if they comply with several criteria and conditions as established by the *Canada Health Act* (1985), such as ensuring that all insured residents of a province or territory receive insured health services (universality). Failure to comply with the

criteria and conditions of the *Canada Health Act* (1985) will result in a reduction in the federal financial contribution to that province or territory. The *Canada Health Act* (1985) articulates the primary goal of healthcare policy in Canada, which is: “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (s. 3). This goal is achieved through a publicly funded healthcare system known as Medicare, in which Canadians access *insured* health services without incurring fees at the point of service.

The core of Canada’s publicly-funded healthcare system is the concept of *insured medical services*, which is defined by the *Canada Health Act* (1985) as medically necessary “hospital services, physician services and surgical-dental services” (s. C-6). Thus, health services delivered in a hospital or by a physician are covered by the *Canada Health Act* if they are deemed medically necessary for the purpose of maintaining health. Certain extended health care services are covered by the *Canada Health Act* (1985), such as aspects of long-term residential care, ambulatory services, and home care. Each province/territory has established a health insurance plan to articulate the types of services that are paid for by the government. Provincial/territorial governments may provide additional funding for other supplementary services; however, there is no obligation to cover services that fall outside the scope of the *Canada Health Act* (1985).

The emphasis on hospital-based, physician-provided services in the *Canada Health Act* (1985) is significant for the mental health system, since many necessary mental health services are provided in a non-hospital-based, community-setting and by mental health professionals other than physicians. Services that are delivered in psychiatric facilities and the services delivered by psychologists and counsellors are omitted from the *Canada Health Act* (1985), though psychiatric facilities and other community mental health

services are funded by the provincial/territorial governments. The extent to which governments are willing to financially support non-medically-necessary services varies between the provinces/territories. In their recent review of the Canadian healthcare system, the Commission on the Future of Health Care in Canada referred to mental health as the “orphan child” of Medicare (Romanow, 2002, 178) and the Commissioner, Roy Romanow, has suggested elsewhere that an emphasis on physical illness and health has contributed to the poor status of mental health services across Canada (Romanow & Marchildon, 2003). Canada still remains the only Group of Eight (G8) country without a national policy or federal agency to address issues concerning mental health and mental illness; however, the recently established Mental Health Commission of Canada, a national body that is funded by the federal government to improve health and social outcomes for people living with a mental illness, is working to address this gap. The de-emphasis, or exclusion, of mental health in federal health policy seems to contradict the aspiration of protecting, promoting, and restoring the mental well-being of Canadians. Indeed, the manner in which the Canadian healthcare system is structured and funded presents significant challenges for the forensic and civil mental health systems.

It is important to consider the broad impacts of the *Constitution* (1982) and the *Canada Health Act* (1985) on the forensic mental health system. Equally important is the impact of provincial/territorial health statutes on the forensic mental health system. Since the provinces and territories have the constitutional authority over health matters, the health policies that they enact significantly impact the structure and delivery of forensic mental health services. All Canadian forensic mental health systems provide treatment and rehabilitative services to mentally disordered accused persons with the goals of either reintegrating them into the community or, in the case of persons who are unfit to stand

trial, restoring their fitness; however, the provinces/territories differ in their approaches for achieving these goals (Livingston, 2006). Like other health systems, the forensic mental health systems of each Canadian province/territory have evolved independent of one another according to factors such as geography, existing services, population needs and characteristics, availability of resources and expertise, and political climate. Each province/territory has enacted its own mental health legislation, which is typically focused heavily on pathology, institutional services, and involuntary care (Goering, Wasylenki, & Durbin, 2000; Savage & McKague, 1987). The provinces and territories differ substantially in their legislative approach for dealing with involuntary commitment and treating people with mental illness (see Gray & O'Reilly, 2001). As will be discussed later in this paper, Canadian forensic mental health systems are significantly affected by inter-provincial differences in involuntary commitment practices.

Inter-provincial differences in other health-related policies have produced forensic mental health systems that differ in the degree to which their administration is concentrated in a single centre (centralization) as well as the degree to which services are joined with the civil mental health system (integration) (Hodgins, 1988; Livingston, 2006). For example, British Columbia enacted a *Forensic Psychiatry Act* (1996) which enables forensic mental health services to be delivered in a specialized system that is separate from the civil mental health system. By legislating a specialized mandate and, thereby, securing a protected funding envelope for forensic mental health services, the *Forensic Psychiatry Act* (1996) is a key policy that has influenced the evolution of British Columbia's unique, highly-specialized forensic mental health system. No other Canadian province or territory has enacted a comparable piece of legislation. Forensic mental health systems in other provinces and territories, such as Ontario, that lack a legislated mandate

or clear policy framework appear to struggle within the larger mental health system to obtain their fair share of funding and resources (Ontario, 2002).

Despite the fact that forensic mental health in Canada is often characterized as a unitary system, it is – as a consequence of the distribution of legislative authority in the *Constitution Act* (1982) – constructed of many diverse systems (Livingston, 2006). The degree of integration, co-ordination, and organization of the agencies (or components) within the forensic mental health system affects the process of reintegrating forensic patients into the community. Ideally, patients' movements between agencies within a health system should be seamless, thereby ensuring that their treatment is not disrupted. In the forensic mental health system, patients should transition smoothly between hospital and community settings; as well, the services provided by criminal justice, social services, forensic mental health, and civil mental health agencies should be sufficiently co-ordinated and integrated to ensure that patients easily access necessary services. Many obstacles exist to prevent systems from achieving optimal levels of integration and co-ordination. As a consequence of different health policy frameworks, forensic mental health patients in each province/ territory receive services that likely differ in comprehensiveness, accessibility, and effectiveness; these inequalities impact the functioning of the mental disorder provisions of the *Criminal Code* (1985). The complexity of the criminal justice, psychiatric, and social problems existing within the forensic mental health population certainly presents challenges for co-ordinating and integrating services for this group, as is articulated by Wolff (2002a):

Mentally disordered offenders are an interesting 'integration' case study in part because their needs span the boundaries of health, mental health, social services, and law enforcement systems, in part because the complexity of their needs along with their difficult and

sometimes dangerous behavioural traits combine to make them undesirable clients, and in part because the criminal behaviour of some of these individuals occasionally excites moral panic among the public, leading to a community care backlash. (p. 16)

The forensic mental health system is also challenged with balancing clinical responsibilities to the patient with the legal responsibilities to the state.

3.1.2 Criminal Justice Framework

The term ‘forensic’ literally means connection with courts of law (Barber, 2001) and forensic mental health refers to the delivery of mental health services within a legal context. The forensic mental health system is established by the *Criminal Code* (1985) as a compassionate way for the legal system to deal with persons who lack the essential mental element necessary to justify punishment. The forensic mental health system provides necessary services to persons with concurrent mental health and legal problems who are often excluded from civil mental health services. While the provinces and territories in Canada have primary legislative authority over health matters (*Constitution Act*, 1982, s. 92.15), the *Constitution Act* (1982) clearly grants the federal government with legislative authority over criminal law, including procedures in criminal matters (s. 91.27). Thus, the federal government of Canada is responsible for creating criminal laws and handling criminal justice matters of national concern. In Canada, the principal piece of federal criminal justice policy is the *Criminal Code* (1985). The most relevant sections of the *Criminal Code* (1985) to the forensic mental health system are sections 16 and 672, which articulate the legal policy for admitting, assessing, managing, and discharging mentally disordered accused persons. For the purposes of this section, the criminal justice elements of the forensic mental healthcare system will be emphasized.

The features that distinguish the forensic mental health system from the civil mental health system are its direct interface with the legal system and its concentration on risk for violence and re-offending. Because forensic clients have committed an illegal act in the past, it is generally presumed (by society) that they pose a greater risk for violence and re-offending than their counterparts in the civil mental health system. Although, the Supreme Court of Canada, in *Winko v. British Columbia (Forensic Psychiatric Institute)* (1999), encourages an individualized approach to treating NCR-accused persons that rejects the presumption of dangerousness: “The individualized process is the antithesis of the logic of stereotype, the evil of which lies in prejudging the individual’s actual situation and needs on the basis of the group to which he or she is assigned” (para. 88). The forensic system is specifically designed to assess, treat, and manage the potential risk of persons suffering from mental illness. Inpatient services in the forensic mental health system are provided in secure facilities and the professionals that work with forensic patients are required to have specialized training in the assessment and management of violence risk. In addition to treating and rehabilitating mentally disordered accused persons, forensic mental health professionals also serve the Courts and must be knowledgeable of the mental disorder sections of the *Criminal Code* (1985) and relevant case law.

Mentally disordered accused persons are not convicted offenders; therefore, the legal system must treat them differently than persons who are found guilty of an offence. In the *Winko* (1999) case, Justice McLachlin stressed the “fundamental distinction” between how the State treats NCR-accused and convicted persons (para. 93). In the same manner, Justice Gonthier, in *Winko* (1999), stated the following:

Criminal law simply ‘runs its legitimate course’ differently for NCR accused than for convicted persons... Offenders, other than NCR accused, who are convicted will be deprived of their liberty whether they are still dangerous or not. By contrast, if the NCR accused is not dangerous, he or she will be absolutely discharged. (para. 170)

Even though each province and territory has created its own special way of dealing with mentally disordered accused persons, a certain degree of consistency between the forensic mental health systems is produced by the *Criminal Code* (1985). The mental disorder provisions of the *Criminal Code* (1985) provide the policies and procedures for every juncture of the forensic mental health system, including assessments, appeals, dispositions, and hearings. All forensic mental health systems within Canada are required to adhere to the *Criminal Code*’s (1985) guidelines. For example, all forensic mental health systems must offer hospital- and community-based assessment and treatment services to meet the demands of the Courts. As well, regardless of where a mentally disordered accused person lives in Canada, their management within the forensic mental health system must be overseen by an independent, quasi-judicial Review Board.

Review Boards are multi-disciplinary tribunals – comprised of a judge (or a person with the required qualifications), a psychiatrist, and at least one other person (e.g., psychologist, criminologist, social worker) – that have the following function: “to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is rendered” (*Criminal Code*, 1985, s. 672.38 (1)). Review Boards hold regular hearings to review and decide on the disposition of persons found Unfit to Stand Trial or NCR-MD. Review Boards can order to either detain an Unfit or NCR-accused person in hospital (custodial order) or discharge them to the community with conditions (conditional discharge).

Review Boards may also discharge NCR-accused persons to the community without conditions (absolute discharge). As required by the *Criminal Code* (1985), Review Boards must choose the “least onerous and least restrictive” disposition option for mentally disordered accused persons after considering the multiple factors including public safety and the needs of the accused person (s. 672.54). Amendments to the mental disorder provisions of the *Criminal Code* (1985) have granted additional powers to Review Boards, such as the ability to order forensic assessments and the authority to recommend that a court grant a stay of proceedings for persons who are permanently unfit to stand trial who are not a threat to public safety (s. 672.851). While the Court is considered to be the gatekeeper to the forensic mental health system, the Review Board serves as the primary body that governs the management of individuals within the system.

The procedures and practices within the forensic mental health system and the structure of the system itself will continue to change as case law evolves through the appellate courts. Since health matters are in the hands of provincial/territorial governments, the primary means of maintaining uniformity between Canadian forensic mental health systems is through the Supreme Court of Canada. In the case of *Winko* (1999), the Supreme Court of Canada transformed the system by declaring that the forensic mental health system should only contain those NCR-accused persons that are deemed to be a significant threat to society. The Supreme Court stressed that the liberties of persons found NCR-MD may only be restricted if they present a significant risk of serious physical or psychological harm to individuals in the community: “Absent dangerousness amounting to a significant threat to public safety, there is no constitutional basis for the criminal law to restrict the liberty of an NCR accused” (Justice McLachlin, *Winko*, 1999, para. 50). In *R. v. Demers* (2004), the Supreme Court of Canada also

applied this standard to persons who are found unfit to stand trial; however, the *Criminal Code* (1985) stipulates that – regardless of the continued, significant threat criterion – a stay of proceedings may not be granted in these situations if it is contrary to “the interests of the proper administration of justice” (s. 672.851(8)). Another Supreme Court case – *Penetanguishene Mental Health Centre v. Ontario (Attorney General)* (2004) – established uniformed guidelines for Review Boards to use when forming the conditions of a disposition for an NCR-accused. This case clarified that both the disposition (i.e., absolute discharge, conditional discharge, custodial order) and the conditions that are applied to conditional discharge and custodial dispositions orders (e.g., the level of security in which an individual is detained) must be consider the ‘least onerous and least restrictive’ principle, as is required by section 672.54 of the *Criminal Code* (1985). By reinterpreting the formula that is used to adjudicate dispositions for mentally disordered accused persons, the Supreme Court of Canada has influenced both Review Board decision-making and the manner in which mentally disordered persons are managed within the forensic mental health system (Balachandra, Swaminath, & Litman, 2004).

The primary focus of the mental disorder provisions of the *Criminal Code* (1985, s. 672) are to ensure that society is protected from dangerous individuals. It is through this criminal justice policy framework that forensic mental health has evolved into a system that is chiefly concerned with identifying, managing, and reducing the risk of criminal and violent recidivism. The *Criminal Code* (1985) and the appellant Courts ensure that the quest for public safety does not infringe on the *Charter* (1982) rights of mentally disordered accused persons.

3.1.3 Merger of Health and Criminal Justice Policy

In the above sections, health and criminal justice policies that encompass the forensic mental health system were discussed separately. In reality, these policies and principles operate simultaneously and interact. The mental disorder provisions of the *Criminal Code* (1985) and provincial/territorial statutes are complementary in several respects. The forensic and civil mental health systems share a common goal of protecting society by placing restrictions on the liberty of mentally ill persons who pose a threat to society. The civil mental health system performs this protective role through involuntary commitment. Professionals within both forensic and civil mental health systems are challenged with reconciling the duties to the patient (e.g., health, privacy) and the State (e.g., protection) (see Verdun-Jones, 2000). Both systems use a ‘threat to society’ standard to guide decisions concerning the restrictions that should be imposed on people with mental illness.

Even though the forensic and civil mental health systems share some common principles, significant differences exist as a result of the civil system being a product of mental health statutes and the forensic system being a product of criminal justice legislation. Unlike the civil mental health system, the forensic system must contend with problems that result from the intersection of health and criminal justice policies. Each of these policies generates a unique perspective to understanding both the forensic client and the purpose of the forensic mental health system. From a health perspective, forensic clients are ‘patients’ and the purpose of the system is to provide services to treat their mental illness. From a criminal justice perspective, forensic clients are ‘accused persons’ and the purpose of the system is to detain dangerous individuals and reduce risk for

violent and criminal recidivism. Reconciling these differences is a challenge. The following sections in this dissertation discuss the problems that arise from the intersection and interaction of federal criminal justice and provincial/territorial mental health policies, including issues related to the decision-making powers, the involuntary treatment of mentally disordered accused persons, and systemic issues in the delivery of forensic mental health services.

3.1.3.1 Authority of Hospital Directors and Psychiatrists

The *Criminal Code* (1985) and provincial/territorial mental health statutes have substantially different positions on the amount of authority that should be given to hospital directors and psychiatrists. Provincial/territorial mental health statutes provide psychiatrists with substantial authority to make decisions, on the basis of their own clinical judgement, for their patients. Psychiatrists in the civil mental health system have discretionary powers to admit mentally ill persons to hospital. They also have the power to make numerous other decisions concerning the treatment and management of patients without the involvement of the civil Review Panel, including the following: whether or not to discharge patients from hospital; what conditions to impose on a patient's extended leave from hospital; whether to adjust the level of restrictions that are imposed on a patient; and whether to re-hospitalize a patient who is receiving compulsory community treatment. The composition and functioning of the Review Panel differs by province/territory. In British Columbia, the Review Panel is an administrative tribunal that consists of a medical practitioner (e.g., psychiatrist), a member in good standing of the Law Society of British Columbia or a person with equivalent training, and a person

who is not a medical practitioner or a lawyer (*Mental Health Act*, 1996, s. 24.1(3)). Under provincial/territorial mental health statutes, the Review Panel has little or no authority to influence the management of civil mental health patients. Generally, the only function of the civil Review Panel is to review whether individuals continue to satisfy the criteria for civil commitment and whether they should be discharged from involuntary status (e.g., involuntary hospitalization, compulsory community treatment). In British Columbia, cases involving extended leave statuses are examined by the Review Panel only when an individual makes a request for a hearing. For example, someone who wishes to be discharged from their involuntary status, but their psychiatrist refuses to do so, may request a Review Panel hearing.

Within the forensic mental health system, clinical practices are secondary to legal considerations and rulings. The powers that are traditionally held by hospital directors and psychiatrists in the civil system are substantially diluted in the forensic mental health system by the mental disorder provisions of the *Criminal Code* (1985). In the forensic mental health system, the *Criminal Code* (1985) grants considerable authority to the criminal Review Boards for directing the management of individuals with mental illness and, as a result, physicians are given less power to make autonomous decisions concerning the management of their patients (*Mazzei v. British Columbia*, 2006). Unlike other health systems, the admission and discharge of persons to/from the forensic mental health system is decided through the application of legal rules derived from the *Criminal Code* (1985), rather than clinical practices. The decision to admit persons to the forensic mental health system is under the authority of legal bodies, such as the Courts or Review Boards, which are guided by federal criminal justice legislation. Therefore, patients are admitted to the forensic system via court-ordered assessments or subsequent to court

adjudications of NCR-MD or 'Unfit to Stand Trial'. Psychiatrists in the forensic system have a role in making recommendations to the Courts on issues of criminal responsibility and fitness to stand trial; however, these legal matters are ultimately under the jurisdiction of the Courts and Review Boards.

In the civil mental health system, an individual may only access services (e.g., hospital admission) if they suffer from a mental illness at the time of admission. In contrast, the presence of mental illness is not necessarily required for an admission to the forensic mental health system. The forensic mental health system must deal with 'patients' who would not typically qualify to enter the civil mental health system. Court-ordered assessment cases must be admitted to the forensic system regardless of whether or not the individual is suffering from a mental disorder. As well, NCR-accused persons are admitted to the forensic mental health system on account of a mental disorder at the time the index offence was committed, not at the time of admission to hospital. Persons are admitted to the forensic system regardless of the treatability of their mental condition. In addition to having to deal with persons who have untreatable or no mental disorder at the time of admission, the forensic mental health system is also challenged with dealing with persons who feign mental illness in order to avoid criminal conviction.

Psychiatrists in the forensic mental health system have little control over the timing of a patient's discharge from hospital (via a conditional discharge), or discharge from the forensic system altogether (via an absolute discharge). Mentally disordered accused persons are discharged from hospital through the authorization of the Review Board, even if the attending psychiatrist is not in favour of the discharge. Review Boards are required to follow the provisions of the *Criminal Code* (1985) regardless of whether or not the decision is clinically appropriate. This arrangement makes it difficult for

clinicians to plan the treatment of mentally disordered accused persons. Mentally disordered accused persons may also be forced to stay in the forensic mental health system under the authority of the Review Board regardless of whether or not it makes clinical sense for the person to continue with treatment. The forensic mental health system continues to be challenged with managing mentally disordered accused persons who do not fit within the usual treatment milieu.

3.1.3.2 Treatment

Mentally disordered accused persons who are detained in a hospital under the authority of the *Criminal Code* (1985) are simultaneously under the authority of provincial/territorial mental health (civil commitment) legislation. While the admission and discharge of mentally disordered accused persons is regulated by the *Criminal Code* (1985), the actual treatment of the patients within the forensic mental health system is governed by provincial/territorial mental health legislation. Since matters of health fall outside the authority of the *Criminal Code* (1985), psychiatrists and hospital directors in the forensic system have almost exclusive power to make decisions that strictly concern the health and treatment of the mentally disordered accused. In speaking about the limited role of the federal government to control the treatment of mentally disordered accused persons, the Supreme Court of Canada Chief Justice Lamer made the following comment:

Of course Parliament is sympathetic to persons suffering from psychological illnesses and it will not hold them responsible for their actions or punish them. However, it is not Parliament's responsibility to treat these people; Parliament must concern itself with the consequences for society if these individuals are released while dangerous. The fact that the *Code* provisions themselves do not focus on treatment is not callousness on the part of Parliament, but simply a recognition of the responsibilities and priorities

assigned to it by the division of powers provisions in the Constitution. (*R. v. Swain*, 1991)

The federal and provincial/territorial governments share responsibility for mentally disordered accused persons; however, this arrangement becomes problematic when policies of the federal and provincial/territorial governments conflict on a particular issue.

One problematic issue for the forensic mental health system is the involuntary treatment of mentally disordered accused persons. Indeed, the *Criminal Code* (1985) and provincial/ territorial mental health statutes appear to differ on the matter of involuntary treatment. During the consultation stage of the 1992 amendments to the mental disorder provisions of the *Criminal Code* (1985), psychiatrists had recommended that the *Criminal Code* (1985) include involuntary treatment provisions for persons who are unfit to stand trial or NCR-MD (Tollefson, 2000). Civil rights advocates, on the other hand, argued that mentally disordered accused persons should have the right to make treatment decisions (Tollefson, 2000). Recognizing that the federal government does not have jurisdiction over health matters, the Department of Justice decided not to legislate involuntary treatment; instead, the responsibility over treatment matters was transferred to the provincial/territorial governments.

Accordingly, the *Criminal Code* (1985) states that Courts and Review Boards shall not order the treatment of mentally disordered accused persons without the consent of the individual or their proxy decision-maker. The Department of Justice does recognize that the federal government can legislate on health matters when they impact on criminal justice matters (Tollefson, 2000). Under section 672.58 of the *Criminal Code* (1985), a person who is unfit to stand trial can be court-ordered to comply with treatment if it is used for the purpose of restoring their cognitive capacity. Interestingly, this provision of

the *Criminal Code* (1985) is inconsistent with the mental health statutes of several Canadian jurisdictions, not including British Columbia, which only allow involuntary treatment to be imposed on mentally incompetent persons if their proxy decision-maker is willing to consent to the treatment. Consent from proxy decision-makers is not required by section 672.58 of the *Criminal Code* (1985).

The *Criminal Code* (1985) provisions were designed to allow for involuntary treatment to be imposed on mentally disordered accused persons in the narrowest of circumstances; however, provincial/territorial mental health legislation expands the application of involuntary treatment for mentally disordered accused persons. Even though Courts and Review Boards are unable to order forced treatment, mentally disordered accused persons who are detained in hospital may still be forced by provincial/territorial mental health statutes to comply with treatment (Solomon, O'Reilly, Gray, & Nikolic, 2008). The involuntary treatment provisions of mental health statutes appear to undermine the 'treatment shall not be ordered' clause of the *Criminal Code* (1985). This issue was examined in the case of *British Columbia (Forensic Psychiatric Services Commission) v. British Columbia (Mental Health Act Review Panel)* (2001), in which a person was remanded to hospital for a court-ordered fitness assessment under the authority of the *Criminal Code* (1985) and was subsequently certified under the BC *Mental Health Act* (1996). The attending psychiatrists involuntarily treated the patient notwithstanding the fact that section 672.19 of the *Criminal Code* (1985) states that "no assessment order may direct that psychiatric or any other treatment of the accused be carried out, or direct the accused to submit to such treatment." Upon review of the certification, the *Mental Health Act* Review Panel – acknowledging issues related to the protection of statements made by the patient during the assessment process – decided that

certification under the *Mental Health Act* (1996) was in conflict with the *Criminal Code*'s (1985) prohibition against treatment. On appeal, the Supreme Court of British Columbia ruled that civil mental health proceedings by Review Panels are not authorized under the *Criminal Code* (1985) and, therefore, are not bound by the treatment prohibition provisions of the *Criminal Code* (1985). The Court concluded that providing involuntary treatment to mentally disordered accused under the BC *Mental Health Act* (1996) was not in conflict with the provisions of the *Criminal Code* (1985).

The provinces and territories use different models of imposing involuntary treatment on people with mental illness. In most Canadian jurisdictions, mentally disordered accused persons who are involuntarily detained in hospital are only subjected to compulsory treatment if they are incapable of making treatment decisions. This approach is to be commended for respecting the dignity and autonomy of mentally ill persons; however, it produces the problematic scenario in which someone is detained in hospital but does not receive treatment (Solomon et al., 2008). In the case of *Starson v. Swayze* (2003), an NCR-accused person, Mr. Starson, was detained in a hospital under the authority of the Ontario Review Board, but he refused to consent to treatment. Mr. Starson was declared to be incapable of making treatment decisions and was, subsequently, involuntarily treated. The incapacity decision was overturned by the Ontario Superior Court, the Ontario Court of Appeal, and the majority of the Supreme Court of Canada, on the basis that the finding of incapacity was unreasonable and that the statutory test for capacity was misapplied. The Supreme Court of Canada ruled that treatment could not be forced on Mr. Starson even though he continued to be detained in an Ontario psychiatric hospital under the authority of the Review Board. Therefore, the hospital – an institution designed to provide treatment to the ill – is forced to act

essentially as a detention centre.

The practice of detaining mentally disordered accused persons in hospital without providing additional treatment may seem inappropriate, unethical, or illogical; however, Supreme Court Justice McLachlin has stated that justice is served by providing mentally disordered accused persons with the *opportunity* for psychiatric or other treatment (Winko, 1999, para. 40). The *Criminal Code* (1985) accomplishes this by sending mentally disordered accused persons to psychiatric hospitals, where treatment is available, rather than locking them up in prisons. Interestingly, if Mr. Starson lived in a different Canadian jurisdiction that permits the compulsory treatment of all involuntarily hospitalized mentally ill persons, such as British Columbia, he would have been given treatment regardless of his competency or refusal to consent to treatment (Solomon et al., 2008). In this province, mentally disordered accused persons who are detained in hospital are not only provided with the *opportunity* for treatment, but the mental health statutes also ensure that these persons *receive* treatment. This approach impinges on the basic right to refuse treatment; however, some would suggest that involuntarily treating all hospitalized mentally disordered accused persons may have the advantage of stabilizing the mental condition in an expedient manner, which may serve to better protect the safety of the hospital staff and co-patients, and shorten a person's length of stay in hospital.

Another issue related to the treatment of mentally disordered accused persons concerns the authority of legal bodies to direct the type of assessment and treatment services that are supplied by the mental health system. Do Courts and Review Boards have the authority to choose the mental health services that they feel are most appropriate for persons under their authority? This question was raised in the case of *R. v. Gray* (2002), in which a Provincial Court Judge ordered that a psychiatric assessment be

conducted to query a specific disorder (Fetal Alcohol Spectrum Disorder) and that the assessment be conducted by a specific service provider. Since this particular court order attempted to circumvent the standard procedures for carrying out forensic psychiatric assessments, the government of British Columbia refused to pay for the specialized assessment. The provincial government's decision was brought to the Supreme Court of British Columbia, which found that the Provincial Court Judge exceeded her jurisdiction by using Part XX.I of the *Criminal Code* (1985) to require an assessment of a specific disorder at a specific location. The Supreme Court ruled that the government's refusal to pay for the request was not in violation of the *Charter* (1982).

In another case on a similar matter, *Mazzei v. British Columbia (Adult Forensic Psychiatric Services)* (2004), the British Columbia Review Board ordered the Director of the provincial forensic psychiatric services to provide an NCR-accused person with specified mental health services, such as an independent assessment of risk and culturally appropriate treatment programs. The director appealed the conditions of the disposition on the basis that a Review Board has authority over an NCR-accused person, not over the services he or she receives within the forensic mental health system. The Director submitted that the order was unreasonable and that the Review Board overstepped its authority. The British Columbia Court of Appeal (BCCA) concurred with the Director of forensic psychiatric services and concluded that the Review Board did not have the authority to impose an order upon the director. Accordingly, the Court struck down the pertinent conditions of the Review Board's order. This decision was appealed to the Supreme Court of Canada, which overturned the BCCA's decision and ruled that: "Review Boards generally have the jurisdiction to make orders and conditions binding on persons other than the accused.... The Director, and the treatment team and hospital

administration by implication, are bound by Board orders and conditions” (*Mazzei*, 2006, para. 18). The Supreme Court of Canada also ruled that, while the Review Board had the power to supervise medical treatment, it does not have the power to impose medical treatment on an NCR-accused or require hospital authorities to administer a certain course of treatment.

The cases of *Gray* (2002) and *Mazzei* (2004/2006) illustrate the amount of pressure that provincial forensic mental health services, particularly in British Columbia, are under to comply with the requests of Courts and Review Boards. These two cases also highlight the potential for conflict between the Courts or Review Boards and forensic mental health services. Thus far, forensic mental health services have, for the most part, retained their control over the health matters of mentally disordered accused persons.

3.1.3.3 Service System

Though the *Criminal Code* (1985) gives substantial powers to Courts and Review Boards in directing the management of mentally disordered accused persons, the provinces and territories are responsible for the design and organization of the forensic mental health service system. Research has documented the presence of inter-provincial differences in the structure and organization of forensic mental health services in Canada (Livingston, 2006). The effectiveness and efficiency of the forensic mental health service models likely varies between Canada’s provinces and territories, though the models have not yet been empirically evaluated. Recent court cases imply that proper function of the *Criminal Code*’s (1985) mental disorder provisions is contingent on the ability of local mental health services to meet the demands of the Courts and Review Boards.

Court and Review Board decisions concerning mentally disordered accused persons are greatly impacted by the quality and comprehensiveness of services that exist within the local mental health system. Poor access to services in the community certainly impacts the likelihood that a forensic patient will be discharged from hospital to the community. In *Winko* (1999), the Supreme Court of Canada made it clear that, in determining whether the accused poses a significant threat, the Review Board may consider whether or not appropriate services exist in the community to support an NCR-accused person. Logically, if community support services (e.g., mental health, housing, employment, addiction services) are weak, ineffective, or unavailable, the decisions of Courts and Review Boards will necessarily be impacted – potentially leading to a lengthy (and arbitrary) detention in custody for the NCR-accused and Unfit persons.

The initiation of court-ordered assessment and treatment services may be delayed because of poorly resourced mental health systems. In the recent case of *Ontario (Crown Attorney) v. Hussein* (2004), an individual was court-ordered to undergo an assessment on issues of fitness and criminal responsibility at a local hospital, but was detained in jail for an extended duration (32 days) without being assessed pending the availability of a hospital bed. The Ontario Superior Court of Justice ruled that the practice of placing accused persons who are subject to an assessment order on waiting lists is contrary to the provisions of the *Criminal Code* (1985) and violates sections 7 and 9 of the *Charter* (1982). Accordingly, the Court advised the Ontario health officials to ensure that there are a sufficient number of available beds to meet their demands. Accessibility of hospital beds was also an issue in the case of *Orru v. Penetanguishene Mental Health Centre* (2004), in which an NCR-accused person continued to be held in a maximum-security facility despite the Ontario Review Board's order for him to be transferred to a medium-

security facility. The Ontario Superior Court of Justice ruled that failure to transfer the accused in a timely manner violated section 7 of the *Charter* (1982) and ordered that the accused be transferred within 15 days to the appropriate hospital. Clearly, the functioning of the *Criminal Code*'s (1985) mental disorder provisions is dependent on the responsiveness of provincial/territorial mental health systems.

The relationship between the Courts and the forensic mental health system is one-sided. Judges are under no obligation to consider the availability of hospital beds when ordering forensic assessments. Consequently, provincial/territorial governments are forced to make adjustments to their forensic mental health systems to meet the demands of the Courts. Even though the provinces and territories have constitutional authority over healthcare, the federal government has the authority to play a role in health matters that impact the administration of the mental disorder provisions of the *Criminal Code* (1985). As well, the federal government has a role in protecting the health of Canadians and promoting national strategies to improve health. It is not Parliament's role to provide treatment to persons with mental disorders, but the federal government should realize that an ineffective, inefficient mental health system negatively impacts the administration of the mental disorder provisions of the *Criminal Code* (1985) and the operation of the forensic mental health system.

3.1.3.4 Community-Based Forensic Mental Health Treatment

Most individuals who are adjudicated NCR-MD are initially detained in a forensic inpatient setting, but are eventually discharged to the community mental health system. For example, a study of 276 persons found NCR-MD in British Columbia in the 1990s

found that 72% were discharged to the community during the study period (Livingston, Wilson, Tien, & Bond, 2003). As was mentioned earlier, section 672.45 (2) of the *Criminal Code* (1985) provides for the disposition of a conditional discharge, which is comparable to compulsory community treatment found in the civil mental health system.

Individuals must abide by the terms specified within the conditional discharge or risk being found in breach of their conditions and returned to hospital. Conditional discharge dispositions commonly require individuals to comply with the following clauses: (a) remain under the direction and supervision of the Director of the forensic service, (b) keep the peace and maintain good behaviour, (c) report to a specified forensic or mental health outpatient clinic, (d) abstain from the use of alcohol or non-prescription drugs, and (e) reside in a supervised setting deemed appropriate by the Director (Livingston et al., 2003). Psychiatric treatment may not be ordered or imposed by the Court or Review Board; however, for individuals who are on a conditional discharge order, it is usually implied that failure to comply with a prescribed medication regime would result in destabilizing an individual's mental state. Consequently, an individual's refusal or failure to take psychiatric medication has the potential to increase their risk for violence, therefore resulting in their continued detention in hospital. All forensic mental health clients who are on conditional discharge must consent to receiving psychiatric medication, so, technically their treatment is 'voluntary'; however, it is debatable whether or not this is actually a choice, since failure to consent to psychiatric treatment ultimately means that the individual will not be allowed to live in the community. An individual's 'choice' concerning psychiatric treatment (i.e., their ability to refuse) is restricted by the coercion and legal leverage that is imposed on them. Decisions made by people with

mental illness in this context would not satisfy the pure voluntariness standard of treatment consent, which requires that a choice is made without any undue coercion or duress (Somerville, 1994). For this reason, the conditional discharge disposition is, for all intents and purposes, a form of compulsory community treatment.

3.1.4 Forensic Labelling: A Consequence of Policy

The ‘forensic’ label is assigned to a person with mental illness after they have committed an illegal act and have been court-ordered to receive forensic mental health services. The phrase ‘forensic mental health client’ basically communicates that the person has concurrent legal and mental health problems. Buchanan (2002) indicates that the term ‘forensic’ is simply an administrative concept to describe patients that have previously been looked after by forensic services. In addition to communicating that the person has mental health and legal problems, ‘forensic’ also indicates that the person will be, or has been, provided treatment services within the forensic mental health system. In their critical evaluation of the subspecialty of forensic psychiatry, Turner and Salter (2008) highlight problems with the definition of ‘forensic’, including what it reflects about individuals who are labelled as such: “the defining feature of a forensic case is a retrospective view of the concern provoked by an event that, by definition, has already occurred” (p. 4). Therefore, while the ‘forensic’ label describes some feature of an individual’s past and current circumstances, it simultaneously and insidiously (perhaps unintended) implies something about their future. Due to their criminal history, a ‘forensic’ mental health client is presumed to be at risk for committing future violence or other criminal behaviour. McGuire (2002) states that the term inaccurately refers to “a

whole gamut of activities associated with persons who have broken the law” (p. 256) and that, recently, the term has been used synonymously with violence (e.g., ‘forensic behavior’).

The creation of specialized subsystems of healthcare, such as *mental* health or *forensic mental* health, is intended to ensure that resources are directed towards addressing particular health problems. For example, *forensic mental* health services have allocated resources to address the unique risk-related needs of persons with mental disorders who are in conflict with the law. It is assumed that specialized subsystems of healthcare will supply clients with greater access to services that they would not have been able to access in the mainstream system. Concentrating expertise and resources on a specialized health problem also has the effect of advancing interest and knowledge in that particular area. The establishment of forensic mental health services may also serve a protective purpose by ensuring that the resources and services provided to persons with socially offensive problems, such as pedophilia, are not diverted to more socially palatable health problems. For instance, the enactment of the *Forensic Psychiatry Act* (1996) in British Columbia ensures that healthcare funding is designated to support the delivery of inpatient and outpatient treatment services to persons who are in need of such care. Without this legislated protection, there is the potential that the allocation of healthcare dollars for forensic mental health services would be heavily influenced by public opinion and politics. As well, a forensic mental health system pacifies some of the public’s fears related to mental illness, crime, and violence. In addition to the positive aspects of establishing a specialized forensic mental health system, theoretically, creating

a specialized subsystem of healthcare may also be associated with negative consequences, which are considered below.

3.1.4.1 Impact of 'Forensic' Specialization

Since mental health systems typically operate independent of other primary health systems, the phenomenon of mental illness has been shaped into something that is distinct from other health problems. Consequently, in comparison with other health problems, persons with mental illness are faced with higher levels of stigmatization and marginalization. For that reason, the World Health Organization recommends that mental health and primary health care be integrated to minimize the exclusion and stigmatization of persons with mental illness (World Health Organization, 2003). Similarly, transforming *forensic mental health* into something different than *mental health* carries the negative consequence of marginalizing the subsystem and its consumers.

As has been mentioned previously, the features that distinguish the forensic mental health system from the civil mental health system are its direct interface with the legal system and its concentration on risk. The forensic system is specifically designed to assess, treat, and manage the potential risk of persons suffering from mental illness. The civil mental health system also deals with issues involving risk for violence and protection of public safety when determining if a client must be involuntarily committed and treated; however, unlike the forensic mental health system, the principle duty of the civil mental health system is to treat mental illness rather than to assess and manage criminogenic risk.

Some NCR-accused persons within the forensic mental health system have committed seriously violent offences (Livingston et al., 2003) and may pose a significant threat to the safety of others. Therefore, it is essential to identify these individuals and manage their risk accordingly. However, critical questions about the forensic mental health system should be asked, including: Are there any negative consequences associated with presuming that *all* forensic clients are at some level of risk for violence or re-offending? What are the impacts of a system that views its clients on a continuum of risk? Busfield (2002) maintains that concentrating on risk for violence produces the negative effect of diverting resources away from forensic clients that are not at risk for violence and creates barriers for understanding the problems faced by persons with mental illness by diverting attention away from more important clinical or social issues. Despite the fact that one of the primary responsibilities of the forensic mental health system is to protect public safety, Busfield (2002) argues risk-related issues should not necessarily be prioritized ahead of other needs: “Risk should not be the dominant lens through which we view the realm of psychiatric problems” (p. 84).

The forensic mental health system contains the expertise and resources to best address the legal and risk management needs of forensic mental health clients. A consequence of having a highly-specialized forensic system is that professionals in non-forensic mental health settings are eventually deskilled in forensic-related matters, such as assessing and treating violent behaviour (Skipworth & Humberstone, 2002). Since the civil mental health system does not have the appropriate expertise and resources to deal with forensic matters, the professionals within that system are reluctant to provide services to forensic clients. Accordingly, forensic clients could potentially be excluded

from the services and programs of the civil mental health system and become increasingly dependent on specialized 'forensic' services. To compensate for the services that forensic clients are unable to access in the civil mental health system, the forensic mental health system must then create additional specialized services, such as forensic boarding homes, to meet the needs of its client population. Even though the creation of the forensic mental health system is intended to supply clients with greater access to services, it could simultaneously produce a cycle that restricts forensic clients from accessing non-forensic services, which has the potential to increase their dependence on the forensic system.

Other hazards of establishing a specialized forensic mental health system include duplication of services, competition between mental health agencies for financial and human resources, and overly restrictive mandates. Fragmented funding is considered by Wolff (2002) to be particularly destructive to the integration of treatment services for forensic mental health clients:

Separating systems by categorical funding mandates undermines policy efforts to organise the pieces around the whole person. Administrative barriers that have historically hindered systems and services integration persist because categorical funding streams define individualised systems and reinforce their independence. (p. 25)

Anything that generates competition and division between mental health systems or agencies, such as limited or fragmented funding, is detrimental to the continuity of care for people with mental illness. Indeed, the systemic separation between the forensic and civil mental health creates significant challenges to delivering integrated and coordinated services to individuals who have been categorized as 'forensic' clients.

3.1.4.2 Impact of the ‘Forensic’ Label

Professionals working within the forensic mental health system are well aware of the stigma associated with the ‘forensic’ label and the resulting challenges faced by their clients. Forensic mental health clients bear the dual stigma of being labelled mentally ill as well as criminal. The combination of these two social categories ultimately confirms public suspicion that persons with mental illness are violent and dangerous. Moreover, the forensic mental health system’s concentration on ‘risk’ may serve to reinforce the notion that *all* forensic clients are at risk for committing future crime and violence.

The dual stigma faced by ‘forensic’ clients has the potential of creating barriers for accessing services (e.g., housing, recreational) that are essential for community reintegration and are generally available to other people with mental illness. Poor access to services and supports in the community certainly impacts the likelihood that a forensic patient will be discharged from hospital to the community. An NCR-accused without access to appropriate community supports and services will not be granted a conditional discharge, since the Review Board will be unable to conclude that they can be safely maintained in the community. Some contend that the reluctance of the general mental health system to accept forensic clients will “result in prolonged inpatient admissions for FMH [forensic mental health] patients, fostering institutionalization and ultimately thwarting rehabilitation” (Skipworth & Humberstone, 2002, p. 47). Poor access to community supports and services has the potential to impact forensic clients who are discharged to the community by slowing their treatment progress and making them more vulnerable to mental decompensation and criminal behaviour. Therefore, the community

tenure of people with mental illness who have a forensic designation may be disrupted by periods of hospitalization and involvement with the criminal justice system.

The modified labelling theory (Link et al., 1989) may be used to illustrate how the ‘forensic’ label may contribute to prolonging a person’s mental illness and hindering their ability to successfully reintegrate back into society. By being perceived as a risk and prevented from participating in certain activities, forensic mental health clients may begin to perceive themselves as a risk to society and withdraw in order to protect themselves against further stigmatization. Forensic clients who withdraw and become isolated limit their opportunities to build relationships with others, to gain employment, and to learn and practice socially acceptable behaviour. Isolation may also produce loneliness and lower levels of self-esteem, self-efficacy, and life satisfaction. Individuals with mental illness who withdraw from society certainly become vulnerable to mental decompensation and re-offending.

Unfortunately, forensic mental health clients who live in the community may be prevented from being part of their community because of stigma (Hocking, 2003). If the goal of the forensic mental health system is to reintegrate individuals back into society, then the degree to which stigma and systemic barriers impede community reintegration must be evaluated. Provincial forensic mental health systems have identified the adverse consequences of ‘forensic’ stigma for people who use their services. For example, in Ontario, a Forensic Mental Health Services Expert Advisory panel recently produced a report that identified several interrelated barriers to successfully managing forensic patients in the community (Ontario, 2002). Stigma resulting from the ‘forensic’ label is a key issue cited within the report:

An individual who acquires the “forensic” label is severely compromised in his/her ability to access opportunities (e.g., employment, housing) normally available to civilly committed clients and the general population. This stigmatization has had a direct impact on the lack of appropriate accommodation in the community for forensic clients who might otherwise be discharged from hospital. (Ontario, 2002, p. 25)

The report also notes that some components of the mental health system are reluctant to accept forensic clients, which increases the length of stay of patients in hospital. To address these concerns of stigmatization, the advisory panel recommended greater integration of lower risk forensic clients into broader mental health programs. Since low risk clients do not require the specialized services provided by the forensic mental health system, the panel suggested the ‘forensic’ stigma should be minimized by having them managing in the civil mental health system. Similarly, in British Columbia, the approach of providing community services to forensic clients through specialized forensic community clinics has been identified as a potential barrier for low-risk mentally disordered offenders (British Columbia, 1998).

The labelling perspective provides a framework for understanding the potential consequences that are associated with creating a separate, specialized forensic mental health system and, in turn, constructing the ‘forensic’ mental health client. If attaching a ‘forensic’ label to people who use mental health services significantly impairs their ability to access necessary services and reintegrate into the community, then perhaps system-wide changes should be made to bridge the divide between the forensic and civil mental health systems. Indeed, the effects of the ‘forensic’ label go beyond just the possibility of limiting service access. According to the theories reviewed earlier, the creation of a special class of mental health consumers has the potential to marginalize a social group and transform the identity of individuals within that group. The next section discusses the

policy framework that produces another subtype of mental health consumer – the civilly committed client.

3.2 CIVIL COMMITMENT POLICY

Involuntary commitment, also known as civil commitment, refers to a legal obligation imposed by the State that impinges on the liberty of a person with mental illness. Generally, two forms of involuntary commitment exist – namely, inpatient and outpatient involuntary commitment. Inpatient commitment involves the removal of persons with mental illness from the community and detention in a designated hospital under the State’s authority. Outpatient commitment is a more recent phenomenon in Canada, in which persons with mental illness live in the community and are legally required to comply with conditions of treatment and supervision. The fundamental assumption of all forms of involuntary commitment is that certain persons with mental illness are unable to realize their need for psychiatric treatment and, therefore, are at risk of harming themselves or society. Mental health statutes of Canadian provinces and territories supply the legal framework to involuntarily hospitalize and involuntarily treat persons with mental illness.

Involuntary commitment is undoubtedly a mechanism of formalized social control, which is described by Cohen (1985) as “the organized way in which society responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable in some way or another” (p. 1). To some degree, all forms of healthcare provide a social control function by maintaining normative standards through the treatment of sickness and disease. Because the boundary between

mental normalcy and abnormality is difficult to define, the mental health system and its professionals are subjected to considerably more criticism and scrutiny than the physical health system. Involuntary commitment legislation provides the State with the legal authority to identify and deal with ‘problematic’ people with mental illness. In certain communist countries, such as China and the former Soviet Union, involuntary commitment has been used by the State as a means of controlling political dissidents and nonconformists (Birley, 2002; Munro, 2000). In democratic, industrialized societies, such as Canada, involuntary commitment is primarily used by the State as a means of controlling the behaviour of persons with mental illness that is beyond the reach of the criminal justice system.

Opponents of involuntary commitment view it as an inhumane, unconstitutional, coercive practice; the facilitators of the process (i.e., psychiatrists) are regarded as simply agents of social control (Szasz, 2003). It has been suggested that the trend towards increasingly coercive mental health legislation is in direct opposition to other efforts that seek to foster social inclusion and reduce the stigma for people with mental illness (Kaiser, in press). In contrast, proponents of involuntary commitment argue it is a socially responsible practice that provides necessary medical treatment and sanctuary to people suffering from mental illness. Proponents deny that involuntary commitment and psychiatry are purely mechanisms of social control and insist that, through involuntary commitment, psychiatry aims to relieve symptoms, restore functioning, and return involuntarily committed individuals to the community as quickly as possible (Gray, O’Reilly, & Clements, 2002). Savage & McKague (1987) suggest that a more balanced opinion of involuntary commitment “accepts the reality of the state’s role in civil commitment without necessarily applauding it” (p 256).

This section provides a critical analysis of involuntary commitment and relevant mental health statutes. First, the structure of mental health legislation in Canada and the underlying principles of involuntary commitment are considered. Next, issues related to involuntary treatment, including treatment consent and mental competency, are discussed. Lastly, two forms of involuntary commitment –involuntary hospitalization and compulsory community treatment – are reviewed.

3.2.1 Policy Overview

Each Canadian province and territory has enacted mental health legislation that provides the legal framework for the involuntary commitment of persons with mental illness. Since there is no uniform mental health legislation across Canada, the structure and content of the mental health legislation differs significantly between provinces and territories (Gray & O'Reilly, 2001). The majority of the provinces and territories have enacted a *Mental Health Act* that specifically deals with both involuntary hospitalization and treatment. Nova Scotia is unique in that it deals with involuntary hospitalization and treatment through the *Hospitals Act* (1989), which also has other provisions for regulating the management of all provincial hospitals. In Ontario, the *Mental Health Act* (1990) regulates involuntary hospitalization and the *Health Care Consent Act* (1996) deals with issues related to mental capacity and treatment consent. In Saskatchewan, involuntary commitment and treatment regulations are embedded within the *Mental Health Services Act* (1985-85-86), which also deals with the promotion of mental health and well-being in the province, as well as the accessibility, delivery, and management of all provincial mental health services. Similarly, New Brunswick has established a *Mental Health*

Services Act (1997) to guide the delivery of mental health services in the province; however, the issues of involuntary commitment and treatment are dealt with separately in a *Mental Health Act* (1973). In Quebec – which is governed by Civil Law rather than Common Law – involuntary commitment and treatment is regulated by the mental disorder provisions contained in the *Civil Code of Quebec* (1991) and is complemented by *An Act Respecting the Protection of Persons whose Mental State Presents a Danger to Themselves or to Others* (2002).

The inter-provincial differences in the legal structures of involuntary commitment and treatment are a consequence of the constitutional assignment of healthcare to the provinces and territories, rather than the federal government. While some argue that the different approaches to involuntary commitment are accidental (Savage & McKague, 1987), others suggest that the variability in the legislation for involuntary commitment reflects differences in values (Hoyer, 2000). Savage & McKague (1987) argue that ‘mental health’ legislation in most provinces is a misnomer and should be referred to as “legislation on the procedures for dealing with persons who are institutionalized” (p. 256). Mental health legislation of most provinces and territories focus heavily on pathology, institutional services, and involuntary care (Goering et al., 2000; Savage & McKague, 1987). A few provinces and territories briefly mention non-institutional mental health services in the introductory sections of their mental health statutes; however, considerably greater attention is directed toward involuntary hospitalization and treatment.

3.2.2 Purpose of Involuntary Commitment

Involuntary commitment serves different, and often incompatible, purposes. In Canada, the primary purpose of all forms of involuntary commitment is to protect society through the control of deviance and dangerousness, as is defined by the various provincial/territorial mental health statutes. Mental health legislation accomplishes this goal by removing ‘harmful’ or ‘dangerous’ people with mental illness from society and detaining them in hospitals. With the advent of compulsory community treatment, this goal can also be achieved by restricting the freedom of people with mental illness while they live in the community. In this regard, the value of public safety is prioritized ahead of the mentally ill individual’s right to liberty (Brown & Murphy, 2000). Since the mental health system is the vehicle for carrying out involuntary commitment, it also assumes a protective function for society (Henry, 2001). The protective function of the mental health system is most evident when persons are indeterminately detained in hospital under involuntary commitment legislation without receiving any further treatment (see *Starson v. Swayze*, 2003), which is permitted in several Canadian jurisdictions.

A secondary purpose of involuntary commitment, based on the welfare standard, is to relieve the suffering of persons who live with mental illness (Brown & Murphy, 2000; Gray & O'Reilly, 2005). Under the principles of *parens patriae*, the State uses involuntary commitment legislation to protect the welfare of mentally ill persons who, due to their mental state, are incapable of realizing their own treatment needs. Involuntary commitment can be regarded as a product of the State’s moral obligation to relieve the suffering of its citizens (Hoyer et al., 2002). By treating the underlying mental illness, which is presumed to be the cause of the dangerousness, involuntary commitment

simultaneously addresses the health needs of people with mental illness and the protective needs of society (Henry, 2001).

The third purpose of involuntary commitment legislation is to establish substantive and procedural protections through every stage of the commitment process (Gray et al., 2002; O'Reilly 2004). The protection of legal rights is not an actual objective of involuntary commitment, *per se*; however, it is an essential element of the provincial/territorial mental health statutes. Therefore, rules are legally enshrined in mental health legislation – in a manner that respects the *Canadian Charter of Rights and Freedoms* (1982) – to deal with issues such as the initial apprehension and detention of mentally ill persons, the assessment and certification processes, certification review and renewals, mental capacity and treatment consent, and discharge from hospital.

Commendably, a few Canadian jurisdictions (e.g., the Yukon, Nova Scotia) have explicitly articulated the rights of mental health patients within their mental health legislation. The policy-makers of a few provinces/territories, including British Columbia, have refused to budge from their welfare-based approach. Consequently, in these jurisdictions, individuals with mental illness may be civil committed under a broad range of circumstances such as concerns that they may be at substantial risk for physical or mental deterioration. In contrast, other Canadian jurisdictions have moved toward ensuring that the liberty rights of people with mental illness are restricted in only the narrowest of circumstances, which has shifted the fundamental philosophy of involuntary commitment away from the broadly-defined welfare standard and towards the narrowly-defined societal protection, or dangerousness, standard (Brown & Murphy, 2000; Hoyer, 2000; Poletiek, 2002). Despite this, critics have recently begun to suggest that, in Canada, the pendulum is swinging back toward a mental policy framework that encourages

“paternalism, interventionism, coercion and clinical discretionary powers” (Kaiser, in press).

3.2.3 Involuntary Treatment

“The right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy” (Justice Major, *Starson v. Swayze*, 2003, para. 75). Despite this principle, individuals who are involuntarily hospitalized can be forced to submit to treatment. Taking away a person’s right to refuse treatment and forcing them to ingest mind-altering drugs may be the most serious and prevalent infringement of civil liberties in our society today. Is this infringement justified in a free and democratic society? Proponents of involuntary treatment argue that the State has an obligation to assist mentally ill persons who are incapable of making autonomous decisions because of their impaired cognitive functioning and judgement, as is articulated by Chief Justice McLachlin in the Supreme Court of Canada:

The policy of the law is that where a person, due to mental illness, lacks the capacity to make a sound and considered decision on treatment, the person should not for that reason be denied access to medical treatment that can improve functioning and alleviate suffering. Rather, that person's incapacity should be recognized and someone else appointed to make the decision for him or her. (*Starson v. Swayze*, 2003, para. 9)

In fact, many would argue that involuntary treatment legislation preserves an individual’s personal safety, protects their right to receive treatment, and aims to restore their liberty and freedom. Opponents of involuntary treatment argue that such a violation of fundamental civil rights is legally unjustifiable and is morally inexcusable.

In Canada, the involuntary treatment of a person with mental illness is permitted

by every jurisdiction. All provinces/territories allow for the forced treatment of certain individuals who are under the authority of mental health legislation; however, the legal practices and procedures for determining who should be involuntarily treated differ substantially. The involuntary treatment models that exist in Canada are reviewed below, which is followed by an examination of the key concepts of ‘consent’ and ‘capacity’.

3.2.3.2 Involuntary Treatment Models

Models of involuntary treatment are differentiated by the degree to which legislation respects an individual’s autonomy subsequent to being involuntarily hospitalized or being declared mentally incapable. Conversely, the involuntary treatment models vary according to the amount of power given to the State for making treatment decisions on behalf of those who are involuntarily hospitalized. Gray and O’Reilly (2001) have categorized Canadian involuntary treatment legislative approaches into *State authorization* versus *private authorization* models, depending on who is appointed to make treatment decisions for mentally incapable persons. The State authorization model can be further divided into consent-based and non-consent-based approaches.

In the *State authorization* model, an appointee of the State authorizes treatment for involuntarily hospitalized individuals who are deemed incapable of making treatment decisions (Gray & O’Reilly, 2001). State agents, such as hospital directors, attending physicians, or courts/tribunals, decide on the treatment plan for incompetent individuals based on what they perceive to be in the best interests of the person. In certain State authorization models, such as those used by New Brunswick and Quebec, treatment decisions can only be made by the State after a person is both involuntarily hospitalized

and declared mentally incapable of consenting to treatment. Under this approach, involuntarily hospitalized, cognitively competent persons retain the right to give or refuse treatment. In other State authorization models, as in British Columbia, individuals need only to satisfy the criteria for involuntary hospitalization in order for the State to begin making treatment decisions. This also applies to individuals who are adjudicated NCR-MD and are detained in a forensic psychiatric hospital. These non-consent-based approaches permit involuntary treatment to be forced on persons who have the capacity to refuse treatment. Saskatchewan also uses a State authorization model; however, it is the only Canadian jurisdiction to include ‘incapacity’ as a criterion for involuntary hospitalization. Consequently, only mentally incapable persons can be involuntarily hospitalized and involuntarily treated.

In the *private authorization* model, a proxy decision-maker is appointed to make treatment decisions on behalf of involuntarily hospitalized persons who are declared mentally incompetent (Gray & O'Reilly, 2001, 2005). In contrast to the *State authorization* model, an agent of the patient, rather than the State, is authorized to make treatment decisions. The provinces and territories have different procedures for appointing proxy decision-makers, but the proxies typically include guardians, spouses, family members, or next of kin. If an agent of the patient cannot be found, then a public guardian is typically appointed as the patient’s proxy decision-maker. Under the private authorization model, forced treatment cannot be imposed on individuals who are capable of making treatment decisions.

Contrasting principles and values underlie the State and private authorization models of involuntary treatment. The *State authorization* model is indicative of a social welfare model, in which State power is used to ensure the health and well-being of

citizens. In the *State authorization* model, the process of finding and appointing appropriate proxy decision-makers is perceived as a hindrance to providing treatment in an expedient manner. Another underlying principle of the *State authorization* model is that trained medical professionals possess the best understanding of the treatment needs of persons suffering from mental illness, which is in keeping with the welfare purpose of involuntary commitment. In contrast, the *private authorization* model exemplifies a civil rights model, in which the principles of autonomy, liberty, and due process are prioritized and State interference is minimized. Under the *private authorization* model, the State is given considerably less power to intrude in the lives of mentally ill persons who are declared mentally incompetent. Both involuntary treatment models have strengths and weaknesses. Because of the focus on expediency, the *State authorization* model may (in the short term) accelerate a patient's recovery, reduce hospital stays, and reduce usage of physical restraints during the initial phase of hospitalization (Brown & Murphy, 2000). Legislation that permits the State to impose treatment on all involuntarily hospitalized patients circumvent the troubling scenario in which persons are involuntarily detained but do not receive treatment because they refuse to consent. On the other hand, the *State authorization* model is overly paternalistic, and the non-consent-based approach, which endorses the forced treatment of mentally competent individuals, has been heavily criticized for violating fundamental constitutional rights (Bloom, 2004; Brown & Murphy, 2000; Hoyer, 2000).

The *Canadian Charter of Rights and Freedoms* (1982) provides every citizen with the fundamental freedom of conscience, thought, belief, opinion, and expression (s. 2). The *Charter* (1982) also guarantees every Canadian with the right to life, liberty and security (s. 7), and the right not to be arbitrarily detained or imprisoned (s. 9). As will be

discussed below, the mechanisms of involuntary hospitalization, compulsory community treatment, and involuntary treatment seemingly violate many of these rights and freedoms. Of central importance is whether or not these violations are reasonable and demonstrably justified in a free and democratic society, as per section 1 of the *Charter* (1982).

A significant quandary is produced when people with mental illness threaten the safety of themselves or others. Should the State interfere in the lives of mentally ill persons to protect the safety of the individual and the public? Or, should State interference be suspended until such time when the individual can be controlled by the criminal justice system? Legislative action is only justified when a person is a danger to themselves or others; therefore, mental health statutes should only be applicable to these circumstances. Mechanisms other than involuntary commitment, such as guardianship, home care, or intensive community support (e.g., assertive case management), should be considered in situations in which a person's mental or physical state is deteriorating. State interference in the lives of people with mental illness must be done with the utmost respect for liberty rights; therefore, the State's interest in forcing treatment on those who are involuntarily hospitalized should not be prioritized over a person's right to refuse unwanted medical treatment. Unfortunately, partly on account of Canada's fragmented and under-funded mental health system, involuntary commitment is a necessary practice. It is also unfortunate that provincial/territorial governments have looked towards expanding coercive mental health treatment practices, such as compulsory community treatment, to compensate for other problems within our current mental health system (Kaiser, in press).

3.2.3.1 Consent and Capacity

Treatment consent is an expression of willingness to comply with a prescribed treatment plan. An individual's choice to give or refuse treatment consent is legally valid if it satisfies three conditions – voluntariness, informed, and capacity (Savage & McKague, 1987). A pure voluntariness standard requires that a decision be the result of free will and not influenced by coercion or duress (Somerville, 1994). Individuals who are involuntarily detained in hospital may be pressured to comply with treatment due to fears that their refusal to cooperate will result in continued hospitalization or treatment against their will. Since involuntary commitment is inherently coercive, it is doubtful that decisions made within this context can satisfy a pure voluntariness standard. Therefore, it must be concluded that a modified voluntariness standard, which excuses the coercive factors normally present in an involuntary commitment setting, is employed in the context of involuntary commitment legislation. The second condition of consent requires that the decision be informed. Informed consent implies that the person has been provided with necessary information about the nature of the treatment, including all the known risks of the treatment and the risks of not undergoing treatment (*Reibl v. Hughes*, 1980). An individual has not consented to treatment unless they have been informed of all the risks; psychiatric treatment that is performed without disclosure of all the risks is negligence (*Reibl v. Hughes*, 1980). The third condition of consent requires that the individual has the necessary mental capacity to make decisions. Treatment consent is not valid unless the mental capacity condition is satisfied, regardless of whether the 'voluntariness' and 'informed' conditions are met.

Having a mental illness or being committed to a psychiatric hospital does not, in

most jurisdictions, necessarily mean that an individual is incapable of refusing or consenting to treatment. In Ontario, for example, individuals are presumed to be mentally competent and entitled to make their own treatment decisions unless it is demonstrated, on the balance of probabilities, that they are incompetent or incapable (*Starson v. Swayze*, 2003). The serious effect that a declaration of mental incompetence has on a person's autonomy and liberty should necessitate a rigorous and thorough evaluation of mental capacity. Mental capacity is dynamic – changing with time, circumstances, and context. Accordingly, incapacity decisions should be reviewed frequently. As well, all-encompassing incapacity decisions should be avoided, since individuals who are incapable of making decisions in one area may be capable in other areas. Indeed, Ontario's *Health Care Consent Act* (1996) explicitly recognizes that mental capacity is dependent on both time and context (s. 15).

The evaluation of mental capacity is typically performed by a psychiatrist or physician and focuses on an individual's cognitive ability to make decisions, rather than on the appropriateness of the actual decision. In *Starson v. Swayze* (2003), the Supreme Court of Canada outlined a two-pronged test of mental capacity. The cognitive capacity test is essentially an assessment of a person's ability to understand the treatment-related information and their appreciation of the consequences that may result from a decision to either comply with or refuse the treatment (*Starson v. Swayze*, 2003). To satisfy the first prong of the cognitive capacity test, the individual must "be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks" (Chief Justice McLachlin, *Starson v. Swayze*, 2003, para. 16). This includes acknowledging their symptoms (though, not necessarily the illness), understanding the nature and purpose of the proposed treatment, and recognizing how

their symptoms may be affected by the proposed treatment (*Starson v. Swayze*, 2003). The second prong requires the person to be able to weigh the benefits and consequences of refusing or consenting to the proposed treatment. Whether or not a person's evaluation is consistent with their physician's opinion is inconsequential. Individuals who are mentally competent have the right to disagree with the proposed course of treatment. As Chief Justice McLachlin emphasised, disagreement does not qualify an individual for an incapacity designation: "It is crucial to guard against interpreting disagreement with a particular diagnosis or proposed treatment plan as itself evidence of incapacity" *Starson v. Swayze*, 2003, para. 19). The Supreme Court of Canada's ruling in *Starson* (2003) applies to the situation in Ontario, which may not – at this point in time – generalize to the legislative schemes of other Canadian jurisdictions.

The concepts of 'consent' and 'capacity' are vitally important to both involuntary hospitalization and treatment. Capacity to consent is a necessary requirement for voluntary admission to a psychiatric hospital. Statutory tests of capacity ensure that treatment is not forced on people with mental illness who are capable of making their own treatment decisions. Forcing medical treatment on the cognitively capable without consent constitutes a violation of human dignity and autonomy. Savage and McKague (1987) argue that the right to choose what is done to one's body separates the practices of "democratic countries from those in totalitarian regimes" (p. 134). Yet, even within a democratic country such as Canada, 'consent' and 'capacity' are valued to a different degree across the land. The fact that a person is mentally capable of making treatment decisions does not necessarily save them from involuntary treatment in certain jurisdictions of Canada.

3.2.4 Involuntary Hospitalization

Involuntary hospitalization strictly concerns the detention of individuals in an inpatient psychiatric setting without their consent. The criteria for involuntary hospitalization vary among Canadian jurisdictions. Involuntary hospitalization, in every Canadian province/territory, requires that the person has a mental illness and is not willing to be voluntarily hospitalized. If an individual meets these two criteria, and is also deemed at risk for harming themselves or the public, then they can be involuntarily hospitalized in any Canadian province/territory. This section will examine issues related to the criteria for involuntary hospitalization in Canada.

3.2.4.1 'Non-Voluntary' Criterion

Most people with mental illness who access services in the mental health system do so voluntarily. It is unnecessary for the State to involuntarily hospitalize people with mental illness who are capable of consenting to a hospital admission and who voluntarily choose to be admitted. The *Mental Health Act* of Ontario (1990) states the following about voluntary admissions: “Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient” (s. 14). The sentiment of this statement is reflected in the mental health statutes of every Canadian province and territory. The purpose of this criterion is to encourage people with mental illness to voluntarily seek treatment, to encourage active participation in their treatment, and to ensure that their liberty rights are respected. As Gray and O’Reilly (2001, 2005) point out, no special legislation is needed for such voluntary patients; however, within the context of mental health legislation, the distinction between the voluntary and involuntary

patient is especially complex and tenuous. For example, people with mental illness who request to be hospitalized may be committed involuntary if they do not have the capacity to consent to the hospital admission. In some jurisdictions of Canada, such as British Columbia, individuals who request a hospital admission and are capable of consenting to the admission may be committed if they are found to be incapable of consenting to treatment. Furthermore, the status of voluntary patients may change to involuntary if they do not comply with the prescribed treatment or if they seek discharge from hospital against medical advice. In all of these circumstances, people with mental illness who enter a hospital voluntarily may find themselves under the authority of provincial/territorial mental health statutes.

3.2.4.2 'Mental Disorder' Criterion

A person must be suffering from a mental illness/disorder in order to be involuntarily hospitalized. Hoyer (2000) states that the basic criterion of a mental disorder is “an absolute condition in all western mental health legislation as well as in relevant human rights declarations and ethical guidelines addressing the mental health care sector” (p. 65). While this criterion seems straightforward, an inspection of different mental health statutes reveals the nebulous nature of the concept of ‘mental disorder’ (see Gray & O’Reilly, 2001). Indeed, even the American Psychiatric Association (2000) has difficulty defining the term ‘mental disorder’: “...it must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder’” (p. xxi). Imprecise definitions of ‘mental disorder’ also exist in the mental health statutes of the provinces and territories (Savage & McKague, 1987).

Some provinces have chosen to define ‘mental disorder’ broadly in their mental health legislation. For example, the mental health statutes of both Newfoundland and Ontario define a mental disorder as meaning any disease or disability of the mind. The Nova Scotia *Hospitals Act* (1989) adopts the same broad definition, but specifies that mental disorder includes alcoholism and drug addiction. These are the only three Canadian jurisdictions in which non-severe, untreatable conditions, such as mental retardation, may potentially qualify as a mental disorder (see Gray & O'Reilly, 2001). The BC *Mental Health Act* (1996) has also adopted a broad definition of mental disorder, but specifies that the disorder must require treatment and must impair the person’s ability to react appropriately to their environment or to associate with others. Every other province and territory in Canada more precisely characterizes ‘mental disorder’ as a substantial disorder of thought, mood, perception, orientation, memory, or feeling that grossly impairs judgement, behaviour, the capacity to recognize reality, or the ability to meet the ordinary demands of life. Additionally, Saskatchewan’s *Mental Health Services Act* (1984-85-86) requires that the condition be treatable in order to be classified as a ‘mental disorder’ for the purposes of involuntary hospitalization.

Broad legal interpretations of the meaning of ‘mental disorder’ have led to unusual applications of involuntary hospitalization. Inpatient commitment legislation in some countries has expanded the scope of ‘mental disorder’ to include personality disorders and sexual disorders. In the United States and Britain, dangerous sexual offenders can be involuntarily committed on the basis of psychopathic personality disorders (see Fitch & Ortega, 2000; Henry, 2001). In Ontario, the Courts have ruled that pedophilia satisfies the broad definition of ‘mental disorder’ under the Ontario *Mental Health Act* (1990). Therefore, sexual offenders in Ontario are able to be confined in a

hospital under involuntary commitment legislation after they are released from prison (see *Penetanguishene Mental Health Centre v. Stock*, 1994; *Starnaman v. Penetanguishene Mental Health Centre*, 1995) – a practice known as ‘psychiatric gating’ (Hannah-Suarez, 2005). Henry (2001) argues that “these offenders do not clearly fit within the boundaries or the mandate of the mental health system, which is to confine and treat those with an identifiable mental disorder” (para. 38). Clearly, the flexibility of the concept of ‘mental disorder’ supplies the State with substantial protective powers under mental health statutes that are not available through criminal justice legislation.

3.2.4.3 ‘Harm’ Criterion

As is mentioned previously, the practice of inpatient commitment principally serves a protective function. Persons with mental illness who satisfy a ‘harm’ or ‘threat to society’ criterion may be involuntarily hospitalized. In all Canadian jurisdictions, inpatient commitment is applicable to self-harm and harm directed toward others (threatened, attempted, or performed); however, the provinces and territories differ in their interpretation of what type of event qualifies as ‘harm’ (Brown & Murphy, 2000). In provinces such as Alberta, Quebec, and Ontario, only physical injury will satisfy the ‘harm’ criterion of their mental health statutes (Gray & O’Reilly, 2001). In contrast, the mental health statutes of British Columbia, New Brunswick, and Manitoba, define ‘harm’ as being both physical and psychological, which may include harm in the areas of social functioning, family, employment, or finances (*McCorkell v. Director of Riverview Hospital*, 1993). In several provinces, the ‘harm’ criterion is broadly characterized to allow for the commitment of individuals on the basis of future mental or physical

deterioration. Ontario and the Yukon extend the ‘harm’ criterion to encompass serious physical injury that is likely to result from an individual’s inability to care for themselves. Rather than specifying the type of ‘harm’ that may lead to involuntary hospitalization, other provinces, such as Saskatchewan, Newfoundland, Nova Scotia, and Prince Edward Island, vaguely refer to the ‘harm’ criterion as ‘an individual’s own safety or the safety of others’.

The definition of ‘harm’ in provincial/territorial mental health statutes also differs in relation to the degree of risk, the severity, and the immediacy of the harmful event. For involuntary hospitalization, most jurisdictions require that an individual’s current mental condition will *likely* result in *substantial* or *serious* harm to themselves or others. The term ‘likely’ has generally been interpreted as simply meaning probable, rather than *highly* probable (Brown & Murphy, 2000). Mental health statutes do not generally articulate how imminent the harm must be to satisfy the ‘harm’ criterion. On issues of physical or mental deterioration, the mental health statutes of the Yukon, Northwest Territories, and Nunavut specify that the harm must be “impending” or “imminent”. On the other hand, Brown and Murphy (2000) indicate that the Ontario Courts are willing to look weeks into the future. Interestingly, in 2000, the term ‘imminent’ was removed from the commitment criteria of the Ontario *Mental Health Act* (1990) due to the apparent “misapplication” and “widespread confusion” over the term (Ontario, 2000). In comparison with other Canadian provinces/territories, New Brunswick’s definition of ‘harm’ as a “substantial risk of imminent physical or psychological harm to the person or to others” is the least ambiguous. The concepts of ‘harm’ and ‘threat’ are also contained in the mental disorder provisions of the *Criminal Code* (1985) and have been recently clarified by the Supreme Court of Canada. In the case of *Winko* (1999), Justice

McLachlin indicates that the threat must be significant, the risk must be real, and the harm must be serious and criminal in nature. However, it is uncertain if the Supreme Court's interpretation of 'harm' and 'threat' in the criminal justice arena can be transferred to civil mental health matters (see *McCorkell v. Director of Riverview Hospital*, 1993).

The 'harm' (or dangerousness) criterion for inpatient commitment has gained importance in Canadian mental health legislation (Poletiek, 2002). Not only does this reflect the willingness of society to impinge on the liberty rights of persons who are perceived as dangerous, but, ironically, the 'harm' criterion also decreases the use of involuntary hospitalization by narrowing the circumstances in which it can be applied (Brown & Murphy, 2000; Fitch & Ortega, 2000; Hoyer, 2000). The focus on issues of dangerousness rather than need for treatment has led some to argue that inpatient commitment legislation has become anti-therapeutic and that the civil mental health system has moved too far towards the criminal justice philosophy (Bloom, 2004; Brown & Murphy, 2000).

3.2.4.4 Other Involuntary Hospitalization Criteria

The mental health statutes of some provinces and territories have additional considerations for involuntary hospitalization. Some provincial/territorial mental health statutes require the consideration of less restrictive treatment options before involuntary hospitalization can occur. For example, New Brunswick's *Mental Health Act* (1973) states that involuntary commitment may proceed only if "less restrictive alternatives would be inappropriate" (s. 8.1.c). Nova Scotia's *Involuntary Psychiatric Treatment Act*

(2005) also articulates the principal that “treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person’s home surroundings at the earliest possible time” (s. 2(c)). An additional consideration for involuntary hospitalization is the need for treatment, which exists in British Columbia, Manitoba, Saskatchewan, and Nova Scotia. Likewise, in Ontario, involuntary patients who are not detained under the *Criminal Code* (1985) and who are no longer need care, treatment, and observation must be discharged from a psychiatric facility. While these provinces require that the involuntarily hospitalized individual is in need of treatment, it is unclear what is meant by ‘treatment’ (see Brown & Murphy, 2000; Richardson, 2005).

3.2.5 Compulsory Community Treatment

Compared to involuntary hospitalization, the practice of compulsory community treatment – also known as community commitment – is a relatively new phenomenon in Canada. Compulsory community treatment is the latest product of the deinstitutionalization movement, in which the locus of treating mental illness was transferred from the hospital to the community (Trueman, 2003; Winick, 2003).

Community-based mental health services have become the primary means of treating and supporting persons with mental illnesses, and psychiatric hospitalization is now primarily used in emergency/crisis situations and for treating severe, persistent mental illnesses that cannot be adequately dealt with in the community. Consistent with the notion that people with mental illness should be treated in the least restrictive setting, compulsory community treatment provides another strategy for those who are not in need of

traditional involuntary hospitalization, but still require treatment, supervision, and support. The mental health legislation of a few provinces and territories do not formally contain any community commitment provisions; however, the movement of mental health systems towards less restrictive treatment alternatives suggests that these jurisdictions will soon establish some form of community commitment (Gray & O'Reilly, 2005).

The two types of compulsory community treatment that exist within Canada are extended leaves and community treatment orders (Gray & O'Reilly, 2005). Extended leaves are available in several Canadian jurisdictions, such as British Columbia, for involuntarily committed persons who do not require hospitalization, but need ongoing treatment and support. Essentially, an extended leave enables a psychiatric hospital to transition an individual into the community and to evaluate the person's ability to function in the community. The extended leave must be consented to by either the individual or their proxy decision-maker. A person who no longer satisfies the involuntary hospitalization criteria must be discharged from the extended leave without any further restrictions. Those who are on extended leave remain under the control and supervision of a psychiatrist and are required to comply with a prescribed treatment plan and other conditions. Failure to comply with the conditions of the leave will result in the person being involuntarily re-hospitalized. The length of time in which a person may remain on extended leave varies between the different jurisdictions, but generally ranges from ten days to three months (Gray & O'Reilly, 2005). British Columbia will only grant an extended leave if the necessary services exist in the community to meet the conditions of the leave. Prior to granting an extended leave, Manitoba's *Mental Health Act* requires the individual's been either hospitalized for at least 60 days or admitted at least three times within the last two years. Since 2005, this same criteria has been used in Nova

Scotia prior to granting a community treatment order. Extended leave provisions enable the gradual reduction of restrictions that are imposed on involuntarily hospitalized persons, but persons must be hospitalized in order to receive this type of community support.

Community treatment order provisions were added to the mental health statutes of Saskatchewan in 1994, Ontario in 2000, and Nova Scotia in 2005 (O'Reilly, 2004; O'Reilly et al., 2003). Similar to the extended leave, the community treatment order provides a less restrictive alternative to treat persons who satisfy the involuntary hospitalization criteria, but who do not require hospitalization. Unlike the extended leave, community treatment orders may be imposed on people who are living in the community at the time of the order. The community treatment order requires that a person has recently had a pattern of repeated psychiatric hospitalization and the order will only be granted if the proper services exist in the community and are available to be used. In Canada, community treatment orders must be consented to by either the patient or their proxy decision-maker. The community treatment order is designed to support persons with severe mental illness who frequently use hospital-based services and have difficulty with treatment compliance or following a treatment plan in the community. For a variety of reasons, treatment compliance is a significant problem for persons with severe mental illness (Adewuya et al., 2009; Awad & Voruganti, 2004; Velligan et al., 2009). A community treatment order tries to address this problem by legally requiring persons to follow a community treatment plan in the hope that the added supervision and support will reduce the likelihood that they will require repeated hospitalization. The community treatment order is also designed to prevent relapse, homelessness, and incarceration (Swartz & Swanson, 2004).

As discussed in the previous section, the conditional discharge of persons adjudicated ‘Not Criminally Responsible on account of Mental Disorder’ is another form of compulsory community treatment in Canada. Other types of compulsory community treatment that exist in jurisdictions outside of Canada, such as the United States, include diversionary community treatment orders and preventative commitment (O'Reilly, 2004; O'Reilly et al., 2003; Winick, 2003). Diversionary community treatment orders and preventative commitment are used to treat and support severely mentally ill persons who do not fully satisfy involuntary hospitalization criteria (O'Reilly et al., 2003). The diversionary community treatment orders require consent by the mentally ill person or their proxy decision-maker; consent is not required for preventative commitment. Under preventative commitment, persons are court-ordered to comply with a proposed treatment plan regardless of whether or not the patient has consented (Winick, 2003). Both approaches aim to prevent hospitalization and significant mental decompensation by identifying mentally ill persons who will likely deteriorate unless they are supplied with support and treatment (O'Reilly et al., 2003; Winick, 2003). However, these two approaches also have low thresholds in relation to involuntary commitment standards, which also expand the circumstances in which restrictions can be placed on the freedoms of people with mental illness.

The core principle of compulsory community treatment in many jurisdictions outside of Canada is that services should be provided to people with mental illness in the least onerous and least restrictive manner (Kaiser, in press; Winick, 2003). While the ‘least restrictive’ requirement is explicitly articulated in the mental health legislation of some provinces/territories (e.g., Nova Scotia, New Brunswick), most provincial/territorial *Mental Health Acts*, including that of British Columbia, fail to mention this basic

requirement (Kaiser, in press). Compulsory community treatment provides the option for people with mental illness to receive treatment while living in the community, which is considered to be a less restrictive setting than a hospital. Gray and O'Reilly (2005) assert that compulsory community treatment, particularly the models used within Canadian jurisdictions, exemplifies the 'least restrictive' legal principle; however, this is debated within the literature (Bloom, 2004). For example, Kaiser (in press) insists that compulsory community treatment schemes legitimate the use of coercive mental health practices, expand the legislative scope of civil commitment, and enhance the power of psychiatrists:

Canadian mental health legislation has continued its devotion to specifying conditions for coercive interventions, with its historic concentration on involuntary assessments, detention and treatment within psychiatric facilities and its more recent extension of its tentacles well into the community through leave certificates and community treatment orders (CTO's). The typical mental health statute evinces almost complete silence on human rights protections, equality rights and discrimination, health promotion, crisis prevention and positive rights to supports and services based upon a broad conception of health determinants (Overview section, para. 2).

Since consent is required for all forms of compulsory community treatment in Canada, some suggest that it is likely that many of these persons would be willing to participate in a treatment plan that does not involve coercion or committal (Dawson, Romans, Gibbs, & Ratter, 2003). Hoyer (2000) reminds us that "...the alternative to coercion is not to abandon the patient" (p. 70). Indeed, the least restrictive and least onerous approach to mental health treatment is not community commitment; rather, it is a mental health system that provides appropriate levels of support, has continuity between service delivery agencies, and makes a concerted effort to engage people in treatment, thereby eliminating or minimizing the need for coercion and commitment (Winick, 2003). The

narrow focus of federal and provincial/territorial health legislation and over-reliance on hospital-based services has resulted in insufficient resources for community-based mental health systems (Goering et al., 2000). Even though deinstitutionalization has occurred, the institutional approach to mental health treatment – which associates treatment with coercion – is still evident in community treatment practices (Trueman, 2003).

3.3 SUMMARY

The continued existence of compulsory community treatment legislation in Canada suggests that our society has endorsed a model of care that handles certain individuals with mental illness with elevated amounts of legal leverage and coercion. This is particularly true in British Columbia, which continues to be one of the few provinces to impose involuntary treatment on people with mental illness regardless of their capacity to make such decisions. As well, the establishment of a specialized forensic mental health system in British Columbia indicates the public support of a model for delivering mental health services that prioritizes public safety. In both cases, society has identified a ‘problematic’ subgroup of people with mental illness and has employed legislative means to ensure a normative status of compulsory wellness by curtailing individual freedom, autonomy, agency, and liberty; a phenomenon that applies to no other health condition.

The degree to which compulsory treatment contributes to self-stigma experiences among people with mental illness is an important empirical question. As was revealed by the literature review, a high level of self-stigma is associated with hopelessness, poorer self-esteem, lowered empowerment/ mastery, reduced self-efficacy, decreased quality of life, and weakened social support/ integration. Although the implications are significant,

few studies have examined the impact of compulsory community treatment on the level of self-stigma for people with mental illness. In fact, the literature review uncovered only one quantitative study to date that has examined the relationship between stigma and compulsory mental health treatment (Link et al., 2008). Although, several qualitative studies have investigated the affects of legal coercion on the subjective experiences of people who use mental health services (Canvin et al., 2002; Gibbs et al., 2006; O'Reilly et al., 2006; Tan et al., 2010), none have specifically focused on perceptions and experiences of self-stigma. The study described below addresses this research gap by focusing on the influence that the aforementioned policy frameworks have on the subjective experience of self-stigma (assessed quantitatively and qualitatively) for people with mental illness who are legally mandated to receive community mental health treatment services.

In order to truly understand the pernicious effects of self-stigma on the lives of people with mental illness, it is imperative to examine adverse affects on other domains of life. For the present study, quality of life has been selected as the main dependent variable because it encompasses several key domains for people with mental illness, including subjective well-being and satisfaction, functioning in daily life, and external resources (Katschnig, 2000). While there are several cross-sectional studies that have assessed the relationship between self-stigma and quality of life, few studies have been carried out using longitudinal research designs. Longitudinal research is needed to disentangle the temporal order of events or outcomes, such as stigma and quality of life. Moreover, no published studies, to date, have described the relationship between self-stigma and quality of life among people with mental illness who receive compulsory

community treatment services. Findings of the present study will contribute to both of these areas of research.

Another important question that will be considered below is the extent to which the structure of forensic mental health systems impacts on the experience of self-stigma for people who use such services. Indeed, in an effort to do things in a more cost-effective manner, governments are seeking evidence that will inform decisions about optimal ways of organizing services (e.g., health, correctional, criminal justice). Regarding forensic mental health services, questions remain unanswered regarding the relative strengths and weaknesses of specialized and integrated models. What model is most effective? What model has the least adverse consequences? To date, there has been ample conjecture, but little empirical evidence (Coid, Hickey, & Yang, 2007; Crocker & Cote, 2009; Hodgins et al., 2007; Ontario, 2002; Seto, Harris, & Rice, 2004). In particular, research has not yet documented the whether highly-specialized forensic mental health systems, and ‘forensic’ labelling processes, contribute to the self-stigma experiences for individual who use these services. Margetic and colleagues (2008) have examined self-stigma among people who use forensic mental health services; however, their study had a number of methodological limitations such as a weak measure of self-stigma and lack of comparison group. The present study is designed to address the aforementioned system-level questions in a more precise manner by using standardized measures of self-stigma and by comparing the experiences of forensic and non-forensic mental health services users.

CHAPTER 4: RESEARCH OBJECTIVES AND METHODS

4.1 RESEARCH OBJECTIVES

The overall objective of this research is to gain a better understanding of the self-stigma experiences of those individuals with severe mental illness who are receiving compulsory community treatment in the forensic and civil mental health systems of British Columbia. The specific research objectives and hypotheses are:

1. To describe the level of self-stigma that is experienced by people with mental illness who receive compulsory community treatment and the degree to which it changes over time. Because this was a descriptive research objective, it was not guided by specific hypotheses.
2. To assess the degree to which group membership (forensic versus civil) contributes to experiences of self-stigma. It was hypothesized that higher levels of self-stigma would be found among participants in the forensic cohort compared to those in the civil cohort.
3. To identify the sociodemographic, psychosocial and clinical correlates and predictors of self-stigma for people with mental illness who receive compulsory community treatment. Because this was an exploratory research objective, it was not guided by specific hypotheses.

4. To investigate whether self-stigma is a predictor of quality of life for people with mental illness who receive compulsory community treatment. It was hypothesized that self-stigma at T1 would be negatively associated with quality of life at T2.

4.2 PARTICIPANTS

At the time of recruitment, each research participant was receiving compulsory community treatment services within the civil or forensic mental health systems of British Columbia. For the purpose of this study, the civil mental health system refers to publicly-funded, therapeutic and support services that provide assessment, treatment, and rehabilitation to people living with mental illness (see Goering et al., 2000; Canada, 2004). Inclusion criteria for the civil mental health cohort were: (i) certified under the British Columbia *Mental Health Act*; (ii) discharged from hospital on extended leave; (iii) has been on extended leave for at least 30 days; (iv) residing in the community within Metro Vancouver, British Columbia; (v) 18 to 65 years of age; (vi) capable of providing research consent; (vii) capable of communicating in English; (viii) diagnosed with either schizophrenia, other psychotic disorder, or bipolar disorder by their treating psychiatrist; and (ix) deemed suitable (e.g., clinically stable, not aggressive) to participate in the research by their case manager. Individuals from both cohorts were excluded from the study if they: (i) were deemed unsuitable to participate by their case manager (e.g., clinically unstable, aggressive or hostile, severe health problems); (ii) could not be located; or (iii) were receiving services from a mental health centre that was not an approved recruitment site for the study.

For the purpose of this study, the forensic mental health system is generally defined as publicly-funded, specialized therapeutic and support services that provide assessment, treatment, and rehabilitation to people living with mental illness whose past and/or present behaviour may lead to criminal offending (see Mullen, 2000). The inclusion criteria for the forensic mental health cohort were: (i) adjudicated ‘Not Criminally Responsible on Account of Mental Disorder’; (ii) conditionally discharged from the British Columbia Forensic Psychiatric Hospital; (iii) has been on conditional discharge for at least 30 days; (iv) residing in the community within British Columbia; (v) 18 to 65 years of age; (vi) capable of providing research consent; (vii) capable of communicating in English; (viii) diagnosed with either schizophrenia, other psychotic disorder, or bipolar disorder by their treating psychiatrist; and (ix) deemed suitable (e.g., clinically stable, not aggressive) to participate in the research by their case manager.

4.3 RECRUITMENT AND RESEARCH CONSENT

The research protocol for the present study was approved by the Simon Fraser University Research Ethics Board, as well as the research review boards of the Forensic Psychiatric Services Commission, Riverview Hospital, Vancouver Coastal Health Authority, and Fraser Health Authority. All of the procedures described below were performed by either the principal investigator or a trained graduate-level research assistant.

A purposive sampling method was used to recruit the study participants. Randomized sampling was not a viable option for this study since group membership could not be randomly allocated and the sample size was too small for random selection.

Between April 2006 and December 2008, potential participants were identified by reviewing active case lists that were provided by administrative staff members at three hospitals and 15 community mental health centres throughout British Columbia. Once a potential participant was identified, their community case manager (e.g., psychiatric nurse, social worker) was contacted by phone or email to ascertain whether the individual satisfied the aforementioned inclusion criteria. For individuals who satisfied the inclusion criteria, case managers agreed to provide them with information about the study, including a research recruitment flyer. The research team members were not blinded to the subject allocation (e.g., forensic or civil groups) or the research hypotheses.

Initial contact with individuals who expressed an interest in study participation was coordinated in conjunction with the case manager and was synchronized with the individual's regularly scheduled clinical appointment at their local community mental health centre. Upon initial contact, a member of the research team explained the study, answered questions about the study, and confirmed that the individual was interested in participating in the research. Individuals who confirmed their interest were then asked to sign a consent form that was first orally reviewed by the research team member. All participants provided written consent agreeing to the baseline interview and the one-year follow-up interview. As well, participants provided written consent for a review of their medical charts by the research team and for their case manager to be interviewed in order to gather information about service needs. Each case manager who was interviewed for the study also provided written informed consent for their own participation. Toward the end of the one-year follow-up period, participants were reached using the contact

information that they had provided, or via their community mental health team. At the follow-up interview, the consent form was verbally reviewed with each participant.

4.4 DESIGN AND PROCEDURE

The study used a longitudinal, prospective, cohort design to examine the experiences of people with mental illness who were receiving compulsory community treatment in the forensic and civil mental health systems of British Columbia (Ellis, 1999). A quantitatively-driven mixed method design with a simultaneous qualitative supplemental component (QUAN+qual) was used (Morse & Niehaus, 2009). In the present study, open-ended questions were embedded into a quantitative interview guide, which is a standard technique in projects that use a QUAN+qual approach: “The most common way that qualitative research contributes to quantitatively-driven research is by inserting open-ended questions within a quantitative survey or questionnaire” (Morse & Niehaus, 2009, p. 127). The qualitative component was included in order to compensate for the inadequacies of the quantitative measures for understanding the complexity of the subjective experiences of self-stigma. As is characteristic of a mixed method design, the qualitative component in the present study adds strength to the core quantitative component, but is not designed to stand alone (Morse & Niehaus, 2009).

Since one of the research questions pertains to change over time, the research was designed with two study periods, with a one-year time interval between the baseline (T1) and follow-up (T2) data collection periods. A one-year time interval was chosen for the present study because it is the convention for longitudinal research examining experiences of self-stigma for persons with mental illness (Link et al., 2008; Link,

Struening, Rahav, Phelan, & Nuttbrock, 1997; Mueller et al., 2006; Yen et al., 2009). The one year time interval also removes the possible effects of seasonal variation in mood. Potential problems with longitudinal cohort studies include attrition, effects due to repeated measurement (e.g., burnout, testing effects), and cost (Ellis, 1999).

The primary mechanism for collecting data was self-report, in-person, structured interviews with persons who have a severe mental illness. Data was also collected via retrospective chart reviews and interviews with mental health service providers. The procedures for collecting data at the baseline and follow-up periods are in the following section. The structured interview is a types of interview (i.e., semi-structured, unstructured) that involves collecting self-report data from participants using an established set of standardized questions that are primarily closed ended (McNeill & Chapman, 2005). Structured interviews have the benefit of producing data that is quantifiable and replicable, and may be administered to a large number of participants. Structured interviews are the desired approach when the research objective requires reliable investigation of hypotheses (Crano & Brewer, 2002). A negative feature of this type of interview, compared with an unstructured interview format, is that it relies on deductive approach and predetermines the information that is valuable and important. While standardization in a structured interview is, in once sense, a methodological strength, it may also be considered a major weakness since the lack of flexibly fails to account for variability in the social reality of the participants. Moreover, the structured format has the potential to interfere with building rapport (including trust and openness) between the interviewer and interviewee (Crano & Brewer, 2002; McNeill & Chapman, 2005). Unlike a rigidly prescribed structured interview, the mixed-method approach that

was adopted for the present study provided a degree of flexibility to the interviewer by allowing them to probe participants' responses in order to uncover deeper meaning.

A potential problem with using the interview method for data collection is interview bias, which refers to the influence of interviewer characteristics (e.g., gender, age, social class, and ethnicity) on the types of responses that are provided by interviewees and their willingness to disclose sensitive information (Crano & Brewer, 2002; McNeill & Chapman, 2005). In recognition of this potential problem, the interviewers in the present study made a concerted effort to appear unthreatening, non-judgemental, and sensitive to the participants. As well, underreporting was dealt with by regularly providing encouragement to the participants and by reassuring them of the privacy, confidentiality, and anonymity of their responses (Crano & Brewer, 2002). The intent was to make the interview process as pleasant as possible, so that the participants would be open to sharing their experience and would return for a second interview.

4.4.1 Baseline (T1) Data Collection

Structured interviews were conducted with participants after they agreed to participate in the study. All T1 interviews were conducted in a mental health setting, such as a community mental health clinic or group home, to ensure that support was available to participants if they became emotionally upset. Standardized, quantitative measures were administered during the interviews to query information in relation to participants' experiences with stigma, current symptoms and functioning, quality of life, and use of mental health services. The quantitative measures were supplemented with open-ended questions that were inserted into the structured interview guide. For the stigma-related

questions, the participants were encouraged to provide qualitative responses to explain their answers, which were noted by the interviewer. Interview questions were read aloud to each participant and, to optimize engagement, were also visually displayed on a laptop computer. On average, the T1 interviews with participants lasted for 90 minutes, ranging from 45 minutes to two hours. Each participant was paid 20 dollars for completion of the T1 interview. This modest financial remuneration compensated participants for their time and effort, and provided incentive to a population that is difficult to engage in research (Grady, 2001; Schafer et al., 2010).

As stated earlier, each interview was administered in private by either a graduate-level research assistant or the principal investigator. The research assistant underwent training with the principal investigator, which involved orientation to the standardized interview procedures and direct supervision. The research assistant observed the principal investigator conduct at least three interviews with participants, and then led at least three interviews under the supervision of the principal investigator. Debriefing sessions were held after each training interview and the two interviewers' independent ratings were compared and discussed.

Following the interview with each research participant, a member of the research team reviewed their clinical chart and interviewed their case manager. Clinical chart reviews were performed at the community mental health centre or hospital in which the participant predominantly received treatment services. A standardized coding form was developed by the principal investigator to gather retrospective information from participants' clinical charts, including sociodemographic characteristics, psychiatric history, and criminal justice history.

Interviews with case managers were administered either in person or via telephone, and typically lasted less than 30 minutes. Using the Camberwell Assessment of Need Forensic – Research Version (CANFOR), case managers were asked to assess the participant’s psychosocial difficulties and service needs during the previous month. Following each T1 interview, case managers were provided with a five-dollar gift certificate as a token of appreciation for contributing their time to the research study.

4.4.2 Follow-Up (T2) Data Collection

Data collection for T2 replicated the procedures of the baseline period described above. Approximately one year after the T1 interview (mean = 362.6 days, SD = 59.6 days), all participants were contacted to participate in a second interview. T2 interviews were conducted in either a community mental health centre, a psychiatric group home, a psychiatric hospital, or in the community, depending on where the participant was living. Follow-up interviews with participants were conducted regardless of whether or not they were still living in the community or still receiving compulsory community treatment. For participant interviews, the T1 battery of measures was administered again to query information pertaining to stigma, symptoms, quality of life, and service use. Each participant was paid 30 dollars for completion of the T2 interview. An abbreviated version of the CANFOR was administered to case managers for the T2 staff interview.

4.5 MEASURES

Structured interviews were conducted using several standardized quantitative measures pertaining to stigma, symptoms and functioning, quality of life, mental health

service use, and service needs, as is summarized below. Three measures of self-stigma were chosen (as opposed to one), because, at the time, none of the instruments was supported by a large body of research. These three self-stigma measures (ISMI, ISE, MCESQ) were selected because they appeared to cover the most relevant topics for the research questions that were being asked within the present study. For the reasons articulated in Section 2.3.2.3, all three tools have been categorized as measures of self-stigma. The measure of symptoms and functioning (BASIS-24) was chosen for the present study because of its brevity, readability, and strong psychometric properties. It was anticipated that the statistical analysis would need to control for variability in psychiatric symptom severity. The quality of life measure (WQL) was selected primarily on the basis of a recommendation by a respected researcher who had administered the instrument to a similar population. The service use (CCHS) and service needs (CANFOR) measures were chosen because, at the time, they were the only available standardized tools for assessing those particular areas.

4.5.1 Internalized Stigma of Mental Illness (ISMI)

Self-stigma was measured on the Internalized Stigma of Mental Illness (ISMI) scale. The ISMI is a self-report questionnaire that is designed to measure the internalized, subjective experiences of stigma for people living with mental illness (Ritsher et al., 2003). The ISMI consists of 29 items and contains five subscales: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, and Stigma Resistance. The Alienation subscale consists of six items that measure the subjective experience of being devalued by society. The Stereotype Endorsement subscale contains seven items that

measure the extent to which participants agree with common stereotypes about people with mental illness. The Discrimination Experience subscale has five items that measure respondents' perception of how they, as persons with mental illness, are treated by others. The Social Withdrawal subscale consists of six items that assess the degree to which respondents avoid people or situations because of their mental illness. The Stigma Resistance subscale consists of five items that measure the degree to which respondents are unaffected by – or overtly resist – stigma. The ISMI poses a series of statements for which participants are asked to rate their level of agreement using a four-point anchored Likert scale that ranges from strongly disagree (1) to strongly agree (4). Subscale scores and a total score are calculated by averaging the respondents' ratings, with higher scores indicating higher levels of self-stigma.

For the purpose of the present study, an adjusted total ISMI score (calculated using the following procedure) was used. Pearson product-moment correlation tests and internal consistency analyses were performed on baseline data to determine whether the five subscales of the ISMI should be combined into a total score. This revealed a high degree of internal consistency for all five subscales, coefficient $\alpha = 0.79$, which was increased to 0.83 once the Stigma Resistance subscale was removed. Correlations among the five ISMI subscale scores revealed that the first four scores were all significantly related to one another ($p < .05$), with the fifth subscale, Stigma Resistance, significantly correlated with only two of the subscales (Alienation and Discrimination Experience). Therefore, the Stigma Resistance subscale was excluded in calculations of the adjusted ISMI total score, which is consistent with procedures that have been used by others (Lysaker, Davis, Warman, Strasburger, & Beattie, 2007; Lysaker, Roe, & Yanos, 2007).

As well, analyses by Sibitz and colleagues (2009a) indicate that Stigma Resistance is a separate construct from internalized stigma. The ISMI has demonstrated high levels of internal consistency reliability, test-retest reliability, concurrent validity, and divergent validity (Ritsher, 2003).

For the present study, two custom items were added to the ISMI in order to query the perceptions of forensic participants. The items asked participants in the forensic cohort to rate their level of agreement with the following statements: (i) ‘Compared with other mental health patients, I have greater difficulty accessing services because I am a forensic patient’, and (ii) ‘Forensic patients are more dangerous than other mental health patients’. These custom items were analyzed separately and were not incorporated into calculations of the ISMI subscale or total scores.

4.5.2 Inventory of Stigmatizing Experiences (ISE)

Lifetime experiences of stigma were measured using the Inventory of Stigmatizing Experiences (ISE). As well, the ISE was used to produce qualitative narratives about the participants’ experiences with stigma. The ISE is designed to capture self-reported lifetime experiences of stigma from the perspective of persons with mental illness (Stuart, Milev, & Koller, 2005). The ISE consists of 26 questions and contains two subscales. The Stigma Experiences subscale is a composite measure consisting of 10 items that assess lifetime experiences of stigma by posing a series of yes/no questions and asking respondents to explain their answers in their own words. The subscale score is a summed total that ranges from 0 to 10. The Stigma Impact subscale has seven items that assess the psychosocial impact of stigma by asking respondents to rate the degree to

which stigma has affected different aspects of their own life and their family's life, using an 11-point rating scale that ranges from 'lowest amount' to 'highest amount'. The subscale score, calculated by averaging the ratings across the seven items, ranges from 0 to 10. The ISE has demonstrated high levels of internal consistency reliability (Stuart et al., 2005). One custom item was added to the ISE to ask participants in the forensic cohort about whether they feel more stigmatized in comparison to other mental health patients. This custom item was analyzed separately and was not incorporated into calculations of the ISE subscale or total scores.

4.5.3 Modified Consumer Experiences of Stigma Questionnaire (MCESQ)

Recent experiences of stigma and discrimination were measured using the Modified Consumer Experiences of Stigma Questionnaire (MCESQ). The MCESQ is a self-report survey that assesses recent experiences of stigma and discrimination for people living with a mental illness (Dickerson et al., 2002). The MCESQ measures how often a person with mental illness has experienced events in the past month that they perceive to be stigmatizing or discriminating. The measure consists of 21 items and has two subscales. The Stigma Experiences subscale contains eight items that measure a person's perceptions and concerns about how they are viewed by others. The Discrimination Experiences subscale has 10 items that measure experiences of rejection, exclusion, and unfairness resulting from their mental illness. Two items were removed from the MCESQ, since they ask questions (about health insurance) that are not pertinent to the Canadian healthcare system. Therefore, 19 MCESQ items were used for the present study. For each item, respondents rate the occurrence of the experience on a five-point

anchored scale that ranges from ‘Never’ (1) to ‘Very Often’ (5). Experiences were considered ‘frequent’ if they had occurred ‘Often’ or ‘Very Often’ in the past month. A respondent was considered to have ‘numerous’ experiences if more than three ‘frequent’ experiences had occurred in the past month. Subscale and total scores are calculated by averaging respondents’ ratings. The item asked participants to rate how often, over the past month, they felt discriminated against by others for being a forensic patient. For the present study, the coefficient for internal consistency for the 19 items at T1 is $\alpha = 0.73$. One custom item was added to the MCESQ in order to query the perceptions of forensic participants. This custom item was analyzed separately and was not incorporated into calculations of the MCESQ subscale or total scores.

4.5.4 Behavior and Symptom Identification Scale-24 (BASIS-24)

Psychiatric symptoms severity was measured using the Behavior and Symptom Identification Scale-24 (BASIS-24). The BASIS-24 is a self-report measure for assessing the symptom severity and functional difficulties of people with mental illness (Eisen, Normand, Belanger, Spiro, & Esch, 2004). It consists of 24 items and has six subscales that assess major areas of difficulty and distress, including depression/functioning (six items), interpersonal relationships (five items), psychotic symptoms (four items), alcohol/drug use (four items), emotional lability (three items), and self-harm (two items). The BASIS-24 is scored on a zero to four anchored rating scale, with a higher score indicating greater symptom/problem severity or frequency. Respondents answer each question in terms of how they have been during the past week. Subscale and overall scores are weighted sums that are calculated by multiplying the rating for each item by its

weight and totalling the weighted ratings for each question. The BASIS-24 has demonstrated acceptable test-retest and internal consistency reliability (Eisen et al., 2004). For the present study, the coefficient for internal consistency for the 24 items at T1 is $\alpha = 0.83$.

4.5.5 Wisconsin Quality of Life Index (WQL)

Quality of life was measured using the Wisconsin Quality of Life Index (WQL). The WQL is a self-report, comprehensive, multidimensional measure of quality of life for persons with severe mental illness (Becker, Diamond, & Sainfort, 1993). The WQL consists of approximately 100 items and addresses eight different domains or content areas, including life satisfaction (20 items), occupational activities (3 items), psychological well-being (11 items), physical health (2 items), social relationships (8 items), finances (3 items), activities of daily living (8 items), and psychiatric symptoms and outlook (5 items). Using a variety of rating scales, respondents assess their level of satisfaction or problems across several life domains. Subscale and global scores are calculated using formulae provided by the authors of the WQL. The WQL is one of the few quality of life measures that is designed for people with severe mental illness that meets minimal standards of being based on a conceptual model and having published psychometric properties (Malla et al., 2006). The WQL has demonstrated good internal consistency, test-retest reliability, construct validity, and convergent validity (Diaz, Mercier, Hachey, Caron, & Boyer, 1999). For the present study, the coefficient for internal consistency for the 45 items (that are used to calculate a total W-QoL score) at T1 is $\alpha = 0.87$.

4.5.6 Canadian Community Health Survey – Cycle 1.2 (CCHA)

Service utilization and satisfaction was measured using the ‘Mental Health Services’ component of the Canadian Community Health Survey – Cycle 1.2 (Statistics Canada, 2003). The CCHA is a self-report survey that asks respondents about the frequency in which they have used different types of mental health services over the past month, including psychiatric hospital beds, self-help group attendance, and therapeutic appointments with a range professional groups. As well, respondents are asked to rate, using a five-point rating scale that ranges from ‘Very Dissatisfied’ (1) to ‘Very Satisfied’ (5), their level of satisfaction with the services they have received from each mental health professional seen in the past month.

4.5.7 Camberwell Assessment of Need Forensic – Research Version (CANFOR)

Service needs were measured using the forensic version of the Camberwell Assessment of Need (CANFOR). The CANFOR is a comprehensive tool for assessing the social, psychological, and physical needs of persons with mental illness (Thomas et al., 2003). The CANFOR evaluates service needs across 25 domains and queries whether community services and supports (informal and formal) have sufficiently met the needs of the service user. A need is identified when the respondent indicates that there have been difficulties in a particular area over the past month. A met need indicates that an individual is receiving appropriate intervention or support for a particular service need. In contrast, an unmet need indicates that an individual is not receiving sufficient intervention or support to address a particular service need. While the CANFOR is designed to capture

the perceptions of service needs from multiple perspectives (e.g., service users, staff members, caregivers), it was only administered to mental health staff (i.e., case managers) in the present study. The CANFOR has demonstrated high levels of inter-rater reliability and moderate to high levels of test-retest reliability (Thomas et al., 2008).

4.6 ANALYTIC STRATEGY

The strategy for analyzing data collected for the present study was structured around the four research objectives outlined in section 4.1. All quantitative analyses were completed using the Statistical Package for Social Science software (SPSS Inc, Chicago, IL) version 14.

In addition to the quantitative analyses that are described in detail below, qualitative data from baseline and follow-up periods were combined and analyzed using an inductive thematic analytic framework to identify predominant themes and recurring patterns. A strategy for analyzing the qualitative data was adopted from Braun and Clark (2006). After becoming familiar with the data, the text was coded line-by-line, which generated approximately 130 unique codes. Through a recursive process of moving back and forth between the original text and codes, the initial codes were collapsed into 16 unique codes, which were then refined into six overarching themes. These six themes are described under section 5.6.1. A separate thematic analysis, using a similar process, was performed on the text relating to the forensic-specific questions that were added to the interview guide. The resulting four forensic-specific themes are described under section 5.6.2. Each theme represents the sentiments of several participants; however, the prevalence of data or codes, such as the percentage of participants who endorsed a

particular code, was generally not relied upon to guide the development of themes. Rather, the themes were selected on the basis of their ability to capture key ideas and patterns that were considered to be important and meaningful to the research questions.

Objective 1: To describe the level of self-stigma that is experienced by people with mental illness who receive compulsory community treatment and the degree to which it changes over time.

Concerning the level of self-stigma, quantitative data were analyzed using descriptive statistics on overall and subscale scores of all baseline measures of stigma. The primary measure of self-stigma for the present study was the ISMI. Tests of normality on the ISMI adjusted total score indicate that it was normally distributed, $D = .08$, $df = 90$, $p > .05$.

In order to assess the degree to which self-stigma changed for participants during the study period, a repeated measure of analysis of variance was performed on ISMI adjusted total scores at T1 and T2. Analyses were performed using the 71 participants who had no missing values on any of the variables. The analysis was first performed without covariates. This analysis was then repeated by adding a between-subjects factor in order to divide the sample into discrete groups based on their ISMI total score at T1 (minimal, mild, or moderate/severe). A final repeated measure analysis of variance was performed to assess change in self-stigma while statistically controlling for psychiatric symptoms. A 'change in symptoms' variable was created by subtracting T1 and T2 BASIS-24 total scores and variable was added to the analysis as a covariate. Tests of normality indicate that ISMI adjusted total scores at T1 were normally distributed, $D =$

.07, $df = 72$, $p > .05$, but that T2 scores were not, $D = .11$, $df = 72$, $p < .05$. Paired deletion of one outlier improved the normal distribution for T2, $D = .10$, $df = 71$, $p > .05$, without substantially impacting T1, $D = .08$, $df = 71$, $p > .05$. To examine the bivariate association between self-stigma at T1 and T2, Pearson product-moment correlation analyses were performed on the ISMI subscale and total scores.

Objective 2: To assess the degree to which group membership (forensic versus civil) contributes to experiences of self-stigma.

Multiple linear hierarchical regression analyses were performed to assess the relationship between group membership and self-stigma, while statistically controlling for key sociodemographic and clinical variables. Analyses were performed using the 88 participants who had no missing values on any of the variables. Control variables were forced into the first step of the model, and group membership was entered into the second step of the regression model. Multiple regression, rather than logistic regression, was chosen because the intent of the analysis was to examine how much variation in a scale-level dependent variable (self-stigma) could be explained by variability in a dichotomous independent variable (group membership), while controlling for the effects of several other independent variables. A hierarchical (or sequential) regression strategy was selected, rather than stepwise (or statistical) regression, because it provides the researcher with additional control over the regression process in order to test explicit hypotheses pertaining to the amount of variance that is accounted for by a particular independent variable after controlling for the variance of other independent variables (Tabacknick & Fidell, 2007). The observed power for a multiple regression analyses (alpha level = .05,

effect size = .15, individual predictors = 5) with the present study's sample size of 88 is 0.86 (Soper, 2010b).

Dependent Variable

Self-stigma was measured using the ISMI scale. Regression models were performed on the ISMI adjusted total score. Analyses were performed using SPSS Regression and SPSS Explore for evaluation of assumptions.

Independent Variables

Group membership was coded as a dummy variable (forensic=1, civil=0). Sociodemographic and clinical variables were added to the second step of the hierarchical regression model to serve as statistical controls. Bivariate correlations were calculated to investigate associations between participant characteristics and the group membership variable. The Pearson product-moment correlation coefficient was calculated when both variables were continuous. The point-biserial correlation coefficient was calculated when one variable was continuous and the other variable was dichotomous. Three variables – T1 gender (male=1, female=0), T1 housing type (private dwelling=1, supported or transitional=0), and T1 history of incarceration (yes=1, no=0) – were selected because of their significant bivariate correlations ($p < .05$) with the group membership variable. T1 psychiatric symptom severity (BASIS-24 total score) was also added as a covariate because of its relevance and importance for the primary dependent and independent variables.

Objective 3: To identify the sociodemographic, psychosocial and clinical correlates and predictors of self-stigma for people with mental illness who receive compulsory community treatment.

Cross-Sectional Modelling

Multiple linear hierarchical regression analyses were performed to assess the relationship between T1 self-stigma and selected socio-demographic, clinical, and psychosocial variables (Tabacknick & Fidell, 2007). For the purpose of this analysis, the two groups (forensic and civil) were combined. Analyses were performed using the 86 participants who had no missing values on any of the variables. Socio-demographic variables were entered into the first step of the model, followed by clinical and psychosocial variables in the second and third steps, respectively. The observed power for a multiple regression analyses (alpha level = .05, effect size = .15, individual predictors = 5) with the present study's sample size of 86 is 0.85 (Soper, 2010b).

Dependent variable

Self-stigma was measured with ISMI scale. Regression models were performed on the ISMI adjusted total score at T1. Analyses were performed using SPSS Regression and SPSS Explore for evaluation of assumptions.

Independent variables

In order to reduce the number of variables that were added to the model, only those that had significant ($p < .01$) bivariate correlations with the T1 ISMI total score were included (see Tables 11-13, pgs 172-174). The Pearson product-moment correlation

coefficient was calculated when both variables were continuous. The point-biserial correlation coefficient was calculated when one variable was continuous and the other variable was dichotomous. Collinearity diagnostics detected the following three psychiatric symptom variables to be highly correlated: T1 depression symptoms (BASIS-24), T1 psychiatric symptom severity (BASIS-24), and T1 symptoms/outlook (WQL); therefore, only T1 psychiatric symptom severity (BASIS-24) was included in the analysis. The following five variables were selected for the regression analysis: T1 history of homelessness (yes=1, no=0), T1 history of incarceration (yes=1, no=0), T1 psychiatric symptom severity (BASIS-24), T1 life satisfaction (WQL), and T1 well-being (WQL). These variables were entered into the regression model in the following order: (1) socio-demographic variables; (2) clinical variables, and (3) psychosocial variables.

Longitudinal Modelling

Multiple hierarchical linear regression analyses were performed to assess the relationship between sociodemographic, psychosocial, and clinical variables at T1 and self-stigma at T2. Self-stigma at T1 was entered into the regression model first, followed by key predictor variables in the second step of the model. For the purpose of this analysis, the two groups (forensic and civil) were combined. Analyses were performed using the 70 participants who had no missing values on any of the variables. Multiple hierarchical linear regression analysis was selected as the most appropriate regression strategy for the same reasons that were discussed in Objective 2 (see above). The observed power for a multiple regression analyses (alpha level = .05, effect size = .15, individual predictors = 4) with the present study's sample size of 70 is 0.79 (Soper, 2010b).

Dependent variable

Self-stigma was measured with the ISMI scale. Regression models were performed on the ISMI adjusted total score. Analyses were performed using SPSS Regression and SPSS Explore for evaluation of assumptions.

Independent variables

In order to reduce the number of variables that were added to the models, only those that had bivariate correlations at a .10 significance level with T2 ISMI total score were included. The Pearson product-moment correlation coefficient was calculated when both variables were continuous. The point-biserial correlation coefficient was calculated when one variable was continuous and the other variable was dichotomous. Collinearity diagnostics detected the following four psychiatric symptom variables to be highly correlated: T1 depressive symptoms (BASIS-24), T1 psychotic symptoms (BASIS-24), T1 total psychiatric symptom severity (BASIS-24), and T1 symptoms/outlook (WQL); therefore, only T1 psychiatric symptom severity (BASIS-24) was included in the analysis. Using this procedure, the following three variables were selected for the regression analysis: age (years), T1 total psychiatric symptom severity (BASIS-24), and T1 well-being (WQL).

Objective 4: To investigate whether self-stigma is a predictor of quality of life for people with mental illness who receive compulsory community treatment.

Multiple hierarchical linear regression analyses were performed to assess the relationship between self-stigma at baseline (T1) and quality of life at follow-up (T2). For the purpose of this analysis, data for the two groups (forensic and civil) were combined.

Analyses were performed with the 60 participants who had no missing values on any of the dependent and independent variables. To control for the effects of T1 quality of life, it was forced into the regression model first, followed by other potential confounding variables that are delineated below. Self-stigma at T1 was forced into the second step of the regression model. The observed power for a multiple regression analyses (alpha level = .05, effect size = .15, individual predictors = 5) with the present study's sample size of 60 is 0.66 (Soper, 2010b).

Dependent variable

Quality of life was assessed using the WQL. Regression models were performed on the T2 WQL unweighted total score. Analyses were performed using SPSS Regression and SPSS Explore for evaluation of assumptions.

Independent variables

Self-stigma is measured with the ISMI scale. Regression models were performed on the ISMI adjusted total score. Clinical and sociodemographic variables that were statistically associated with both the predictor variable (T1 self-stigma) and the outcome variable (T2 quality of life) were considered potential confounders and were entered into the regression models as covariates. The Pearson product-moment correlation coefficient was calculated when both variables were continuous. The point-biserial correlation coefficient was calculated when one variable was continuous and the other variable was dichotomous. Five variables were statistically associated with T1 self-stigma ($p < .05$), including T1 history of homelessness (yes=1, no=0), T1 history of incarceration (yes=1, no=0), T1 psychiatric symptom severity, T1 service satisfaction, and change in stigma. Of

these, three variables (T1 psychiatric symptom severity, T1 service satisfaction, and change in stigma) were also significantly associated with T2 quality of life ($p < .05$), and were, therefore, forced into the model as control variables. Service satisfaction is a continuous variable from the CCHS that was measured by averaging the participants' ratings of their level of satisfaction with each mental health professional. Psychiatric symptom severity is a continuous variable that was measured with the BASIS-24 total score. Change in stigma was measured by calculating the difference between T1 and T2 self-stigma adjusted total scores.

CHAPTER 5: RESULTS

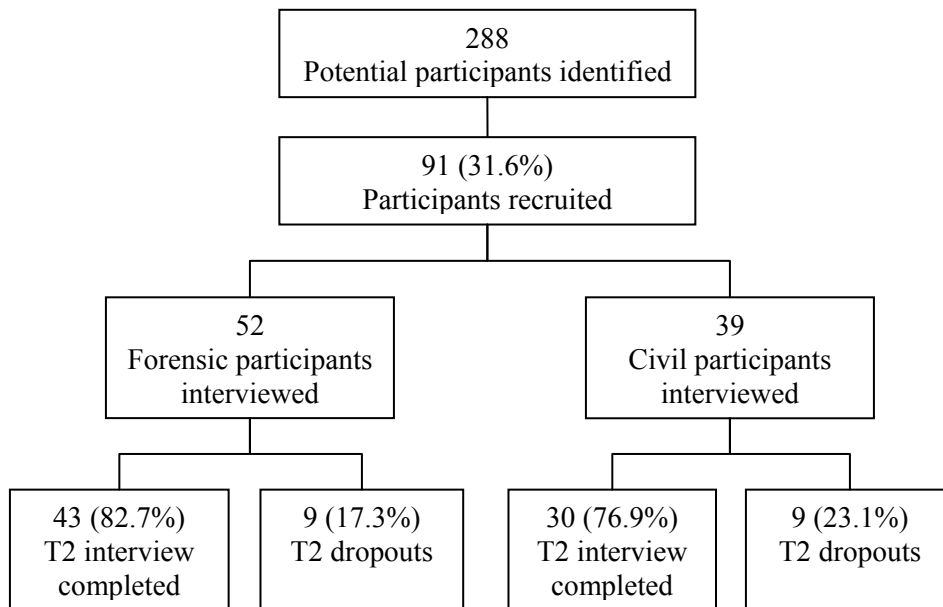
5.1 PARTICIPANT CHARACTERISTICS

5.1.1 Recruitment and Retention

During the 33-month recruitment period, 288 individuals were identified as satisfying the study's inclusion criteria, including 108 forensic clients and 180 civil clients. Of these, 91 (31.6%) individuals agreed to participate, 125 (43.4%) explicitly refused to participate, and 72 (25.0%) agreed to participate but were unable to because of logistical reasons (e.g., failure to attend multiple appointments, or problems with scheduling). The relatively high rate of research refusals and missed appointments was not unexpected, given that treatment non-compliance, low illness insight, and poor service engagement are prevalent issues for compulsory community treatment populations. Individuals who refused to participate did so by communicating with their case managers and were not directly contacted by a member of the research team. Privacy concerns and the resulting restrictions on accessing information about individuals who did not agree to participate in the study prohibited a comparison of the study sample with the entire population of eligible participants. Therefore, it was not possible to analyze self-selection biases; however, published studies on similar populations were examined and socio-demographic comparisons are described in the following section.

Of the 91 participants who enrolled in the study, 73 (80.2%) completed the 1-year follow-up interview. The reasons for dropout were that participants could not be reached or scheduled for another interview (N = 12), they explicitly refused to be interviewed (N = 3), they were deceased at follow-up (N = 2), or their poor mental state did not permit an interview (N = 1). The figure below illustrates the flow and distribution of participants.

Figure 2. Flowchart and distribution of participants



As is indicated in the table below, statistical comparisons of participants that were, and were not, retained for the 1-year follow-up interview revealed no significant differences on key variables. The data does suggest that, in comparison to those who did not complete the study, the participants who completed the study were: less likely to be married, more likely to have completed high school, and had higher levels of quality of life.

Table 2. Comparison of participants who either completed or did not complete T2

Characteristic	Completers (N=73)		Non-completers (N=18)		Test Statistic	df	P
	N	Value	N	Value			
Age, mean (SD)	73	39.6 (12.0)	18	36.9 (9.8)	F = 0.77	1	.38
Gender							
Male, %	55	75.3	14	77.8	$\chi^2 = 0.05$	1	.83
Female, %	18	24.7	4	22.2			
Ethnicity							
Caucasian, %	45	61.6	11	61.1	$\chi^2 = 0.00$	1	.97
Non-Caucasian, %	28	38.4	7	38.9			
Relationship status							
Married, %	44	60.3	13	72.2	$\chi^2 = 0.88$	1	.35
Not married, %	29	39.7	5	27.8			
Education level							
Did not complete high school/GED, %	31	42.5	9	50.0	$\chi^2 = 0.33$	1	.56
Completed high school/GED, %	42	57.5	9	50.0			
Years with mental illness, mean (SD)	73	13.0 (11.0)	18	12.7 (10.3)	F = 0.01	1	.93
Psychiatric symptoms (BASIS-24 Total)							
Mean	72	0.73	18	0.90	F = 2.01	1	.16
Median	72	0.68	18	0.73			
SD	72	0.44	18	0.56			
Quality of life (WQL Total)							
Mean	62	1.51	16	1.26	F = 1.47	1	.23
Median	62	1.55	16	1.21			
SD	62	0.66	16	1.03			
Self-stigma (ISMI adjusted total)							
Mean	71	2.12	18	2.19	F = 0.57	1	.45
Median	71	2.13	18	2.21			
SD	71	0.39	18	0.35			

5.1.2 Sociodemographic Characteristics

An overview of participants' T1 sociodemographic characteristics is provided in the table below.

Table 3. Participant T1 sociodemographic characteristics by group

Characteristic	Forensic (N=52)		Civil (N=39)		Total (N=91)	
	N	Value	N	Value	N	Value
Gender						
Male, %	47	90.4	22	56.4	69	75.8
Female, %	5	9.6	17	43.6	22	24.2
Age, mean (SD)	52	38.2 (10.9)	39	40.1 (12.6)	91	39.0 (11.6)
Ethnicity						
Caucasian, %	32	61.5	24	61.5	56	61.5
Non-Caucasian, %	20	38.5	15	38.5	35	38.5
Relationship status						
Married, %	29	55.8	28	71.8	57	62.6
Not married, %	23	44.2	11	28.2	34	37.4
Parenting status						
Parent, %	19	36.5	13	33.3	32	35.2
Non-parent, %	33	63.5	26	66.7	59	64.8
Employment status						
Employed, %	16	30.8	6	15.4	22	24.2
Not employed, %	36	69.2	33	84.6	69	75.8
On income assistance						
Yes, %	45	86.5	36	92.3	81	89.0
No, %	7	13.5	3	7.7	10	11.0
Education level						
Did not complete high school/GED, %	24	46.2	16	41.0	40	44.0
Completed high school/GED, %	28	53.8	23	59.0	51	56.0
Housing type						
Private dwelling, %	24	46.2	29	74.4	53	58.5
Supported or transitional, %	28	53.8	10	25.6	38	41.8
Living with						
Alone, %	16	30.8	23	59.0	39	42.9
Others, %	36	69.2	16	41.0	52	57.1
History of homelessness						
Yes, %	23	44.2	21	53.8	44	48.4
No, %	29	55.8	18	46.2	47	51.6
Criminal justice history						
Apprehended or arrested, % yes	52	100.0	26	66.7	78	85.7

Convicted, % yes	35	68.6	17	43.6	52	57.8
Remanded or incarcerated, % yes	49	94.2	23	59.0	72	79.1
Victimization in past month						
Violent, % yes	4	7.7	1	2.6	5	5.6
Non-violent, % yes	9	17.3	7	18.4	16	17.8

Their age ranged from 21 to 65 years, with a mean of 39 (SD = 11.6) years. Three-quarters of the sample (75.8%, N = 69) were male, with the civil cohort having a significantly higher proportion of female participants ($\chi^2 = 14.03$, $df = 1$, $p < .01$), which is consistent with the gender composition of the two groups. The majority of participants were Caucasian (61.5%, N = 56), while other participants identified with Aboriginal (9.9%, N = 9), Asian (6.6%, N = 6), East Indian (5.5%, N = 5), African (3.3%, N = 3), and Hispanic (2.2%, N = 2) ethnic heritage. Most participants (62.6%, N = 57) were formally or informally (i.e., common law) married. Almost half of the participants (44.0%, N = 40) had not completed high school or an equivalent diploma, while 15.4% (N = 14) had obtained a college or university diploma/degree. Participants were predominantly unemployed (75.8%, N = 69) and most were receiving income assistance (89.0%, N = 81) such as disability pension. Homelessness had been experienced by 48.4% (N = 44) of participants at some point during their lifetime. The self-reported criminal justice history of participants was as follows: 85.7% (N = 78) had been apprehended or arrested by the police, 57.8% (N = 52) had been convicted of a crime, and 79.1% (N = 72) had spent time in jail or prison. Over the past month, 5.6% (N = 5) and 17.8% (N = 16) of participants reported experiencing violent (i.e., assaults, threats) or non-violent (i.e., theft, harassment) victimization, respectively.

As is presented in the table below, the socio-demographic characteristics of the present forensic subsample were compared with two studies.

Table 4. Comparison of present sample characteristics with other published studies

	Present Study		Other Studies	
	N	Value	N	Value
Gender				
Male, %	69	75.8	236	85.5
Female, %	22	24.2	40	14.5
Age, mean (SD)	91	39.0 (11.6)	60	41.9 (12.8)
Ethnicity				
Caucasian, %	56	61.5	221	80.0
Non-Caucasian, %	35	38.5	55	20.0
Relationship status				
Married, %	57	62.6	30	11.0
Not married, %	34	37.4	246	89.0
Employment status				
Employed, %	22	24.2	11	5.7
Not employed, %	69	75.8	260	94.3

The first study is comprised of individuals (N = 276) who were found NCR-MD in BC from 1992-1998 (Livingston et al., 2003). The only variables that were available for statistical comparison were gender, ethnicity, marital status, and employment status. The forensic participants in the present study had a similar gender distribution ($\chi^2 = 0.88$, $df = 1$, $p > .05$), but were different on several socio-demographic variables. The present sample was more likely to be non-Caucasian ($\chi^2 = 8.52$, $df = 1$, $p < .01$), married ($\chi^2 = 32.19$, $df = 1$, $p < .001$), and employed ($\chi^2 = 30.99$, $df = 1$, $p < .001$). Whereas the present study focused on people who were living in the community, the comparison study was comprised of individuals who were either living in the hospital or in the community (Livingston et al., 2003). In addition, the study by Livingston and colleagues (2003) describes socio-demographic characteristics of people at the time of NCR-MD adjudication, whereas the present study focuses on a period of community reintegration. Therefore, while there is some evidence that the socio-demographic profile of participants

in the present study may be different than the overall population, it is possible that these differences may be an artefact of variation in methodological design. The average age of forensic participants in the present study were a similar to that which is reported in a Canadian study of 96 hospitalized forensic mental health clients in the province of Quebec ($t = 0.39$, $df = 146$, $p > .05$) (Crocker & Cote, 2009). The table below provides data that compares the participants of present study and the aforementioned published studies.

There are no published population statistics regarding individuals on extended leave in British Columbia; however, one large Canadian study has been published on the characteristics of 711 individuals who were involuntarily hospitalized in the province of Alberta (Crisanti & Love, 2001). Gender and criminal history were the only variables that could be statistically compared. The gender distribution of civil participants in the present study (male = 56%) is similar to the aforementioned study (male = 54%) ($\chi^2 = 0.08$, $df = 1$, $p > .05$); however, the present sample was significantly more likely to have a criminal history (86% versus 19%, respectively) ($\chi^2 = 13.19$, $df = 1$, $p < .001$).

5.1.3 Psychosocial Characteristics

The table below summarizes the T1 psychosocial characteristics of the participants.

Table 5. Participant T1 psychosocial characteristics by group

Characteristic	Forensic (N=52)		Civil (N=39)		Total (N=91)	
	N	Value	N	Value	N	Value
Quality of life (WQL)						
General life satisfaction						
Mean	50	1.28	39	1.36	89	1.31
Median	50	1.43	39	1.60	89	1.48
SD	50	1.13	39	1.13	89	1.12
Psychological well being						
Mean	50	1.63	39	1.16	89	1.43
Median	50	1.95	39	0.60	89	1.50
SD	50	1.73	39	1.58	89	1.67
Occupational activities						
Mean	50	1.21	39	0.91	89	1.08
Median	50	0.67	39	1.00	89	0.67
SD	50	1.33	39	1.48	89	1.40
Physical health						
Mean	50	0.31	39	0.25	89	0.28
Median	50	0.50	39	0.50	89	0.50
SD	50	1.58	39	1.55	89	1.56
Symptoms/ outlook						
Mean	49	2.47	39	2.26	88	2.38
Median	49	2.70	39	2.40	88	2.40
SD	49	0.63	39	0.70	88	0.67
Social relationships/ support						
Mean	44	1.96	36	2.19	80	2.06
Median	44	2.08	36	2.17	80	2.17
SD	44	1.09	36	1.14	80	1.11
Activities of daily living						
Mean	50	2.59	39	2.10	89	2.38
Median	50	2.83	39	2.33	89	2.67
SD	50	0.54	39	0.91	89	0.76
Financial resources						
Mean	50	0.59	39	0.15	89	0.40
Median	50	0.67	39	0.00	89	0.33
SD	50	1.33	39	1.42	89	1.38
Total						
Mean	43	1.55	36	1.34	79	1.45
Median	43	1.56	36	1.12	79	1.51
SD	43	0.66	36	0.84	79	0.75
Service satisfaction, mean (SD)						
Mean	50	4.04	38	4.10	88	4.07

Median	50	4.00	38	4.33	88	4.00
SD	50	0.81	38	0.92	88	0.85

The mean scores and standard deviations on the quality of life scale (WQL), which ranges from -3 to 3, were: general life satisfaction 1.31 (SD = 1.12), psychological well-being 1.43 (SD = 1.67), occupational activities 1.08 (SD = 1.40), physical health 0.28 (SD = 1.56), symptoms/outlook 2.38 (SD = 0.67), social relationships/support 2.06 (SD = 1.11), activities of daily living 2.38 (SD = 0.76), financial resources 0.40 (SD = 1.38), and total score 1.45 (SD = 0.75). Most participants (79.8%, N = 71) rated their own mental health as being moderate to high at the time of the interview. Regarding how much control that participants felt they had over the important areas of their own life, 22.0% (N = 20) indicated ‘none’ to ‘some’, while 75.9% (N = 69) of participants indicated a ‘moderate’ to ‘great’ amount of control. On average, participants were highly satisfied with the mental health services that they were receiving up to one month prior to the interview (mean = 4.07, SD = 0.85). The average service satisfaction scores for 10.2% (N = 9) of the participants were below the middle of the 5-point rating scale, which indicates that they were dissatisfied with the mental health services that they were receiving.

5.1.4 Clinical Characteristics

The table below summarizes the T1 clinical characteristics of the study participants.

Table 6. Participant T1 clinical characteristics by group

Characteristic	Forensic (N=52)		Civil (N=39)		Total (N=91)	
	N	Value	N	Value	N	Value
Primary Diagnosis						
Schizophrenia, %	30	57.7	23	59.0	53	58.2

Characteristic	Forensic (N=52)		Civil (N=39)		Total (N=91)	
	N	Value	N	Value	N	Value
Schizoaffective disorder, %	13	25.0	10	25.6	23	25.3
Other psychotic disorder, %	8	15.4	2	5.1	10	11.0
Bipolar disorder, %	1	1.9	4	10.3	5	5.5
Substance diagnosis						
Yes, %	29	55.8	20	51.3	49	53.8
No, %	23	44.2	19	48.7	42	46.2
Age of 1 st psychiatric hospitalization, mean (SD)						
	52	24.7 (8.5)	39	28.0 (11.9)	91	26.1 (10.2)
Years with mental illness, mean, SD						
	52	13.5 (9.8)	39	12.2 (12.1)	91	12.9 (10.8)
< 5 years, %	7	13.5	9	23.1	16	17.6
6-10 years, %	19	36.5	15	38.5	34	37.4
11-15 years, %	10	19.2	6	15.4	16	17.6
> 15 years, %	16	30.8	9	23.1	25	27.5
Psychiatric symptoms (BASIS-24)						
Depression						
Mean	51	0.78	39	0.85	90	0.81
Median	51	0.68	39	0.92	90	0.70
SD	51	0.67	39	0.65	90	0.66
Interpersonal						
Mean	51	1.11	39	1.30	90	1.19
Median	51	1.00	39	1.18	90	1.02
SD	51	0.77	39	0.90	90	0.83
Self harm						
Mean	51	0.09	39	0.08	90	0.08
Median	51	0.00	39	0.00	90	0.00
SD	51	0.37	39	0.25	90	0.32
Emotional lability						
Mean	51	0.74	39	0.75	90	0.75
Median	51	0.61	39	0.72	90	0.67
SD	51	0.82	39	0.75	90	0.79
Psychotic						
Mean	51	0.47	39	0.71	90	0.57
Median	51	0.14	39	0.47	90	0.21
SD	51	0.62	39	0.94	90	0.78
Substance use						
Mean	51	0.64	39	0.62	90	0.63
Median	51	0.23	39	0.34	90	0.34
SD	51	0.82	39	0.72	90	0.77
Overall						
Mean	51	0.73	39	0.82	90	0.77
Median	51	0.67	39	0.72	90	0.68
SD	51	0.46	39	0.47	90	0.47
Service needs (CANFOR-R)						
Met needs, mean (SD)	51	7.02 (2.83)	38	5.68 (2.21)	89	6.45 (2.65)
Unmet needs, mean (SD)	51	0.75	38	2.03	89	1.29

Characteristic	Forensic (N=52)		Civil (N=39)		Total (N=91)	
	N	Value	N	Value	N	Value
		(1.16)		(1.78)		(1.58)
Unmet needs, % yes	20	39.2	26	68.4	46	51.7
Total needs, mean (SD)	51	7.76 (2.55)	38	7.71 (2.97)	89	7.74 (2.90)
Severity of medication side effects, mean (SD)	52	2.37 (1.43)	39	2.95 (1.50)	91	2.62 (1.48)

Many of the participants had been living with a mental illness for a substantial portion of their lifetime, with a mean (SD) duration of 12.9 (10.8) years. While 17.6% (N = 16) had lived with mental illness for less than five years, 27.5% (N = 25) had lived with mental illness for more than fifteen years. With respect to participants' psychiatric diagnosis, 58.2% (N = 53) had schizophrenia, 25.3% (N = 23) had schizoaffective disorder, 11.0% (N = 10) had 'other' psychotic disorder, and 5.5% (N = 5) had bipolar disorder. Moreover, 53.8% (N = 49) of participants were diagnosed with a comorbid substance use problem. Regarding the single WQL item that queried the severity of psychiatric medication side-effects, 31.9% (N = 19) of participants self-reported experiencing moderate to severe side-effects.

The mean scores and standard deviations on the psychiatric symptoms scale (BASIS-24) were: depression/functioning 0.81 (SD = 0.66), interpersonal relationships 1.19 (SD = 0.83), self-harm 0.08 (SD = 0.32), emotional lability 0.75 (SD = 0.79), psychotic symptoms 0.57 (SD = 0.78), substance use 0.63 (SD = 0.77), and total score 0.77 (SD = 0.47). In comparison to the BASIS-24 scores of a US benchmark sample of outpatients with mental illness (N = 850), the current sample's average scores overall and on three individual subscales (depression/ functioning, self-harm, and emotional lability) were significantly lower ($p < .001$), indicating that they have less problem severity in

those domains than the comparison group. Their score on the substance use subscale was significantly higher ($p < .05$) than that of the comparison group, indicating higher levels of problems. The other subscale scores (interpersonal problems, psychosis) were not significantly different ($p > .05$) from comparison scores.

On average, the case managers indicated that the participants had approximately eight met or unmet service needs (out of a possible 25), primarily in the areas of psychotic symptoms, housing, social relationships, daytime activities, and finances. Half of the participants (51.7%, $N = 46$) had at least one unmet service need, with those in the civil cohort having significantly more unmet service needs than participants in the forensic cohort ($F = 16.84$, $df = 1$, $p < .01$).

5.2 SELF-STIGMA EXPERIENCES

5.2.1 Participants' Level of Self-Stigma

Means and standard deviations of T1 scores for the quantitative stigma measures are presented in the table below.

Table 7. Participant T1 stigma by group

	Forensic (N=52)		Civil (N=39)		Total (N=91)		Test Statistic	df	P
	N	Value	N	Value	N	Value			
Self-stigma (ISMI)									
Alienation, mean (SD)	52	2.22 (0.57)	39	2.19 (0.51)	91	2.20 (0.54)	$F = 0.07$	1	.79
Alienation, % high	14	26.9	15	38.5	29	31.9	$\chi^2 = 1.37$	1	.24
Stereotype endorsement, mean (SD)	52	1.96 (0.37)	38	1.87 (0.35)	90	1.92 (0.36)	$F = 1.63$	1	.21
Stereotype endorsement, % high	3	5.8	1	2.6	4	4.4	fisher exact	na	.64
Discrimination experience (mean, SD)	52	2.39 (0.53)	39	2.25 (0.55)	91	2.33 (0.54)	$F = 1.60$	1	.21

	Forensic (N=52)		Civil (N=39)		Total (N=91)		Test Statistic	df	P
	N	Value	N	Value	N	Value			
Discrimination experience, % high	20	38.5	13	33.3	33	36.3	$\chi^2 = 0.25$	1	.62
Social withdrawal, mean (SD)	52	2.15 (0.47)	39	2.09 (0.51)	91	2.12 (0.48)	F = 0.25	1	.62
Social withdrawal, % high	14	26.9	8	20.5	22	24.2	$\chi^2 = 0.50$	1	.48
Stigma resistance, mean (SD)	52	2.14 (0.41)	39	2.00 (0.34)	91	2.08 (0.39)	F = 3.06	1	.08
Stigma resistance, % high	7	13.5	2	5.1	9	9.9	fisher exact	na	.29
Total, mean (SD)	52	2.16 (0.36)	38	2.06 (0.32)	90	2.12 (0.35)	F = 1.983	1	.16
Total, % high	7	13.5	2	5.3	9	10.0	fisher exact	na	.29
Adjusted total, mean (SD)	51	2.18 (0.37)	38	2.07 (0.38)	89	2.13 (0.38)	F = 1.84	1	.18
Lifetime experiences (ISE)									
Number of experiences, mean (SD)	52	4.48 (2.34)	39	4.05 (2.69)	91	4.30 (2.49)	F = 0.66	1	.42
None, %	1	1.9	2	5.1	3	3.3	$\chi^2 = 0.81$	2	.67
Some, %	36	69.2	25	64.1	61	67.0			
Numerous, %	15	28.9	12	30.8	27	29.7			
Impact, mean (SD)	50	4.07 (2.37)	39	3.98 (2.90)	89	4.03 (2.60)	F = 0.03	1	.88
Low impact, %	14	28.0	13	33.3	27	30.3	$\chi^2 = 0.47$	2	.79
Moderate impact, %	33	66.0	23	59.0	56	62.9			
High impact, %	3	6.0	3	7.7	6	6.7			
Recent experiences (MCESQ)									
Stigma, mean (SD)	52	16.88 (6.03)	39	16.05 (5.15)	91	16.53 (5.65)	F = 0.48	1	.49
Discrimination, mean (SD)	52	12.37 (6.29)	39	7.08 (4.17)	91	10.10 (6.06)	F = 20.72	1	<.01
Total, mean (SD)	52	29.25 (10.59)	39	23.13 (7.64)	91	26.63 (9.87)	F = 9.37	1	<.01
Numerous & frequent total, %	10	19.2	5	12.8	15	16.5	$\chi^2 = 0.67$	1	.42

For the ISMI scale, which assessed self-stigma, the mean and standard deviations for the subscales and total scores were as follows: alienation 2.20 (SD = 0.54), stereotype endorsement 1.92 (SD = 0.36), discrimination experience 2.33 (SD = 0.54), social withdrawal 2.12 (SD = 0.48), stigma resistance 2.08 (SD = 0.39), and adjusted total score

2.13 (SD = 0.38). The percentage of participants that scored above the mid-point (2.5) on the ISMI subscales and total scores – indicating high levels – were: alienation 31.9% (N = 29), stereotype endorsement 4.4% (N = 4), discrimination experience 36.3% (N = 33), social withdrawal 24.2% (N = 22), stigma resistance 9.9% (N = 9), and total score 10.0% (N = 9). The ISMI total score can be further subdivided into four categories, which revealed the following distribution of participants in relation to their levels of self-stigma: minimal 34.4% (N = 31), mild 50.0% (N = 45), moderate 14.4% (N = 13), and severe 1.1% (N = 1).

The following three ISMI items were rated highest by participants, indicating high levels of agreement: ‘I feel comfortable being seen in public with an obviously mentally ill person’ (mean = 2.51, SD = 0.74), ‘Others think that I can’t achieve much in life because I have a mental illness’ (mean = 2.43, SD = 0.77), and ‘People often patronize me, or treat me like a child just because I have a mental illness’ (mean = 2.41, SD = 0.73). It is notable that these three items relate to social reactions toward persons with mental illness. In contrast, the following three ISMI items with lowest average ratings relate to the ability for people with mental illness to attain social status: ‘I can’t contribute anything to society because I have a mental illness’ (mean = 1.67, SD = 0.65), ‘Mentally ill people shouldn’t get married’ (mean = 1.80, SD = 0.68), and ‘People with mental illness cannot live a good, rewarding life’ (mean = 1.81, SD = 0.68). Regarding the two items that were added to the ISMI for the forensic participants in this study, 36.0% (N = 18) indicated that they have greater difficulty accessing programs and services than other mental health patients, and 54.0% (N = 27) were of the opinion that, in comparison with other mental health patients, forensic patients are more dangerous.

Recent experiences of stigma and discrimination were measured with the Modified Consumer Experiences of Stigma Questionnaire (MCESQ). Frequent experiences with stigma or discrimination in the past month (i.e., an event/situation that occurred ‘often’ or ‘very often’) were reported by 58.2% (N = 53) and 22.0% (N = 20) of participants, respectively. Numerous and frequent combined experiences of stigma and discrimination in the past month (i.e., more than three events/situations that occurred ‘often’ or ‘very often’) were reported by 16.5% (N = 15) of participants. Interestingly, two of the three highest rated items – indicating that they had occurred the most frequently in the past month – that were applicable to the majority of the participants were regarding positive experiences: ‘Friends were understanding and supportive after learning that I receive psychiatric treatment’ (mean = 3.17, SD = 1.36), ‘I have been treated fairly by others who knew that I receive psychiatric treatment’ (mean = 2.48, SD = 1.15), and ‘I have avoided telling people outside my family that I have received psychiatric treatment’ (mean = 2.13, SD = 1.30). The one item that was added to the MCESQ for forensic participants revealed that 13.4% (N = 7) felt that, in the past month, they were frequently (i.e., ‘often’ or ‘very often’) discriminated against by others who knew that they were a forensic patient.

Lifetime experiences of stigma and discrimination was measured with the Inventory of Stigma Experiences (ISE). On average, participants reported having 4.30 (SD = 2.49), out of a possible ten, stigmatizing experiences in their lifetime. Most participants (67.0%, N = 61) had some (i.e., 1 to 5) stigma experiences in their lifetime, 3.3% (N = 3) of participants had none, and 29.7% (N = 27) reported numerous (i.e., 6 to 10) lifetime stigmatizing experiences. The majority of participants endorsed items

concerning the following: feeling that others will fear those who have a mental illness (72.5%, N = 66), feeling that others will devalue them because of their mental illness (61.5%, N = 56), and feeling treated unfairly or denied rights because of their mental illness (52.7%, N = 48). For the ‘stigma impact’ subscale, participants’ average total score was 4.03 (SD = 2.60) which is well below the mid-point of the scale (5.5). The one item that was added to the ISE revealed that 52.0% (N = 26) of forensic participants felt that they, in comparison with other mental health patients, were more highly stigmatized.

5.2.2 Longitudinal Changes in Self-Stigma

The table below provides a correlation matrix of ISMI subscale and total scores at T1 and T2. None of the participants had an average score at the highest (4.0) or lowest (1.0) ends of the ISMI, which suggests that the measure did not suffer from floor and ceiling effects.

Table 8. Correlation matrix of T1 and T2 self-stigma

Variables ¹	Time 2					
	1. A	2. SE	3. DE	4. SW	5. SR	6. TOT
Time 1						
1. ISMI Alienation (A)	.46***	.26*	.24*	.46***	.26*	.40***
2. ISMI Stereotype endorsement (SE)	.46***	.62***	.23	.49***	.13	.55***
3. ISMI Discrimination experience (DE)	.37***	.17	.50***	.44***	.10	.39***
4. ISMI Social withdrawal (SW)	.50***	.46***	.33**	.61***	.28*	.56***
5. ISMI Stigma resistance (SR)	.13	.09	-.03	.24*	.21	.04
6. ISMI Adjusted total (TOT)	.52***	.43***	.32**	.56***	.27*	.57***

¹ N = 71 to 73

*p < .05, two tailed; **p < .01, two tailed; ***p < .001, two tailed

The majority of the subscales were significantly correlated at T1 and T2, with the exception of the Stigma Resistance subscale. Total self-stigma at T2 is moderately to

strongly correlated with T1 alienation, T1 stereotype endorsement, T1 discrimination experience, T1 social withdrawal, and T1 total self-stigma.

The table below provides a comparison of average ISMI subscale and total scores at T1 and T2.

Table 9. Comparison of T1 and T2 self-stigma

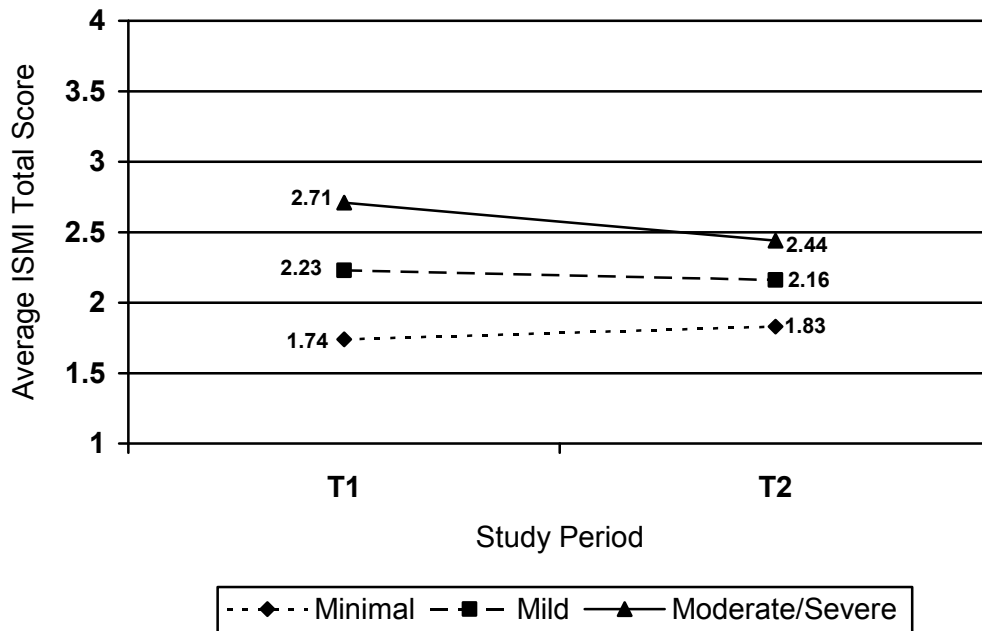
	T1		T2		Test Statistic	df	P
	N	Value	N	Value			
Self-stigma (ISMI)							
Alienation, mean (SD)	71	2.17 (0.54)	71	2.11 (0.54)	F = 0.81	1	.37
Stereotype endorsement, mean (SD)	71	1.92 (0.37)	71	1.88 (0.44)	F = 1.01	1	.32
Discrimination experience, mean (SD)	71	2.31 (0.51)	71	2.28 (0.43)	F = 0.37	1	.55
Social withdrawal, mean (SD)	71	2.13 (0.47)	71	2.11 (0.48)	F = 0.20	1	.66
Stigma resistance, mean (SD)	71	2.07 (0.36)	71	2.05 (0.32)	F = 0.18	1	.67
Adjusted total, mean (SD)	71	2.12 (0.39)	71	2.08 (0.39)	F = 0.90	1	.35

A repeated measures analysis of variance, without adding any covariates and focused only on within-subject contrasts, revealed that the decrease in ISMI total scores from T1 (mean = 2.12, SD = 0.39) and T2 (mean = 2.08, SD = 0.39) did not reach significance, $F(1, 71) = 0.90, p > .05$. After adding ‘change in symptoms’ as a covariate, the decrease in adjusted ISMI total score at T1 and T2 approached significance, $F(1, 70) = 3.66, p = .06$. Therefore, after statistically removing the effects of psychiatric symptoms, the self-stigma variable demonstrated substantial, but not significant, decreases over the one-year study period.

Another repeated measure analysis of variance was performed by adding a between-subjects factor that divided the sample into three discrete groups based on their

ISMI total score at T1 (minimal, mild, or moderate/severe). The figure below provides a comparison of T1 and T2 average ISMI scores for these groups.

Figure 3. Comparison of T1 and T2 self-stigma by group



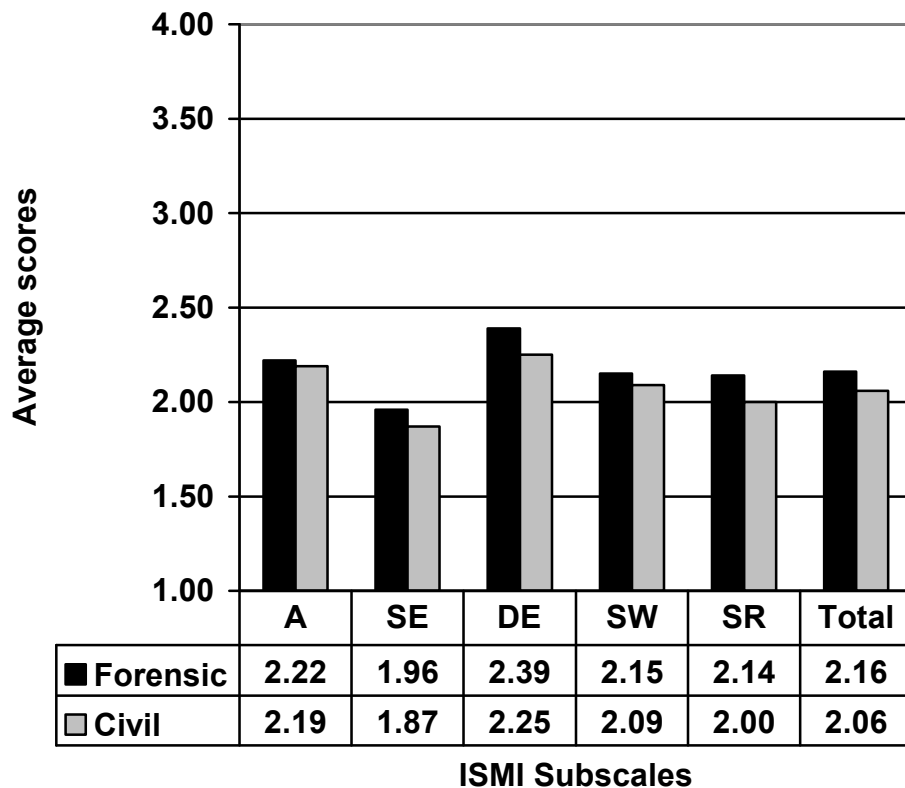
While the within-subject main effects remain non-significant, $F(1, 71) = 3.30, p > .05$; the interaction effects are significant, $F(2, 71) = 4.63, p < .05$. Therefore, the degree to which self-stigma changed over the two study periods was largely influenced by participants' level of self-stigma at baseline. On average, those with mild (mean = $N = 35$) or moderate/severe ($N = 10$) levels of self-stigma at baseline experienced a decrease in self-stigma, with the latter group demonstrating more dramatic reductions during the one-year study period. In contrast, participants with minimal ($N = 26$) levels of self-stigma at baseline experienced an increase in self-stigma during the study period.

To further explore longitudinal change in self-stigma, additional post-hoc subgroup analyses were carried out by dividing the participants into two groups: those who experienced an increase in self-stigma over the study period and those who experienced a decrease or no change. An increase in self-stigma (ISMI) from T1 and T2 was experienced by 46.5% (N = 33) of participants (mean difference = 0.23, SD = 0.22). A repeated measures analysis of variance indicated that the increase in self-stigma for this subgroup is significant, $F(1, 32) = 34.59, p < .001$. Similarly, analysis of total self-stigma scores for the 53.5% (N = 38) of participants who had experienced a decrease (mean difference = -0.27, SD = 0.29) revealed that this change was also significant, $F(1, 37) = 32.76, p < .001$.

5.3 ASSOCIATION BETWEEN GROUP MEMBERSHIP AND SELF-STIGMA

The ISMI subscale and total average scores for participants in the forensic and civil groups are illustrated in the figure below.

Figure 4. Average subscale and total scores on the Internalized Stigma of Mental illness scale by group



Point biserial correlations, presented in Table 11 (p. 172), indicate that cohort (forensic versus civil) was not significantly related to the ISMI total score ($r_{pb} = 0.14, p > .05$).

Table 7 (pgs. 162-163) outlines the results of a series of analyses (t-tests, chi squares) that confirm the two groups were not significantly different on most of the self-stigma scores.

The only exception is that participants in the forensic cohort, in comparison to those in the civil cohort, reported more frequent discrimination experiences in the past month ($t = 4.55, df = 89, p < .001$). When asked the direct question of whether they felt more stigmatized than non-forensic mental health patients, more than half of the forensic participants (52.0%, $N = 26$) answered ‘yes’; however, levels of self-stigma (as measured

by the ISMI adjusted total score) did not significantly differ between those who answered ‘yes’ (mean = 2.17, SD = 0.47) or ‘no’ (mean = 2.17, SD = 0.26) to this question, $F = .002$, $df = 1$, $p > .05$.

The results of a multiple linear regression analysis are presented in the table below.

Table 10. Relationship between T1 group membership and T1 self-stigma

	Unstandardized Coefficients		Standardized Coefficients		Sig.	Collinearity Statistics	
	B	Std. Error	Beta	t		Tolerance	VIF
Baseline Model (N = 88)							
T1 Psychiatric symptom severity	0.32	0.08	0.39	4.03	.000	.99	1.01
T1 History of incarceration	0.32	0.10	0.35	3.26	.002	.81	1.24
T1 Gender	-0.12	0.10	-0.13	-1.26	.213	.80	1.25
T1 Housing type	0.01	0.07	0.02	0.19	.854	.98	1.02
R	.49						
R ²	.24						
Sig.	.000						
Model with Group Membership							
T1 Group membership	0.09	0.09	0.11	0.98	.330	.69	0.32
T1 Psychiatric symptom severity	0.32	0.08	0.40	4.11	.000	.98	1.02
T1 History of incarceration	0.29	0.10	0.31	2.78	.007	.72	1.38
T1 Gender	-0.15	0.10	-0.16	-1.46	.148	.75	1.33
T1 Housing type	0.04	0.08	0.05	0.47	.639	.89	1.12
R	.50						
R ²	.25						
R ² change	.01						
Sig.	.000						

The baseline model, which contained four potential confounding variables, indicated that psychiatric symptom severity, history of incarceration, gender, and housing type

accounted for 24.2% of the variance in self-stigma. ‘Psychiatric symptom severity’ was the strongest contributor to self-stigma ($B = 0.32$, $SE = 0.08$, $p < .001$), followed by ‘history of incarceration’ ($B = 0.32$, $SE = 0.10$, $p = .002$). Adding group membership to the regression analysis had little effect on the model, accounting for an additional one percent of the variance in self-stigma. The group membership variable was not a significant contributor to level of self-stigma ($B = 0.09$, $SE = 0.09$, $p > .05$). Therefore, whether participants were receiving services in the forensic or civil mental health systems had no significant association with their levels of self-stigma.

5.4 CORRELATES AND PREDICTORS OF SELF-STIGMA

The tables below present the bivariate correlations between self-stigma and other key sociodemographic, psychosocial, and clinical variables at T1.

Table 11. Correlation matrix of T1 self-stigma and T1 sociodemographic variables

Variables ¹	ISMI Scales					
	A	S	D	W	R	Total
Cohort (Forensic=1)	.03	.14	.13	.05	.18	.14
Gender (Male=1)	-.07	.12	-.16	-.03	.00	-.01
Age (years)	-.01	-.07	.04	.09	.16	.02
Ethnicity (Caucasian=1)	.04	-.15	.25*	.05	-.08	.11
Relationship status (Married=1)	.05	.21	-.02	.22*	-.02	.10
Parenting status (Children=1)	.14	-.03	.16	-.07	.01	.08
Employment status (Employed=1)	.09	.03	-.05	-.02	.21*	.01
Receiving income assistance (Yes=1)	.09	.12	.02	.19	.13	.14
Education level (At least high school=1)	.06	-.13	.06	.02	.00	-.01
Housing type (Independent=1)	.05	-.07	.05	-.17	-.09	-.03
Living with others (Yes=1)	-.16	-.19	-.10	-.24*	-.15	-.18
Homelessness history (Yes=1)	.16	.18	.32**	.20	.04	.31**
Conviction history (Yes=1)	-.10	.13	.03	.07	.10	.07

Incarceration history (Yes=1)	.21*	.29**	.21*	.15	.22*	.28**
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¹ N = 88 to 91

*p < .05, two tailed

**p < .01, two tailed

A=Alienation; S=Stereotype Endorsement; D=Discrimination Experience;

W=Social Withdrawal; R=Stigma Resistance

Table 12. Correlation matrix of T1 self-stigma and T1 clinical variables

Variables ¹	ISMI Scales					
	A	S	D	W	R	Tot
Substance use disorder (Yes=1)	.05	.15	.07	.16	-.08	.15
Illness duration (years)	.04	.10	.07	.20	.06	.12
Age of 1 st hospitalization (years)	-.05	-.18	-.03	-.11	.12	-.10
Depression (BASIS24)	.35**	.21*	.31**	.32**	.02	.36**
Interpersonal (BASIS24)	.08	.06	-.03	.20	.18	.04
Self harm (BASIS24)	.11	.25*	.13	.28**	-.05	.23*
Emotional lability (BASIS24)	.20	.10	.31**	.21*	-.03	.23*
Psychotic (BASIS24)	.14	.19	.19	.30**	-.14	.25*
Substance use (BASIS24)	.11	.22*	.16	.16	-.11	.20
Overall symptoms (BASIS24)	.35**	.25*	.32**	.38**	.02	.38**
Unmet service needs (CANFOR)	.12	.12	.11	.20	-.13	.17
Total service needs (CANFOR)	.01	-.02	-.10	.16	-.22*	.07
Medication side effects (WQL item)	.04	-.02	.11	.12	-.11	.03

¹ N = 89 to 91

*p < .05, two tailed

**p < .01, two tailed

A=Alienation; S=Stereotype Endorsement; D=Discrimination Experience;

W=Social Withdrawal; R=Stigma Resistance

Table 13. Correlation matrix of T1 self-stigma and T1 psychosocial variables

Variables ¹	ISMI Scales					
	A	S	D	W	R	Tot
QoL – Life satisfaction	-.35**	-.16	-.38**	-.30**	-.25*	-.35**
QoL – Well being	-.39**	-.24*	-.25*	-.40**	-.15	-.36**
QoL – Occupational	-.19	-.02	-.19	-.10	-.10	-.12
QoL – Physical health	-.22*	-.09	-.22*	-.20	-.27*	-.19

QoL – Symptoms/ outlook	-.29**	-.23*	-.18	-.32**	.00	-.31**
QoL – Social relations	-.12	-.03	-.22*	-.16	.00	-.17
QoL – Activities of daily living	-.21	-.23*	-.07	-.21	.02	-.24*
QoL – Finances	-.27*	.02	-.23*	-.20	-.10	-.23*
QoL – Total	-.37**	-.15	-.30**	-.37**	-.19	-.34**
Service satisfaction	-.29**	-.10	-.28**	-.15	-.02	-.26*
Personal control (WQL item)	-.23*	-.03	-.24*	-.18	-.36**	-.19
Hope (WQL item)	-.20	-.06	-.09	-.14	-.11	-.12

¹ N = 79 to 91

*p < .05, two tailed

**p < .01, two tailed

A=Alienation; S=Stereotype Endorsement; D=Discrimination Experience;

W=Social Withdrawal; R=Stigma Resistance

Total self-stigma was associated with the following variables at a .01 significance level:

T1 homelessness history ($r_{pb} = .31$), T1 incarceration history ($r_{pb} = .28$), T1 total psychiatric symptom severity ($r = .38$), T1 life satisfaction ($r = -.35$), and T1 well being ($r = -.36$). In addition, T1 depression symptoms ($r = .36$) and T1 symptoms/outlook ($r = -.31$) were also correlated with T1 self-stigma; however, they were omitted from the model on account of multicollinearity problems.

As is detailed in the table below, the multiple hierarchical linear regression analysis revealed that these variables account for 32.8% of the variance in self-stigma.

Table 14. Relationship between T1 self-stigma and other T1 variables

	Unstandardized Coefficients		Standardized Coefficients		Sig.	Collinearity Statistics	
	B	Std. Error	Beta	t		Tolerance	VIF
Step 1 (N = 86)							
T1 History of incarceration	0.20	0.09	0.22	2.16	.034	.96	1.04
T1 History of homelessness	0.21	0.08	0.28	2.70	.008	.96	1.04
R	.39						
R ²	.15						
Sig.	.001						
Step 2							
T1 History of incarceration	0.22	0.09	0.24	2.54	.013	.96	1.04
T1 History of homelessness	0.18	0.07	0.23	2.41	.018	.95	1.05
T1 Total psychiatric symptoms	0.29	0.08	0.36	3.83	.000	.98	1.02
R	.53						
R ²	.28						
Sig.	.000						
Step 3							
T1 History of incarceration	0.19	0.09	0.21	2.23	.028	.93	1.07
T1 History of homelessness	0.16	0.07	0.22	2.30	.024	.95	1.06
T1 Total psychiatric symptoms	0.18	0.09	0.22	2.01	.048	.70	1.42
T1 Life satisfaction	-0.05	0.04	-0.14	-1.36	.178	.78	1.28
T1 Well being	-0.05	0.02	-0.19	-1.89	.062	.79	1.26
R	.57						
R ²	.33						
Sig.	.000						

Among all the variables included in the final model, the two socio-demographic variables – history of incarceration (B = 0.19, SE = .09, p < .05) and history of homelessness (B = 0.16, SE = 0.07, p < .05) – and the one clinical variable – psychiatric symptoms (B = 0.18, SE = 0.09, p < .05) – had the strongest relationship with T1 self-stigma. Together,

these three variables contributed 27.7% of the variance to T1 self-stigma. Therefore, higher level of self-stigma at T1 was associated with past experience of being incarcerated, past experience with being homeless, and current level of psychiatric symptoms severity. The two psychosocial variables – T1 life satisfaction ($B = -0.05$, $SE = 0.04$, $p > .05$) and T1 well being ($B = -0.05$, $SE = 0.02$, $p > .05$) – were not significantly associated with self-stigma and, combined, only contributed 5.1% additional variance to the overall model.

Another regression analysis was performed to examine the baseline variables that were associated with self-stigma at T2. After adding T1 self-stigma to the regression model, the following three baseline variables were entered: age, T1 total psychiatric symptom severity, and T1 well being.

Table 15. Relationship between T1 sociodemographic, psychosocial, and clinical variables with T2 self-stigma

	Unstandardized Coefficients		Standardized Coefficients		Sig.	Collinearity Statistics	
	B	Std. Error	Beta	t		Tolerance	VIF
Baseline Model (N = 70)							
T1 Self-stigma	0.57	0.10	0.57	5.69	.000	1.00	1.00
R	0.57						
R ²	0.32						
Sig.	.000						
Model with Predictors							
T1 Self-stigma	0.53	0.10	0.53	5.10	.000	.85	1.18
T1 Age	0.01	0.00	0.25	2.53	.014	.95	1.06
T1 Total psychiatric symptoms	0.20	0.09	0.22	2.12	.038	.83	1.21
T1 Well being	0.01	0.03	0.05	0.51	.614	.81	1.23
R	0.64						
R ²	0.41						
R ² change	0.08						
Sig.	.000						

As is shown in the above table, after removing the effects of self-stigma at T1, the included variables accounted for 8.4% of the variance in T2 self-stigma. In this model, age (B = 0.01, SE = 0.00, $p < .05$) and psychiatric symptom severity (B = 0.20, SE = 0.00, $p < .05$) were statistically significant. Therefore, being older and having higher levels of psychiatric symptom severity at baseline were associated with higher levels of self-stigma one year later.

5.5 ASSOCIATION BETWEEN SELF-STIGMA AND QUALITY OF LIFE

Table 13 (pgs. 173-174) displays the cross-sectional correlations between self-stigma and quality of life at T1. Overall T1 self-stigma was significantly ($p < .01$) related

with T1 life satisfaction ($r = -.35$), T1 psychological well-being ($r = -.36$), T1 symptoms and outlook ($r = -.31$), and T1 overall quality of life ($r = -.34$). Bivariate correlations that examined how variables changed from T1 to T2 (not shown), indicated that change in self-stigma from T1 to T2 was moderately, and negatively, correlated with change in quality of life ($r = -.27$, $p < .05$); however, the relationship was no longer significant after controlling for change in symptoms (Partial $r = -.21$, $p > .05$). This pattern suggests that the association between self-stigma and quality of life may be mediated by psychiatric symptoms. When asked a question directly, most participants (61.1%, $N = 55$) indicated that their quality of life had not been affected by experiences with stigma.

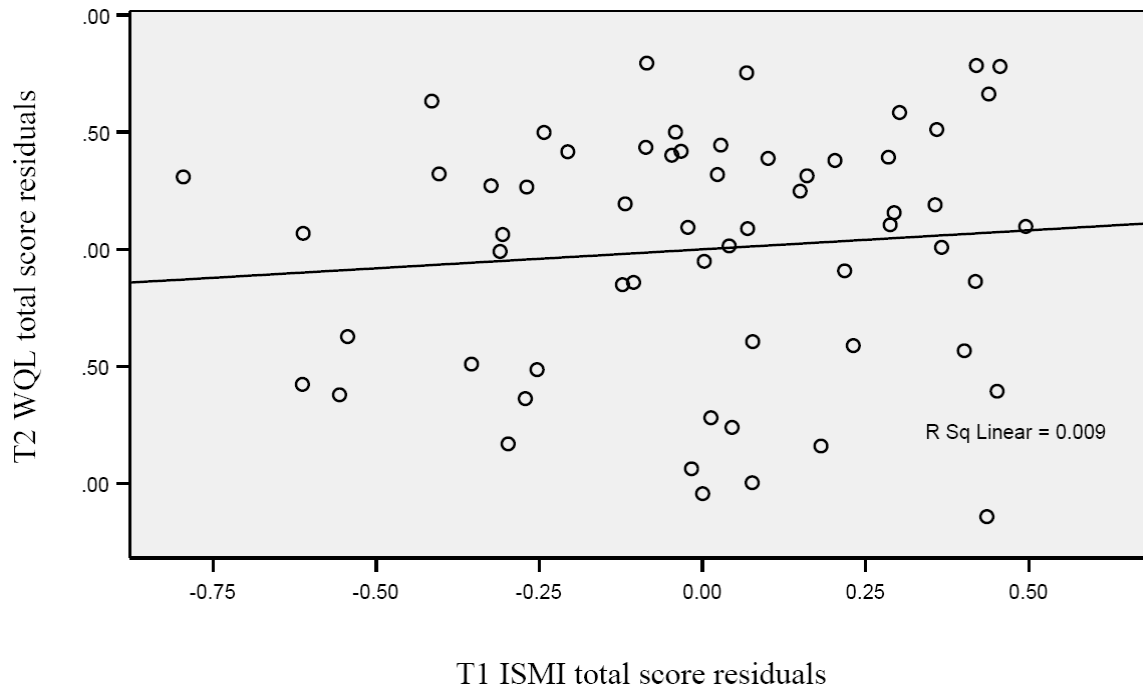
The results of a multiple hierarchical linear regression analysis that examined the extent to which overall self-stigma at T1 contributes to overall quality of life at T2 – independent of T1 quality of life and change in stigma – is presented in the table below.

Table 16. Relationship between T1 self-stigma and T2 quality of life

	Unstandardized Coefficients		Standardized Coefficients		Sig.	Collinearity Statistics	
	B	Std. Error	Beta	t		Tolerance	VIF
Baseline Model (N = 60)							
T1 Quality of life	0.47	0.12	0.44	4.00	.000	.84	1.19
T1 Psychiatric symptom severity	-0.43	0.17	-0.28	-2.54	.014	.87	1.15
T1 Service satisfaction	0.11	0.10	0.13	1.15	.256	.81	1.24
Change in stigma	-0.40	0.20	-0.22	-2.06	.044	.92	1.09
R	.66						
R ²	.43						
Sig.	.000						
Model with Self-Stigma							
T1 Self-stigma	0.16	0.23	0.09	0.72	.475	.66	1.52
T1 Quality of life	0.47	0.12	0.45	4.00	.000	.84	1.19
T1 Psychiatric symptom severity	-0.46	0.17	-0.29	-2.62	.011	.84	1.20
T1 Service satisfaction	0.12	0.10	0.15	1.27	.211	.77	1.30
Change in stigma	-0.33	0.22	-0.18	-1.48	.146	.71	1.40
R	.66						
R ²	.44						
R ² change	.01						
Sig.	.000						

The baseline model, which includes T1 quality of life, T1 psychiatric symptom severity, T1 service satisfaction, and change in stigma, indicates that these variables accounted for 43% of the variance in T2 quality of life. After controlling for the effects of these four variables, the analysis revealed that self-stigma at T1 is not a significant predictor of quality of life at T2 ($B = 0.16$, $SE = 0.23$, $p > .05$) for participants in the present study – accounting for less than one percent of the variance in T2 quality of life. The partial residual plot of the final multiple linear regression model is visually displayed in the figure below.

Figure 5. Partial residual plot of T1 self-stigma (ISMI total score) and T2 quality of life (WQL total score)



5.6 PARTICIPANTS' NARRATIVES

5.6.1 Qualitative Themes about Self-Stigma

Providing participants with the opportunity to talk about their lived experiences supplied rich insights into how they conceptualized and encountered self-stigma. The following six primary themes describe participants' qualitative narratives regarding self-stigma: (a) feeling/being knocked down; (b) passing-managing-overcoming; (c) public (mis)understanding; (d) social identity/location; (e) social disadvantage; and (f)

compulsory wellness. This section briefly describes each of these themes and highlights corresponding narrative excerpts.

The theme ‘feeling/being knocked down’ describes how participants felt that, on account of their illness, they had been mistreated by others and how this, in turn, had adversely affected their feelings about themselves. In relation to the behaviour of others, participants discussed the experiences of having been labelled, teased, gossiped about, belittled, blamed, discredited, dehumanized, ignored, victimized, taken advantage of, and unfairly treated. A common experience for participants was being treated as if they were incompetent or incapable because of their mental illness, as was reflected upon by one participant: “they [the public] think you’re not capable because you’re not a normal person like everyone else...they think you’re inferior just because you’re a little bit off your rocker.” Several participants also spoke about the experience of being treated badly, or thought of negatively, by family members: “My brother understands mental illness, but my sister thinks mental illness is a disgrace to the family. My family phones me but they don’t come to see me...they’re disgraced and think that I’m crazy and stupid.” Regarding how these experiences made participants feel, they described feeling hopeless, worthless, ashamed, depressed, stressed, worried, burdened, and doubtful of themselves. One participant suggested that these feelings compound the problems of mental illness: “makes you want to give up...don’t want that on top of your mental illness.” Another participant discussed how they were affected by the anticipation of social rejection: “...sometimes I think about people who don’t know me and are judging me due to [my] illness and I think less of myself.”

The second theme, 'passing-managing-overcoming', relates to the ways in which the participants coped and dealt with stigma that is associated with their mental illness. Within this theme, one of the most common narratives concerned the disclosure of mental illness, particularly the angst associated with the possibility that their illness will be exposed. One participant worried about the effect of disclosing their illness to others: "How am I going to pull it off? Am I scaring somebody when I say that I'm schizophrenic? There are things that I don't feel comfortable doing. It [stigma] exists when you talk about your illness." Judicious disclosure, a strategy for managing the type of information that is shared with others, was alluded to by many participants: "I don't tell people. I have in the past and they look at me like I'm in outer space. I tell them that I'm depressed and stressed out, not that I'm psychotic. If I said 'schizophrenia', they wouldn't understand."

Several comments within this theme are aligned with Goffman's (1963) concept of 'passing'; that is, trying to appear like someone who does not have a stigmatizing status or condition. For instance, participants provided a number of examples of shaping their own behaviour to ensure that they appeared normal to others: "I adjust my behaviour and try not to show side effects [of medications]...I dress up nicely so people don't think I am mentally ill. Keep clean and keep shaven so people won't suspect." Others described acting 'normal' (e.g., hiding psychiatric symptoms, not saying too much), so as to avoid giving away that they have a mental illness: "I try to prove that I'm normal...maybe not 100% normal, but at least not crazy." Participants also shared their strategies for managing and overcoming stigma, such as thinking positive thoughts, ignoring the negativity, avoiding others who are negative, and engaging in adaptive or

maladaptive activities (e.g., painting, writing, exercise, smoking cigarettes/marijuana, or participating in research). Surprisingly, a few participants talked about the positive features of stigma: “Stigma made me keep quiet about it [mental illness], but also made me more determined to get help.” Another participant indicated that because of social stigma about mental illness, “my family loves me more.” The idea that stigma brought people together, whether it be family members or a close-knit peer network of mental health consumers, was discussed by a few participants. Some participants drew strength from having to overcome the adversity resulting from mental illness stigma, as was articulated by one person: “Stigma motivated me to seek spiritual help...got me thinking that I want to be normal. Stigma positively affected my recovery by making me stronger.”

The third theme, ‘public (mis)understanding’, concerns social stereotypes and public ignorance about mental illness. Participants spoke about the portrayal of mental illness in the media – which they felt focused too heavily on negative and sensational stories – as a factor that shapes the public’s misguided opinions about mental illness. Participants’ narratives also contained several references to the public’s fear of mental illness and people who live with the illness. The public fear was thought to be partly produced by the fact that mental illness is unknown to, or not well understood by, members of the general public: “They’re not putting themselves in their [persons with mental illness] shoes – so they don’t understand. They don’t know how we feel. If they did, they’d be more compassionate.” As well, participants stated that the perception of people with mental illness as being violent, dangerous, and unpredictable produces fear among the general public. Another concern expressed by participants is that, as a group, people with mental illness are viewed in a homogeneous manner without recognition of

their diversity. In particular, the participants spoke about how stereotypes about mental illness are fuelled by visible cases of untreated mental illness, despite the fact that many people with mental illness receive appropriate treatment and manage well with their illness. Moreover, it was felt that the public incorrectly attributes a range of social problems (e.g., homelessness, violence) to mental illness:

When anything goes wrong, like someone jumping from a bridge, the public thinks it's a mental problem or mental illness. People think about the Downtown East Side [one of Canada's most marginalized urban communities] or drugs and alcohol when they think about mental illness.

Indeed, the narratives indicated that public perceptions about people with mental illness – often shaped by sensational news stories or by having street-level interactions with persons suffering from untreated mental illness – affected how participants felt about being associated with this group.

The next theme, 'social identity/location', relates to the experience of being separated from normal society and becoming a member of the 'people with mental illness' group. In one sense, social separation was described by participants as a feeling of being different from other people (e.g., not normal), which is exacerbated by not being able to engage in normal activities on account of the effects of mental illness: "I can't hold down a job...Made me feel like defective merchandise...Couldn't do the stuff that normal people do. It ruined my marriage." Social separation was also described as something that is self-imposed, such as choosing to withdraw from social situations in anticipation of negative social reactions:

I avoid talking to my neighbours because I'm worried that they'll ask me 'what do you do?' and I'll have to explain my mental illness and forensic involvement. [I] stopped going out to coffee as much because people will ask 'what do you do?' and I can't tell

them because of the stigma. I don't want them to look at me differently. It's better to be seen a stranger than mentally ill.

Participants also spoke about social separation as something that is externally imposed, such as when they are socially excluded or rejected by family and friends: "When everyone thinks you are mentally ill, they're not too quick to be friends."

Regarding their thoughts about being associated with 'the mentally ill', some participants indicated that they avoid social activities and groups (e.g., mental health clubhouses, peer support groups) that involve others with mental illness, particularly if they include individuals whose mental illness is untreated. On the other hand, several participants indicated that they embrace the camaraderie with others who live with – and share in – the experience of mental illness. The participants' responses contained many references to the feeling that their identity has been engulfed by mental illness. Some participants mentioned that any change in mood or wrong step that they make is attributed to their illness and is pathologized by others: "If I'm off my game, everyone thinks it's my illness acting up. Just because I'm feeling down doesn't mean that I'm going into a suicidal depression!" Related to this, one participant described the joy that he felt when his parents threw away a stack of books that they had collected about schizophrenia: "they now identify with other aspects of my life that I enjoy, such as fishing and boating." Overlapping with the previous theme, a number of participants alluded to the difficulty of carrying a social identity – of a person with mental illness – that is loaded with stereotypes and negative images: "People perceive the Forensic Psychiatric Hospital as being full of murderers and rapists. Being associated with this is stigmatizing."

In the fifth theme, 'social disadvantage', participants discussed various forms of disadvantage that intersect with the experience of having a mental illness. A predominant

narrative within this theme was the way in which the symptoms of mental illness, as well as the side effects of medication, prevented participants from participating in opportunities and acquiring social status: “When you have mental illness, it makes it hard to achieve joy and happiness like people without a mental illness.” In particular, participants discussed how the illness and side effects adversely affected education (“I got into UBC years ago, but couldn’t go because of the voices”), employment (“the medications make me dizzy and drowsy, which makes it difficult to work”), social networks (“I was getting sick a lot and friends were disappearing on me”) and intimate relationships (“They doped me so much, I can’t have sex or enjoy sex”).

Participants frequently referred to the restrictions that were imposed on them because of being poor, or not being able to find adequate housing: “How can people with mental illness make important contributions to society on a limited income?” For some, the stigma had hindered their advancement: “If I had no stigma I would be able to work, go to school, and my life would change.” Other participants indicated that their lives had changed course because of factors other than the stigma caused by mental illness: “Most of the stigma is from not having social status – job, money, education – from poor life choices, not as a result of the illness.” Reference was made by a few participants to other stigmatizing health conditions. For example, a couple of participants with HIV indicated that this status was more stigmatizing than their mental illness diagnosis. Others noted that, in comparison with mental illness (e.g., schizophrenia), substance use problems carried a greater amount of stigma: “[I] was using street drugs, which is more stigmatizing than mental illness. The two combined is even one hundred times worse for stigma.”

The final theme, ‘compulsory wellness’, relates to the tension between care and control, and the power differentials that participants reported experiencing while receiving compulsory mental health treatment. In the context of stigma, many participants talked about their experiences of being involuntarily hospitalized and detained:

They [the staff] didn’t treat you as a human being. The staff ignored what you had to say regardless of what you said...you were considered just mentally ill. My rights and freedoms have been denied ever since I got involved with mental health. My basic humanity was denied at the psychiatric hospital...Didn’t leave much room for recovery.

This sentiment was articulated by another participant who referred to involuntary hospitalization as an “inhumane experience” and “one of the worst times I could remember.” A number of participants expressed that they were forced to stay in the hospital for too long, which they felt was unfair: “The psychiatrists keep me trapped...keep me confined.” Moreover, being repeatedly removed from the community on account of psychiatric hospitalizations interrupted participants’ lives: “If I wasn’t sent back to hospital last time, I would have been further ahead.” The process of being civilly committed, especially the fact that it involves the police, was condemned by several participants: “How many people do they arrest if they have diabetes?”

Involuntary medication was another predominant narrative within this theme. For example, one participant offered the following comment regarding his own experience:

While in the hospital, I was told by staff that if I didn’t take my medications when I left that I’d be returned to hospital. It’s blackmail. I understand that I need meds to control the psychosis but I feel over-medicated. I’m forced to take medications that screw me up. I suffer from panic attacks from the meds and it slurred my speech.

Related to this, some participants spoke about a challenge of wanting to get well but being reluctant to disclose active symptoms to their treatment team because they would be forced into taking higher doses of psychiatric medication: “There are consequences for disclosing symptoms to the treatment team.” Participants also reflected on how they felt unfairly treated, or disrespected, by mental health service providers, especially psychiatrists. Of primary concern was the amount of power yielded by psychiatrists in relation to treatment decisions: “I want to tell him [the psychiatrist] to go to damn hell. Who is he to tell me how much medication I take? They force pills on you... I need people to stop telling me what to do!” Overall, the profound narratives contained within this theme are suggestive of participants’ feelings of powerlessness – including the perception that their personal autonomy had been constrained, and that their rights and freedoms had been curtailed.

5.6.2 Qualitative Themes about ‘Forensic’ Labelling

Participants in the forensic cohort responded to two open-ended questions regarding their experiences in the forensic mental health system. The following four themes emerged from their narratives: (a) Group of criminals; (b) A system designed for criminals; (c) Rejected; and (d) Cadillac service. This section briefly describes each of these themes, which are highlighted by corresponding narrative excerpts.

The first theme, ‘group of criminals’, captures forensic participants’ feelings about how society perceives and treats people who are involved in the forensic mental health system. A few participants referred to the ‘double stigma’ associated with having a mental illness and having a criminal background. One participant stated: “The public

health system don't hold patients to the same level of threat as forensic patients. Forensic patients are perceived and prejudged as a threat." Several participants talked about the fact that, regardless of their index offence or current level of criminogenic risk, they continued to be associated with a patient population that is generally considered to be violent and dangerous:

Service providers were afraid of me and thought that I was a violent person. The idea that I was institutionalized, not allowed out of hospital, supervised all the time would make people question, "why was he locked up?", and talk about me more.

While reflecting on the assumptions that are made about people who have been in a forensic psychiatric hospital, one participant said the following: "...we're there by law...committed a crime the get there. People wonder if we'll commit the same crime when we get out." A similar comment was made by another participant: "People are afraid of you. They think you're dangerous. They question your motives, actions...they think you need to be turned into the police." In contrast, many participants felt that their forensic involvement had no additional influence on their level of stigma, since people either do not know about their forensic history or do not differentiate between people in the forensic and civil mental health systems. In fact, one participant suggested that he would rather be known as a criminal than a person with mental illness: "I hide it...I tell people I went to Kent [a maximum-security correctional facility] and have probation. I don't associate with forensic because of embarrassment. My friends and family would label me 'mental'."

The second major theme, 'a system designed for criminals', relates to forensic participants' opinions that the forensic mental health system felt like a correctional system. Most of the comments within this theme concerned the characteristics of the

forensic psychiatric hospital: “Not really a hospital. More like a jail. Treated more like a criminal.” Another participant shared his experience, and mixed feelings, about being in the forensic psychiatric hospital: “I felt like garbage. It was like in jail. [I] didn’t like all those years there...it helped me though.” While responding to a question about the stigma associated with being a forensic patient, one participant focused on the experience of being admitted to a forensic psychiatric hospital: “...maybe it’s the hospital horror stories of FPH [Forensic Psychiatric Hospital]. It might be the hospital experience of FPH itself, rather than just being a forensic patient.”

The third theme, ‘rejected’, describes forensic participants’ experiences with discrimination and exclusion, which they attributed to their involvement in the forensic mental health system. Some participants described being rejected from mental health programs for being perceived as dangerous: “Even a clubhouse for people with mental illness shuns people involved with forensics. I can’t believe it – stigma amongst mental patients. Like their shit don’t stink.” In addition, several participants spoke about their difficulty obtaining housing: “...can’t get on a list at BC Housing when you are a forensic patient...things aren’t as accessible as they are in the civil mental health system.” Participants also described the anticipation, or actual experiences, of being rejected from others with mental illnesses who receive services in the civil mental health system. Other examples of rejection that participants attributed to their forensic status or history include being denied access to volunteer, employment, and educational opportunities.

The final theme, ‘Cadillac service’, includes the narratives that were offered by a small subset of forensic participants regarding the perception that forensic mental health services are superior to those offered by the civil mental health system. For example, one

participant who felt the court treated him unfairly by adjudicating him 'Not Criminally Responsible on account of Mental Disorder' changed his mind when he started receiving forensic services: "Being in forensics was good and helpful but it has a stigma. The tools they taught outweighed the stigma. Compared to the forensic system, the civil system just brushes you through without going into depth about my problems." Another participant discussed his experience in different parts of the mental health system and stated that forensic services offered a "higher class of treatment."

CHAPTER 6: STRENGTHS AND LIMITATIONS

The approach that was adopted in the present study provides for several methodological strengths. The QUAN+qual mixed method design enabled different aspects of the experience of self-stigma to be examined. Stigma is a complex construct and, as such, a full understanding of the phenomenon demands the use of more than one research method. Mixed method designs are the preferred approach for exploring research questions that pertain to more than one conceptual level (e.g., micro, meso, or macro) (Morse & Niehaus, 2009) – a principle which is clearly applicable to the present study.

The advantage of using standardized, quantitative measures is that comparisons between groups and variables and across time could be made in a rigorous, transparent, and replicable manner. The supplemental qualitative data allowed for an enriched exploration of the self-stigma construct through the vantage point of the participants' lived experiences. As well, the qualitative responses provided insight into the quantitative patterns and trends that were uncovered. Another advantage is that gathering quantitative and qualitative information allowed the data to be analyzed using both deductive and inductive approaches. The mixed method design also had the benefit of engaging participants whose response preferences varied. For a host of reasons (e.g., active psychiatric symptoms, poor language skills, or medication side effects) some participants had difficulty articulating their experiences and benefited by having fixed response options. Other participants had problems, for various reasons (e.g., poor concentration, or an inclination for story-telling), using the quantitative scales and preferred giving

narratives about their experiences. By offering participants with different ways of answering questions, the research was more accessible and inclusive than if only a single means of contributing (i.e., quantitative or qualitative) was offered.

Another major strength of the present study is the prospective, longitudinal design – which is lacking in the self-stigma research literature. Because variables were measured at two time points, questions concerning patterns of change, and the temporal order of variables, could be answered. This study was able to explore naturalistic change in stigma over a one-year period. In addition, the longitudinal design provided the opportunity to identify the direction and magnitude of relationships between self-stigma and other sociodemographic, psychosocial, and clinical variables. Indeed, a significant finding of the current study was that the association between self-stigma and quality of life was established on a cross-sectional basis, but the relationship was not confirmed longitudinally. Another unique finding that has not been revealed in other published studies is that significant cross-sectional and longitudinal relationship between past experiences of homelessness and incarceration with levels of self-stigma.

The final research strength relates to social justice and inclusiveness. The duty of distributive justice in research is enshrined in the Tri-Council Policy Statement: “there is nonetheless an obligation to conduct research involving such people [vulnerable populations] because it is unjust to exclude them from the benefits that can be expected from research” (Tri-Council Working Group, 1997, p. 5.4). The population that was sampled for the present study may be considered vulnerable, marginalized, and/or oppressed. This is confirmed by the participants’ sociodemographic data and their qualitative narratives concerning social disadvantage. Moreover, those who are legally mandated to receive mental health treatment are particularly difficult to engage in

research. A commitment to social (and distributive) justice was embedded within the present research by including individuals who have historically been excluded, devalued, discriminated against, and not listened to. Despite the fact that many challenges existed in relation to participant recruitment, the great value of shedding light on the perspectives and voices of these participants cannot be overstated. Their research participation has both direct (e.g., feeling included) and indirect (e.g., improving knowledge) benefits for themselves, for the mental health system, and for society.

Five major limitations need to be considered in interpreting the findings and conclusions of the present study. First, the study participants were naturally organized into two groups (forensic and civil); group membership was not randomly allocated and participants in the groups were not matched (other than on diagnosis). Therefore, systematic biases and unidentified confounding variables may threaten the study's internal validity. As a consequence, causation could not be established in the present study. Moreover, explanations of causality are not offered by the present study's findings since they could not meet the criteria of strength of association, consistency, specificity of the cause, and experimental evidence (Hill, 1965). Second, participants were recruited using a non-probabilistic sampling technique, with two-thirds of potential participants who met the inclusion criteria not recruited. Consequently, self-selection bias may undermine the validity of the findings (Marczyk et al., 2005). Systematic error cannot be ruled out since the decision to participate, or not to participate, in the research may have been associated with factors (e.g., level of stigma, severity of symptoms) that are of relevance to the study. The possibility that individuals who are highly self-stigmatized may have been unwilling to participate in a research interview presents a threat to the study's internal validity.

Third, the results are based on the experiences of people who received compulsory community treatment services in selected clinics located in British Columbia, Canada – primarily in the Metro Vancouver area. As well, the majority of participants in the present study were receiving services in the forensic mental health system. In light of this, generalizations based on these findings to compulsory community treatment populations in other jurisdictions, especially those with different mental health service delivery models, should be made with caution. Sufficient details about the study context, the sample characteristics, and the research procedures were provided to allow researchers to assess the degree of ‘fittingness’ or ‘transferability’ of the present study to their own situation or setting (Hellstrom, 2008).

Fourth, the sample size was modest in relation to the number of comparisons made, which could have increased the risk of spurious findings (either Type 1 or Type 2 errors). Several of the regression models are underpowered, particularly the model that examines the relationship between T1 self-stigma and T2 quality of life. With only 60 participants, the statistical power level is .66, which is substantially lower than the desired convention of .80 (Soper, 2010a). Unfortunately, the study’s target sample size of 150 participants could not be achieved within a reasonable timeframe, which would have addressed this limitation.

Lastly, quantitative self-stigma measures revealed levels of self-stigma that appeared relatively low in comparison to what was uncovered by the participants’ qualitative narratives. It is possible that the quantitative measures did not adequately capture key domains, such as autonomy, power, and coercion, which were of particular relevance to the experiences of self-stigma for this sample. Another possibility is that quantitative and qualitative approaches for measuring self-stigma may yield different

results. A study that compared different methods for assessing public attitudes toward people with mental illness found that positive results (i.e., favourable attitudes) were associated with close-ended interview formats and negative results (i.e., stigmatizing attitudes) were related to open-ended interview formats (Brockman, D'Arcy, & Edmonds, 1979).

CHAPTER 7: DISCUSSION AND CONCLUSION

The discussion is organized around the three main objectives of this dissertation. The first objective was to understand how people with severe mental illness who receive compulsory community treatment experience self-stigma. Second, the dissertation sought to understand how the ‘forensic’ label, which is a by-product of structural-level considerations, affects the subjective experience of self-stigma. The final objective concerned the degree to which self-stigma affects the quality of life of people with mental illness who receive compulsory community treatment. For each of these objectives, the findings are interpreted, the implications are discussed, and future research directions are identified. This section ends with concluding remarks about the research and its broad implications.

7.1 COMPULSORY TREATMENT AND STIGMA

The hypothesis that compulsory community treatment is associated with high levels of self-stigma was not supported by the data. In this study, only 10% of participants demonstrated high levels of self-stigma; however, the results uncovered substantial variability regarding participants’ levels of self-stigma. The average ISMI subscale scores of the present sample were compared with the findings of six published studies (Lysaker, Buck, Taylor, & Roe, 2008; Lysaker, Davis et al., 2007; Lysaker, Roe et al., 2007; Lysaker, Salyers, Tsai, Spurrier, & Davis, 2008; Lysaker, Tsai, Yanos, & Roe, 2008;

Lysaker, Vohs, & Tsai, 2009). As is presented in the table below, the median ISMI subscale scores, across the six studies, were as follows: alienation 2.39 (SD = 0.68), stereotype endorsement 2.00 (SD = 0.53), discrimination experience 2.41 (SD = 0.66), social withdrawal 2.34 (SD = 0.67), and stigma resistance 2.17 (SD = 0.51).

Table 17. Comparison of ISMI mean scores within present study and other published studies

	Present Study	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Median (1 to 6)
Alienation, mean	2.20	2.49**	1.39***	2.31	2.39*	2.45**	--	2.39*
Stereotype endorsement, mean	1.92	2.09*	1.14***	1.99	1.97	2.00	2.04	2.00
Discrimination experience, mean	2.33	2.38	1.42*	2.42	2.41	2.48	--	2.41
Social withdrawal, mean	2.21	--	1.31***	2.30	--	2.37*	2.43*	2.34
Stigma resistance, mean	2.08	--	1.24***	2.17	--	2.25**	--	2.17
Adjusted total, mean	2.12	--	1.31***		--	--	--	--

Study 1: Lysaker, Buck, et al. (2008); Study 2: Lysaker, Davis, et al. (2007); Study 3: Lysaker, Roe, et al. (2007); Study 4: Lysaker, Salyers, et al. (2008); Study 5: Lysaker, Tsai, et al. (2008); Study 6: Lysaker, Vohs, et al (2009)

* $p < .05$; ** $p < .01$; *** $p < .001$

Student t-test analyses reveal that the current sample's scores were significantly lower on the alienation subscale ($t = 2.51$, $df = 527$, $p < .05$). The other ISMI subscale scores (stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance) were not statistically different ($p > .05$) from those reported by other studies.

The percentage of participants in the present study that scored above the mid-point (2.5) on the ISMI subscales was also compared with findings from four other published studies (Ritsher & Phelan, 2004; Sibitz et al., 2009a; Werner, Aviv, & Barak, 2008;

Werner, Stein-Shvachman, & Heinik, 2009). As is presented in the table below, the results across the four studies were as follows: alienation 38.5% (N = 146), stereotype endorsement 20.1% (N = 76), discrimination experience 33.8% (N = 128), social withdrawal 30.1% (N = 114), and stigma resistance 46.5% (N = 151).

Table 18. Comparison of ISMI high scores within present study and other studies

	Present Study	Study 1	Study 2	Study 3	Study 4	Total (1 to 6)
Alienation, % high (N)	31.9 (29)	37.8 (31)	44.0 (69)	27.9 (24)	40.7 (22)	38.5 (146)
Stereotype endorsement, % high (N)	4.4 (4)	14.6* (12)	15.3** (24)	30.2*** (26)	25.9*** (14)	20.1*** (76)
Discrimination experience, % high (N)	36.3 (33)	47.6 (39)	37.6 (59)	27.9 (24)	11.1** (6)	33.8 (128)
Social withdrawal, % high (N)	24.2 (22)	40.2* (33)	33.8 (53)	20.9 (18)	18.5 (10)	30.1 (114)
Stigma resistance, % high (N)	9.9 (9)	29.3** (24)	63.1*** (99)	32.6*** (28)	--	46.5*** (151)
Total, % high (N)	10.0 (9)	28.4* (23)	--	--	--	--

Study 1: Ritsher et al. (2004); Study 2: Sibitz et al. (2009); Study 3: Werner et al. (2008); Study 4: Werner et al. (2009)

* $p < .05$; ** $p < .01$; *** $p < .001$

Chi square analyses indicate that significantly fewer participants in the present study scored above the mid-point on the stereotype endorsement subscale ($\chi^2 = 12.52$, $df = 1$, $p < .001$) and the stigma resistance subscale ($\chi^2 = 40.17$, $df = 1$, $p < .001$). There were no other significant differences on the remaining ISMI subscales.

Overall, these results suggest that the present sample did not have substantially higher levels of self-stigma in comparison to other samples of individuals with severe mental illness that are not receiving compulsory mental health treatment. This finding contradicts the assumption that people with mental illness whose treatment is imposed by

means of coercive legal mandates, either via the *Criminal Code* or *Mental Health Act*, would be more likely to: experience stigma (e.g., discrimination experiences), perceive stigma (e.g., alienation, stereotype endorsement), and engage in maladaptive ways of resisting stigma (e.g., social withdrawal).

Link and colleagues (2008) also found that the manner by which people with mental illness receive treatment services (e.g., involuntarily or voluntarily) is unrelated to perceptions of stigma; however, a subjective measure of perceived coercion that was incorporated into their study was found to be significantly associated with self-stigma. The authors suggest that compulsory treatment status may be a poor proxy measure of coercion, which provides some explanation for the present study's findings. Similar to Link and colleagues (2008), the current study uses compulsory community treatment as an objective measure of coercion; however, participants' subjective perceptions about treatment coercion were not formally assessed. One item that queried the participants' perceived level of personal control was not significantly associated with self-stigma ($p > .05$); however, because a single item is insufficient for assessing a complex construct. This study can only conclude that the objective measure of coercion is unrelated to self-stigma for the current sample.

The influence of coercion was only one of the rationales behind the original hypothesis that compulsory community treatment would exacerbate experiences of self-stigma. The other rationale was that the creation of a legally defined subgroup of people with mental illness would contribute to elevated feelings of self-stigma among those who were assigned to that group. A symbolic interactionist approach suggests that an individual's sense of self develops through a social process that involves understanding

how one is perceived by others. Moreover, the secondary deviance hypothesis asserts that the identity of an individual who is deemed deviant may be transformed by the ways in which society reacts to that deviance. In the present study, it was originally presumed that the differential treatment created by formal legal mechanisms would adversely affect the way in which individuals perceive themselves and the world around them. That is, society's choice to force treatment on a subgroup of individuals with mental illness would exacerbate levels of self-stigma for this population.

The data indicate that compulsory community treatment does not engender self-stigmatizing effects beyond that which is produced by mental illness itself. This is evidenced by the fact that most of the qualitative narratives about stigma concerned mental illness itself, rather than the compulsory nature of treatment services. Moreover, the participants reported high levels of satisfaction with the mental health services they were receiving, including those mandated by the conditions of their compulsory community treatment. These findings, together, suggest that experiences of self-stigma, among the present sample, were predominantly affected by concerns with issues other than compulsory treatment service provision. The participants did not seem to identify with being associated with a subgroup within the larger population of people with mental illness. Overall, relative to the effects of mental illness and other forms of social disadvantage (e.g., homelessness), their sense of self appeared unaffected by the fact that they were compelled to adhere to a prescribed course of mental health treatment.

Even though compulsory community treatment was not perceived as a salient social category resulting in identity transformation for the present sample, there is evidence to suggest that it does prevent individuals from achieving social advancement

and reputable social roles. For some participants, the requirements and restrictions imposed on them by compulsory treatment did create additional barriers for social advancement. For example, participants mentioned that they were restricted from traveling, which limited opportunities to visit with family, find employment, and experience other places. The requirement to attend clinical appointments during daytime hours, or else face the consequence of being returned to hospital, also posed some problems in relation to maintaining employment. This finding relates to Chiricos and colleagues' (2007) description of "structural impediments to conventional life" (p. 548) and is consistent with findings from criminological research that legal sanctions may perpetuate exclusionary processes that are known to foster criminality (Bernburg & Krohn, 2003; Bernburg et al., 2006). For participants, these barriers are in addition to those that are directly related to mental illness and other forms of marginalization (e.g., poverty).

Participants' descriptions of their experiences with involuntary hospitalization closely resemble Goffman's (1961) notion of 'total institutions'. Participants reflected on the hospitalization experiences as something that was dehumanizing and with which they had difficulty coming to terms. Through their narratives, participants transformed 'the hospital' into a symbol of oppression, injustice and powerlessness, and psychiatrists were symbolized as the oppressors. Participants were not keen on repeating their hospital experiences. As such, many discussed going through the motions of accepting their mental illness (or at least not aggressively denying it), complying with their medications (despite the side effects), and being on good behaviour so as to avoid the possibility that they would be returned to hospital. They also associated such behaviour with an increased

likelihood that their freedom and liberty would be restored. Moreover, as long as they continued to embody the statuses of ‘mentally disabled’ and ‘unemployed’, participants would continue receiving a marginal income (though greater than welfare) from disability benefits. This pattern bears resemblance to Scheff’s (1968) description of a social system that rewards people for assuming a stereotyped role, which may also serve to reinforce their deviant identity and social exclusion.

In conclusion, the quantitative results do not support the hypothesis that compulsory community mental health treatment is associated with high levels of self-stigma for people with mental illness. Both the quantitative and qualitative findings indicate that self-stigma is more strongly connected to the experience of having a mental illness, rather than being forced to comply with mental health treatment services. The qualitative data do provide some evidence that compulsory community treatment has the potential to create barriers that ultimately prevent people with mental illness from emerging out of stereotyped social roles. These results have implications for designing strategies that seek to reduce self-stigma experiences for people with mental illness; particularly in light of the present study’s finding that self-stigma does naturally change with time and, therefore, may be amenable to intervention. Regardless of whether they actively use treatment services on an involuntary basis, people with mental illness share a common struggle for choice, autonomy, respect, fairness, inclusion, and equality – especially in relation to how their services should be delivered. These issues are interwoven into the stigmatizing experiences related to living with mental illness.

While these preliminary finding suggests that compulsory treatment appears to be unrelated to self-stigma, policy makers and service providers should be aware that the

practice may inadvertently create additional challenges for a person's recovery. Future research should examine the long-term effects of compulsory mental health treatment on stigma, service engagement, social inclusion, and recovery for people with mental illness.

7.2 FORENSIC LABELLING AND STIGMA

The hypothesis that receiving compulsory community treatment in a specialized forensic mental health system is associated with relatively high levels of self-stigma was not supported by the data. Whether participants were receiving services in forensic or civil mental health systems had virtually no bearing on quantitative levels of self-stigma. Similar to other studies that have examined the effects of organizational-level factors on self-stigma (Verhaeghe & Bracke, 2007), the present study found that group membership (forensic or civil) – determined via structural factors (e.g., policy, health system design) – only accounted for a small amount (1%) of variance in self-stigma after controlling for the effects of potential confounding variables. Therefore, forensic group membership did not significantly exacerbate experiences of self-stigma beyond those related to the mental illness itself.

One explanation for this finding is that certain features of the specialized forensic mental health system in British Columbia may serve to protect its clientele against additional experiences of self-stigma. The specialized and dedicated services that have been developed within, and funded by, the forensic system provide clients with ready access to necessary programs and services (e.g., housing, employment, hospital beds, etc). For example, a significantly higher proportion of participants in the forensic group (57.7%, N = 30) were living in supportive housing compared with those in the civil group

(25.6%, N = 10). Therefore, these specialized services, which are specifically designed for 'forensic' mental health service users, may insulate individuals from certain structural barriers as long as they remain under the mandate of the forensic mental health system. This arrangement means that people who receive services in the forensic mental health system may, in fact, encounter fewer service barriers than those in the civil mental health system, which was evidenced by the fact that 'forensic' participants in the present study had significantly fewer unmet service needs than the 'civil' participants. For forensic participants, the fact that they received specialized forensic services (e.g., in a designated forensic clinic) did not appear to be associated with greater stigma above that which is experienced when receiving other forms of mental health services. In fact, some participants suggested that they were receiving higher quality care in the forensic system. The legal framework that guides compulsory community treatment procedures for forensic participants (i.e., conditional discharge) has greater transparency and due process than that which guides compulsory treatment procedures for civil participants (i.e., extended leave) in British Columbia. While this was not mentioned by the participants, it could be another element that increases a sense of procedural fairness and decreases perceptions of self-stigma for individuals in the forensic mental health system.

Another way in which the forensic system may work toward minimizing the stigmatizing effects of being a 'forensic' client is through the active advocacy that is provided by the professionals who deliver forensic services. This 'buffering effect' hypothesis suggests that, in advocating for access to services on behalf of their clients, forensic mental health professionals may bear the brunt of the stigma and discrimination, which is not then transferred to their clients. Therefore, forensic clients may gain access

to programs and services outside of the forensic mental health system without being privy to the challenges that were faced by their case managers as a result of the client's background or status (e.g., history of violence, prior criminal justice involvement, or active substance use problems). Unfortunately, the 'buffering effect' hypothesis was formulated well into the study and could not be evaluated.

In addition to the influence of service-level factors, an intersectional approach suggests another explanation for understanding the non-significant group membership findings. Using this approach, multiple social locations produce interlocking, rather than additive, effects in relation to an individual's experience of disempowerment and marginalization (Collins et al., 2008). Therefore, adding a 'forensic' layer to the 'compulsory treatment' and 'mental illness' statuses would have the effect of shifting a person's self-stigma experiences, rather than exacerbating them. The qualitative data provides evidence of this interlocking effect. Overall, the forensic and civil participants provided comparable narratives in relation to their experiences of self-stigma. The one exception is that the narratives of forensic participants were more focused on how they feel perceived by others as potentially violent and dangerous. Moreover, the forensic sample discussed feeling as if they were treated like a group of criminals, which includes their perceptions about mental health services (i.e., hospital like a jail). Therefore, receiving services from the forensic mental health system appears to offer a different type of subjective experience that is unrelated to the severity of self-stigma.

While additional confirmatory evidence with larger samples is needed before reaching firm conclusions, the present study's data suggest that 'forensic' labelling, or receiving mental health services in a specialized forensic system, is not associated with

increased experiences of self-stigma. Rather the quantitative and qualitative findings suggest that people with mental illness who receive compulsory community treatment services in the forensic and civil mental health systems of British Columbia share common experiences with respect to stigma. These findings have important implications for understanding the relative strengths and weaknesses of organizing forensic mental health services using a specialized service delivery model.

The results suggest that a specialized forensic program, such as the Forensic Psychiatric Services Commission of British Columbia, can function without exacerbating experiences of self-stigma for people who use these services. Further research is needed to identify the service-level variables (e.g., specialized programs, forensic service providers) that play a critical role in mediating the effects of self-stigma. Another question that remains unanswered by the current study is whether specialized forensic service delivery models are associated with higher levels of self-stigma in comparison to that which is experienced within less specialized forensic service delivery models. Lastly, forensic participants in the present study were actively receiving services in the forensic mental health system. Therefore, the study was unable to provide insight into their experiences after they fall outside the mandate of the forensic mental health system (i.e., absolute discharge). It is possible, that forensic labelling has enduring and powerful effects that become apparent after an individual leaves the protection of a specialized forensic mental health system. Future research should examine the possibility that the ‘forensic’ label has effects that endure after an individual leaves the forensic system.

7.3 QUALITY OF LIFE AND STIGMA

It was hypothesized that, over time, self-stigma would have the direct effect of eroding quality of life for people with mental illness who were receiving compulsory community treatment; however, this relationship was not confirmed by the data. While the cross-sectional analyses revealed a moderate, negative relationship between self-stigma and quality of life, the longitudinal analyses indicated that self-stigma does not predict quality of life. In fact, after controlling for the effects of potential confounding variables, baseline self-stigma accounted for less than one percent of the variance in quality of life one year later. Quality of life at one-year follow-up was most strongly predicted by baseline levels of psychiatric symptom severity.

This finding is surprising, given the robust results that were suggested by the large body of published studies concerning the association between self-stigma and quality of life. Several authors have claimed that stigma has a negative influence on the quality of life of people with mental illness (Corrigan, Kerr et al., 2005; Finzen & Hoffman-Richter, 1997; Katschnig, 2000; Wahl, 1999), with a literature review of the determinants of quality of life indicating the following: "...although the scientific evidence so far is not overwhelming, stigma experiences in a broader sense might be a target for intervention with relevance for quality of life" (Hansson, 2006, p. 50). Closer inspection of the published research reveals that of the twenty-four published studies that have examined the relationship between self-stigma and quality of life, only three have used longitudinal designs. One of the longitudinal studies (Lysaker, Davis et al., 2007) detected a cross-sectional correlation between self-stigma (also using the ISMI) and quality of life, but, like the present study, failed to establish a significant relationship between baseline self-

stigma and quality of life six months later. Limitations of that study include a small sample size ($N = 36$) and a narrowly-conceived measure of quality of life. The two other studies that used longitudinal designs to investigate the relationship between quality of life and self-stigma (Markowitz, 1998, 2001) only measured stigma at follow-up, not at baseline. Therefore, the present study represents the only longitudinal research to date that has evaluated the degree to which baseline self-stigma predicts quality of life one year later in a sample of individuals with mental illness, using both a comprehensive measure of quality of life and a sample size that is greater than 40 participants. The present study's findings should be interpreted with caution, since the small sample size and lack of statistical power may have weakened the ability to detect statistical associations between self-stigma and quality of life.

The findings do not suggest that self-stigma has no deleterious effects for people with mental illness. This conclusion is not confirmed by the qualitative data. Rather, the present study offers preliminary evidence to suggest that self-stigma may not a useful predictor of subjective quality of life among people with mental illness who receive compulsory community treatment services. Malla and colleagues (2006) suggest that trait characteristics (i.e., stable), rather than state characteristics (i.e., dynamic), are more likely to influence a stable construct such as quality of life, which may offer some explanation of the non-significant findings in the present study. The critics of labelling theory argue that psychiatric symptoms have more troubling effects for people with mental illness than the effects of labelling and stigma (Gove, 1970), which, in relation to quality of life, is confirmed by the present study. Among the variables measured in the current study, psychiatric symptom severity was the strongest predictor of quality of life.

For participants – who live with severe and persistent mental illness – psychiatric symptoms have the potential to impair all areas of their lives, including finances, employment, relationships, well-being, outlook, and life satisfaction. There is some suggestion in the literature that, for people with mental illness, the effects of stigma are at least as equally pernicious as the effects of the illness itself. However, the present study suggests that the deleterious effects of psychiatric symptoms on quality of life for the present sample may surpass the direct effects of self-stigma.

The recovery model offers an alternative way of viewing these findings. Unlike the deterministic, linear pathway between official labelling and negative outcomes that is suggested by the modified labelling approach (Link et al., 1989), the recovery model emphasizes the role of self-empowerment and self-determination in determining outcomes (Andresen, Caputi, & Oades, 2010; Liberman & Kopelowicz, 2005; Pouncey & Lukens, 2010). Recovery has been defined as, “a way of living a satisfying, hopeful, and contributing life even with the limitations cause by illness” (Anthony, 1993). Accordingly, an individual’s membership within a stigmatized group does not automatically mean that they will be self-stigmatized or that they will suffer from a poor quality of life (Rüsch, Angermeyer, & Corrigan, 2005). The ability for people with mental illness to lead fulfilling lives is evident in several research studies (Jensen & Wadkins, 2007; Suto, Murray, Hale, Amari, & Michalak, 2010). While stigma is often identified as a barrier to recovery and wellness, people with mental illness are not passive recipients of its negative effects (Link & Phelan, 2001). Stigma is something that many people with mental illness manage or resist (Corrigan et al., 2010; Sibitz, Unger, Woppmann, Zidek, & Amering, 2009b), and it may even lead to positive outcomes (e.g., empowerment) (Rüsch et al., 2005), as was revealed by the present study. Consistent with

the recovery model, a sense of hope emerged from findings of the present study. Despite participants' routine experiences with social oppression and disadvantage, baseline levels of self-stigma were not strongly associated with quality of life at one-year follow-up. Moreover, few participants had severe levels of self-stigma. These results paint a more hopeful and optimistic picture, in comparison to that which is suggested by the labelling theoretical perspective, for individuals who are subjected to official labelling processes (e.g., criminal justice processing, mental illness diagnoses, compulsory treatment).

These preliminary findings concerning the relationship between self-stigma and quality of life have important implications for the manner in which mental health interventions are designed and evaluated. Interventions that seek to reduce self-stigma among people with mental illness should not necessarily expect to find significant improvements in quality of life. Moreover, interventions that are designed to improve the quality of life among people with mental illness should not expect to achieve significant results by targeting self-stigma. Additional longitudinal research on other populations, with larger samples, is needed before firm conclusions can be reached regarding the relationship between self-stigma and quality of life.

7.4 CONCLUSION

The overall goal of this dissertation was to examine the social structures and processes that influence the management of mental illness, and how these, in turn, affect the subjective experiences of people who live with mental illness. To achieve this goal, the policies that provide the framework for compulsory community treatment in the forensic and civil mental health systems were thoroughly reviewed. Particular attention

was paid to the tensions and contradictions that are embedded within the policies, including those that concern jurisdictional issues (e.g., provincial versus federal), medical-legal principles (e.g., care versus control), prioritization of needs (e.g., the individual versus the State), and ethics (e.g., beneficence versus malfeasance). These policy tensions have both direct and indirect effects on the way in which mental health services are delivered, organized, and experienced.

The structural-level factors that were examined in this dissertation (i.e., compulsory community treatment legislation, specialized service delivery models) had little influence on quantitative levels of self-stigma; however, these factors were salient to participants' qualitative experiences. While these policy structures theoretically produce subgroups of mental health consumers (e.g., forensic client, compulsory treatment client), it is questionable whether participants actually identified with being members of the subgroups that were delineated in the present study. Indeed, a single factor (e.g., symptoms) or experience (e.g., receiving compulsory treatment) cannot adequately explain why some people with mental illness feel devalued, discredited, and rejected. Self-stigma is manifested through an entangled web of factors and experiences for people with mental illness. The findings of the current study indicate that multiple stigmatizing social categories and statuses have interlocking, rather than additive, effects on subjective experiences of self-stigma.

The range of experiences (quantitative and qualitative) that were reported by participants confirms that idea that self-stigma exists on a continuum (Rüsch et al., 2005). This has implications for strategies that are aimed at reducing the stigma that is associated with mental illness. It is clearly inaccurate to presume that *all* people with mental illness

are highly self-stigmatized. Unfortunately, in an effort to raise awareness about the importance of stigma, some policy-makers and researchers have tended toward overstating its affects:

Stigma and discrimination have a *huge* negative impact on people living with mental health problems and illnesses, affecting *all* aspects and stages of their lives....stigma and discrimination frequently have at least as great an effect on people as does their mental health problem or illness itself, *seriously* impeding their ability to participate fully in society and attain the best possible quality of life [emphasis added]. (Mental Health Commission of Canada, 2009, p. 90)

There is no doubt that stigma associated with mental illness needs to be addressed, and it is admirable that the Mental Health Commission of Canada has taken a national leadership role to tackle this issue. However, as with any public health program, anti-stigma initiatives have the risk of producing unintended adverse effects. By over-generalizing the impact of stigma, there is the potential that these initiatives reinforce stereotyped social roles (e.g., passive, unsuccessful, miserable) and perpetuate the belief that individuals with mental illness are a homogeneous group with uniform experiences and perspectives. In addition, the suggestion that self-stigma is a universal and unavoidable experience for people with mental illness may have the unintended effects of increasing feelings of hopelessness for those who live with mental illness and may also decrease the willingness of people with emerging mental health problems to engage with services and supports. More accurate reflections of people with mental illness would focus on the diversity of their experiences and the *potential*, rather than the *probability*, for stigma to adversely affect their lives.

The key to studying self-stigma is to recognize that while it is experienced at an individual level, it unfolds at the social level. By framing self-stigma in this way, the

onus and responsibility is placed on society, rather than solely with the individual. This is also an important consideration for anti-stigma strategies, since a multi-level, multi-faceted approach is more likely, than a one-dimensional approach, to be successful in addressing the stigma of mental illness (Link, 2001).

APPENDIX A

ARTICLES INCLUDED IN LITERATURE REVIEW

- *Adewuya, A. O., Owoeye, O. A., Erinfolami, A. R., Ogun, O. C., Dada, M. U., Bello-Mojeed, M. A., et al. (2009). Prevalence and correlates of poor medication adherence amongst psychiatric outpatients in southwestern Nigeria. *General Hospital Psychiatry, 31*(2), 167-174.
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