

Patient Narratives: Understanding ‘Recovery’ and Social Bonding Theory in a Forensic Mental Health Hospital

by

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Abstract

For persons living with mental illness, recovery is a complex process in which individuals learn to overcome and manage their symptoms and strive to live productive and fulfilling lives. However, in a forensic mental health hospital, inpatients face the added challenge of also recovering from the impact of their index offences and coping in an often harsh environment. The literature on recovery emphasizes the importance of social connections and positive role models in developing and supporting normative behaviour. Hirschi's (1969) social bonding theory posits that an individual's attachment to parents and peers, commitment to conventional activities, involvement in conventional activities, and belief in social norms are key contributors to normative social behaviour. This study examined qualitative data collected in semi-structured interviews with 30 individuals receiving forensic mental health inpatient services in order to understand their perspectives and experiences with recovery.

Keywords: forensic mental health; inpatient; mental illness; recovery; social bonding theory

I would like to dedicate this thesis to my husband. Thank you, Kevin, for your unwavering and invaluable support.

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Chapter 1.

Introduction

Recovery-oriented care is a crucial ingredient to providing beneficial and effective treatment to individuals receiving therapeutic services in inpatient mental health settings (Jacobson & Curtis, 2000; Jacobson & Greenley, 2001). In the 1980s, first-person accounts of individuals living with mental illness and research began to highlight that “the course of severe mental illness was not an inevitable deterioration” (Jacobson & Greenley, 2001, p. 482). Since then, an increasing number of mental health facilities have begun to emphasize and implement recovery-oriented care (Slade, Amering, & Oades, 2008). Recovery-oriented care identifies the importance of the individualized and subjective journey of recovery. In this framework, recovery can most simply be described as the process in which an individual learns to manage and live well with his or her mental illness (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). This understanding of recovery moves beyond the clinical definition, which focuses primarily on the use of medications and the cessation of symptoms. The recovery-oriented care framework posits that an individual can learn to live with their mental illness when they are empowered with a sense of purpose and hope for the future, and are provided with supportive social relationships. Social relationships aid individuals in their recovery by providing role models and support while an individual works through the challenges of their mental illness, and offer opportunities for learning normative and responsible behaviour (Deegan, 1996).

Recovery within any mental health context is complex. However, when recovery takes place in a forensic mental health hospital, the process is even more complicated owing to the forensic inpatient's need to also recover from the impact of their offending behaviour (Corlett & Miles, 2010). Owing to their contact with the criminal justice system, patients who receive treatment services at forensic mental health hospitals live with restrictions on their autonomy and liberty that may hinder the recovery process (Corlett &

Miles, 2010). Although there is increased interest in providing recovery-oriented services for individuals receiving services from the forensic system, the literature states that there is still a disbelief that recovery is possible for forensic patients, with some researchers having claimed that the “chances of forensic psychiatric patients being able to achieve even relatively modest life goals (a home, friends, work or education and a place in society) are fairly low” (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010, p. 693).

Similar to the literature on recovery, Hirschi’s (1969) social bonding theory (SBT) emphasizes the importance of social relationships for fostering normative behaviour. Hirschi’s theory posits that an individual’s attachment to parents and peers, commitment to conventional activities, involvement in conventional activities (such as educational and occupational activities), and belief in social norms are key contributors to normative social behaviour. According to SBT, the absence of strong social attachment in youth is viewed as a contributing factor for deviant behaviour in that attachment to parents, teachers and peers, commitment to conventional activities, involvement in conventional activities, and belief in social norms teach individuals to conform and behave in ways that are socially acceptable. Therefore, when social bonds are weak or absent, an individual is more likely to engage in deviant behaviour. Research has used social bonding to explain desistance from deviant behaviour such as binge drinking in university students (Durkin, Wolfe, & Clark, 1999), desistance from criminal activities for youth (Exline, 2007) and for explaining an individual’s offending behaviour (Alarid, Burton Jr, & Cullen, 2000). The research suggests that individuals with stronger social bonds are less likely to participate in deviant and non-normative activities.

As both the literature on recovery and social bonding theory address the importance of social relationships in developing and supporting normative behaviour, this thesis examines the roles of normative rules and social bonds, or the lack thereof, in the recovery of individuals living with mental illness in a forensic mental health hospital.

This qualitative study examines how recovery is perceived and understood by people receiving services from a forensic mental health hospital [hereinafter ‘forensic inpatients’] in British Columbia, Canada. Data was obtained from the transcripts of semi-structured in-depth interviews that were conducted with 30 forensic inpatients at the BC Forensic Psychiatric Hospital (BC FPH). In the context of forensic mental health hospital,

social bonding might manifest through relationships with staff and peers, involvement in activities, and adherence to hospital rules, improving the individual's normative behaviour and their recovery. The strength of forensic inpatients' attachments and social bonding may lead to a deeper engagement in their treatment planning and the care they receive at the hospital, which in turn may improve their well-being and the recovery process.

In this thesis, literature on recovery and the recovery model of care provided by mental health and forensic mental health institutions will be examined. The data examined for this study was originally collected for a mixed-method study, and this study will only be examining the qualitative component in order to answer four main research questions:

- (a) What are forensic inpatients' perspectives on recovery?
- (b) Do conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients?
- (c) To what extent do forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory?; and
- (d) What are the current strengths of a forensic mental health hospital and what are the areas that could be improved to aid in forensic inpatients' recovery?

Specifically, this thesis aims to (a) understand the perspectives of patients on recovery at the BC FPH; (b) investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients; (c) examine the extent to which forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory; and (d) identify the strengths of a forensic mental health hospital as well as the areas that patients believe could be improved in order to make their recovery experience more successful. Examining whether the recovery literature and participants' narratives about recovery reflect the central tenets of social bonding theory is important, as it will provide insight into the current barriers for recovery-oriented care in forensic mental health settings while outlining areas that can be strengthened to better facilitate recovery for individuals living with mental illness. If forensic inpatients' narratives of recovery in forensic mental health settings reflect the core elements of social bonding theory, we may gain a better

understanding of how to further strengthen and facilitate the recovery process for individual patients and promote normative behaviour.

Chapter 2 of this thesis will give an overview of mental illness and both personal and clinical understandings of recovery. Recovery from a mental illness has been discussed by clinicians, academics and consumers since the 1980s. This chapter will provide a literature review on recovery from mental illness and recovery in secure forensic mental health settings.

Chapter 3 will examine deviance and social bonding theory as it relates to recovery and mental illness. Hirschi's (1969) social bonding theory posits that human morality is based on the extent to which an individual bonds with others and with society, and thus internalizes society's norms. An individual's attachment to others, commitment to and involvement in conventional activities, and belief in the importance and value of social norms are key contributors to normative social behaviour. Deviant behaviour occurs when an individual's bond to society is weak or broken. This chapter will conclude by examining the paralleling themes between social bonding theory and recovery.

Chapter 4 of this thesis will explain the methodological approach of the study and will describe participant recruitment, data collection and analysis, and the ethical considerations.

Chapter 5 will explore the findings and interpretation of the data, beginning with an exploration of the study participants' understanding of recovery. According to the forensic inpatients who participated in the study, recovery for them in the forensic mental health hospital involved reintegrating into the community, returning to a state of normative behaviour, and abstaining from drugs and alcohol. The next section examines the extent to which social bonding theory is reflected in the forensic inpatient narratives. Participants indicated that engaging in programs and activities was meaningful and aided in their recovery. Participants also perceived the routine and structure provided by hospital rules as beneficial. Similarly, participants spoke about the role of supportive staff and peers in relation to their recovery. This chapter will also discuss what forensic inpatients perceived as hindering their recovery.

Chapter 6 examines the original research questions of this study in light of the data analysis. This section examines: (a) the participants perspectives on recovery, (b) whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients, (c) to what extent do forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory, and (d) the current strengths of a forensic mental health hospital and the areas that could be improved to aid in forensic inpatients' recovery.

Chapter 7 concludes by summarizing the findings of this research and discusses the implications of the findings. The limitations of the study and future research recommendations are also addressed.

Chapter 2.

Mental Illness and Recovery

Mental illness is a serious issue that affects Canadians throughout the country. The 2002 Mental Health and Well-Being Survey interviewed Canadians across the country to examine the extent of mental health symptoms in Canadians and found that 11% of Canadians over the age of 15 reported having symptoms consistent with a mood disorder, anxiety disorder or substance dependence over the past 12 months (Government of Canada, 2006). The survey concluded that:

“1 out of every 10 Canadians aged 15 and over, or about 2.7 million people, reported symptoms consistent with a mood or anxiety disorder, or alcohol or illicit drug dependence; 1 in 20 met the criteria for a mood disorder, either major depression or bipolar 1 disorder; 1 in 20 met the criteria for an anxiety disorder, either panic disorder, agoraphobia or social phobia; and 1 in 30 met the criteria for substance dependence associated with either alcohol or illicit drug use.” (Government of Canada, 2006, p. 30)

One can conclude from such numbers that mental illness is a serious concern for many individuals throughout Canada. In fact, mental illness also impacts individuals who do not live with a mental illness due to the expensive indirect costs of mental illness on a society (Knapp, 2003). Individuals with mental illness are more likely to use drugs which contributes to increased violent behaviour (Hiday, 2006; Soyka, 2000; Steadman et al., 1998; Swanson et al., 2002) and are also more likely to be victims of violence than non-mentally ill individuals (Silver, 2002). Mental illness is also a risk factor for homelessness (Folsom et al., 2005; Susser, Moore, & Link, 1993) and poor physical health (S. Brown, Birtwistle, Roe, & Thompson, 1999). Additionally, there is a disproportionate number of mentally ill individuals in jails and prisons (Lamb & Weinberger, 2001), which is a rising concern for the correction system (Hiday & Burns, 2010). In one study that looked at individuals involved in the British Columbia criminal justice system, researchers found that 29% of the individuals were mentally disordered

offenders, a rate that is almost double that of the province's general population (Somers, Ogloff, Ferguson, & Davis, 2005).

As mental illness is very prevalent in today's society, there are numerous ways that individuals describe and characterize mental illness. Mental illnesses are "characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning" (Government of Canada, 2006, p. 2). The terms "mental illness" and "mental disorder" are often used interchangeably and are characterized by the same alterations in thinking, mood or behaviour, but such symptoms vary from mild to severe and are clinically diagnosed using criteria from the DSM-IV-TR which conceptualizes mental disorders as:

a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychiatric Association, 2000, p. xxxi)

Mental disorders fall into the Axis I category in the DSM-IV-TR, which identifies clinical syndromes. Examples of types of mental disorders include schizophrenia, bipolar disorder, substance related disorders such as substance abuse or dependence, and depression, and can be clinically diagnosed through the emergence of set symptoms and behavioural patterns identified for a certain length of time. Clinical remission is identified through the absence of symptoms or a reduced impact on patient's social lives over a set period of time (i.e., partial or full remission).

Substance-related disorders are classified as Axis I disorders in the DSM-IV-TR and refer to the abuse or dependence on specific substances (e.g., alcohol; amphetamines; cannabis; cocaine; hallucinogens; inhalants; opioids; phencyclidine (PCP); and sedatives, hypnotics, or anxiolytics) (American Psychiatric Association, 2000). Substance abuse is pre-empted by substance dependence and is "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (American Psychiatric Association, 2000, p. 198). Substance abuse is diagnosed based on a maladaptive pattern of substance use that causes significant impairment or distress in the individual, with one or more

symptoms occurring with a 12-month period. Remission from substance-related disorders (i.e., early full remission, early partial remission, sustained full remission, and sustained partial remission) can be indicated by not meeting the criteria for the disorders over a set period of time.

The DSM-IV-TR is very specific in its definition of a mental disorder, whereas the *Criminal Code* vaguely describes it in section 2 as simply “a disease of the mind”. Justice Dickson further clarified this meaning in the Supreme Court of Canada’s ruling, interpreting “disease of the mind” as signifying “any illness, disorder or mental condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion” (*R. v. Cooper*, 1980, p. 1159). For the purposes of this thesis, mental disorders or mental illnesses will be identified as a ‘mental illness’ and include such diagnoses as schizophrenia, bipolar disorder, substance disorders and depression.

There is no single cause of mental illness, but rather, mental illness occurs owing to the complex interactions of bio-psycho-social factors, such as social, economic, psychological, and biological or genetic factors (Mental Health Commission of Canada, 2009). Sociological factors such as demanding social roles or different levels of social support are identified by sociologists as factors that may attribute to one’s mental health problems (Horwitz, 2010). Social integration plays a key role in providing individuals with social support, help and sympathy, which together aid in their ability to cope with their mental illness (Horwitz, 2010). One study found that individuals who had regular weekly social contact with others reported better mental health than those who did not (Grzywacz & Keyes, 2004).

In relation to social definitions of mental illness and deviance, social definitions of mental illness place emphasis and importance on the way in which aberrant behaviour is perceived by others (Humphrey, 2006). Mental illness is most commonly defined by “(1) value judgements made by mental health professionals, (2) normative expectations and reactions of society, and (3) differing beliefs about [its] causes” (Humphrey, 2006, p. 148). In relation to deviance, it is the normative expectations and reactions of society that define mental illness as the deviation of normative behaviour (Goode, 2011; Humphrey, 2006; Scheff, 1966). Normative violations often include behaviour that is

perceived as disruptive, odd, eccentric, highly unusual or even offensive (Goode, 2011; Humphrey, 2006). Symptoms of mental illness are the internal processes of and personal experiences with an illness, such as hallucinations and delusions, and it is manifestations of these symptoms that are externalized and observable to others. Often it is these manifestations of the symptoms of mental illness that society views as normative violations (Scheff, 1966; Thoits, 2010). As a result, individuals living with mental illness are more often stigmatized as deviant than those living with physical disorders or physical illnesses such as cancer (Goode, 2011). According to labelling theory, when an individual's normative violations are persistent, highly visible or severe, or "when rule-breakers are low in power and status relative to 'agents of social control' (i.e., police, social workers, judges, psychiatrists), rule-breakers are much more likely to be publicly and formally labelled as deviant (in this case, mentally ill) and forced into treatment" (Thoits, 2010, p. 120).

The central thesis of this paper is that social bonding theory, a generally accepted theory of the causes of deviance and delinquency, can also be used to explain several guiding themes that help individuals conform to normative behaviour during the process of personal recovery within a forensic mental health setting. In this context, deviant behaviour is not adhering to social norms and rules, while recovery is learning, either through personal recovery or managing the remission of one's symptoms, how to return to a state where an individual can manage and engage in the community without difficulties. Both personal recovery and clinical understandings of remission emphasize the need to maintain normative behaviour while being able to interact and engage meaningfully with others in society.

What is Recovery?

There is no consistent understanding of recovery used in the literature or by clinicians. One author has aptly stated that "recovery has been associated with as many meanings as there are proponents of this term" (Lieberman & Kopelowicz, 2005, p. 740). The term "recovery" has been recorded in the context of an individual's health since the early 16th century and is currently broadly defined as the "restoration of a person ... to a healthy or normal condition, or to consciousness" (Oxford English Dictionary, 2012).

Originally, the DSM stated that clinicians and individuals living with mental illness should have low expectations of returning to premorbid normal functioning (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987, p. 727). However, our current understanding of recovery for individuals living with mental illness is much more optimistic following scholarly discussions amongst academics and those working in the mental health field in the late 1980s, when a significant study posited that “the course of severe mental illness was not an inevitable deterioration” (Jacobson & Greenley, 2001, p. 482). The retrospective study by Harding and colleagues (1987) re-diagnosed 118 patients originally hospitalized in the 1950s, using their patient files and the new DSM-III criteria for schizophrenia. Under the criteria listed in the DSM-III, it was believed that the possibility of improvement for an individual living with schizophrenia was rare and unlikely:

A complete return to premorbid function is unusual—so rare, in fact, that some clinicians would question the diagnosis. However, there is always the *possibility* of full remission or recovery, although its frequency is unknown. The most common course is one of acute exacerbations with increasing residual impairment between episodes. (DSM-III, as cited in Harding et al., 1987, p. 727)

In other words, for individuals diagnosed with schizophrenia and their clinicians, the DSM-III instilled little hope that they would ever improve or recover, meaning they would always suffer from “continued symptoms, unemployment, social isolation, and inability to care for themselves” (Harding et al., 1987, p. 732). Harding and colleagues found that after following up with the participants who had spent several years being rehabilitated and living in the community, for about one half to two-thirds of the study participants, their “long-term outcome was neither downward nor marginal but an evolution of various degrees of productivity, social involvement, wellness, and competent functioning” (Harding et al., 1987, p. 730). This suggested that the negative outlook described by the DSM-III for individuals living with schizophrenia was inaccurate, and improvement from the symptoms should be possible.

Around the same time that Harding and colleagues (1987) published their study, many first-person accounts were written by individuals living with mental illness which also influenced the understandings of recovery (e.g., Anonymous, 1989; Deegan, 1988; Gagne, White, & Anthony, 2007; Leete, 1989). These first-person accounts

demonstrated the lived experiences of recovery for individuals living with mental illness. Since that time, more modern definitions have described personal recovery as a process by which individuals learn to live satisfying lives within the constraints of their mental illness (Anthony, 1993). On the other hand, the clinical model of recovery emphasizes sustained remission, which is indicated by “long-term reduction or ideally removal of symptomatology, accompanied by functional improvement” (Slade et al., 2008, p. 129). Although both the clinical and personal understandings of recovery are different, they both provide insight and hope for those living with mental illness.

While academics and those working in the mental health field have recognized that recovery is not simply the process of being “cured”, there is still no widely accepted operationalized definition for recovery in the mental health field (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). The current understanding of recovery has expanded from the purely clinical model that focuses on the alleviation, absence or removal of symptoms and undesired consequences (e.g., medications, or hospitalization) to include understandings of personal recovery (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Gudjonsson, Webster, & Green, 2010; Slade et al., 2008). This may be understood as the difference between “recovery from” mental illness and “in recovery” from mental illness, where the latter is to be “‘in recovery’ from addiction and/or mental illness [and] refers to the process of living one’s life, pursuing one’s personal hopes and aspirations, with dignity and autonomy, in the face of the ongoing presence of an illness and/or vulnerability to relapse” (Davidson & Roe, 2007, p. 464).

Corrigan and McCracken (1999) have compared the experience of recovery for individuals living with mental illness to the experiences of individuals living with physical disabilities, where recovery means that they are able “to overcome deficits that result from physical illness or trauma and accomplish most life goals and roles when provided suitable assistance and reasonable accommodations” (p. 232). Although this is a good analogy, mental illness is a very complex issue and treating it like other physical disabilities risks ignoring the importance of symptom reduction. Reducing the likelihood of psychotic episodes in an individual living with schizophrenia is important in order to improve the individual’s quality of life and diminish the risk of the individual posing harm to themselves or others.

One of the most commonly cited definitions of recovery in the context of living with mental illness is given by Anthony (1993) as:

[A] deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 527)

This understanding that recovery occurs without the requirement of "the remission of symptoms or other deficits" (Davidson, O'Connell, et al., 2005, p. 484) is now dominant within the literature on psychiatric rehabilitation and is often referred to as personal recovery (Slade et al., 2008). Personal recovery and recovery-oriented mental health care (i.e., recovery-oriented services provided at a system wide level) emphasize "a holistic rather than a purely therapeutic approach and [focus] on the broader concern of the patient's quality of life rather than the narrow tableau of symptom reduction" (Hillbrand, Young, & Griffith, 2010, p. 452). This replaces the traditional outcome measures such as reduced symptoms, hospitalizations and level of functioning (Andresen, Caputi, & Oades, 2010), and focuses instead on the individualized needs and the subjective experiences of individuals living with mental illness.

Although the literature recognizes that recovery is a complex, multi-dimensional subjective experience that is unique to each individual, there is a consensus with respect to several themes and common elements that seem to be important in supporting an individual's journey through recovery. Davidson and colleagues (2005) completed a literature review examining recent literature over a 2-year time period and found that although authors struggled with defining, measuring and validating recovery, there appeared to be consensus on some of its common elements: renewing hope and commitment; redefining self; incorporating illness; being involved in meaningful activities; overcoming stigma; assuming control; becoming an empowered citizen; managing symptoms; and being supported by others (Anthony, 1993; Deegan, 1988; Jacobson & Curtis, 2000; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Ridgway, 2001; Smith, 2000; Walsh, 1996; Young & Ensing, 1999). This is aligned with the working definition produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), which describes recovery as a "process of change through which individuals

improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2011).

Despite there being much discussion in the literature about recovery, there is limited empirical research on the construct (Resnick, Fontana, Lehman, & Rosenheck, 2005). In a study by Andresen and colleagues (2003), the researchers aimed to conceptualize recovery in relation to the personal accounts of individuals living with mental illness. The researchers completed a systematic literature review and through their analysis, Andresen and colleagues identified four key processes of recovery: (i) finding hope; (ii) re-establishment of identity; (iii) finding meaning in life; and (iv) taking responsibility for recovery.

Similarly, a study by Resnick and colleagues (2005) used principle components and confirmatory factor analysis to examine data from a systematic study of individuals living with schizophrenia ($n = 1076$). In their study, the authors proposed that four domains should be used to conceptualize personal recovery and recovery-orientation: empowerment, hope and optimism, knowledge, and life satisfaction. The empowerment domain reflects an individual's feelings of ownership and responsibility over decisions in treatment and care. The hope and optimism domain, which is consistent with the literature on recovery, emphasizes the importance of fostering hope, which the author suggested could be done through role models and peer-led services. The knowledge domain relates to the individual's perception of their symptom management and the system in which they are receiving care. Finally, life satisfaction in relation to recovery is important and Resnick and colleagues found two subthemes of critical importance: relationships with others (i.e., satisfaction with family and social networks), and affordable and safe housing (e.g. community and safety). Their findings are consistent with the literature on recovery.

Recovery from substance addictions and alcohol addictions are treated separately, both in the literature and in the health field (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998), despite the prevalence of comorbid disorders (Kessler, Chiu, Demler, & Walters, 2005). However, research does suggest that psychiatric severity may impact one's recovery from addictions (Weisner, Matzger, & Kaskutas, 2003). Although literature suggests that individuals may recover from alcohol

addictions on their own without treatment (Sobell, Cunningham, & Sobell, 1996), the literature is consistent that family and social supports play an integral role in addiction recovery (Beattie & Longabaugh, 1997; Havassy, Hall, & Wasserman, 1991; Weisner et al., 2003). Weisner and colleagues (2003) compared two cohorts of individuals meeting the criteria for alcohol dependence, those who were admitted to treatment ($n = 359$) and those who were not ($n = 111$), within a 1-year timeframe to examine the importance of treatment in predicting alcohol abstinence and non-problematic alcohol use. The researchers found that individuals receiving treatment had higher abstinence rates. They also found that an individual's social networks were significantly related to their outcomes; individuals who had friends who used more drugs and alcohol or were "non-recovery oriented" rated significantly lower in abstinence and non-problematic use in both samples. The authors stated that recovery-oriented, non-using social networks likely promoted abstinence and non-problematic use: "Recovery-oriented social network members in the treatment sample probably played an important role in encouraging those individuals to [seek] treatment, as well as in ongoing recovery" (Weisner et al., 2003, p. 908). Similarly, other studies assessing treatment outcomes have suggested that friends, family and social integration that discourage substance use are significantly related to better treatment outcomes for the individual (Beattie & Longabaugh, 1997; Havassy et al., 1991).

Over the past few decades, government bodies have begun to align their conceptualization of recovery with the one shared by academics and individuals with lived experiences. The SAMHSA was created in the United States in 1992 and recently published their guiding principles and definition of recovery. According to the SAMHSA, an individual's journey of recovery may be supported through four key dimensions: (a) health, (b) home, (c) purpose, and (d) community. Health refers to the individual's ability to overcome or manage their disease, while "living in a physically and emotionally healthy way" (SAMHSA, 2011). Home represents the idea that having a safe, established and consistent place to live is an important dimension of one's recovery. Likewise, purpose refers to participation in meaningful daily vocational, educational, or familial activities as well as having financial independence, which allows an individual to participate in society and the community. Lastly, fostering a supportive community

through relationships and social networks, which provide the individual with “support, friendship, love, and hope,” aids in their journey through recovery (SAMHSA, 2011).

Unlike the United States, there is no federal mental health system in Canada. Instead, mental health care falls under provincial and territorial jurisdictions (Gray, Shone, & Liddle, 2008). The result is that mental health legislation, care and services vary across the country (Gray et al., 2008) which makes a national strategy to address mental health problems problematic. This triggered the creation of the Mental Health Commission of Canada (MHCC), a non-profit organization funded by the Government of Canada that was established in 2007 after a report by the Standing Senate Committee on Social Affairs, Science and Technology (2006) recommended the need “for a Mental Health Commission to provide an ongoing national focus for mental health issues” (MHCC, 2011). The MHCC is supported by all provincial and territorial governments and aims “to work with stakeholders to change the attitudes of Canadians toward mental health problems, and to improve services and support” by creating a national mental health strategy (MHCC, n.d.). Although the MHCC does not directly fund or deliver mental health services, it seeks to become the catalyst for improving mental health care in Canada. The MHCC aims to create a national integrated mental health system that provides equal and consistent treatment to individuals throughout the country. Understanding the MHCC’s definition of recovery will give insight into the future of recovery-centred care in the mental health systems of each province and territory.

A core component of the MHCC framework and strategic direction is the concept of recovery. In the 2006 report, *Out of the Shadows at Last* (Kirby & Keon, 2006), the Standing Senate Committee on Social Affairs, Science and Technology stated that recovery must be central in mental health reform. This is again emphasized by the MHCC’s report (MHCC, 2009). Aligning itself with much of the current literature, the MHCC views recovery as being more than just the mere clinical definition of a “cure or complete remission of symptoms” (MHCC, 2009, p. 27). The central tenet to the MHCC’s view of recovery is that “a person can recover their life without recovering from their illness” (MHCC, 2009, p. 27). An individual’s recovery is unique to oneself and the MHCC recognizes that although a consensus with respect to recovery is beginning to appear, there is still no single definition because of its unique heterogeneous nature.

Each individual draws his or her “own unique set of resources, strengths, and relationships to confront the specific challenges they face” (MHCC, 2009, p. 27).

Similar to the definition put forward by the SAMHSA, the MHCC emphasizes that the journey of recovery is an individual process that begins with hope and can be aided through support from family members, friends, peers and service providers. Although peers and other individuals may support an individual, the MHCC clearly states that “[r]ecovering must be the result of individuals’ own efforts and must be accomplished using their choice of services and supports. Taking responsibility for and control of one’s own recovery means reclaiming the ability to make decisions for oneself wherever possible” (MHCC, 2009, p. 30). Likewise, the responsibilities of mental health services and other people involved in the recovery process are “fostering hope, enabling choice, encouraging responsibility, and promoting dignity and respect” (MHCC, 2009, p. 31).

Although personal recovery is an important concept that expands recovery beyond the simple cessation of symptoms, biomedical and clinical understandings of recovery also continue to play an important role in the care and treatment of individuals living with mental illness and should not be overlooked or dismissed. Living with acute symptoms such as severe psychosis and extreme depression prevent people from living satisfying lives (Addington, Young, & Addington, 2003; Jones et al., 2006), and must not be dismissed in the context of recovery.

Traditional outcome measures for recovery include assessing an individual’s symptoms, hospitalizations and functioning (Andresen et al., 2010). According to Liberman and Kopelowicz (2005), empirical studies of recovery are difficult to design due to the variability of mental illness, “which leads to persons’ moving into and out of recovery” (p. 735). According to the DSM-IV-TR, there are several different phases of remission for schizophrenia and mood disorders, ranging from partial to full remission. The clinical goal of recovery is complete remission, which signifies a “return to full premorbid functioning” (American Psychiatric Association, 2000, p. 282). Although complete remission may not be common for individuals living with schizophrenia, the partial remission of symptoms is important in improving one’s quality of life and general well-being (Bow-Thomas, Velligan, Miller, & Olsen, 1999; Norman et al., 2000), which can further aid in an individual’s personal recovery.

Clinical definitions of remission vary and individuals are often assessed using a variety of scales to determine the absence or reduction of symptoms. Some scales, such as the Global Assessment of Functioning (GAF) are used for “evaluating an individual’s overall level of functioning” (Yamauchi, Ono, Baba, & Ikegami, 2001, p. 403). Other scales are more specific to particular mental illnesses. The symptoms of schizophrenia are often classified into two groups: negative symptoms, such as affective flattening and avolition, which cause a reduction in brain functioning, and positive symptoms, such as hallucinations and delusions, which “reflect a release of functioning through damage to some specific higher cortical area that inhibits that function” (Andreasen, 1982, p. 785). The presence of these symptoms are assessed using two similar scales: the Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1984a) and the Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984b).

Researchers are then faced with defining remission using scales such as these. For instance, Curtis and colleagues (2001) defined remission for diagnoses of schizophrenia as scoring less than 3 on the Affective Flattening subscale of the SANS, below 2 on the remaining four subscales, a rating of less than 60 on the GAF, and they had to be “free of psychotic symptoms for at least 1 month, not have been hospitalized for psychiatric problems for the past 3 months, have at most only one residual symptom, and currently work and associate with friends” (p. 101). Another study by Amminger and colleagues (1997) defined complete remission from schizophrenia as “the absence of hallucinations, delusions, thought disorder and catatonic behavior” (p. 214), and partial remission as “either 1) disappearance of one or more positive symptoms, with persistence of at least one other positive symptom, or 2) decrease in the frequency or salience of occurrence of these symptoms, resulting in improved overall functioning” (p. 214). Finally, Ho and colleagues (2000) defined positive symptom remission for individuals with schizophrenia as “a rating of 2 or lower (not worse than mild severity) on all global scores within the psychotic and disorganized symptom dimensions persisting for at least 8 consecutive weeks” (p. 810) using the SAPS.

It appears that clinical measures of recovery and measures of personal recovery often do not coincide. An Australian study examining personal recovery and clinical measures failed to find a correlation between the two constructs (Andresen et al., 2010). In this two phase study ($n = 281$), the researchers examined three measures of recovery

(i.e., the Recovery Assessment Scale, the Mental Health Recovery Measure and the Self-Identified Stage of Recovery) with four conventional clinical measures (i.e., Health of the Nation Outcome Scales, Life Skills Profile-16, Global Assessment of Functioning, and Kessler-10). Using Pearson's correlations (2-tailed), the researchers found that although the recovery measures were generally correlated, there were few correlations between the clinical measures and the recovery measures (i.e., only the K-10 correlated with each recovery measure). This is consistent with the literature and demonstrates that personal recovery and clinical recovery do not assess the same constructs in their understanding of recovery.

Recovery must encompass both personal and clinical recovery. The reduction of symptoms is critical in improving an individual's quality of life, and an individual's life may be improved through finding meaning in one's daily activities and living beyond the constraints of one's diagnosis.

Legal Framework

Canada's legal system has procedures and protections in place to ensure that criminal law is just in its interactions with individuals who commit a crime while suffering from a mental illness. In order to treat such individuals fairly, the law has set up safeguards to ensure that individuals who were mentally ill at the time they committed an offence are provided with treatment as opposed to punishment for their offending behaviour. This was outlined by Justice McLachlin in the Supreme Court of Canada's judgement in the *Winko v. British Columbia (Forensic Psychiatric Institute)* (1999) case:

In every society there are those who commit criminal acts because of mental illness. The criminal law must find a way to deal with these people fairly, while protecting the public against further harms. The task is not an easy one. (para. 1)

In order to be convicted of committing an offence, the courts must prove that there was both an *actus reus*, that the accused's conduct or behaviour caused the offence, and that the individual had the appropriate *mens rea*, or that they "deliberately chose to do something wrong" (Verdun-Jones, 2007, p. 185). For individuals who have

committed criminal offences while suffering from a mental illness, this is not always the case.

When an individual suffers from a mental illness at the time they commit an illegal offence, they may use the defence of section 16(1) of the *Criminal Code* (1985), which states that:

No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

This defence is known as “Not Criminally Responsible on Account of Mental Disorder” (herein after NCRMD). As per section 16(2) and 16(3) of the *Criminal Code*:

(2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.

(3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.

This defence was originally founded after the Hadfield case of 1800 and the McNaughton case of 1843 (Moran, 1985). After the acquittal of the accused in both cases, citizens were outraged that individuals who were factually guilty of committing a crime had been acquitted, believing that “madmen could now kill with impunity” (Moran, 1985, p. 39). The Hadfield case altered the plea and defence of insanity such that individuals not guilty by reason of insanity could be presumed to be a risk to the community and were no longer automatically released (Moran, 1985). Years later, the McNaughton case became the foundation of today’s NCRMD defence and laid the groundwork for determining the *mens rea* element of criminal responsibility for such defences. In the McNaughton rules, it was laid out that:

... at the time of the committing of the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he not know he was doing what was wrong. (as cited in Verdun-Jones, 2007, p. 186)

This new standard to determine criminal responsibility for individuals suffering from a mental disorder was very strict, and is believed to have been hard to use successfully (Moran, 1985).

The language used in Canada's current NCRMD defence is very similar to the rules laid out by the McNaughton case, but the wording has changed in an important way. An individual must not merely have not known that what they were doing was wrong, but they must also have been unable to "appreciate the nature of quality of the act" as being morally wrong. In this sense, appreciating is held to a higher degree of scrutiny than simply knowing and is "a second stage in a mental process requiring the analysis of knowledge or experience in one manner or another" (Justice Estey, 1980 as cited by Verdun-Jones, 2007, p. 188).

Prior to the implementation of Bill C-30 in 1992, individuals found NCRMD in Canada were automatically detained for an indefinite amount of time. However, in the case of *R. v. Swain* (1991), the Supreme Court of Canada ruled that the automatic detention of a NCRMD accused was against section 9 of the *Charter* stating that the:

assumption that persons found not guilty by reason of insanity pose a threat to society may well be rational but is not always valid. Not everyone acquitted by reason of insanity has a personal history of violent conduct and such conduct and previous mental disorder does not necessarily indicate a greater possibility of future dangerous conduct. (*R. v. Swain*, 1991, p. 17)

The ruling determined that there must be a new way for reviewing the cases of people deemed NCRMD so as not to impose automatic and indefinite sentences (Desmarais, Hucker, Brink, & De Freitas, 2008). New provisions were put into the *Criminal Code* which were the foundation of Canada's territorial and provincial review boards (Verdun-Jones, 2007). The implementation of Bill C-30 has been found to substantially reduce individuals' length of stay at hospitals, but there has been an influx of persons found NCRMD for more minor offences (Livingston, Wilson, Tien, & Bond, 2003). Since the creation of Review Boards, when an individual is found NCRMD by a Canadian Court, the court of the provincial Review Board may make one of three dispositions as cited in section 672.54 of the *Criminal Code*:

(a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

(b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

(c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

The court or Review Board must choose the least restrictive or onerous disposition for the NCRMD accused while:

taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the [above] dispositions that is the least onerous and least restrictive to the accused. (*Criminal Code*, 1985, section 672.54)

Only if there is no threat to the community, can an individual be discharged without any conditions. If the individual still needs monitoring and contact with supports from the justice system, they will be released on a conditional discharge and have certain criteria limitations on their freedoms that they must uphold (e.g., no substance use, regular meetings with their treatment teams, etc.). Overall, the forensic mental health system is built so that NCR-accused can return to the community only once they are no longer a threat to others. Through proper treatment and care, it is assumed that the individual will one day be able to safely reintegrate into the community with their family and friends. However, although a court or Review Board can determine whether someone is NCRMD, they do not have the power to force treatment unless the provincial *Mental Health Act* permits compulsory treatment, which is the case in British Columbia (Carver & Langlois-Klassen, 2006; Gray et al., 2008).

An important factor in the disposition of individuals found NCRMD is that prior to being given an absolute discharge, the Review Board or the court must be satisfied that the individual does not pose “a significant threat to the safety of the public”. In the case of *Winko v. British Columbia (Forensic Psychiatric Institute)* (1999), the Supreme Court of Canada upheld that section 672.54 is valid under the *Canadian Charter of Rights and*

Freedoms (1982) and does not infringe an individual's sections 7 and 15(1) rights to fundamental justice and equality. In 1983, Winko attacked two pedestrians and was charged with aggravated assault, assault with a weapon, and possession of a weapon for purposes of danger to the public peace but was found NCRMD. In 1995, the Review Board granted him a conditional discharge on the basis that he may still have constituted a significant threat to the community. Believing he should have received an absolute discharge, Winko appealed the ruling, stating that section 672.54 of the *Criminal Code* violated section 7 and 15(1) of the *Charter*. Although Winko's appeal was dismissed, the judgment provided by Justice McLachlin stated that the issue of concern was not whether section 672.54 violates *Charter* rights, but rather, how this section should be understood and applied by the courts and review boards. Justice McLachlin clarified how section 672.54 should be interpreted as read below:

There is no presumption that the NCR accused poses a significant threat to the safety of the public. Restrictions on his or her liberty can only be justified if, at the time of the hearing, the evidence before the court or Review Board shows that the NCR accused actually constitutes such a threat. The court or Review Board cannot avoid coming to a decision on this issue by stating, for example, that it is uncertain or cannot decide whether the NCR accused poses a significant threat to the safety of the public. If it cannot come to a decision with any certainty, then it has not found that the NCR accused poses a significant threat to the safety of the public. (para. 62)

Balachandra and colleagues (2004) examined the impact of the *Winko* decision by comparing the number of absolute discharges in the two years prior to the *Winko* decision, and the two years after the decision. The researchers found that there was a statistically significant increase in the number of absolute discharges made after the *Winko* decision, but they could not determine whether the Supreme Court of Canada's case was the sole influencing factor for this increase. In another study by Desmarais and colleagues (2008), the researchers randomly selected the case files of individuals given absolute discharges in British Columbia, Ontario, and Quebec three years prior to ($n = 291$) and after ($n = 301$) the *Winko* decision. Unlike the Balachandra (2004) study, Desmarais and colleagues did not find any significant differences between the pre and post-*Winko* groups. This is interesting as it suggests that although this is a significant SCC decision, it may have had little impact on how the Review Boards review NCRMD cases. In fact, Desmarais and colleagues suggest that the *Winko* decision reflected and

solidified the practices of review boards already in place. Furthermore, the Chair of the British Columbia Review Board described that the *Winko* case “merely reiterate[d] the established proposition that accused persons may be detained and deprived of their liberties only as long as they pose a foreseeable, nontrivial, significant threat to public safety” (Walter, 2005, p. 135).

In terms of recovery for forensic inpatients, the *Winko* decision greatly impacts the terms in which they can return to the community. Safety and risk play a key role in determining the extent of their freedom. Forensic institutions must balance protecting the public often at the cost of the patients’ autonomy by the implementation of prolonged detention or severe and intrusive monitoring in the community (Carroll, Lyall, & Forrester, 2004). Yet, what is a significant threat to the community? Justice McLachlin described a significant threat to the safety of the public to mean a “real risk of physical or psychological harm to members of the public that is serious in the sense of going beyond the merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature” (*R. v. Winko*, 1999, para 62). Forensic institutions are able to determine the risk of physical or psychological harm to the public by using an array of psychological instruments and assessments.

In regards to reintegration as described in section 672.54, the courts have discussed that reintegration relates to compliance with treatment requirements and reducing an individual’s experiences of isolation. In *R. v. Jones* (1994), the Ontario Court of Appeal determined that reintegration included compliance to medications and treatment. Jones was accused of murder, rape and robbery, but was found not guilty for reason of insanity in 1975. It came to light after the trial that Jones’ diagnosis of a personality disorder with antisocial features was not treatable. Additionally, Jones proved to be in compliant with treatment for his substance use problem. Despite attempts to conditionally release him into the community to promote his reintegration, in July 1992, he was arrested for breaching his conditions by using drugs and alcohol within a month of his discharge. After 18 years in the forensic system and “heroic efforts extended by a significant number of diligent professional therapists’, [Jones] had not shown any ‘appreciable amelioration of [his] antisocial personality’” (*R. v. Jones*, 1994, p. 357) and only three months after breaking the conditions of the charge, the Review Board granted him an absolute discharge stating that Jones’

personality disorder is not amenable to conventional psychiatric treatment and a detention in hospital serves no purpose whatsoever. The best indication of the future behaviour of the accused is his past behaviour. It is, therefore, reasonable to expect that it will bring him into conflict with the law. However, as has often been stated with respect to this accused, the judicial system has adequate means of dealing with any criminal conduct on his part. (as cited in *R. v. Jones*, 1994, p. 359)

The Ontario Court of Appeal determined that the Review Board's conclusion to let the judicial system intervene with Jones was inappropriate, and that compliance to treatment is an important component to successful reintegration into the community, stating the Review Board should have asked itself:

How can we effectively supervise the reintegration of the respondent into society when he has wilfully refused to abide by the conditions of release that we imposed earlier? To abolish the conditions of his release simply because he has refused to comply with them, not only sets a poor precedent to other patients on conditional release, it ignores the statutory framework under which the Review Board acts. (*R. v. Jones*, 1994, p. 361)

In *R. v. Aghdasi* (2011), the NCR accused spoke English as a second language, and requested that he be transferred from a maximum to a minimum security facility, which would be the least onerous and least restrictive disposition as per section 672.54. Justice Rosenberg determined that although the Review Board did not err in determining that the accused was still a risk to the safety of the public, the linguistic and cultural isolation of the accused should be considered in their disposition of which facility Aghdasi should reside in. Justice Rosenberg stated that at Aghdasi's current hospital, the NCR-accused faced isolation due to the distance from family and the lack of culturally appropriate programming or staff. Justice Rosenberg stated that "the Board was obliged to investigate and consider whether his cultural and linguistic isolation was interfering with his successful reintegration into the community and whether Oak Ridge was meeting his other needs" and that there was "no indication of any appreciation of the impact of the appellant's cultural and linguistic isolation and the role which it may be playing in preventing his successful reintegration and how this affects meeting his other needs" (2011, para. 24). Reintegration therefore means connecting with the community and culture, and is therefore viewed by the courts as an important component of an individual's recovery.

Significant Threat to the Safety of the Public

In order for one to reintegrate into the community, the Review Board and the courts must first assess the risk of an individual and protect the public for NCR-accused that are deemed to be dangerous. In *Winko v. British Columbia (Forensic Psychiatric Institute)* (1999), Justice McLachlin stated that in interpreting section 672.45, the court or Review Board must ask themselves whether the evidence suggests that the accused is a “significant threat to the safety of the public”. There are several ways that the Review Board is able to assess whether the individual is a significant threat for future violence, and it is the forensic mental health hospital’s responsibility to continually assess this risk and report it back to the Review Board annually.

Risk can be assessed using both static factors, which do not change over time, such as an individual’s past history of violence, and dynamic factors which are variable and remedial and include things such as illicit substance use or non-compliance with treatment (Kessler et al., 2005). Popular risk assessment tools for forensic inpatients include the HCR-20, the Psychopathy Checklist: Screening Version (PCL:SV), the Violence Screening Checklist (VSC), and the Short Term Assessment of Risk and Treatability (START) (Douglas, Ogloff, Nicholls, & Grant, 1999; Nicholls, Brink, Desmarais, Webster, & Martin, 2006; Nicholls, Ogloff, & Douglas, 2004). In relation to some of the more dynamic factors, there appears to be a convergence between protective factors as identified in the START, and concepts of what supports an individual’s recovery.

The START is a relatively new risk-assessment tool that permits the individuals assessing the forensic inpatient to differentially code “20 dynamic risk and strength-related factors” (Webster, Nicholls, Martin, Desmarais, & Brink, 2006, p. 750). According to Webster and colleagues (2006), strengths are defined as “assets at the disposal of the individual (e.g. a supportive family), which become protective factors” (p. 756) that the inpatient may use at their disposal to reduce or manage risk. Some of the domains in the START that can be identified as strengths include: attitudes, substance use, social support, relationships, social skills, occupation activities, recreational activities, rule adherence and self-care (Nicholls et al., 2006). By using START, clinicians are able to understand a fuller picture of the inpatient such as the underlying importance of

understanding dynamic variables and the strengths that may be utilized to better reduce the individual's risk, and in turn, promote their safe reintegration into the community.

Recovery in a Forensic Mental Health Environment

Forensic mental health hospitals are starting to attempt to balance mainly risk-oriented services with more holistic recovery-oriented services that focus on empowering patients rather than simply reducing their psychiatric symptoms (Hillbrand et al., 2010). Although over the past few decades there has been a rise of interest in recovery-oriented care (Hillbrand et al., 2010; O'Connell, Tondora, Croog, Evans, & Davidson, 2005) and although the literature is beginning to address the personal and subjective experience of recovery for individuals living with severe mental illness, there is still a dearth of research examining the concept from the perspectives of forensic inpatients. While recovery alone is a complex process, recovery in a forensic mental health hospital is believed to be even more complicated due to the secure setting and the patients' need for recovery from living with a mental illness and from the impact of their offending behaviour (Corlett & Miles, 2010; Simpson & Penney, 2011). Their recovery is compounded by the fact that individuals must live with the consequences of their index offences (e.g., the criminal act in which they were found NCRMD), which often means that they have to come to terms with what they did and face the limitations imposed on them by the *Criminal Code* until they are deemed no longer a risk to society.

In light of their contact with the criminal justice system, patients who receive treatment services at forensic mental health hospitals live with restrictions on their autonomy and liberty based on section 672.54 of the *Criminal Code*. While this is required in order to manage the risks associated with these patients, it also may hinder the recovery process (Corlett & Miles, 2010; Gudjonsson et al., 2010). Although the intention of providing care and treatment at a forensic mental health hospital is to contribute to the individual's recovery by preventing further contacts with the justice system, the nature of the system may also negatively impact their recovery. Forensic mental health hospitals are often characterized by an element of coercion and power-imbalance between staff and patients, as the interests of the individual inpatient may be superseded by the interests of the state and public safety (Pouncey & Lukens, 2010). In addition to this, depending on the legislative framework of the forensic mental health

system, many inpatients have no choice but to receive clinical care at a forensic mental health hospital and therefore must live with many rules and procedures that regulate their behaviour and activities. The isolated and compulsory nature of the forensic system may negatively affect the recovery process as it “curtails liberty and several key elements of autonomous decision-making, such as consent to treatment or management of finances” (Simpson & Penney, 2011, p. 302). Other potential barriers to recovery-oriented services in forensic settings may include the patients’ lack of insight or acceptance of having to live with a mental illness and the need to reside in secure units which do not promote trust among patients and staff: in particular as patients are often subjected to invasive procedures such as searches and drug testing. Not only does the nature of the patients’ mental illness (e.g., the presence of negative symptoms, social isolation and lethargy) have a potentially negative influence over their interactions in the hospital, social intolerance and the stigma associated with forensic inpatients impede an individual’s reintegration to society by limiting access to opportunities and programs (Ontario, 2002).

Studies that have examined recovery in forensic mental health environments have found that balancing individual recovery with risk management is possible even though implementing recovery-oriented services may be more challenging owing to the importance of managing risk, protecting the public, and managing service providers’ perceptions of safety (Corlett & Miles, 2010; Livingston, Nijdam-Jones, & Brink, 2012; Mezey et al., 2010). One way in which this can occur is if mental health professionals support recovery through conveying optimism and hope while empowering and engaging patients in their care by incorporating their values and having them participate in the planning of their care (Corlett & Miles, 2010; Gudjonsson et al., 2010; Hillbrand et al., 2010; McLoughlin, 2011).

In one qualitative study, researchers examined the definitions and understanding of recovery of ten forensic inpatients living with mental illness and receiving treatment services in a medium-secure psychiatric institution in Britain (Mezey et al., 2010). Similar to non-forensic mental health patients, individuals receiving forensic treatment services identified symptom reduction as an important component, but not the sole factor that indicates recovery. Mezey and colleagues (2010) found that these individuals identified additional factors that were important in their recovery, including “feeling better about

oneself as a person, being accepted by and making a useful contribution to the community, getting into work or education, finding a home, settling down with a partner, not re-offending, and simply being able to lead an ordinary life” (Mezey et al., 2010, p. 687). When questioned as to what helps bring about recovery for these individuals, the participants suggested that diagnosis, medication and psycho-education about their illness are key aiding factors in their recovery. Mezey and colleagues (2010) posit that medication use and adherence may be viewed as being more positive for forensic patients than non-offenders owing to the fact that emphasizing a medical model “in some way mitigates their responsibility for past transgressions” (p. 693) or because forensic patients are most accustomed to being told about treatment rather than having an active choice. The participants also identified that their detention in a secure unit provided them with support such as having access to sustenance and shelter and protection from the stigma and pressures of the outside world. Another important factor that Mezey and colleagues discovered in their thematic analysis of the interviews was that positive relationships and attachments to staff and peers were perceived as beneficial to their recovery.

As discussed in other forensic recovery literature, (see Corlett & Miles, 2010), Mezey and colleagues (2010) also identified the need for recovery from both living with a mental illness as well as the impact of their offending behaviour, often commenting that participants’ offending behaviour was a stronger barrier to their recovery than living with their mental illness: “[m]any patients referred to the double stigma of being seen as both ‘mad’ and ‘bad’ which they regarded as a barrier to being able to achieve even relatively modest goals in the future” (Mezey et al., 2010, p. 691).

In a recent quantitative study by Livingston, Nijdam-Jones and Brink (2012), the researchers examined the perspectives of 30 forensic inpatients and 28 service providers in a forensic mental health hospital to determine the extent to which principles and practices of patient-centred and recovery-oriented care are present in such hospitals. Using quantitative measures of recovery such as the Recovery Self Assessment Scale (RSA) and the Mental Health Recovery Measure (MHRM), their results suggest that forensic inpatients who felt hospital services promoted inpatient development and pursuing life goals rated higher for basic functioning, such as being active, connecting with others and self care. Also, inpatients who felt that their opinions

and preferences were valued and respected by staff demonstrated higher levels of overall sense of well-being, quality of life scores, and also showed a greater desire to reach new potentials of higher functioning.

In a qualitative study by Barsky and colleagues (2007), the researchers interviewed six inpatients at a medium-secure hospital about their perspectives of secure-mental health hospitals/units versus medium-secure units, and which are more supportive of recovery than high-secure facilities. The participants identified several components of the medium-secure units which aided in their recovery, such as access and involvement in more activities as opposed to the limited opportunities and long waitlist at high-secure facilities. Increased freedom from the ward and access to the community were perceived as other benefits to receiving treatment in a medium-secure hospital. The participants also indicated the importance of a comfortable ward atmosphere, with the high-secure wards being perceived as more serious and tense than the lower security hospital. Staff were also perceived more negatively in the high-secure units, with participants describing staff as aggressive, inconsiderate of the patients' mental illnesses and that they were often antagonistic or treated the patients as prisoners. Finally, although the high-secure units were perceived more negatively, patients did highlight the fact that the high-secure units provided more access to psychological therapies than the medium-secure units.

Summary

Recovery is a subjective experience that has been examined in great depth in the literature. Clinical recovery, or recovery from mental illness, focuses on the cessation of symptoms whereas personal recovery explores the unique subjective experience whereby individuals learn to live meaningful lives while managing their mental illness. Common elements of recovery include: renewing hope and commitment, redefining self, incorporating illness, being involved in meaningful activities, overcoming stigma, assuming control, becoming an empowered citizen, managing symptoms, and being supported by others. The MHCC has created strategic directions to transform and improve Canada's mental health system to provide more unified services and support for the recovery of individuals living with mental illness.

Recovery in a forensic setting is a more complex process owing to the secure setting and the patients' need for recovery while living with a mental illness and from the impact of their offending behaviour. Although it is more complex, the literature suggests that recovery-oriented services in forensic settings is possible through the provision of an environment that fosters optimism and hope, and empowers patients to participate in the planning of their care and treatment.

Recovery and recovery-oriented care is a leading topic of discussion in forensic mental health services, as is indicated by the growth of the literature on the topic, and it is important to understand what recovery means to the individuals who are living with mental illness and receiving such services in Canada. This study aims to further the understanding of the perspectives of patients on recovery at a forensic mental health hospital and to investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients.

Chapter 3.

Deviance and Social Bonding Theory

Control theories are founded on the philosophy of Thomas Hobbes, who questioned the reasons why men follow the rules of society. His response was that:

Of all passions, that which inclineth men least to break the laws, is fear. Nay, excepting some generous natures, it is the only thing (when there is appearance of profit or pleasure by breaking the laws) that makes men keep them. And yet in many cases a crime may be committed through fear. (Hobbes, 2008, p. 204)

Many sociologists and criminologists disagree with Hobbes, arguing that there is more to conformity than just fear, humans are “*morally* obligated to conform, whether or not it is to [their] advantage to do so” (Hirschi, 2002, p. 5) and that really, humans conform because they are constantly aware of others’ expectations. Strain theories describe the cause of deviant behaviour as a reaction to the pressures society has put on people to conform and achieve legitimate desires that the individual cannot achieve in conventional ways (e.g., the only way to achieve one’s goals is to consciously decide to go against society’s laws and expectations) (Hirschi, 2002). Unlike strain theories, control theories refer back to Hobbes’ original question of why humans conform, and ask why humans obey society’s rules. Control theories do not try to answer why deviance occurs, but instead, examine why most individuals conform and do not engage in deviance (Hirschi, 2002).

There are two leading control theories, self-control theory and social control theory, both of which contrast with each other. Social control theory, also known as social bonding theory, was originally developed by Travis Hirschi in 1969 and has become one of the most prominent control theories (Agnew, 1993). Self-control theory, on the other hand, is a more modern theory developed by Gottfredson and Hirschi (1990). Also known as the general theory of crime, the self-control theory posits that the

“variation in the propensity to engage in crime and other deviance is mainly a function of individual differences in self-control” (Longshore, Chang, Hsieh, & Messina, 2004, p. 542) and examines the extent to which ineffective socialization and parenting in one’s youth and adolescence makes them “vulnerable to the temptations of the moment” (Gottfredson & Hirschi, 1990, as cited in Longshore et al., 2004, p. 453). Through less than ideal parenting, an individual does not develop adequate self-control which makes them “prone to quick and easy gratification and, given the opportunity, crime” (Muraven, Pogarsky, & Shmueli, 2006, p. 263).

Although the general theory of crime is a prevalent control theory in research, the most acknowledged and dominant perspective on deviant behaviour in sociology is Hirschi’s social control theory, or social bonding theory (Agnew, 1993; Durkin et al., 1999). Hirschi’s (1969) social bonding theory is an “internally consistent, logically coherent, and parsimonious theory that is applicable to any type of criminal or deviant behavior; not only delinquency” (Akers & Sellers, 2004, p. 117). According to Hirschi, delinquency or deviance is “defined by acts, the detection of which is thought to result in punishment of the person committing them by agents of the larger society” (Hirschi, 2002, p. 47). This is in line with other definitions that identify deviance as behaviour or beliefs which deviate from the norm and will likely generate negative reactions from society (Goode, 2011; Humphrey, 2006; Scheff, 1966).

Although social bonding theory originated in the 1960s, it is still employed today in numerous qualitative and quantitative studies which have examined different forms of delinquency or deviance in youth and adults and still holds strong as a valid explanation of deviant behaviour (e.g. Alarid et al., 2000; Durkin et al., 1999; Exline, 2007). In a multivariate analysis examining binge drinking in 247 university students, Durkin and colleagues (1999) found significant negative correlations between quantified self-report measures of social bonding theory and the undergraduates’ frequency of binge drinking. The authors also completed a regression analysis using measures of social bonding theory and found that it explained almost a quarter of the variance in the amount the university students drank.

Qualitative studies have also found support in explaining desistance from criminal activities. In her qualitative M.A. thesis, Exline (2007) examined the effects of

social bonds in a voluntary running program at a juvenile community correctional facility. Exline concluded that social bonds potentially did increase participants' bond to society and desistance from criminal activities, although she noted that the program may not work for all individuals because of its voluntary nature.

Although social bonding theory was originally created to explain deviance and delinquency in youth, researchers have begun to apply it to adult offenders. In the early 1990s, Sampson and Laub (1990) adapted social bonding theory to a life-course model, by linking social control from childhood into an individual's adulthood, which explains why some individuals participate in deviant activities early or late into adulthood.

In a study examining criminal behaviour in young adults, Alarid and colleagues (2000) used self-report surveys from a sample of 1,153 first-time offenders aged 17-25 in community corrections programs to examine the extent to which social control theory and differential association theory may explain offending behaviour. The researchers found that age and race/ethnicity were the strongest predictors of rates of offending for both men and women, parental attachment was consistently negatively related to crime measures, and being involved in conventional activities was negatively and significantly associated with criminal behaviour. The researchers concluded that although social control theory is a traditional and older theory, it is a general theory of crime and should still be used in future research on delinquency and deviance for populations of all ages.

Social Bonding Theory

Social bonding theory posits that human morality is based on the extent to which an individual bonds with others and with society, and thus internalizes society's norms (Hirschi, 2002). Norms, or socially acceptable behaviours or actions, are "by definition shared by the members of society... [and to] violate a norm, is therefore, to act contrary to the wishes and expectations of other people" (Hirschi, 2002, p. 18). Erikson (1961) goes deeper into the explanation of social norms, describing them as unexpressed codes or rules of society, similar to that of common law. Each social norm 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"

(Erikson, 1961, p. 310), while deviance is the accumulation of behaviour which violates these socially accepted norms.

According to social bonding theory, deviant behaviour, which is discouraged and viewed negatively by society as a whole, occurs when an individual's bond to society is weak or broken. It is an adolescent's attachment to parents, teachers and peers, commitment to conventional activities, involvement in conventional activities, and belief in the importance and value of social norms that are key contributors to normative social behaviour. More recently, however, research has begun to examine the extent to which social bonding theory can explain criminal behaviour in adults (e.g., Alarid et al., 2000).

The following sections briefly outline the four main elements of social bonding theory: attachment, commitment, involvement, and belief.

Attachment

In social bonding theory, attachment refers to “the extent to which we have close affectional ties to others, admire them, and identify with them so that we care about their expectations” (Akers & Sellers, 2004, p. 118). Hirschi highlights attachment to peers and parents as critical in determining adherence or violation of social norms. According to this theory, when individuals are indifferent or insensitive to society's opinions or judgments, it signifies that they have a weakened bond with society. Hirschi argues that it is attachment to other people that determines an individual's adherence to, or violation of, society's conventional rules—regardless of the character of the people to whom the individual is attached (Akers & Sellers, 2004). In other words, even when an individual is not in close proximity to someone they have formed attachments with when an opportunity for deviant behaviour arises, social bonding theory suggests that they will refrain from engaging in deviant behaviour because they value the opinions of those they care about.

For the purpose of social bonding theory, attachment to parents has been measured by examining close parental supervision or discipline, good communication, and affectional identification with parents (Akers & Sellers, 2004). Likewise, attachment to peers can be measured by affectional identification with close friends as well as respect for their opinions (Akers & Sellers, 2004). In research involving youths,

attachment has been operationalized by assessing the extent that an individual communicates with their parents (Durkin et al., 1999)

Commitment

In social bonding theory, commitment refers to the extent to which an individual has invested time and energy into participating in conventional activities, such as occupational or academic aspirations (Akers & Sellers, 2004). Commitment refers to the “aggregate investment of time, energy, and resources in conventional activities” (Durkin et al., 1999, p. 452). Conventional activities have been defined as attaining an education and obtaining a job which are considered “stakes in conformity” (Durkin et al., 1999, p. 452). The concept of commitment is based on the idea that an individual obeys the rules or norms of society in order to avoid the negative costs of engaging in deviant or socially unacceptable behaviour. This element of social bonding theory emphasizes the energy and time an individual has put into living conventionally, and that the stronger the bond to conventional activities and lifestyles, the less likely an individual would risk their reputation or their hard earned effort pursuing conventional activities to behave in a deviant manner (Krohn & Massey, 1980). Commitment to conventional activities can be demonstrated by an individual’s pursuit and achievement of conventional goals (Akers & Sellers, 2004).

Involvement

Involvement refers to being actively involved in conventional activities, such as education, work or participating in pro-social activities (i.e. clubs and sports). This means that an individual is too preoccupied with conventional activities to behave or engage in deviant behaviour (Durkin et al., 1999; Hirschi, 2002). This is different from commitment, which emphasizes the investment that an individual has in participating and valuing conventional activities and goals. Involvement in conventional activities can be measured by examining the amount of time spent with family and friends, or involvement in work, recreation, or school (Akers & Sellers, 2004). In a study looking at deviant behaviour among college students, the researchers defined involvement in conventional activities as “time spent studying or working at a part time job while they are not in class”

(Durkin et al., 1999, p. 425). The underlying concept is that if individuals have busy lives, they will not have time to engage in deviant behaviour.

Belief

Hirschi has argued that there is variation in the extent to which an individual holds strong beliefs in conventional norms, morals and rules of a society, arguing that “the less a person believes he should obey the rules, the more likely he is to violate them” (Hirschi, 2002, p. 26). If an individual has weakened or non-existent beliefs in society’s norms and rules, he or she will be more likely to break them. Individuals who do not endorse or hold strong beliefs in moral and legal norms do not have a strong bond to society, and are therefore more likely to commit deviant acts or behave in a deviant manner. Belief in the moral validity of rules can be measured by an individual’s reference to social or legal values, and belief that norms or rules should be obeyed (Akers & Sellers, 2004). Similarly, belief includes “a general acceptance of the rules of society as being morally valid and binding” (Durkin et al., 1999, p. 452), and indicates a respect for authority.

Critiques of Social Bonding Theory

There are several limitations to social bonding theory that must be discussed. The definitions of constructs in social bonding theory are much weaker than other sociological or criminological theories. For example, Hirschi’s theory may be applied to broadly defined phenomena: criminal, deviant or delinquent behaviour (Akers & Sellers, 2004, p. 117). While being applicable to a wide variety of negatively perceived behaviour, Hirschi only defines delinquency as merely negative behaviours, “the detection of which is thought to result in punishment of the person committing them by agents of the larger society” (Hirschi, 2002, p. 47). As mentioned earlier in this chapter, weak social bonds have been used to explain delinquency in youths, binge drinking among undergraduate students, and crimes committed by first-time offenders. Although being a general theory of crime is a strength of social bonding theory, more discussion must be put forward into how deviance is conceptualized and defined by society as a whole. Similarly, conventional activities are loosely defined as educational or

occupational pursuits without clarifying why these are socially normal and acceptable behaviours.

Another shortfall of social bonding theory is the lack of empirical analysis into the relationships between its four elements. Therefore, the possibility that the four components of the theory may work together to explain delinquency is not adequately explored (Empey, 1978, as cited in Wiatrowski, Griswold, & Roberts, 1981). Similarly, Hirschi is criticized for not considering the other factors that may influence deviant behaviour, including macro-forces such as gender, socio-economic status, ethnicity and social disorganization (Lilly, Ball, & Cullen, 2010). Many constructs which build social bonds beyond educational and occupational aspirations, such as the individual's socio-economic level and the influence of an individual's partner are also ignored (Empey, 1978, as cited in Wiatrowski et al., 1981). For example, although an analysis using multivariate models of social control theory on delinquency in youth found that several components of social bonding theory were consistent, low scores on commitment did not strongly predict weakened bonds or delinquent behaviour (Wiatrowski et al., 1981) but found that social economic status and mental ability were significantly important in explaining the four components of social bonding theory.

Social Bonding Theory and Recovery

Recovery is the experiential shift from despair to hope, alienation to purpose, isolation to relationship, withdrawal to involvement, and from passive adjustment to active coping. (White, Boyle, & Loveland, 2005, p. 235)

Many of the elements of social bonding theory are reflected in the literature on recovery such as the importance of meaningful activities as well as strong social bonds and support. Likewise positive relationships and role models have been identified in the literature as an important element of the recovery process (Corlett & Miles, 2010; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Mezey et al., 2010; Pouncey & Lukens, 2010; Smith, 2000). According to the SAMHSA's definition of recovery, a guiding principle is support through peer support and allies which offer social learning, and social networks which offer "hope, support, and encouragement; and who also suggest strategies and resources for change" (SAMHSA, 2011). These relationships and

friendships provide opportunities for individuals to learn and engage in new empowering roles that foster feelings of “belonging, personhood, empowerment, autonomy, social inclusion, and community participation” (SAMHSA, 2011). First-person accounts of living with mental illness have discussed the benefits of peer support in the recovery process, stating that an individual is “committing to a larger process of building community” and that having that support can help individuals move “through and beyond difficult situations, and ... learn how crisis can be an opportunity for growth and change” (Mead & Copeland, 2000, p. 7).

Similarly, in a small qualitative study that examined the perspectives of patients in relation to therapeutic environments in both medium and high secure psychiatric units, researchers found that involvement in activities increased the patients’ quality of life, whereas being unable to participate in activities owing to long waiting lists or no choice for participation was perceived to have a “detrimental impact” on the participant’s mental health (Barsky & West, 2007, p. 7).

Although there are several components of social bonding theory that appear to be in line with concepts of recovery such as the importance of social relationships and involvement in conventional and meaningful activities, there are also components of the recovery paradigm that cannot be explained by social bonding theory. Social bonding theory is very much a sociological explanation of normative behaviour and deviance, and does not account for pathological or psychological determinants of mental illness. However, social bonding theory can be used to examine the social components of recovery even though it obviously is unable to highlight the importance of medication and therapy in an individual’s journey of recovery.

The examination of whether social bonding theory is reflected in the narratives of inpatients at a forensic mental health hospital is a useful tool for understanding how relationships with peers, service providers, friends and family can support an individual through their subjective and unique process of recovery. By better understanding how social bonding theory may explain an individual’s recovery and return to normative behaviour, programs and services can be improved to strengthen the bond and relationships patients have with fellow peers, staff and the community. This has the

potential to facilitate recovery for patients as well as their safe reintegration into the community.

Summary

Hirschi's (1969) social bonding theory posits that human morality is based on the extent to which an individual bonds with others and society, and thus internalizes society's norms. An individual's attachment to others, commitment and involvement in conventional activities, and belief in the importance and value of social norms are key contributors to normative social behaviour. Therefore, it is when an individual's bond to society is weak or broken that deviant behaviour can occur.

The four elements of social bonding theory, belief, attachment, involvement and commitment, highlight the importance of social bonds in maintaining normative behaviour. These elements are in line with themes outlined in the literature on recovery from mental illness, and in the following chapters, this study will examine the extent to which they are reflected in the narratives of inpatients at a forensic mental health hospital. This will allow further understanding of how relationships with peers, service providers, friends and family can support an individual through their subjective and unique process of recovery. Through exploring whether elements of social bonding theory foster an individual's recovery and normative behaviour in a forensic setting, this study may shed light on ways in which forensic services can strengthen the bonds and relationships between patients and their fellow peers, service providers, and the community.

Chapter 4.

Methods

Using qualitative description as a methodological approach, the research objectives of this thesis were to (a) understand the perspectives of patients on recovery at the BC FPH; (b) investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic inpatients, (c) examine the extent to which forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory; and (d) identify the strengths of a forensic mental health hospital as well as the areas that patients believe could be improved in order to make their recovery experience more successful. The data examined for this study was originally collected for a mixed-method study (QUAN+*qual*), and this study only analyzed the qualitative component of the semi-structured interviews.

Qualitative description allows for a full and complex description of experiences or events (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Although qualitative description can have overtones or elements of other research approaches such as ethnography, phenomenology or narrative studies, the core of this approach is to provide "straight descriptive summary of the informational contents of data organized in a way that best fits the data" (Sandelowski, 2000b, p. 338) by presenting an emic, or insider's, perspective (Milne & Oberle, 2005). Unlike ethnography which aims to provide a robust description, grounded theory which aims to develop theory, or phenomenology which creates interpretative meaning of the data, qualitative description aims to highlight participants' voices in describing their experiences in their own language (Neergaard et al., 2009). In qualitative description, the researchers aim for descriptive validity, whereby they are accurately presenting events or experiences as those with lived experiences or observers would perceive it (Sandelowski, 2000b). Researchers employing qualitative description also aim for interpretative validity, whereby the summary of the data and participant meanings are represented accurately (Sandelowski, 2000b). Although not as

interpretative as other qualitative research methods, qualitative descriptive studies are “detailed and nuanced interpretive products” whose findings are “closer to the data as given, or data-near” (Sandelowski, 2010, p. 78). Although qualitative description is the least theoretical of qualitative research methods (Neergaard et al., 2009; Sandelowski, 2000b), it is not atheoretical as it is influenced by theory and previous knowledge (Sandelowski, 2010).

Setting

Data for this thesis was collected as part of a project at the BC FPH, a forensic mental health hospital in British Columbia, Canada. The accredited hospital has 190 beds in nine units which range between low, medium and high security. Patients in the hospital are adults living with severe mental illness who are (a) undergoing a court ordered assessment (b) receiving care under a temporary absence from a BC Corrections facility, or (c) receiving tertiary-level mental health treatment and have been adjudicated by a court to be ‘Unfit to Stand Trial’ or ‘Not Criminally Responsible on Account of Mental Disorder’ for non-violent, violent and sexual index offences. The hospital also has an assessment population (e.g., NCRMD, Fitness) and a small number of people on temporary absence from BC Correction facilities. For the forensic inpatients who have been adjudicated NCRMD, they have been deemed by the British Columbia Review Board, established under the *Criminal Code* of Canada, to be a significant threat to public safety, and therefore, inappropriate for being managed in the community. A study of the BC FPH by Nicholls and colleagues (2009) determined that the patient population in 2004 was made up of 88% men, with an age range of 17 years to 78 years (M=36.0, SD=11.6), with 61% diagnosed with schizophrenia spectrum disorder and 63% diagnosed with a substance use disorder. The study further found that 42% of the patients in the hospital there for remand, 37% were adjudicated NCRMD, and 21% were involuntarily admitted or found Unfit to Stand Trial.

In the forensic mental health hospital where this study took place, there are various cascading levels of security on the units in which forensic inpatients reside. For example, in the low secure units, forensic inpatients have a lot of freedom and independence and actively lead the planning, shopping and cooking of their own meals.

Additionally, they may have access to hospital grounds more freely than on the other units. On the other hand, in the high security units, the inpatients have restricted access to all activities and to the hospital grounds and are closely monitored and regulated in order to reduce safety risks. Forensic inpatients' access to programs and privileges are also regulated based on the individual's clinical state, his or her need, as well as in consideration of the individual's safety and the safety of the hospital staff and the community (Forensic Psychiatric Services Commission, 2009). Reviewed on a regular basis, patients are assigned specific privileges which cascade in relation to the degree of freedoms they can have while receiving treatment at the hospital (i.e., which areas of the hospital the patient can attend supervised or unescorted or under what circumstances the individual may access the community).

Procedure

This study employed the secondary analysis of existing research data collected using semi-structured interviews. The original data were collected for the Patient-Centred Care Study (PCC Study) and were an evaluation component to the BC FPH's Patient Engagement Project, funded by the Canadian Health Services Research Foundation. The PCC study was a mixed-method (*QUAN+qual*) study which examined patient-centred care from the perspectives of patients and service providers at BC FPH. Patient-centred care is a healthcare service approach "under which care is personalized to meet the patients' individual needs and to be consistent with their preferences" (Sidani, 2008, p. 24) in order to provide a therapeutic milieu where patients are engaged and empowered in their recovery process. The quantitative data from this study has been published elsewhere (see Livingston et al., 2012). The current study is focused on the qualitative data generated from interviews with forensic inpatients at the BC FPH.

The data from the PCC Study were used in this analysis with the formal written permission and support of the principal investigators. Ethics approval for secondary data analysis was granted by the Office of Research Ethics at Simon Fraser University on January 11, 2012. The original PCC Study protocols were approved by the University of British Columbia's Research Ethics Board and the Forensic Psychiatric Services Commission Research Advisory Committee. Although the data from the PCC Study are

being analyzed as secondary qualitative data, the author of this thesis was involved in the original data collection process (i.e. coordination, performing interviews) as a research assistant at the BC FPH. Data collection began in May 2011 and was completed by July 2011. All participants provided written informed consent, which included permission for their interviews to be digitally recorded and transcribed.

There were 30 in-person interviews conducted with patients receiving care and treatment in the hospital. In qualitative research, the requirements to determine the appropriate sample size vary based on the intended purposes of the study (Sandelowski, 1995; Suzuki, Ahluwalia, Arora, & Mattis, 2007). The researcher must consider the scope of the study, the nature of the topic, the quality of data, the study's design, and the use of "shadowed data," or data where the participants discuss their experiences in relation to that of others (Morse, 2000). The participants should represent the variety of the target population, including individuals of different genders, ages and ethnicities "so that a broad spectrum of individual experiences and attitudes are explored" (Murray, 1998). Purposive sampling was used to ensure that the participants represented characteristics relevant to the study (e.g., demographic and clinical characteristics) (Suzuki et al., 2007; Whitley & Crawford, 2005). As the data was originally collected for the mixed-method study, the sample size was determined based on the number of participants that were interested in the study, and this number was determined to be adequate to represent the diverse populations and perspectives of patients at the forensic mental health hospital. Although the purpose of the sample size was not based on theoretical saturation, in which "redundancy occurs when, on importing new data into the analysis, no new findings of note are generated" (Morrow, 2007, p. 217), by the end of the coding process, no new themes had emerged from the interview transcripts.

Patient participants were recruited using a purposive sampling strategy, which deliberately involved individuals who fit the eligibility criteria. Participants were recruited using the following methods: (a) recruitment advertisements were posted in designated patient areas of the BC FPH (see Appendix A); (b) brief presentations were given at patient meetings and gatherings; and (c) hospital staff were encouraged to provide information about the study to individuals they deemed suitable candidates for the study. Individuals who indicated an interest in participating were provided with additional

information and advised that their participation must first be approved by their psychiatrist to ensure the participant did not pose a threat of harm to self or others and had the capacity to consent to participate. Two participants decided they were no longer interested in participating, either due to lack of interest or because they were not interested in getting approval from their psychiatrists. Individuals who received approval from their psychiatrist to participate in the study were taken through the informed consent procedures, and screened for capacity to understand the consent form. Of the interested individuals who did not end up participating in the study, only one decided not to participate because he did not want the researchers to contact his psychiatrist, one individual failed the capacity screening, four individuals did not fit the recruitment criteria (e.g., language barrier or had not received one month of treatment services at the hospital), and one person was discharged after the research team received approval from his psychiatrist to participate, so it was impossible to coordinate an interview. The consent form (see Appendix B) was thoroughly reviewed with participants, who were given the opportunity to ask questions prior to signing the form.

Participants

To take part in the study, participants must have been: (a) 19 years of age or older; (b) diagnosed with a mental illness; (c) receiving treatment services in the BC FPH for at least one month; (d) able to communicate in English; and (e) deemed by their psychiatrist to be capable of participating in the research study (e.g., sufficient cognitive capacity and no risk of harm to staff—see Appendix C).

Of the 30 study participants, the majority were male ($n = 24$, 80%), and the average age was 40 ($n = 30$, $SD = 11.1$), ranging from 22 to 62 years of age. Participants identified as White ($n = 26$, 87%), mixed background ($n = 2$, 6.7%), Asian ($n = 1$, 3.3%) and Aboriginal ($n = 1$, 3.3%). More than half ($n = 17$, 57%) had completed high school or received equivalent education, 70% had attended college or university ($n = 21$), and 37% had graduated from college or university ($n = 11$). Participants self-reported their mental health diagnoses as: schizophrenia ($n = 18$, 60%), schizoaffective disorder ($n = 5$, 17%), bipolar disorder ($n = 3$, 10%), other psychotic disorders ($n = 2$, 7%), and unknown ($n = 2$, 7%). Additionally, over half of the participants indicated that

they had a history of alcohol or substance abuse ($n = 16$, 53%). Finally, on average, each participant self-reported having been admitted to the forensic mental health hospital three times over their lifetime, ($n = 30$, $SD = 3.6$, $Mdn = 2$, $Max = 15$), with the median length of their most recent stay being just under 2 years ($n = 30$, $M = 46.1$ months, $Mdn = 23$ months, $SD = 54.8$).

Interviews

Qualitative research is an approach used for collecting, analysing and interpreting data not easily represented by numbers (Brown & Lloyd, 2001; Whitley & Crawford, 2005). Qualitative methods permit an in-depth and detailed understanding of the “complex processes and illustrate the multifaceted nature of human phenomena” (Morrow, 2007, p. 211). This approach to research “illuminate[s] the particulars of human experience” (Ayres, Kavanaugh, & Knafl, 2003, p. 871) by enabling individuals to speak for themselves about their lived experiences (Kuper, Reeves, & Levinson, 2008). It attempts to document complex experiences in order to increase understanding by focusing on how individuals interpret the world around them (Leech & Onwuegbuzie, 2007; Whitley & Crawford, 2005).

Interviews are one of the most common research methods in qualitative research (DiCicco-Bloom & Crabtree, 2006) and semi-structured interviews with open-ended questions are often used in studies employing qualitative description (Neergaard et al., 2009; Sandelowski, 2000b). Using an in-depth or semi-structured interview, a researcher is able to gain knowledge about the social world as constructed and understood by the participant through an “interactional exchange of dialogue” (Mason, 2002, p. 62). An important component to qualitative interviews is their interactive nature, which lends flexibility and structure to the exchange of information and knowledge (Donalek, 2005; Legard, Keegan, & Ward, 2003). During the exchange of dialogue, interviewees must be treated with respect and empowered as “experts” in the material in order to build rapport and a trusting environment (Hesse-Biber & Leavy, 2010). As the researcher interacts with and probes the participant for more information, he or she is able to guide the semi-structured interview and be “responsive to relevant issues raised spontaneously by the interviewee” (Legard et al., 2003, p. 141). Interviews are an active interaction between

individuals in which the researcher focuses on *how* people's everyday lives are constructed and filled (Fontana & Frey, 2007).

Interviews are particularly beneficial when there is a specific issue or topic that the researcher would like to explore with the participant (Hesse-Biber & Leavy, 2010). Interview guides may include open or close-ended questions to query participants about certain experiences. The variety of question-structure permits both the interviewer and interviewee to share control in the interview process (Whitley & Crawford, 2005). Research interviews are often beneficial to all involved as the interviewer learns about the social lives and perspectives of those with lived experiences, and participants share their stories and first-hand knowledge (Hesse-Biber & Leavy, 2010; Hutchinson, Wilson, & Wilson, 1994). Additionally, interviews permit for self-report and disclosure, in which participants share their own perspectives of the world and their experiences, data which are often unobtainable using other methods (Barker, Pistrang, & Elliott, 2002)

In the PCC study, each participant took part in a semi-structured interview (see Appendix D for Interview Guide) conducted in private by a female graduate-level research assistant ($n = 28$; i.e., the author of this thesis)¹ at the BC FPH. All but one interview occurred in one continuous session, and the interviews lasted between 40 to 108 minutes. The patients were compensated \$10 for their participation. The graduate-level research assistant was formally trained in interview methods and coached by the lead researcher of the PCC study on interview techniques. The graduate-level research assistant was provided with literature on interviewing skills and observed one interview done by the lead researcher. The research assistant then conducted an interview under the observation of the lead researcher and was provided feedback. From that point forward, the research assistant conducted the interviews by herself, but continually debriefed with the lead researcher throughout the project. After several interviews, the interview guide was also reviewed by the research assistant and the lead researcher, and it was slightly altered to ensure the questions were clear and on topic. During the interview and after its completion, the interviewer would record notes on the interview guides.

¹ Two interviews were conducted by the male lead researcher of the PCC study in order to demonstrate the desired interview approach to the research assistant and because one participant was flagged as a potential concern for female staff.

Interviews were appropriate for this research topic as they provided the participants an opportunity to explain their lived experiences of recovery within the context of a forensic mental health hospital. Semi-structured interviews were used to allow for open-ended questions to focus on specific experiences participants had in the hospital in relation to their recovery. Since recovery is a deeply personal and subjective experience, exploring participant narratives of their experiences was the most appropriate approach to understanding the role social relationships and bonds have had on their experience of recovery. Semi-structured interviews were the preferred type of interview for this project as the original PCC study was a mixed-method study (QUAN+*qual*). A QUAN+*qual* design is used when the study's core intent is to measure certain constructs, and a qualitative approach is used to supplement the measurement and obtain explanation or description that the measures cannot (Morse & Niehaus, 2009). Semi-structured interviews permitted the combination of the quantitative measures and allowed for the exploration of those constructs qualitatively.

Materials

The mixed-method interview guide contained six quantitative measures of constructs that were relevant and complementary indicators of patient-centred care, including patient engagement, patient empowerment, personal recovery, recovery-oriented care, therapeutic milieu, and internalized stigma. As noted by Livingston, Nijdam-Jones and Brink (2012, pp. 6-7), the standardized measures are described below:

The degree to which services were aligned with the principles of the recovery model was measured using the 'person in recovery' version of the Recovery Self Assessment Scale (RSA) (O'Connell et al., 2005). The RSA has 32 items and five domains: life goals, service involvement, diversity of treatment options, choice, and individually tailored services. ...

Hospital milieu was assessed with the Essen Climate Evaluation Schema (EssenCES), which was designed for use in forensic mental health inpatient settings (Schalast, Redies, Collins, Stacey, & Howells, 2008). The EssenCES is a 15-item scale with three domains: patients' cohesion, experienced safety, and therapeutic hold. ...

The personal recovery process was assessed using the Mental Health Recovery Measure (MHRM) (Bullock, 2005). The MHRM contains 30 items and seven subscales that reflect different stages of recovery: overcoming stuckness, self-empowerment, learning and self redefinition, basic functioning, overall well-being, new potentials, and advocacy/enrichment. ...

Patient engagement in mental health services was measured using the Singh O'Brien Level of Engagement Scale (SOLES) (O'Brien, White, Fahmy, & Singh, 2009). The SOLES contains 16 items and assesses two domains: acceptance of need for treatment and perceived benefit of treatment. ...

Personal empowerment was assessed using the Making Decisions Empowerment Scale (MDES) (Rogers, Chamberlin, Ellison, & Crean, 1997). The 28-item instrument contains five domains: self-esteem/ self-efficacy, power-powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger. ...

Subjective, internalized experiences of stigma were assessed using the Internalized Stigma of Mental Illness scale (ISMI) (Ritsher, Otilingam, & Grajales, 2003). The 29-item measure covers five domains: alienation, stereotype endorsement, discrimination experiences, social withdrawal, and stigma resistance.

Throughout the interview, the participants were encouraged to elaborate on the six standardized measures and speak to their experiences at the hospital. In particular, the interview contained scripted probes that asked participants to elaborate on statements that were relevant to recovery and social bonding theory, including: "I find seeing the members of my treatment team helpful" (SOLES), "I have benefited from mental health services" (SOLES), "Staff encourage me to have hope and high expectations for myself and my recovery" (RSA), and "I engage in work or other activities that enrich myself and the world around me" (MHRM).

In addition to the above measures, the interview guide contained open-ended questions that pertained to the participants' perception of patient-centred care at the hospital, social bonds, their experiences within the hospital, and their thoughts and recommendations for improvements that might aid in their own recovery at the forensic mental health hospital. Seven open-ended questions were specific to examining social bonding theory and recovery at the hospital (see Table 1 below).

Table 1: Sample of Interview Questions Around Recovery

1. In your own words, what does “recovery” mean to you?

2. What has helped you with your recovery at FPH?

3. What has interfered in your recovery at FPH?

4. How has staying at FPH affected your relationships? How has this affected your recovery?

5. How has staying at FPH affected your views around recovery? How and why do you think your attitude and behaviour has changed?

6. How do you feel about the rules you are expected to follow during your stay at FPH? What affect do these rules have on your recovery?

7. Can you tell me some reasons why you choose to follow the rules at FPH? Have you ever broken the rules at FPH? If so, can you give me a recent example and tell me about why you did it? Has this affected your recovery?

The first three questions were adapted from the Recovery Interview by Heil and Johnson (1998, as cited in Ralph, Kidder, & Phillips, 2000). The Recovery Interview is a qualitative questionnaire developed by the Ohio University Institute for Local Government and Rural Development that explores recovery from the perspective of the individual with lived experiences (Ralph et al., 2000). The original questions were:

1. What does recovery from mental illness mean to you, personally?
2. What has contributed in your recovery process?
3. What has interfered in your recovery process?

(as cited in Ralph et al., 2000, p. 74)

The final four questions were developed around the concepts of social bonding theory relating to attachment, belief, involvement and commitment, and were informed by an M.A. thesis interview guide that examined social bonding theory and the perceived effects of a juvenile voluntary running program at a community correctional facility in Ohio (see Exline, 2007).

As the interview guide was semi-structured, the interview was flexible and the interviewer had the opportunity to move off-script to explore ideas and thoughts with the participants in order to gain a deeper understanding of the explored concepts. This is

important in qualitative description as it promotes participants to speak freely and identify important topics to raise, and also aids in building trust and rapport between the interviewer and interviewee (Milne & Oberle, 2005).

Transcription

Verbal data often provide unique rich information on constructs that may be difficult to quantify (Halcomb & Davidson, 2006). In qualitative research, transcription is a process in which sound or images are transformed and translated into written text (Davidson, 2009). The methods and procedures involved in transcription often fall on the continuum of naturalism and denaturalism. When applying naturalism to transcription, “every utterance is transcribed in as much detail as possible” (Oliver, Serovich, & Mason, 2005, p. 1273), and often textual symbols such as full stops, commas and paragraphs are used to denote oral patterns. Typically, overlapping speech, stuttering, laughter, and response tokens such as “*mmhmm*” or “*yeah*” are transcribed verbatim. This method of transcription focuses heavily on how language is used, and is often chosen for conversation analysis. On the other hand, when applying the denaturalism method to transcription, “idiosyncratic elements of speech (e.g., stutters, pauses, involuntary vocalizations) are removed” (Oliver et al., 2005, p. 1273). Like naturalized transcription, denaturalized transcription is a verbatim depiction of the interview, but it is used in instances where the research intends to examine the substance of the participant’s speech and the meanings and perceptions that are depicted within their conversations as opposed to the mechanics of how it is said. Neither method of transcription is superior. Often researchers use a method that falls in between the continuum of denaturalized and naturalized techniques.

For the purposes of this study, the interviews were transcribed using a denaturalized approach, as the study aimed to examine how participants understood their personal recovery at the hospital. However, stutters, response tokens, and non-verbal vocalizations were also noted in order to clarify the context of the interview. Indicating with notes in the transcriptions that the participant was either laughing, crying or sniffing permits clarity and adds context to the conversations which facilitates accurate analysis (Oliver et al., 2005).

Interviews were digitally recorded and stored on a secure computer network at the BC FPH. Interviews were transcribed by several research assistants. Although it is ideal for the researcher who completes the interviews to also transcribe them to ensure accurate transcription (Easton, McComish, & Greenberg, 2000), owing to time constraints and other project deadlines, the interviews were transcribed by three research assistants (ANJ, *n* = 6; KC, *n* = 24, and RJ, *n* = reviewed all 30). For each hour of recorded interview, it took a research assistant approximately 4 hours to transcribe. Recorded interviews ranged from 41 to 108 minutes. The author of this study personally transcribed six interviews which was an important step in the analysis. Transcribing is a “key phase of data analysis” (Bird, 2005, p. 247) and permits the researcher to become more familiar with the data and aware of any emerging themes (Bailey, 2008). As Lapadat and Lindsay aptly describe transcription, it is an important component of the research process as “[a]nalysis takes place and understandings are derived through the process of constructing a transcript by listening and re-listening” (p. 82).

The process of transcription was a thorough and detailed process which included several checks to ensure accurate transcription. One research assistant would transcribe the interview in its entirety before reviewing the file again while reading through the transcription to ensure it was accurate. If a word, sentence, or statement was incomprehensible, it was time-stamped and documented on a spreadsheet. After the original transcriber completed reviewing the transcript, a second research assistant reviewed the file in its entirety to ensure accurate representations of the audio file. This also ensured that common transcription errors which may change the meaning of the sentences (e.g., inaccurate punctuation, mistyped words, forgotten question marks, etc.) were corrected before formal data analysis began. Repeating reviews of the transcription is a crucial step in the research process and may establish the dependability, confirmability and authenticity of the research data (Easton et al., 2000; Milne & Oberle, 2005).

For the purposes of this study and displaying the results, quotes were “cleaned up,” or sanitized, for a more denaturalized reading of the transcripts. It is important to ensure that the edited quote clearly and accurately reflects the original interview text while at the same time not embarrassing, belittling or offending the interview participant (Minnesota Historical Society, 2001). Although involuntary vocalizations (e.g., stutters),

response tokens (i.e., “*mmhmm*”, “*yeah*”, etc.), and non-verbal vocalizations were transcribed to clarify the context of the interview to the researcher analyzing the data, they may sound foolish or have the undesirable effect of identifying the participant and therefore compromising the confidentiality and anonymity of the study participants. Additionally, involuntary vocalizations may also distract the reader from the participant’s true meaning. As such, they were removed from the final presentations of quotations to permit a clearer reading of the participants’ voices.

Data Analysis

Data analysis, the “systematic search for meaning” (Hatch, 2002, as quoted in Leech & Onwuegbuzie, 2007, p. 564), is a key component to research and should be done in a methodical and transparent manner (Attride-Stirling, 2001). The purpose of qualitative data analysis is to provide an “accurate representation of the phenomena under study using detailed or ‘thick’ description” (Brown & Lloyd, 2001, p. 353). In order to ease analysis, *NVivo 8* was used to organize the data. In qualitative analysis of research interviews, there may be several hundreds of pages of transcripts that the researcher must handle and organize. In order to facilitate an efficient in-depth and organized analysis of the data, computer software is often employed (Leech & Onwuegbuzie, 2011). Using an electronic analysis program to code qualitative data which is “textual, non-numerical and unstructured” (Basit, 2003, p. 152) is beneficial because it aids the researcher in organizing and making sense of hundreds of pages of transcripts. Coding is a key component to analysing qualitative data, one which builds the foundation for the analyst’s findings (MacQueen, McLellan, Kay, & Milstein, 1998). Coding involves not only labelling or categorizing data, but also “allocating units of meaning to the descriptive or inferential information compiled during a study” (Basit, 2003, p. 144). A software program will not complete the analysis for the researcher, as it is merely a tool that allows him or her to organize the data for analysis (Leech & Onwuegbuzie, 2011), facilitating the process by providing flexibility and organization to the data coding process (Basit, 2003). According to Bazeley (2007), there are five main principles in how *NVivo* facilitates and supports qualitative analysis of data. It: (a) assists in managing data; (b) organizes and manages conceptual and theoretical ideas; (c) facilitates querying of data; (d) graphically models cases, ideas or concepts based in the

data; and (e) facilitates reporting the data. Although becoming familiar with the software may take time, once trained in using the program, *NVivo* may save a researcher countless hours in coding material manually, allowing him or her to work “more methodically, more thoroughly, [and] more attentively” (Bazeley, 2007, p. 3).

Although content analysis is primarily used in qualitative descriptive studies (Sandelowski, 2000b), the interviews were coded and analyzed using a qualitative thematic analysis approach. Qualitative description aims to provide a descriptive summary of a specific event or experience and using thematic analysis as an analytic method permits researcher to analyze and interpret the research data through identifying “repeated patterns of meaning” (Braun & Clarke, 2006, p. 86) as opposed to content analysis, which focuses on the frequency and the “characteristics of language as communication with attention to the content or contextual meaning of the text” (Hsieh & Shannon, 2005, p. 1278). A key to thematic analysis is to present data using thematic networks which demonstrate the main themes of the studied phenomenon (Attride-Stirling, 2001).

The analysis of the data was both inductive and deductive: the theoretical framework of social bonding theory and literature on recovery was used to create a priori codes (i.e., attachment, commitment, belief, and involvement, managing symptoms, assuming control, among others); and additional themes and codes that emerged from the data were also coded and analyzed. Qualitative description best fit the research objectives of this study, as qualitative description may begin with an examination of the current literature on a specific theory to inform data analysis, but it does not necessarily mean that the researcher must commit to that theory if it does not fit the data (Sandelowski, 2010). This permitted the analysis to accurately represent the participants’ narratives and experiences (Neergaard et al., 2009) and ensured that if the data did not reflect the tenets of social bonding theory, they were not forced into the pre-existing codes and themes.

The thematic analysis of data in this study was performed at the latent level, exploring the underlying ideas, assumptions, conceptualizations, and ideologies of the patients. The process of this analysis was framed using guidelines that were provided by Braun and Clark (2006), which consist of six phases. During the first phase, all

transcripts were read twice and informal notes were written down. The second phase involved the generation of initial codes using *NVivo 8*. The transcripts were coded for particular or repeated instances of emerging themes relevant to the research questions. A code in qualitative research is “most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldaña, 2009, p. 3). In the third phase, codes were sorted into distinct themes using *NVivo*, with thematic maps being utilized to identify which individual themes were significant. Next, during the fourth phase, the themes were reviewed and refined to ensure that the coded data extracts were relevant to each theme. Each theme was reviewed as a whole and was assessed on whether the thematic maps “‘accurately’ reflect[ed] the meanings evident in the data set as a whole” (Braun & Clarke, 2006, p. 91). The final two phases of thematic analysis involved defining and naming the themes as well as compiling the results. When possible, the titles of codes and themes were obtained *in vivo*, using the actual words of the participants (Leech & Onwuegbuzie, 2007). This practice is frequently used in qualitative description as a method of staying close to the data (Neergaard et al., 2009).

The entire transcripts were coded and analyzed fully and themes were extracted from the entirety of each interview. However, in order to examine each participant's understanding and definition of recovery, after coding all of the material, a coding matrix was employed using *NVivo 8* to identify the specific codes and themes that emerged for only the question “*In your own words, what does ‘recovery’ mean to you?*” This was done to stay true to the participants’ words and perceived understandings of the construct, as it was a question that they were directly asked. Participants’ responses to this question were also included in the analysis of all the other themes in relation to social bonding theory and recovery.

Numerical Results

Using numbers to describe qualitative research is a controversial topic (Maxwell, 2010). Research is often evaluated as being “scientific” or “evidence-based,” with quantitative analyzes often being viewed as indicators of the level of generalizability and validity to one’s research (Maxwell, 2010). Mixed-method research occurs when

qualitative and quantitative research techniques are combined in the approaches to sampling, data collection, and data analysis in a research study to produce innovative approaches to research (Sandelowski, 2000a). Presenting numbers or frequencies is a way to add interpretive validity to qualitative description as it demonstrates an accurate representation of the participants' accounts (Neergaard et al., 2009). Maxwell (2010) addressed the benefits and problems associated with using numerical results in his discussion of qualitative data. He showed that using numerical data may be beneficial because they: (a) contribute to the internal generalizability of the results and how well the results represent the specific sample; (b) "identify and correctly characterize the diversity of actions, perceptions, or beliefs in the setting or group studied" (Maxwell, 2010, p. 4); (c) help to identify patterns; and (d) show that the study's interpretations are based on evidence and not specifically chosen to support the researcher's interpretations. However, Maxwell also warned that using numbers in qualitative research may (a) imply greater generalizability when the sample size may be unrepresentative; (b) impose the belief of causal relationships; (c) take away from the descriptive qualitative data; and (d) be used rhetorically and used to make the findings seem more "precise, rigorous, and scientific, without playing any real role in the logic of the study and thus misrepresenting the actual basis for the conclusions" (Maxwell, 2010, pp. 5-6).

In order to address the concerns of Maxwell (2010), the results of this study used descriptive statistics for frequencies and counts of participant responses and comments. According to Becker (1970), "[o]ne of the greatest faults in most observational case studies has been their failure to make explicit the quasi-statistical basis of their conclusion" (p. 82). Therefore, this study has used frequencies and counts to describe the patterns in order to put the findings into context.

Assessing the Validity of the Research

Despite an individual's best intentions to report data accurately, the "spoken or written word always has a residue of ambiguity" (Fontana & Frey, 2007, p. 118). A primary way to improve the rigour and credibility of a qualitative research study is to be transparent in the reporting of "important aspects of the research team, study methods,

context of the study, findings, analysis and interpretations” (Tong, Sainsbury, & Craig, 2007, p. 356). Tong and colleagues (2007) compiled a 32-item checklist for reporting qualitative research which was used to inform the writing of this thesis.

There are also several ways in which a researcher can increase the quality and rigour of his or her qualitative study including “(a) using more than one type of analysis, (b) assessing interrater reliability, and (c) member checking” (Leech & Onwuegbuzie, 2007, p. 576). Another method to assess the validity of the research is to use negative case analysis, which is the “process of expanding and revising one’s interpretation until all outliers have been explained” (Onwuegbuzie & Leech, 2007, p. 245). If the negative cases do not fit in with the data, elements of the data which are not in line with the dominant explanation should be reported in order to allow readers to access the credibility of the research analysis (Mays & Pope, 2000; Onwuegbuzie & Leech, 2007). Such findings will be discussed in this study.

While the author was not able to use triangulation or to have more than one individual code the material, owing to the scope and time constraints of this study, several methods were employed to ensure the quality of the research analysis. For example, two experienced qualitative researchers were consulted during the coding process to provide guidance. Conferring with experienced researchers is recommended in order to provide a venue for discussion and to facilitate the clarification of new and emergent ideas and insights (Saldaña, 2009). Member checking was also employed to assess the validity of the findings. Informant feedback or “member checking” allows researchers to evaluate whether their interpretation of the data is consistent with the participants’ intentions, to assess the validity of their findings (Onwuegbuzie & Leech, 2007; Whitley & Crawford, 2005) and to increase the “rigor and trustworthiness of the findings” (Leech & Onwuegbuzie, 2007, p. 576). Respondent validation of the research findings is an important component to qualitative descriptive studies and promotes the integrity of the findings (Milne & Oberle, 2005). According to Lincoln & Guba (1985), member checking is “the most crucial technique for establishing credibility” (Lincoln & Guba, 1985, p. 313). Through member checking, the researcher must recognize that his or her perspective and interpretations may be different from those of the participants (Yanow & Schwartz-Shea, 2006), and it is a legitimate way to eliminate the “possibility of misrepresentation and misinterpretation of the ‘voice’” (Onwuegbuzie & Leech, 2007, p.

241). By bringing the material back to the members and providing an opportunity for discussion, the researchers are able to reflect whether their interpretation of the data is credible and accurately represents the participants' lived experiences (Creswell & Miller, 2000; Yanow & Schwartz-Shea, 2006).

Member checking can occur in both an informal and formal process (Lincoln & Guba, 1985). For the purposes of this research, the preliminary findings were presented to a small subset of participants ($n = 6$). The presentation was approximately 20 minutes long and participants were given the opportunity to provide feedback both in a group, and then individually with the author. The responses from the participants were positive, with one individual stating that the findings should be presented to hospital management, as they were very much in line with his beliefs about what supports recovery in the forensic mental health hospital.

Ethical Considerations

The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2) (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010) is a document that has “establish[ed] principles to guide the design, ethical conduct and ethics review process of research involving humans” (p. 15) for universities and institutions in Canada. The TCPS 2 outlines three core principles that must guide the development and implementation of all research that involves human participants, while balancing the potential benefits of the research: respect for persons, and concern for welfare and justice. Respect for persons refers to the “dual moral obligations to respect autonomy and to protect those with developing, impaired or diminished autonomy” (Canadian Institutes of Health Research et al., 2010, p. 8). Autonomy means an individual's choice to make informed decisions about his or her involvement in any research process and autonomy can be diminished through inadequate information or due to an individual's lack of capacity to be able to make his or her own decisions. Concern for welfare and justice refers to an awareness of the individual's experiences of quality of life and “consists of impact on individuals of factors such as their physical, mental and spiritual health, as well as their physical, economic

and social circumstances” (Canadian Institutes of Health Research et al., 2010, p. 9). In conducting research, it is critical that researchers are aware of the negative impacts of their study and minimize those impacts, while keeping participants apprised of any potential negative risks to their well-being. Lastly, it is important that researchers maintain justice by treating all individuals with respect and as equals. Research studies can do this by ensuring that “no segment of the population is unduly burdened by the harms of research or denied the benefits of the knowledge generated from it” (Canadian Institutes of Health Research et al., 2010, p. 10).

The TPCS 2 identifies one of the goals of qualitative research as “giving voice” to individuals (Canadian Institutes of Health Research et al., 2010, p. 137) and is subject to rigorous standards for consent, confidentiality and maintaining the participant’s privacy. It is also crucial to let individuals weigh the potential risks and benefits of participating in a study. Although research does not always offer direct benefits to the individual participating in the study, potential benefits of the study relate to the fact that the results will advance knowledge and may create positive change for the individuals participating or future generations (Canadian Institutes of Health Research et al., 2010). Participating in research does carry potential risks or harms which may negatively impact the participant’s welfare either socially, behaviourally, psychologically, physically or economically (Canadian Institutes of Health Research et al., 2010). Potential harms range “from minimal (e.g., inconvenience of participation in research) to substantial (e.g., a major physical injury or an emotional trauma)” (Canadian Institutes of Health Research et al., 2010, p. 23) and can be either transient or permanent. In this study, participants went through a lengthy consent process to ensure that all participants understood the study’s purpose and the potential risks and benefits prior to giving consent. Although there were no serious risks associated with participating in this study for participants, it was possible that participants may have experienced some emotional distress or discomfort disclosing their attitudes, feelings, and beliefs regarding their experiences within the hospital. To minimize this risk, participants were informed of the following during the consent procedure: (a) participation in the study is voluntary; (b) they do not have to participate in parts of the discussion about which they feel uncomfortable; and (c) they may withdraw from the study at any time. Participants were encouraged to take breaks during interviews, and were provided with the option of splitting up the process

over multiple sessions. They were also informed that declining to answer certain questions or withdrawing from the study would not have any consequences in general and that their treatment at the hospital would not be affected. To my knowledge, there were no adverse events as a result of this study.

As mentioned above, this project received ethics approval from the Simon Fraser University to complete secondary analysis of the data. Secondary analysis of qualitative data is described as the “study of non-naturalistic or artefactual data derived from previous studies, such as fieldnotes, observational records, and tapes and transcripts of interviews and focus groups” (Heaton, 2004, p. 7). Some of ethics around using secondary data that are discussed in the literature on secondary qualitative data analysis include the moral responsibility for the original researchers to seek consent for reusing data and maintaining the duty of confidentiality (Bishop, 2009).

Providing appropriate visibility as to the use of a participant’s data is an important ethical component in research (Bishop, 2009). Simply put, the consent issue that one must consider when using secondary data is “not whether the analysis is primary or secondary, but [whether the] specificity of research purposes [is] known in advance” (Bishop, 2007, p. 5). Although the participants of the PCC Study were not told that the data they would share would be analyzed for this specific project, the consent form advised them that the information on patient-centred care that they gave in the interviews was being “collected in order to produce a report that will be distributed and presented to academic, professional, or community audiences [and a]dditional written academic articles will also be produced from this information” (see Appendix C for the PCC Consent Form). As this project falls under the overall umbrella of the original research project, the consent form made the specificity of research purposes clear to the participants.

Maintaining a participant’s privacy and treating their information in a confidential manner are important components to the research process and is an “internationally recognized norm and ethical standard” (Canadian Institutes of Health Research et al., 2010, p. 55). Privacy risks may occur at any stage of the research study and “relate to the identifiability of participants, and the potential harms they, or groups to which they belong, may experience from the collection, use and disclosure of personal information”

(Canadian Institutes of Health Research et al., 2010, p. 55). Privacy relates to an individual's ability to control their own personal information by giving consent over who many collect or use their information (Canadian Institutes of Health Research et al., 2010). In order to maintain a participant's privacy, it is crucial to keep information confidential and to ensure that the information is not disclosed or used in a way that is inconsistent with the study's procedure as communicated to the participant. This is important in all instances of research, yet especially so with vulnerable populations like those who participated in the PCC study as there are already many power differentials and forensic inpatients have concerns about information being recorded in their medical files. In order to assure anonymity and to maintain confidentiality in this study, participants were given participant numbers. Hard-copies of interview guides were secured in a locked filing cabinet in a locked office at the BC FPH in Port Coquitlam, B.C. In addition, all electronic data (i.e., participant list) were saved on a password protected network of the Provincial Health Services Authority. Access to the folder containing individually identifiable information was restricted to only designated members of the research team. Despite the author's role as research assistant for the PCC Study, the transcripts were anonymized with study IDs and stripped of any identifiers prior to accessing the data for this thesis.

Summary

As the recovery literature identifies several key components which support recovery in the community, this study explores the perspectives of forensic inpatients on recovery to investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients. This study also aims to examine the extent to which forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory, while identifying the strengths of a forensic mental health hospital as well as the areas that patients believe could be improved in order to make their recovery experience more successful. In order to answer these research questions, this study employed qualitative description and the thematic analysis of data collected from 30 semi-structured interviews with patients in a forensic mental health hospital. Using *NVivo 8*, the data was analyzed using the theoretical

framework of social bonding theory and literature on recovery as well as by identifying emergent themes in the data.

Chapter 5.

Results: Forensic Inpatient Narratives

Several core themes emerged from the forensic inpatients' interviews during data analysis. Prior to the analysis, the complete interviews were deductively and inductively coded. Although the interviews were coded in their entirety, the question entailing inquiry into what recovery meant to participants personally was extracted and inductively analyzed independently of the rest of the transcripts. Participants of this study identified several focal points regarding their personal perspectives on recovery. Consistent with the literature on personal recovery, participants identified recovery as reintegration into the community, returning to a state of normative behaviour, and becoming or remaining abstinent from drugs and alcohol. Participants identified reintegration as congruent with being accepted by society, as well as fitting in and making positive and meaningful contributions. Participants also spoke about returning to a state of normative behaviour, where recovery is a transformation of their behaviour that facilitates their fitting into societal norms, either by learning how to manage and live with the symptoms of their illness or by returning to their previous, or better, level of functioning than before their mental health crisis. Finally, another important component of recovery for participants was their ability to manage their addiction issues and thereby take control of their lives once again.

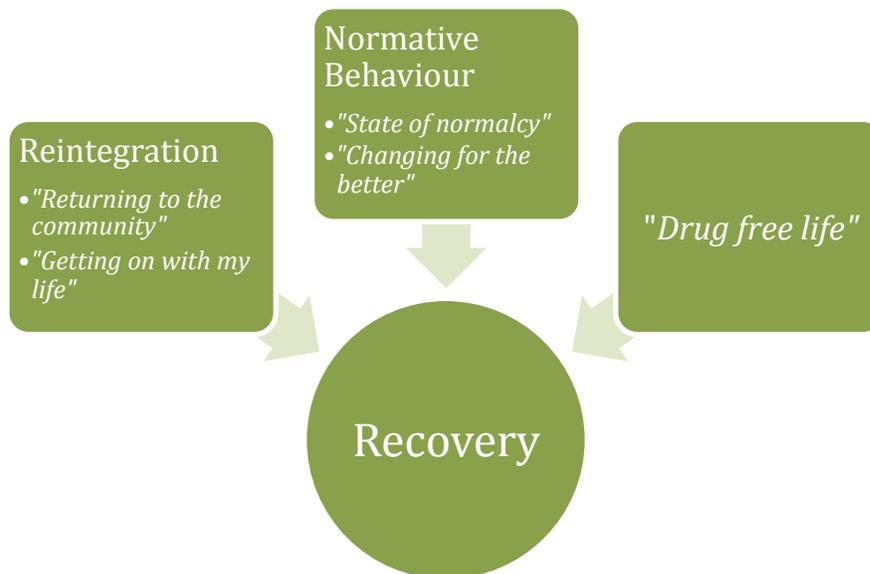
The participants' narratives suggested that their understanding and experiences of recovery coincided with components of Hirschi's social bonding theory as well as relevant literature on recovery. Consequently, these themes were assessed in terms of how they fit with social bonding theory. Had the participants not emphasized the importance of social relationships, involvement in activities or concern for rules and what others think, the narratives would not have been analyzed as consistent with social bonding theory. Interestingly, although all four components of social bonding theory were reflected in the participants' narratives, the importance of social relationships,

involvement in activities and belief in norms and rules were more proliferate than commitment. This may be because forensic inpatients have limited opportunities to invest time and energy in participating in conventional activities due to the nature of their confinement in the forensic mental health setting.

Defining Recovery

Study participants were asked how they would personally define recovery. This information was coded with the entire text but then analyzed independently of the rest of the data. This was done to ensure the inductive qualitative description of recovery as verbally defined by the participants. Several core themes emerged from the participants' narratives. According to the forensic inpatients who participated in the study, recovery involved reintegration into the community, returning to a state of normative behaviour, and becoming or remaining abstinent from drugs and alcohol.

Figure 1: What Recovery Means to Forensic Inpatients



Reintegration

Almost half ($n = 14$, 46.7%) of the participants involved in the study spoke of the importance of meaningful social reintegration into the community as being a key

component to their recovery. Although an important component to reintegration was no longer being hospitalized, the participants referred to reintegration as something more than being discharged from hospital; importantly, reintegration involved being accepted by society, fitting in and making positive and meaningful contributions. Participants also addressed the importance of making future plans concerning relationships or careers. The participant narratives concerning “returning to the community” and “getting on with life” are describe below.

“Returning to the community”

Over a quarter of the participants ($n = 8$, 26.7%) spoke about their desire to return to the community as a crucial component to what recovery meant to them. For example, several participants spoke about leaving the hospital (i.e., receiving an absolute discharge) and participating in conventional daily activities such as engaging in their work or hobbies:

“Recovery means that your illness is stabilized and you’re ready to get support in reintegrating into the community and finding work or ... hobbies and to get on with your life and not have to focus on the illness so much.”
(Participant 08)

“[Recovery] means to be out in the community and shopping for yourself and things like that.” (Participant 16)

In the above quotes, the participants spoke about the importance of engaging in daily activities within the community. The first quote highlights the individual’s desire to have control over her illness so that she can be involved in the community through work or other activities. The second individual indicated the importance of independence and autonomy, and being able to take care of himself. Other individuals, however, described recovery as reintegrating into a community where they fit in:

“To get back to a state of normalcy, including reintegration.” (Participant 17)

“In a certain sense, you don’t fit anywhere because your mental illness prevents you from fitting. But if you can recover from mental illness, then you can fit in somewhere, you know?” (Participant 25)

In the above quotes, the participants spoke to their desire to “fit in” and their need to feel like they are just like everyone else—as opposed to different—which speaks to

the self-stigma that is associated with receiving forensic mental health services (Livingston, Rossiter, & Verdun-Jones, 2011).

The next quote reflects one participant's desire to be in a less socially disorganized neighbourhood. For this individual, recovery meant being in a safe environment free of threats or harm. This could reflect the fact that forensic inpatients often come from socially disorganized areas prior to admission in forensic mental health services (Coid, Kahtan, Cook, Gault, & Jarman, 2001):

"[Recovery is] like a tree or a personal universe. There's no other universe exactly the same as you. So you have to do what you gotta do to protect it, and you have to realize that you need healthy people around you. [... You need to be] living in a safe environment [where] you don't feel threatened, you feel safe. You want to be where you're comfortable too. Your neighbourhood has to be good neighbourhood." (Participant 28)

The theme of returning to the community is also common in the literature on recovery and specifically acknowledges the importance of making meaningful contributions to the community (Mezey et al., 2010). This part of recovery speaks to reconnecting with the social world and stresses the social aspects of recovery in which the individual goes from being isolated within their illness to "rejoining the social world through establishing and maintaining relationships, assuming social roles and having friends" (Schrank & Slade, 2007, p. 322). Returning to the community may also be a very important factor of recovery for individuals living in the forensic system, due to their limited access to the community while receiving forensic mental health services. Similar to the research on recovery for both civil and forensic inpatients (Mezey et al., 2010; Piat et al., 2009), a fundamental component in the narratives on recovery of the participating forensic inpatients was being discharged from the hospital and returning to the community.

"Getting on with my life"

Another component of reintegrating back into the community was making future plans. In addition to speaking about returning to the community, a third ($n = 9$, 30%) of the participants referred to doing so in a meaningful way that involved rebuilding relationships with friends and family and finding stable employment.

“Well [recovery] means ... getting on with my life, having mental wellness. ... I wanna get on with my career ... [and] I want to have a good relationship with my wife and my family and my friends.” (Participant 01)

“Recovery is getting your life back together again and be[ing] quite happy and to smile and say ‘Wow, I did it! I can’t believe I did it!’ [To] just move on and do things that you really want to do with your life and start saving money and everything, [and] doing things with other people.” (Participant 07)

Participants spoke about recovery as culminating in the reacquisition of stable employment and the rebuilding relationships with other people. This reflects their limited access to work, friends and family, which depends on the level of their privileges in the secure forensic mental health hospital environment. By articulating their desire to be able to provide for themselves and their family, the inpatients are also addressing their need for autonomy and self-management while fostering positive personal relationships (Jacobson & Greenley, 2001). In speaking of future plans, the study participants referred to the need to be in control of their lives and move forward. This aligns with other research findings that people receiving forensic inpatient services identify recovery as “being accepted by and making a useful contribution to the community, getting into work or education, finding a home, settling down with a partner, not re-offending, and simply being able to lead an ordinary life” (Mezey et al., 2010, p. 687).

The participants’ discussion of reintegration reflects the internalization of the mandate of a secure forensic setting, as safe community reintegration is often one of the final steps towards an individual’s rehabilitation (BC Mental Health & Addiction Services, 2010; Ontario, 2002). Successful reintegration has been operationalized to mean that the individual does not reoffend and is not readmitted into the hospital (Viljoen, Nicholls, Greaves, Ruiters, & Brink, 2011). Although one of the goals of secure forensic facilities is safe community reintegration, there is a lacuna in scholarship on the successful community reintegration of adults in the forensic mental health system (Viljoen et al., 2011).

Normative Behaviour

In addition to the definition of recovery at a societal level, the study participants also defined recovery at a more individualized and personal level. For several individuals

($n = 17$, 56.7%), recovery meant a transformation of their behaviour that would allow them to fit into societal norms. Participants suggested this could be done by either learning how to manage and live with the symptoms of their illness or by returning to the same, or better, level of functioning than before their mental illness brought them in contact with the justice system. Speaking of recovery in terms of feeling normal or achieving goals similar to those who do not live with the challenges of mental illness is a common theme in the literature on personal recovery, often from the perspective of consumers (Deegan, 1988; Leete, 1989; Walsh, 1996; Young & Ensing, 1999, p. 25). However, recovery and normative behaviour are not simple concepts; the goal of recovery may involve moving beyond normalcy in order to “embrace our human vocation of becoming more deeply, more fully human” (Deegan, 1996, p. 92). Recovery and normative behaviour describe processes for fitting in with the community and finding acceptance amongst peers. It is clear from both the literature on recovery, and the understandings of recovery shared by the participants in this study, that a “return to a normal condition” is not its only meaning (Davidson, Lawless, & Leary, 2005, p. 482).

“State of normalcy”

Almost a third of the study participants ($n = 9$, 30%) spoke about recovery as the process of finding ways to live with past and current problems or symptoms, and pursuing a life that is meaningful beyond simple symptom management. Often, participants described managing their symptoms or problems as being hand-in-hand with leading a “normal” life in recovery.

“[Recovery is] getting to the point where things that bothered you in the past are either gone or you’ve been able to develop methods to live with them. [...] You have to understand your problems, where are they coming from and what you can do about it.” (Participant 12)

“[Recovery is] getting over your mental illness.” (Participant 23)

The above quotes speak to the participants’ desire to be in control of their lives and being able to overcome the challenges they have faced. The narratives alluded to recovery signifying an ability to cope with daily challenges that others in the community encounter on a regular basis:

“Recovery means [being] able to do my daily tasks in a normal fashion. So waking up [in the] morning, exercising, and then getting ready for

work. And coming back from work. That's a normal recovery. [...] [To be] like everybody else." (Participant 22)

Lastly, the next quote exemplifies how participants identified managing their illness and living beyond their symptom management as a way for them to regain control of their own lives and was an important component to recovery and wellness:

"Being not schizophrenic anymore. Or at least being happy with my own life. ... For my own wellness, it would be how I make the choices in my own life. If I can do that and still succeed with my medications, then I probably will be very well." (Participant 26)

The above quotes speak to personal recovery, in which an individual is able to manage the symptoms of their mental illness and live a normal life within the limitations of that illness. Consistent with the literature, participants spoke of living satisfying lives within the constraints of their mental illnesses and maintaining a similar quality of life to individuals not living with a mental illness, an element of recovery that goes beyond symptom reduction (Andresen et al., 2003, p. 589; Anonymous, 1989; Anthony, 1993; Campbell-Orde et al., 2005; Corlett & Miles, 2010; Corrigan & McCracken, 1999; Deegan, 1988; Hillbrand et al., 2010, p. 452; Leete, 1989). So although the remission of symptoms was identified as a key component to participants' understanding of recovery, complete remission was not the only way for the participants to feel that they were in control.

"Changing for the better"

In addition to the definition of recovery as living "normally" and feeling like others, many participants ($n = 10$, 33.3%) also discussed how recovery involved returning to a former and better personal state than before their mental health crisis and coming into contact with the criminal justice system.

"Getting better from mental illness or something bad that happened to you." (Participant 05)

"[Recovery] means getting over a series of problems or events or conditions either physical or mental that are bad." (Participant 13)

These participants addressed resiliency and the clinical model of recovery, in which it is common to define recovery as the cessation of symptoms and living with

one's mental illness. In the clinical model of recovery from a mental illness, recovery is the alleviation, absence or removal of symptoms and undesired consequences (e.g. medications, or hospitalization) (Davidson, O'Connell, et al., 2005). It is common for mental health consumers to define recovery as the cure or cessation of symptoms or as returning to their former selves (Piat et al., 2009). This points to individuals' need for autonomy and their desire to reclaim "who they were before mental illness struck" (Piat et al., 2009, p. 32) as well as a return to a basic state of functioning, as indicated in the quote below:

"[Recovery is] getting back towards what you were [in] the first place. ... [If] you're ill ... and you're not feeling well and you're not behaving well, and you're not taking baths, and you're not looking after yourself, "recovery" means returning to a state of cleanliness, a state of understanding your illness and a state of coping with it." (Participant 09)

Both consumers and clinicians often speak about recovery as the return to one's former or better self. However, only some of the literature on recovery addresses this return to a normal state of functionality in terms of being able to address basic needs such as taking care of oneself (Smith, 2000; Young & Ensing, 1999, p. 24). It is argued that addressing self-care and returning to basic functioning is an important component of recovery for individuals with mental illness, but the scholarship may not always broach this subject matter for several reasons: "a) recognizing that people sometimes struggle to take care of basic needs is perceived as inconsistent with a recovery-orientated ideology, which tends to focus on strengths and self-efficacy, and b) writing about basic self-care is simply not perceived as very interesting or informative" (Young & Ensing, 1999, pp. 23-28).

Participants also spoke of resiliency and overcoming life's challenges. As Fitzpatrick (2011) has argued, resiliency is very much in line with desistance, which both focuses and recognizes the importance of overcoming life's problems and "emphasize[s] the capacity of individuals to be robust and to live positive, productive lives in the future" (p. 232). The quotes below speak to participant understanding of resilience, overcoming their past challenges and "beating" what was holding them back by changing for the better:

"[To] come back from something that had you down and you beat it. Once you've finished recovery, it means you've recovered. You know, reinventing, and just coming [back]. Like, you're lost, and you recovered. You were wiped out, and you recovered." (Participant 18)

"It means evolving into a state of well-being beyond what your original state of well-being was. Because something wasn't working in your life." (Participant 19)

"Recovery is just when you go through a hard time and you pull through. [...] It's basically change. It's changing for the better." (Participant 30)

One study participant identified that "changing for the better" and returning to one's former self is part of recovery, but that one can only recover from one's mental illness on the condition that they have something positive to recover to in the first place:

"Recovery means returning to a point that was better off for you to begin with. You can't be recovered unless you actually were there to begin with, that's my belief. Let's say there's someone who was raised in a bad family and then has never known a good life. And then to send them to jail and say 'We're going to rehabilitate you.' To rehabilitate him to what? 'Cause he's never known anything other than what he's been raised with." (Participant 06)

Not all consumers of mental health services agree that recovery is about returning to a former level of functioning. Some suggest that because the "experience of the disability, and the stigma attached to it, changes [individuals] forever" (Walsh, 1996, p. 87), individuals with lived experiences of mental illness may feel that experiencing and living with mental illness has made them a stronger, better person (Andresen et al., 2003, p. 588). However, many of the participants in this study gauged recovery as being able to return to their former level of functioning. This may be the result of the link between their mental illness, their index offence(s) and their mandatory treatment at a forensic mental health hospital.

The clinical model approach to recovery and returning to normative behaviour was also discussed by patients in relation to risk to the public and past behavioural issues. The participants spoke to the unique challenges facing forensic mental health inpatients. These individuals must contend with the need to recover from both the mental illness as well as the impact of their offending behaviour (Corlett & Miles, 2010; Simpson & Penney, 2011). In this study, participants discussed risk and safety and identified these concerns as important components of their recovery processes:

“Recovery means getting back to a sense of where you fit in the world and how you can go about your actions ensuring that you stay safe for yourself and other people. And maximize your potential.” (Participant 25)

“Taking the time to... go over your past experiences and learn from what has gone wrong and try and think about how to make things better in the future.” (Participant 29)

The above quotes speak to the nature of the forensic mental health system, of which, pursuant to section 672.54 of the *Criminal Code*, an individual shall not be released to the community unless they are “not a significant threat to the safety of the public”. The quoted excerpts speak to the participants’ insight and understanding that there is a strong need for them to learn skills to prevent deviant or risky behaviour, something that is unique to forensic inpatients. Although individuals living with mental illness may pose a risk of violence during acute stages of the illness, forensic inpatients are unique in that their past risk has manifested in a criminal or violent act, and in humanely diverting the individuals for treatment at a forensic mental health hospital (as opposed to incarceration), the forensic system must constantly assess their risk of future violence before they can return to the community. For forensic inpatients, the requirement that they not be a significant risk to the safety of the public is a core component to the system’s understanding of recovery and is an essential consideration in their successful reintegration into the community.

This last quote below speaks more to this understanding of risk, and was given in elaboration to another question in the interview guide:

“The whole time that I’ve been in the system, I’ve never even seen the side room². Never been in a fight, never had an argument with anybody or nothing. And there’s been no violence, there’s been no risk of anything. ... and the only violence in my whole life was my incident that brought me into here. And of course I was found not guilty because of my disability. ... [drugs and criminal behaviour] does spiral down into other harmful habits and I’m tired of it. ... I want to be a respectable citizen of society again. I want to be able to go to college and finish off my business [degree] and have my own house.” (Participant 28)

² A room where an individual may be confined and isolated from other patients and staff in order to contain potentially harmful and dangerous behaviour.

This quote emphasizes forensic inpatients' desire to lead lives that fit in with societal norms; lives that are not defined by criminal, violent, or potentially unsafe behaviour.

“Drug free life”

Over half of the participants self-reported a history of substance abuse ($n = 16$, 53.3%). This was reflected in their narratives of recovery as well as in answers to explicit questions inquiring into their histories with drug and alcohol addiction. Several participants ($n = 9$, 30%) spoke about how their substance abuse hindered their recovery. For some, recovery meant that they would be able to manage their addiction issues and thereby regain control of their lives.

“[Recovery means to] be drug free and alcohol free. I think [of] those two things and I can succeed in life a lot more than I have so far.” (Participant 10)

“Abstinent from alcohol or drugs. Living a proper life ... Going to your program or work and abstaining from using any drugs or alcohol.” (Participant 11)

“[Recovery is] a drug free life. Not going back to using marijuana and cocaine.” (Participant 14)

“Alcohol; you quit drinking, you're in recovery.” (Participant 15)

Recovery from a concurrent disorder can occur simultaneously or sequentially (i.e., dual and serial recovery, respectively) (White et al., 2005). For several of the participants in this study, the importance of moving past their alcohol or drug addiction was a key factor in their understanding of what recovery was for them. Recovery is often defined as reclaiming one's life and to “improve and maintain personal capacity in one or more of the major domains of life” (Jacobson & Curtis, 2000, p. 2). Recovery from addiction disorders involves “reducing the impairment and disability, and improv[ing] quality of life” (Gagne et al., 2007, p. 34). As substance abuse can have a debilitating and catastrophic effect on an individual, abstinence may be a way for individuals to regain power and autonomy in their lives, as illustrated by the quote below, in which an individual attributed their long stay at the hospital to their struggles with alcohol:

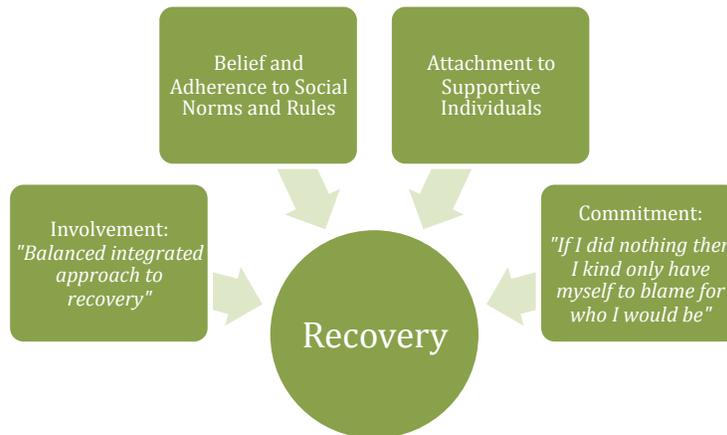
“Don’t do drugs. I haven’t done drugs in two and a half years I haven’t touched marijuana, which is good. My alcohol problem still bothers me because I run away and get drunk. And I can’t control myself. ... If I can stop drinking, I’d be out of here. Because I wouldn’t need to run away just to get drunk all the time.” (Participant 21)

The above quote addresses the unique environment of forensic mental health hospitals. Forensic inpatients are prohibited from consuming drugs or alcohol as well as from smoking cigarettes on hospital grounds (due to provincial legislation that bans smoking). Individuals are subjected to urine tests to ensure that they are not using illicit substances, and if the results return positive for drug use, it may affect their chances of leaving the hospital. Additionally, many individuals on conditional discharges are required to abstain from illegal drug use and alcohol and are submitted to urine analysis tests (Latimer & Lawrence, 2011). Breaking the conditions of their discharge may result in their removal from the community and return to the forensic mental health hospital.

Social Bonding Theory and Recovery

The participant narratives addressed many factors that aid in recovery, including being aware and learning about individual diagnoses, receiving emotional support through programs, and receiving the proper medication. The interviews, which were coded in their entirety and then inductively and deductively analyzed, drew upon the theoretical framework of social bonding theory and literature on recovery to create a priori codes (i.e., attachment, commitment, belief, and involvement, managing symptoms, among others). Additional themes and codes that emerged from the data were also coded and then analyzed. After initial coding, the codes were categorized in themes and assessed on how they fit into the social bonding theory. Several themes aligned with the four central tenets of Hirschi’s social bonding theory, including: (a) involvement in programs; (b) belief in the structure and rules as well as social norms; (c) attachment to other individuals, such as supportive staff, family and friends; and finally, (d) commitment to education and skills that might lead to work in the community. The last theme on commitment was not as prevalent in the forensic inpatient narratives, but it was addressed by a few participants.

Figure 2: Patient Narratives on Recovery in Relation to Social Bonding Theory



Involvement: “Balanced, integrated approach to life recovery”

In social bonding theory, involvement refers to being actively involved in conventional activities. This promotes normative behaviour because when an individual is preoccupied with such activities, he or she is less likely to behave or engage in deviant behaviour. In the inpatient narratives, involvement in activities was discussed ($n = 19, 63.3\%$) within the context of forensic mental health services as an important component of recovery. Participants indicated that involvement in programs and therapies kept them busy and gave them a sense of accomplishment.

“[Occupational therapy has] given me some structure to my day. I like to be productive, I like to accomplish things, and it’s allowed me to do that. I’ve done the [school] courses, I’ve worked on [learning languages] and ... cooking skills, I’ve played music, and it’s all given me a sort of a balanced, integrated approach to life recovery.” (Participant 01)

The quote above alludes to the importance of recovery involving more than symptom management. For forensic inpatients, involvement in activities establishes a sense of productivity and induces feelings of accomplishment. The quotes below also speak to the need for productivity and involvement as a way of moving forward towards reintegrating into the community:

“I really like doing programs and I wanna get a job again. And I do things like cooking class and work programs. ... [I]t feels better [to be involved in programs] because I’m doing something productive.” (Participant 08)

"I've been working really hard in the past few months. Like getting more programs, getting involved in the community, looking for jobs, getting help with that." (Participant 05)

Involvement in meaningful activities or hobbies is a key component to recovery (Anthony, 1993; Davidson, O'Connell, et al., 2005; Jacobson & Greenley, 2001; Ridgway, 2001; Roberts & Hollins, 2007; Smith, 2000; Young & Ensing, 1999). In a small qualitative study by Barsky and West (2007) examining the differences of forensic secure and medium-secure wards, the authors found that "[p]articipants cited the opportunity to have a busy and varied timetable of activities as contributing to their improved motivation, confidence and self-worth" (Barsky & West, 2007, p. 10). The narratives of the participants in this study also discussed the importance of "keeping busy" for building connections and remaining active in healthy and rewarding activities. Other research suggests that keeping active and involved in positive activities helps individuals living with mental illness in their recovery as activities foster contact, connection with others, and personal fulfilment, thereby decreasing isolation which may cause feelings of loneliness and disconnection from the outside world (Smith, 2000). This view is also reflected in the following quotes by two female participants:

"[I had a job] in the community so I got to spend more time out in the community and that's going to help me re-integrate ... it's really an institution in this place and if you spend more time in here then it kind of keeps you in this structure and if you have a job outside then you get to talk to people who are in the community—So it helps your recovery." (Participant 08)

"I just like to get involved pretty much in work and activities every day. So I don't have nothing to do. And it helps me and the things around me do better maybe, well not do better, but just keep busy pretty much. ... I used to do recycling and canteen Monday to Friday's or on the weekends, but now that I've quit, I'm joining other activities such as lady's fitness, and it just helps me and other people around me because I'm getting involved, talking to other people." (Participant 24)

Similar to the narratives in this study, Hendryx and colleagues discovered in a quantitative analysis of 153 participants examining the role of social support and activities in recovery from mental illness, that being involved in a diverse range of activities (i.e., "more or less social in nature, more or less physically active, or occur inside or out of the home") was associated with better recovery (Hendryx, Green, & Perrin, 2009, p. 325). This also reflects the findings of a study that examined successful

reintegration into the community for women who received treatment services at a forensic mental health hospital (Viljoen et al., 2011). Viljoen and colleagues (2011) found that one of the protective factors for the women who successfully reintegrated included being engaged in more pro-social activities as well as displaying more pro-social attitudes than other women.

An additional benefit to “keeping busy” in the context of recovery is how involvement in activities prevents boredom, a subject matter that the following quotes also address:

“I guess overall they try to get me involved with things that I want to be involved in [like] woodworking [and] greenhouse. ... [Programs] keep me from getting bored.” (Participant 15)

“Joining as many programs as possible [has helped with my recovery]. They keep me busy.” (Participant 05)

In the above quotes, the forensic inpatients spoke about the need to leave their units and to occupy their time with activities. A forensic mental health hospital imposes rigorous restrictions on an individual’s liberty, and although there are many different programs, an individual’s privilege level determines whether they may participate. The comments made by the participants indicate that being busy promoted their recovery.

“The reason why we’re unsettled is because we’ve got nothing to do”

Several participants ($n = 19$, 63.3%) in this study also spoke about their lack of involvement in programs, activities and access to the community as a hindrance to their recovery, and a cause for problematic behaviour. Although some participants identified the need to manage risk and safety for both the patients and staff, it was suggested that as soon as possible, patients, especially in the high security units, should have access to a variety of programs:

“They should offer some programs and services right away that aren’t really a big deal to anybody ... just something that they don’t need a big leap of support or whatever, [or] a big level of security clearance or anything like that. ... [Just to] keep them busy.” (Participant 27)

“Being locked up all the time and not released [hindered my recovery].” (Participant 14)

One participant spoke very strongly about the use of medications to manage forensic inpatients. This individual felt that although medication helped with symptom management, medications caused some patients to be too lethargic which prevented them from taking part in activities and programs. This individual felt that involvement in activities and interactions with peers would be more beneficial than remaining on their unit:

“[There’s] a focus on [sedating] people to manage the population of the hospital. People should be up and walking around and happy, laughing, and having a good time and making a better recovery instead of sleeping all day.” (Participant 19)

Another individual felt that being confined to his unit and the required waiting time for referrals into programs hindered his recovery. Although it is part of the forensic mental health system that there are appropriate committees to review whether access to a certain activity is appropriate for an individual, this individual felt that this time would be better used engaged and involved in activities but was, instead, wasted waiting for the appropriate approvals from the hospital:

“What has interfered [with my recovery] is bureaucracy. The red tape you have to go through. Like you have to get a referral and it takes time for the referral, like I had to wait like four weeks just to get into the resource centre for email ... I would [like to] be engaged in day-to-day activities that normal people do, so it would help me in my recovery [and] keeping myself busy.” (Participant 22)

Another participant reflected the previous participant’s sentiment that access and involvement in activity aids an individual’s recovery by keeping them busy and less agitated. The following quote speaks to the forensic inpatient’s perception that not being involved in activities actually makes individuals feel worse and hinders their recovery:

“They need more programs. More programs that keep you more busy instead of pacing around the unit. I find guys are pacing the unit getting themselves into trouble. And the staff write down ‘oh, these guys are agitated’ or ‘they’re unsettled’. Well, the reason why we’re unsettled is because we’ve got nothing to do, so we pace around.” (Participant 30)

Programs and institutionally organized activities also provide individuals with the education that can help them on their path to recovery by learning new ways to manage their challenges. The privilege to attend meetings and participate in work programs

empowers patients to feel in control of their recovery. When asked what has helped with recovery at the hospital, one participant stated that the social support he received from being involved in AA meetings promoted abstinence:

“[B]eing able to go to AA meetings twice a week. [It] keeps me abstinent from drugs or alcohol which is a plus in my life.” (Participant 011)

Another participant spoke to the importance of being in control of his life and having the privilege to participate in certain activities gave him the feeling of autonomy:

“Sometimes I don’t always feel in control, but now the past couple of weeks since I’ve got my privileges back I feel good. I’m off the ward and I’m working, and I have tea at [the wood shop] ... [I didn’t feel that way before], ‘cause I only got two days of work. Two days of work, and I wanted to get more and [the staff] said I can’t.” (Participant 02)

Involvement in activities empowered the participants to feel in control of their lives and connected with others. Lacking something to do was perceived as a negative factor in their recovery process and was a negative influence on their behaviour. This is consistent with Hirschi’s social bonding theory, which posits that involvement in meaningful activities promotes normative and non-deviant behaviour.

“There’s danger levels and factors of risk”

Although participants indicated that engaging in programs and activities aided in their recovery and that being “locked up” did not facilitate achieving this goal, they seemed to understand that such restrictions were necessary to ensure both their own safety and the safety of others as they work on their journey through recovery. The need to protect the safety of the public requires careful clinical risk management strategies that may impact negatively on recovery. Balancing safety concerns and community reintegration is an important and challenging component recognized in scholarship on recovery in forensic settings (Hillbrand et al., 2010; Livingston et al., 2012; Pouncey & Lukens, 2010). Based on the forensic inpatient narratives, it appears that this perspective on recovery is not isolated to the sphere of practitioners, clinicians and academics; several participants also seemed to understand that risk management is an important component to their care at the hospital:

“Getting sick again [impacted my recovery]. And the relapse ... I’ve had two incidents now where both my mental health deteriorated such that I

was violent in two incidents now. So, I'm doing all that I can to work on my mental health and to stop or prevent something happening again. Catching my illness before it gets away from me." (Participant 17)

"[I need to be involved in mental health services] because I have a mental illness, and my charges they wouldn't have happened if I had been taking medication." (Participant 21)

In the following quote, the participant addressed a common internal conflict on inpatient institutionalization: although the more secure units feel "like dungeons," forensic inpatients occasionally do need to have restrictions on their liberty to ensure the safety of themselves and others:

"All the other units just seem so enclosed ... they're almost like dungeons ... There's no place to go and you can't sit still. And when you do sit still, you're watching stupid shows on TV. And it's like how does locking somebody up into a little cage and feeding them medications help them? You know it's just like cutting them off of everything ... but [other patients] have to realize, they have to do it that way though because people come in for serious charges. There's danger levels [and] factors of risk." (Participant 28)

This quote above suggests that even though some participants indicated that they needed more activities and things to keep them productive and busy, the participants also understood the logic behind the severe safety precautions.

Belief and Adherence to Social Norms and Rules: "For the most part the rules make sense"

In the context of social bonding theory, the concept of belief refers to the extent to which an individual gives credence to the conventional norms, morals and rules of a society. However, the narratives about the rules and structure at the forensic mental health hospital varied. Participants did not agree with the rules unanimously (e.g., no smoking on hospital grounds), but many individuals believed that having them in place was for their benefit and aided in their recovery. The belief that the rules made sense and provided structure, that breaking the rules was not worth the risks, and that often participants followed the rules in order to show respect for staff emerged as important themes in the inpatient narratives.

“Reasonable rules”

Several participants ($n = 13$, 43.3%) maintained that the hospital rules and expectations of staff made sense and were necessary for the hospital to run safely. In the quotes below, participants commented that the majority of the rules they are expected to follow at the hospital “don’t stink” because they exist to aid them in their recovery.

“Most of the rules don’t stink. They’re placed there to help us. There’s a few that stink [like no smoking].” (Participant 15)

“[T]hey’re proper rules. Yeah, I don’t think they’re anything too tough, that’s too hard to follow for us ... Like no horsing around. Play fighting. Well that’s just so that nobody gets a bloody nose and lashes out and big fight starts ... [They’re] really there for our safety.” (Participant 16)

“Well it’s everything from curfews to time limits being on grounds, [and] drugs and alcohol don’t come into it ... They’re reasonable rules, they make sense. For an institution like this, it makes sense. You know, they’re not unrealistic.” (Participant 17)

In the quote below, the participant commented that the rules people follow in the hospital are similar to the rules that they would need to follow in the community, while almost referring to others as “normal” people. This once again speaks to the unique environment of forensic mental health hospitals, where forensic inpatients seem to internalize a difference between them and the non-forensic community.

“Actually [the rules are] a good thing, those kind of rules, go to bed at eleven, they’re for the purpose to run the hospital so they’re not really that bad ... [I]t’s pretty basic day-to-day kind of rules that norm-, most people follow right? You know, no threats, no anything like that right? Most people don’t wanna walk around threatening people and stuff, it’s pretty basic right? Everybody can follow that.” (Participant 19)

Contrary to the narratives of many of the interviewed inpatients, one participant indicated that the rules did not aid in his recovery but exist in the forensic institution because all social environments have rules as they are necessary to maintain order:

“[Following rules] doesn’t help [my recovery], but it gets things going more smoothly. I mean they have to have them, no matter where you are. Even you have rules ... a rules a rule.” (Participant 21)

Although the above participant stated that rules did not aid him in his recovery, his later comments suggest that if he were able to adhere to the hospital rules it would benefit his recovery. This participant's narrative indicated that he believed it is because he is unable to follow the rules and abstain from alcohol that he was still in the hospital. This, in turn, contributed to his ascertaining that it is unlikely that he will recover in the context of the forensic mental health system; in his words, if he "was going to recover, [he] would have recovered years ago". This suggests that he perceives a major barrier to his recovery is his inability to follow the norms and rules, or, in other words, the conditions given to him in his disposition.

Several other participants spoke about how they believed the rules were appropriate given the forensic nature of the hospital. According to Hirschi, if an individual has a weakened or non-existent belief in social norms and rules, the likelihood that the individual will break them increases. In the case of several of the participants, their narratives about expectations and hospital restrictions for their behaviour suggest that they share the social values and beliefs of other patients as well as hospital staff. For example, the forensic nature of the institution was brought up by a number of participants during discussions about the hospital norms, rules and expectations. One individual suggested that the rules might be restrictive but concluded that considering the nature of the institution, that was to be expected:

"Some are maybe restrictive, but I agree with most of the rules ... we're just limited right now as to what we can do anyways." (Participant 27)

The following quote speaks to the participant's belief in the rules as important components of a forensic institution but also highlights how the efficacy of the rules is undermined by the inconsistency of their implementation:

"I understand why the rules are there because it's an institution and you need to have everything under control. But I feel that it's unfair sometimes because the staff will make up new rules and depending on which staff you talk to, they'll say different things about the same thing." (Participant 08)

It's important to note, however, that although participants in this study believed that the rules and expectations of the hospital made sense, this did not necessarily result

in their consistent compliance to said rules. This was exemplified particularly well in the quote below:

“Yeah there’s [rules I agree with], like no fighting - no doing drugs, I agree with that one, even though I do have a drug problem myself, I agree that it can upset your recovery. I do [drugs] anyways, but I still agree with it.”
(Participant 06)

This excerpt demonstrates the difficulty and challenges forensic inpatients face with relation to substance use. Although they may want to live free of drugs or alcohol, remaining abstinent is a ceaseless inner battle that often prevails over their desire to adhere to hospital rules.

“Rules are about routine and having a routine is actually quite beneficial”

Several participants ($n = 6$, 20%) perceived hospital rules as not only making sense but also as a way to give their life structure and routine; indeed, the participants considered rules to be of utmost importance in aiding their recovery or improving their life.

“I feel the rules are pretty good. I mean, you need to get up in the morning, lock your door ... [take] medications, com[e] back on time. You know, the rules are about routine and having a routine is actually quite beneficial. Before I came here I didn’t really have routine ... Just trying to commit to doing something for the day when you go for day-leave you have to be back by [a] certain time, so when you’re there you have to structure your time out. I think those things are pretty positive ... [F]or the most part the rules make sense.” (Participant 01)

“The rules are positive because it means we have more structure and that helps with recovery.” (Participant 08)

“Some people need the structure of rules right? They need that structure of rules ... To keep people safe and if they’re followed, it generally runs the hospital quite well.” (Participant 19)

The next quote speaks to one participant’s experience with breaking the rules. She commented on how learning the rules at the hospital taught her about normative behaviour and how to socialize with others by being more aware of her actions. When she would break rules at the hospital, she felt reassured that the staff would speak to her about it, and she felt that it was a learning experience in which she could better herself, and learn more about appropriate behaviour:

“I think that’s fine for everyone to learn [the rules around mealtime]: have to all be sitting, stand in line, don’t get too close, just a lot of finicky rules that you would never do at home ... There’s lots of rules but they seem to all be for good. [...] I think [the rules] make you feel better ... since [when you break the rules, the staff] talked to you about them, they’ve said something to you about the way you’re acting, socializing and usually, you take notice of yourself.” (Participant 20)

Other participants spoke about the importance of having routine and structure to ensure that they avoid returning to non-normative behaviour:

“Stability. Just having the right, rather, more relaxed people on the ward and that kind of thing. Three square meals a day that kind of stuff ... structure’s helped in recovery.” (Participant 27)

“If you can’t have a routine, you fall into old habits, [and] there’s no recovery. [Structure helps] change your actual lifestyle.” (Participant 28)

Rules and norms provide routine and structure to an individual’s life, factors which have been documented in forensic mental health literature as important to an individual’s recovery (Smith, 2000). Routine, structure and learning how to regulate behaviour help individuals learn to engage in certain activities with little effort (Smith, 2000). As exemplified by the above quotes, it appears that the external rules of the hospital can be internalized by forensic inpatients as they come to believe that adhering to conventional norms and rules aid in their recovery by providing routine and structure for their interactions with others and daily activities.

“If you don’t follow the rules, you’re never going to recover”

Another common theme in the narratives of the participating inpatients was prompted by their concern for negative consequence: participants followed the rules because they feared the repercussions for breaking them ($n = 25$, 83.3%) (e.g., seclusion and loss of privileges). As discussed in Chapter 2, the rules in a forensic mental health hospital are strict and adamantly monitored by staff at all times, much more so than in the community. For example, smoking, drinking or the use of illicit substances is strictly prohibited, and individuals’ personal possessions are regulated as well as their movement around the hospital and into the community. Breaking the rules may result in the loss of privileges or relocation to a more secure unit in the hospital. Several participants believed that breaking the rules would affect their recovery ($n = 8$, 26.7%), as it was maintained by participants that breaking the rules would result in

regressing in inpatient progression at the hospital or seclusion, both of which would hinder their recovery.

In the following quote, an individual addressed his personal experience in learning from his past transgressions with hospital rules, elaborating on how his disobedience taught him to regulate his behaviour to not be in conflict with the system:

“I break the odd rule, but I learn from my mistakes. So it’s good for me ... They tell me about [breaking the rule] and I get disciplined by getting my privileges taken away for a while. I understand that we can’t be acting like that all the time so I don’t anymore.” (Participant 11)

Other participants spoke of how adherence to rules aided inpatient progress through the hospital system to reach the more open and less secure units, stepping stones in their reintegration into the community. Participants identified that breaking the rules risked their return to a lower privilege status or to a more secure unit:

“I want to get through the hospital as quick as possible. I wouldn’t be in the [low secure unit] right now if I wasn’t following the rules. So, it helps you to progress through the hospital.” (Participant 17)

“I might lose my day-leave privileges [if I break the rules]. Might be even transferred from [the open unit] back to [secure unit] or something like that.” (Participant 01)

“Don’t follow the rules, don’t have privileges.” (Participant 17)

“I like following the rules because if I know there are rules and then I break them, I’d be sorry.” (Participant 20)

Participants also identified discharge from the hospital and recovery as almost synonymous with following the rules:

“There’s a girl here that’s always screaming, crying, and she’s been here for a year probably and she doesn’t have many privileges at all but that’s because she keeps breaking the rules and she keeps getting into fights with people. So I just think [breaking rules] wouldn’t really help her recovery here ‘cause she might not never get out.” (Participant 24)

“The reasons [I follow rules] are I guess, as stated by the staff, that they help me get out of here sooner. Compliance is official to your path out ... As you change wards, you gain privileges and freedoms and they demote you if you mess up or whatever.” (Participant 27)

Quite a few of the participants expressed their concern about being placed into seclusion (i.e., the side room) if they broke the rules. This was a deterring factor and several patients indicated that it significantly influenced their behavioural decisions:

“I know for a lot of people, the rules might suck. No smoking, no weed, no drinking. I’m actually okay with it ‘cause it just reminds me of school, you know, you’re supposed to follow the rules. So when I’m here, I’m just like following the rules. ‘Cause if you don’t follow the rules, you’re never going to recover, you’re always gonna be put in the side room.” (Participant 24)

“I don’t like going over there to have a couple puffs of [cigarettes] because it makes me really nervous inside. Like I’m going to get caught, so I just wait ‘till four every day and smoke then ... I stayed longer [when I broke the rules]. I had to go in the side room, stuff like that.” (Participant 05)

“It’s just easier [to follow the rules]. There’s no point in balking and kicking up a fuss about it, you just wind up in the seclusion.” (Participant 09)

The way in which patients weighed the risks and benefits of transgressing the rules undoubtedly reflects the secure nature of a forensic mental health hospital. The participants are involuntarily detained in the hospital and may only access the community at the discretion of the hospital director, who is granted authority by the Review Board to make decisions concerning visit leaves and access to the community. Although it is the Review Board which ultimately determines whether an individual is a significant threat to public safety and inappropriate for management in the community (Eaves, Lamb, & Tien, 2000), the hospital director may make decisions concerning supervised access to the community or day leaves where the individual may enter the community alone for set periods of time. It is apparent from the participant narratives that forensic inpatients feel that following the rules results in receiving more privileges, and thus provides greater access to the community. By following the rules to avoid the negative consequences, the inpatients demonstrate that they value social norms and may internalize them as a means to their independence and autonomy.

“Respect for this institution”

Another reason behind ($n = 5$, 16.7%) inpatient adherence to hospital rules implied different levels of respect for hospital staff and the institution. Participants spoke about caring about staff expectations as well as not wanting to disappoint the people that are helping them.

“... I’m much happier in the company of staff than I am in the company of patients. And that’s true. I identify more with normal people than I do with mentally ill people. And so I’m much more comfortable with their rules, I just accept there’s reasons for them, I don’t question them much. And I’m probably unique here in that respect, you know? Because everybody I’ve encountered they [have] like a jail prisoner relationship with the staff but I respect them and I treat them well, and they treat me well in return.”
(Participant 02)

By stating that the participant identifies more with “normal people” than those living with a mentally illness, the participant speaks to his desire to no longer be labelled a deviant rule-breaker, but rather, he would prefer to be perceived as a law-abiding citizen. This, in turn, encourages him to follow the rules and norms as identified by the hospital director and staff to illustrate that he fits in with conventional society and to distance himself from those who do not follow the rules. The following quote reflects similar sentiments:

“I think that, if I want to smoke weed, it’s my choice, but I’m not going to. Just because I have respect for the law, I have respect for people that are taking care for me and I’m really honestly trying to get away from that scene anyways. Because it does spiral down into other harmful habits and criminal behaviour and I’m tired of it.” (Participant 28)

Other participants spoke about following the rules because it is important to hospital staff, and these inpatients prioritize gaining and maintaining staff trust more than the benefits that they may receive from breaking the rules:

“I have no reason not to [follow the rules]. I think one of the reasons I’m given so much trust by [the staff] is the fact that they trust me ‘cause I’ve never broken the rules.” (Participant 13)

“Well, you know, sometimes I think [the staff are] helping me, and sometimes I think that they aren’t. But really, I know that if I clean up, if I completely stop doing drugs, I’ll get out. That’s all they want. And they don’t want to see any violence.” (Participant 18)

The study participants articulated feelings of respect for staff and others and indicated that this was one of the motivating factors for adhering to conventional norms and hospital rules. This may be a result of the feelings of personal attachment and friendship which inpatients cultivate with hospital staff and vice versa. Hirschi (2002) has described the relationship between an individual’s belief and adherence to rules and bonds with others as a “more or less straightforward connection between attachment to

others and belief in the moral validity of rules” (p. 29). Participants’ adherence to societal rules and expectations is likely based on their desire to show respect to others that they trust.

Finally, one participant spoke about his desire to respect the hospital, as it is a special place for people who have been found not criminally responsible on account of mental disorder. This individual believes in the norms and rules of the hospital because breaking them would suggest disrespect to the safety that hospital provides:

“... I don’t like breaking rules for the sake of breaking rules. I like the people that are telling me to obey the rules that they’re telling me to obey. And if I break any of the rules, it implies that I don’t have respect for this institution which I do, because it is very important for people with mental illnesses to have a special place to go if they commit a crime.”
(Participant 25)

Attachment to Supportive Individuals

According to Hirschi’s social bonding theory, attachment is the extent to which individuals have close affectional ties to others and care about their expectations because they admire and identify with them. It is attachment to others that determines an individual’s adherence or violation of social norms and normative behaviour. Similarly, the literature on recovery identifies the concept as a social process which involves “rejoining the social world” (Jacobson & Greenley, 2001, p. 483). In this recovery process, larger social support networks have been correlated with their recovery, feelings of hope and perseverance towards success (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Corrigan & Phelan, 2004 ; Hendryx et al., 2009). In this study, participant narratives on recovery experiences at the forensic mental health hospital identified social relationships with staff, friends and family as key components of support for recovery (Smith, 2000).

Relationships with staff

Patients at the forensic hospital have reduced access to the community and are often limited to building relationships with other patients and staff. Many of the participants ($n = 18$, 60%) discussed both supportive and unsupportive staff at the hospital. In other words, some staff members were perceived as contributing to patients’

personal recovery, whereas others' attitudes and behaviours were perceived as hindering patient recovery. Almost all of the participants ($n = 29$, 96.6%) considered hospital staff as being overall supportive and caring. Despite this almost complete consensus, many participants ($n = 19$, 63.3%) also indicated that some staff members are disengaged, uncaring or burnt out. The majority of participants ($n = 28$, 93.3%) asserted at least once throughout the interview process that power differentials existed between staff and patients.

In the following two quotes, the participants spoke about how they perceived some staff as uncaring and unsupportive of them and their recovery, with the first participant noting inpatient-staff relationships on his unit as being more militaristic and based on power imbalances than therapeutic.

“There are some staff that are, it appears, without having any proof just to really say this, but it appears that they're not too engaged in supporting patients. They come across more as, in some ways, sort of a militant style instead of more empathetic style or approach with patients. So, you're treated more like one of their little soldiers than you are a patient. That's just the odd staff worker that's in the system ... not all staff are like that, if you go to other units, the staff are very supportive.” (Participant 17)

The next quote speaks to one participant's perception that several hospital staff prioritize receiving their paycheque over providing support and care for inpatients.

“There's a lot of staff that work here that have personal biases and prejudice ... I think there's too many people that work here that are here for the paycheque and not for the care of the patients.” (Participant 28)

Other qualitative research done in secure forensic settings has produced similar findings (Barsky & West, 2007; Mezey et al., 2010). It is common for inpatients in secure forensic settings to describe staff negatively, often emphasizing feelings of power differentials and being treated like a prisoner. It is also common for some staff members to be described as unengaged with patients, uncaring and only there to make money (Barsky & West, 2007; Mezey et al., 2010). Just as supportive and caring staff can support an individual's recovery in a secure setting, “unkind, insensitive, or intolerant treatment or remarks can have an equally powerful negative impact” (Mezey et al., 2010, p. 692).

However, despite perceiving a few staff as unsupportive, many participants ($n = 29, 96.7\%$) spoke about connecting with certain staff members and that a majority of the staff with which they interact on a day-to-day basis were helpful, caring and supportive. In the following quotes, participants spoke about having a special relationship with certain staff members. Participants described knowing which staff they should go and talk to when they have problems, pointing to the unique relationships developed between staff and inpatients based on individual characteristics:

“Me and everybody’s got a different staff that you like or don’t like and ... Depends on the staff and individual patient.” (Participant 10)

“When [you] got a problem, you got to know which staff to talk to ... there’s no bother talking to some of them. ‘Cause not all of them are the same.” (Participant 15)

In the following quote, the participant explains why he believes some staff are more patient-centred and supportive than others. He attributed the differences between staff members at the forensic mental health hospital as relating to their individual characters, leading to the conclusion that it is just human nature for some individuals to be more kind than others:

“There’s about eighty percent of the staff that are okay. And twenty percent of the staff that are just jerks ... [I]t’s just like eighty percent of the people that live here [patients], are going to be okay, and twenty percent of the people you deal with, that live here, are going to be assholes ... [S]ome of the people have bad days and some people have great days and not everybody—the sun can’t shine every day, right?” (Participant 30)

In the subsequent quote, the participant spoke about forensic inpatients’ focus on talking and gossiping about the staff with other inpatients, often speaking more about what the staff were up to than about their own family. He alluded that it is because of the constant contact and power struggles between inpatients and staff that they may fixate on the more negative interactions.

“What I would like to say is the staff, most, actually ninety percent of them, are trying to help me get out of here. They do try hard. You hear guys saying bad things about them, but it’s just that something happened, like if they say, ‘well, maybe you can’t do this,’ then they get mad and hold a grudge. And they walk around telling people about how bad [the staff] are. It’s like gossip around here. It’s like a soap opera around here, you know. [Patients] never talk about their family, or stuff, or what they’re

going to do when we get out of here, or what can we do for the weekend, it's always about the staff.” (Participant 21)

Despite gossip and conflicts, deep connections exist between certain service providers at the hospital and inpatients, sentiments which are well articulated in the below quotes. These relationships offer patients support, guidance, and assistance while receiving services in the forensic mental health system:

“It's been rewarding to me then, the care I've gotten from staff and patients and friends. It's really helped me, support me in all kinds of ways. I feel good about that ... They get time to understand me, they know I'm just not a nut bar. They listen to what I got to say when I talk to them. I don't come across aggressively anymore or anything like that. I used to be quite the aggressive man, but I'm a pacifist now. And I like it like that.” (Participant 11)

I: *“What has helped you with your recovery at the hospital?”*

P: *“The support that I've got from my treatment team and other kind hearted people—the staff.” (Participant 17)*

In the next quote, the participant addressed not wanting to disappoint the staff in their behaviour because staff support had been an important element of his daily life throughout his stay at the hospital. This reflects Hirschi's social bonding theory as it alludes to the importance of close affectional ties to others, where the individual cares about others' expectations and does not want to let them down.

“For so long, people have helped me here. And it's sometimes going out of their way ... the staff have expected a lot from me. And I hate it when I let the people that care about me down...” (Participant 18)

The participant in the quote below felt reassured that she would be able to see her treatment team on a regular basis. After years of having unstable relationships, she indicated that it has helped her to know that there is a group of people who care about her well-being and check in on her on a regular basis.

“I know that my [treatment] team's gonna check in and see how I'm doing every once in a while and meet with me once a month or whatever it is. [It] stabilizes my relationships. 'Cause there's been many years I was alone, didn't have any real relationships. So it's helped—knowing that they're going to be with me one week or it's going to be soon.” (Participant 20)

Several of the participants spoke about how important it is that staff provide continual support and encouragement in inpatient progression through the hospital and individual recovery in the context of a forensic mental health setting. The way that the participants spoke of these encouraging and caring staff members illustrates how such support really impacts patient perceptions of care quality.

“I think for the most part it’s all the good staff that work here. [They] help me with my recovery because they don’t stop. They just keep, keep, keep supporting me no matter what. They don’t give up!” (Participant 28)

“There’s a lot of staff who do care, and then the staff who try their hardest. And this hospital, it’s really, it’s a good place.” (Participant 30)

Several participants described their relationships with staff as unique and special, defining them more like friendships than like inpatient-service provider relationships defined by specific power dynamics. This reflects the forensic inpatients’ desire to be more like “normal” non-forensic individuals. In the following quote, the participant spoke about how his relationships with staff are better than those he had with friends prior to institutionalization:

“I have a good kind of rapport with a lot of the staff here. ‘Cause I’ve been here for so long, I get to know these people. And we’re actually really good friends. So it’s pretty cool. I’ve actually felt closer to people here than I ever felt [back home].” (Participant 13)

It has been suggested that individuals who are detained in secure forensic mental health settings place a great deal of importance on the friendships they develop within the hospital (Mezey et al., 2010). This can be attributed to many things: confinement to the hospital for long periods of time, the absence of other positive or affirming relationships in the community, and a connection with others who have shared similar experiences. This was reflected in a study by Mezey and colleagues (2010) who found that the forensic hospital provided patients with “a sense of belonging, acceptance, inclusion, and companionship that they had never previously encountered” (Mezey et al., 2010, p. 690). In this study several participants spoke about the importance of relationships and supports within the hospital.

In some cases, staff served to provide hope and encouragement to the participants on their journey of recovery in the forensic mental health setting. It is a

common theme in literature on recovery that an individual's recovery can be fostered when someone believes in them, helps them realize their own self-worth, and provides persistent support even in the face of challenges (Kelly & Gamble, 2005). This level of support from staff was reflected in many of the inpatient narratives. In the following quotes, the participants spoke about individual staff at the hospital who encouraged the participants to challenge themselves with regards to their physical health, mental health, relationships and occupational goals.

"The young man that works as a nurse here, he asks me a lot of questions regarding my mental health [and] physical health ... That's one guy that I could really appreciate his input into my life ... [I]t's actually the one nurse that works here that is most influential in that respect. He encourages me to live well in different ways." (Participant 02)

"The health care worker say things to me like, I should be able to get out of here and get a job and they also talk about my relationships ... And at my TPC's [Treatment Planning Conferences] my psychiatrist says that I'm smart and that she expects more of me, in terms of a career ... [I]t feels like I have more hope." (Participant 08)

"There's a lot of staff that do care and have put on somewhat of a role model description. You know, there's a lot that I, there's some people that I look up to in here. Especially in the wood shop ... the facilitator that runs the shop, I look up to him. He knows a lot about the trades and he's taught me a lot of stuff and you know, I get along really good with him. I get along with him like we're friends." (Participant 28)

As indicated by the above quotes, support from mental health service providers is an important component to an individual's recovery from mental illness (Smith, 2000). However, this support is best illustrated in the sharing of authority and power by trusting individual inpatients and supporting their goals (Roberts & Hollins, 2007, p. 397). Having individuals that "believe in and stand by the person in need of recovery" (Anthony, 1993, p. 532) is crucial in the individual's journey, especially if the individual does not yet have faith in his or her own ability to recover (Anthony, 1993; Walsh, 1996).

In this final quote pertaining to staff relationships, the participant reflects on the support they were provided to deal with difficulties associated with having committed a serious index offence during an acute phase of their illness:

"My index offence was so terrible. I wouldn't have been able to go on much longer personally without their support ... Even going forward ..."

they're reminding me that ... I never would have done what I did had I not gotten mentally ill. Their support [in] so many different ways has benefitted me." (Participant 17)

This speaks to the struggles forensic inpatients experience in relation to their offending behaviour. It is unique to the forensic mental health setting that individuals living with mental illness must also come to terms with having committed potentially very severe crimes when they were acutely ill.

"Being patronized by staff"

While the participants of this study spoke positively about the many ways in which staff supported and encouraged their recovery, some interactions were also a source of stress and conflict. The most prominent theme that emerged from the narratives encompassed power differentials between staff and patients ($n = 28$, 93.3%). Although many participants had good relationships with the service providers at the hospital, some inpatients described how staff sometimes left them feeling powerless and in little control over their own lives.

In the following quote, the participant articulates a common problem identified in the forensic mental health hospital: the inconsistency of the application of rules by hospital staff.

"... there'll be one nurse on one day and they'll tell me one thing and the next nurse I talk to, like another time, will say something completely different." (Participant 05)

Other participants described feeling that the forensic mental health setting was structured in such a way that it completely eradicated individual autonomy:

"Like I know what the hospital want[s]; they just wanna take control over everybody that they can control their lives for them and it's not right." (Participant 07)

As mentioned previously, several participants were cognizant of the fact that containment and management of risk is necessary in the context of a forensic mental health hospital. However, the following participant suggested that even though it is a safe environment for individuals who have been found NCRMD, this should not mean that they are treated with less respect:

“I think that’s kind of patronizing and I’ve heard patients several times say that they feel that this place treats them like urine sometimes, which is better than how you’d be treated in a maximum security prison ... [I]t’s safer in here for people with mental illnesses than it is on some big ward somewhere else. But at the same time, just because it is safer here doesn’t mean that we like being patronized by the staff.” (Participant 25)

Participants ($n = 7$, 23.3%) also occasionally spoke of feeling patronized and bullied. Just as supportive and caring staff relationships aid in an individual’s recovery, insensitive and intolerant treatment from staff may also negatively impact an individual’s recovery (Mezey et al., 2010).

“That’s one [staff member] that I feel gets off on pickin’ on us. And I know there is a bully streak in some people ... And some of those people just happened to work here at this hospital. And so, us as patients, we get to deal with these people who just get off on picking on people. And we’re the people that they pick on.” (Participant 06)

In the following quotes, participants described how some staff were inconsiderate of the personal struggles that forensic inpatients suffer within the context of their illness, their institutionalization and their personal lives:

“A lot of the time they laugh at you ... [A patient] was really sick, he was freaking out! Walking the hallways muttering and [the staff] start laughing at him, right? ... they start laughing at the situation like it was a big joke, when it was escalating to something serious for him and his psychological level right? They took it as a joke.” (Participant 19)

“... some of [the staff] are so strict and cruel, they have no conscious[ness] of the condition of life that the client is in. And we tell them that and it’s almost like some of us just keep getting abused. And it sucks.” (Participant 28)

“Not really listened to”

Another concern that the participants perceived as potentially hindering their recovery was their lack of involvement in treatment decisions. Participants ($n = 16$, 53.3%) spoke about being uninvolved in the treatment planning process and not being listened to when it came to their medication dosages.

In the following quotes, the participants described how they wanted to be more involved in making the decisions that affect their daily lives:

"I would like the case manager and social worker to give the patient as much responsibility as the patient desires. And not treat him, not patronizing, but maybe patronizing is the word I'm looking for ... They insist on looking after all the details and I think if a patient is willing to take on some responsibility, I think they should be happy to let him."

(Participant 02)

"They don't even try to talk to me while [the treatment planning conference] meetings are scheduled." (Participant 03)

Other participants described how they felt that they were powerless and that their opinions had little impact on outcomes or decisions that specifically related to them:

"I feel like the nurses have more power over what I can do than what I would choose to do. Like if I have a conversation with my treatment team, it's usually what they say is what's going to happen, not what I ask for."

(Participant 05)

"When I've turned around and explained the situations to them, to my doctor and what have you, they don't take it as being serious."

(Participant 15)

Under the British Columbia Mental Health Act, forensic inpatients can receive involuntary treatment for their mental illnesses (Eaves et al., 2000). It is the director of the hospital who authorizes such treatment and as long as they are under the care of the forensic mental health hospital, the inpatient has no option to refuse care or treatment. The forensic inpatient narratives reflect the participants' wishes to have more input into the dosages of their medications and controlling the side effects:

"They just tell us what we need and then give it to us. You know? Patients have very little say in what their treatment involves." (Participant 06)

"I've given my opinions as to how the medications are affecting me and my psychiatrist has not really listened to it. She just went with her opinion." (Participant 08)

"I've been trying to tell my psychiatrist [that] two days before I get my injection I'm a wreck. I get it every two weeks, and so yesterday, and the day before, my mood was all messed up ... I'm trying to get it every twelve days instead of every two weeks. But he's not catching on!"

(Participant 18)

"I've seemed to have had problems with medication and doctors before. Side effects ... [the doctor] not really listening to me having side effects and stuff like that ... It was very frustrating." (Participant 27)

Feeling listened to and involved in treatment decisions is an important component to an individual's recovery. It provides the individual with input and control over their treatment as well as the management of their own symptoms (Davidson, O'Connell, et al., 2005). Procedural justice principles should be implemented in coercive treatment situations to improve long-term therapeutic outcomes (McKenna, Simpson, & Coverdale, 2000). Procedural justice principles involve keeping patients informed, listening to their concerns and letting them provide input into their care while "treating them with concern, fairness and respect" (McKenna et al., 2000, p. 675).

Although several participants spoke of experiencing being uninvolved in several treatment decisions, there were individuals who described how they felt involved and listened to by the staff at the hospital. Interestingly, in the following quote, the participant used coercive terminology to describe how the staff at the hospital listen to him. This just emphasizes the extent to which forensic inpatients may internalize the rules and norms at the hospital:

"I don't ask for anything out of the ordinary but, if there is something I need I specifically talk to them about that and they understand, and they usually comply with that." (Participant 11)

"Patients like me for who I am"

Participants in this study had mixed responses as to how their stay at the hospital had affected their relationships with friends and family. In regards to relationships with fellow patients, over a quarter of the participants ($n = 8$, 26.7%) spoke about their relationships at the hospital with other patients as being a source of support and acceptance, as they were all going through the same emotional and physical challenges, giving the participants a feeling of not being alone:

"I've made friends here at the hospital ... it makes me feel like I can just worry about what I'm doing with my own recovery rather than worrying about what other people around me are doing, 'cause if I have friends around me then I don't have to feel excluded." (Participant 06)

Other individuals spoke about feelings of solidarity in that their problems were similar to the others in the hospital. In the following quote, the participant alluded to feelings of hope originating in the fact that he no longer felt alone because others were going through the same experiences:

"[Here] I saw a bunch of guys that got the same problem. They don't talk too much about it but when I question some people they don't admit to having a problem but I see that they do ... It seems like [there are] so many [people] that's got the same situation as me sort of thing. I feel like I'm not alone. Like there's somebody here that's got the same problem as me." (Participant 014)

In the next quote the participant described how his fellow forensic inpatients were more compassionate towards each other because they knew they were all going through the same trials:

"I think everybody's [all the patients] in the boat type thing. 'Cause everybody's feeling the aches and pains. So I think everybody's extra, extra, compassionate towards each other." (Participant 16)

"Patients that want to get out, they have a mutual team work so they kind of support each other ... they keep on talking to each other about their plan, how they're going to do it. So they have more of a relationship with that." (Participant 22)

In the following quotes, the participants spoke about the support they have received from friends they met at the hospital. In the first quote, the friendship provided the individual with guidance and assistance in times of trouble and was perceived as a positive factor in his recovery process:

"I feel good when I have a relationship with a patient. And I've got one of those, she's out now but she comes to see me all the time. [She's been] a good friend, close companion to me ... It's improved [my recovery] I feel good about talking to her about stuff that's bothering me. It's like a release valve when she comes around, she listens properly, and gives me advice." (Participant 11)

The next participant spoke about the relationship he had with one of the other inpatients, describing it more as a familial bond than simply a friendship. The participant spoke about how his peer motivates him to change for the better and takes care of him:

"He's [a patient] one of my best friends. He's the only one who keeps me going ... He's a good guy. [...] He's younger than me, but he's like my older brother to me." (Participant 21)

Relationships with peers and peer support are key factors that aid in an individual's recovery and influence "positive changes in patients' emotions, behaviors, and perspectives" (Bouchard, Montreuil, & Gros, 2010, p. 595). Mutual and peer support

can increase an individual's feelings of acceptance and community, while increasing hope and promoting change (Davidson et al., 1999; Johansson & Lundman, 2002; Mead & Copeland, 2000). In a secure forensic setting, the forensic inpatients may find hope and encouragement in the interactions they have within the hospital. In a previous study, Mezey and colleagues (2010) found that hospitals provide a safe space where patients are protected from "a hostile and uncomprehending public" (p. 689-690). This feeling of safety and being understood was reflected in the following narratives:

"We have an attitude around here, the patients have an attitude where we like to help each other out if we can. Other than the gauging each other for smoking, that's one way where we like to shaft each other when we get the chance, but other than that, if we see someone out on grounds who's having a hard time, the rest of the patients will try and help him out." (Participant 06)

"I can only date people who are in this hospital ... I think I've gotten support from my boyfriends ... I think the relationships in this hospital have helped me because it's like peer support ... I think most people here have mental illnesses so you feel like someone is going to understand how you're feeling and there isn't, as much stigma going on inside here." (Participant 08)

"You know I can, mingle with the other patients but then when I'm out there, I have to face the public as well. Like what other people say [outside the hospital] about me and stuff like that and I find it isn't true but, but I know deep down inside, um, the patients like me for who I am because I know them." (Participant 24)

Although many participants discussed the value of friendships with peers in the hospital, some indicated that they felt disconnected from the other inpatients. Moreover, one participant discussed feeling as though her relationships were forced because of the peer status of all being forensic inpatients in the hospital:

"You can't pick and choose friends here. You have to be friends and mix together with the people you're put with ... [Y]ou have to have some kind of social relationships and if you weren't in the hospital, you probably would just not ever know who they were right? ... a lot of the boys think that they have the right to all the women here because there's like five good lookin' girls and there's like five hundred men and I hate them! They're, they're bastards. They won't leave me alone!" (Participant 05)

“My friends and my family are the best supports that I have”

Relationships with family and friends outside of the hospital were important to several participants in this study. Although the literature suggests that mental health service providers and peers may be the leading support networks for individuals living with the challenges of mental illness, family support still plays an important role (Corrigan & Phelan, 2004; Smith, 2000). Several participants ($n = 7$, 23.3%) spoke about the importance of having contact with their partners, children and parents. This first participant spoke about how the relationship he has with his wife and family gives him hope for when he will return to the community whereas the second participant identified the role of parents in providing support to him:

“My relationship with my wife has helped [my recovery]. And with my parents ... they give me hope in the future. They [make] me excited about spending more time with my wife. And their sort of unconditional support has meant a lot.” (Participant 01)

“I have good family support. And they’ve been involved with [my psychiatrist] since the beginning of this. My dad and step-mom, they come up about once a month and we go out.” (Participant 13)

In the next two quotes, the participants spoke about the important role of siblings in their lives since they began receiving inpatient care at the forensic mental health hospital. The first participant indicated that being at the hospital brought her in closer proximity to her sister, whereas the second participant indicated that his sister provided him with support and strength during hard times:

“Well I’m [physically] closer to my sister. Which is a good thing.”
(Participant 12)

“You know that’s what I feel like, yeah, nobody, I don’t have anybody on the outside that I know of that waits for me everything like that. Other than my sister at home. [... I] talk to her regularly on the phone and she’s been strong when she needed to, yeah. She’s been there for me ... it’s been good to have somebody that I know cares about me, you know.”
(Participant 14)

It is not clear how many of the participants had children, but several spoke about the impact their hospital stay had on their relationship with their children. Most parents spoke about being far away from their children and not seeing them:

I haven't seen my wife and kids in seventeen years. I've been here fifteen years and the last time I see them was back in the Nineties. (Participant 04)

I've lost my house, my home, you know, [and] I lost my daughter. (Participant 19)

It's awful, my boyfriend's far away and my son. I can't get to my [children]. It's been awful. I don't know how to contact anybody. Normally I just go to them, to their houses. Or I see [my friends] on the street or something. It's been awful. (Participant 29)

Conversely, one of the female participants who had children spoke of how being at the hospital was an improvement for her relationship with her children, as it allowed her to have more contact with them than when she was remanded in prison:

"[Staying here has] helped me with my kids and I. Compared to being in jail. I can see them now." (Participant 20)

Another barrier to the support of family and friends for inpatients in secure settings is the stigma and social isolation associated with receiving treatment services in a hospital. Although participants spoke about friends and family being supportive, the distance ($n = 11, 36.7\%$) put between them during the inpatient's stay at the hospital added a stress on their relationships and their recovery:

"I haven't been able to meet with my family. So it's basically [my] family relations [which] have been affected ... this affected [my] recovery—I would have time to go outside and interact with family, more interaction with the family, which would give [me] a good mood." (Participant 22)

"My friends and my family are the best supports that I have, like I really stick close by with them and try and be a part of everybody's life and I just spend my whole day walking around visiting friends and stuff [when living in the community]. So, not to have that is just so weird. It's just so strange." (Participant 29)

Participants of this study also spoke about their friends and family moving on without them, and not being able to maintain regular contact with their loved ones due to geographical distance and detachment from their day-to-day lives. Separation from family and friends often elicited feelings of frustration, loneliness and sadness. The next few quotes reflect participants' feelings of being disconnected from their relationships because of their stay at the hospital:

“None of my friends have been in touch with me. I don’t have that many friends, but, ... not a single one, even once. My sister’s been here twice, two successive days. And my dad comes here once a month ... my dad doesn’t really want anyone to know that I’m here either.” (Participant 25)

“Well, I don’t have a lot of friends, but the ones I do have [live far away], so staying here I’m separated from my friends. I have one friend in the community here, but he has an alcohol problem and, and since I realized that, I don’t see him very often. ‘Cause I also had an alcohol problem, I don’t want to get back into that, lifestyle.” (Participant 02)

The following quotes demonstrate participants feeling of sadness from being far away from their families and relationships and how that has negatively impacted them, often reflecting that they no longer have relationships outside of the hospital:

“[Thinking of] my family makes me kind of sad because I don’t ever get to see them.” (Participant 03)

“I have no more relationships [since being here], nobody comes to visit me. [The hospital] is too far away. It’s too far away and all my friends have moved on. My girlfriend’s moved on ... after a while, I thought well hey, nobody cares about me, right. And that was big. I had to go through the emotional loss of losing everything again.” (Participant 19)

“I don’t have relationships at that moment. I’m just keeping in touch. It sort of limited my ability to maintain relationships. [It’s been] negative, yeah. I think it’s hard to organize [visits]. For them and being busy people and all that stuff it’s sort of better for my spirit to keep up contacts ... It’s fairly encouraging, you always feel good after talking to family members or something like that.” (Participant 26)

The next several quotes allude to the participants’ desire to be back with their family, and feelings of missing out on time with their loved ones:

[I’m away from] friends and family too. And my other family, my brothers and my sisters. I’d like to leave now. I’d like to go home.” (Participant 04)

“I wanna see my auntie and my uncle, and if they don’t let me go out I’ll be a bit upset. Because my uncle isn’t well, I’m not sure about my auntie. I dunno if they would want me [to visit] but if they do, it would be nice because they’re not going to be around that much longer.” (Participant 12)

This next participant indicated that he felt “written off” by his friends because he had stayed at the hospital for so long:

“I’ve detected a distinct feeling of being persona non grata among some of my friends from [back home]. It’s like they don’t really want to talk to me anymore. I’ve been here so long, I think that I’ve been written off.”
(Participant 13)

This next participant spoke about feeling lonely because he is unable to have or maintain romantic relationships while at the hospital, and how that has created feelings of loneliness for him:

“Being here, though, relationships, there hasn’t been a lot of like, sexual relationships, especially this time around. And really, to be straight up with ya, I ain’t getting none. You know what I mean. And it’s killing me. But it’s affecting my relationships that way. I got nobody. I need somebody to hold me. I’ve been locked up for a long time, I need somewhere to put my head, you know what I mean? ... I’m lonely. Loneliness is a huge trigger for me.” (Participant 18)

Participants also specifically addressed the stigma associated with their mental illness and how their hospitalization was a point of concern for their friends and family:

“I don’t have any. No friends [chuckles]. I have one girl contact me after I’ve been here ten years and she said she’d call back and never did, so. As far as I’m concern, they’re gone ... The stigma associated with this place was just immense. It really is. You can’t do anything out there if you’ve been in a mental institution especially for a lengthy time.”
(Participant 09)

In the following quote, the participant identified the fact that he did not want his friends to know about his situation (i.e., being at the hospital) because it might make them feel uncomfortable or distressed. However, despite noting his belief that his stay at the hospital might concern his friends, he commented that it would help him to have them to talk to again:

“And how has [staying at this hospital] affected my recovery? It’s been kind of comme ci, comme ça, because, in certain respects, I don’t want my friends to know what’s happening to me here. Because I think that would be very distressing for them. And in some respects I think that if I still had people to talk to, I would probably be a little bit less stressed out than I sometimes am.” (Participant 25)

Two of the participants spoke about how their stay at the hospital had altered the way their family perceived them. The first participant stated that having to stay at the

hospital made her mother worry about her, while the second participant said it made his family think less of him because of his behaviour:

“The thing is staying at [the hospital affects] my relationship with my mom, [it] makes me more mad at her ‘cause she thinks I’m sick and ill and stuff like that ... But I just think mentally, it’s making her worry too much [that I’m here]. It makes my relationships kind of, maybe stronger with my family, but just too much worry[ing] where I just don’t want them to worry about me, like, I’ll be okay.” (Participant 24)

“It has affected my family. My family thinks I’m a fuck up and all. Right? And you know, my family is passing away ... It affects my recovery, puts stress on me. Makes me sad.” (Participant 30)

From the forensic inpatient participant narratives, it seems that their relationships with family were different from their relationships with staff and peers. Although relationships with family were described as supportive, participants’ stay at the hospital was perceived as a barrier to maintaining contact with family members. It is unclear whether this is because of the nature of the individual’s index offence, as NCR-accused persons often offend against family members, or whether it was due to the physical distance between the hospital and the individual’s family. The lack of clarification on this point may be due to the fact that the semi-structured interview guide was intended to evaluate patient-centred care at the hospital, and therefore, many of the standardized measures that elicited comments from participants were worded around staff and fellow patient interactions. However, the limited role of family in an individual’s journey towards recovery is consistent with the literature examining the role of social support networks. Research has shown that peer and professional supportive social networks are more associated with improved recovery than family support (Corrigan & Phelan, 2004; Smith, 2000). This does not mean that family supports are unimportant in an individual’s recovery; instead it may reflect that friendships and mental health professional networks have more “relative plasticity” and can expand and grow more than an individual’s family network (Corrigan & Phelan, 2004, p. 521). In relation to the forensic inpatient narratives indicating more staff and peer support in secure settings, this may be the result of the continuity of contact that staff and fellow patients have, which makes them more dominant in inpatient narratives on recovery than family members.

“My index offence destroyed my relationships”

There is a significant amount of stigma associated with mental illness and forensic services. Recovery for forensic inpatients must extend beyond solely recovering from the effects of their mental illness; it is also recovery from the impacts of their offending behaviour (Corlett & Miles, 2010; Mezey et al., 2010). Participants of this study spoke about how their mental illness and index offences have affected their relationships with family and interactions in the community.

In the following two quotes, both female participants described their hesitations about going out into the community. Both participants alluded to feeling judged by the community and recognized as being different:

“People on the SkyTrain, they give me looks and they say things. You know, I don’t want to say it to the staff but sometimes I really don’t wanna go out there, when I go out there. I only go out because if I didn’t I’d go nuts staying here.” (Participant 12)

“I can mingle with the other patients but then when I’m out there, I have to face the public as well. Like what other people say about me and stuff like that and I find it isn’t true but I know deep down inside the patients like me for who I am because I know them.” (Participant 24)

It is interesting that these two female participants perceived the community as criticizing or identifying them as different. Both of the participants spoke about how they needed to work on being comfortable in the community. The first participant described the need to go out into the community as a way to cope with her daily situation of staying at the forensic mental health hospital, whereas the second participant said that she felt more comfortable at the hospital, but knew that reintegration and feeling comfortable in the community is a challenge she must learn to face.

In the next quote, the participant described how his index offence was what impacted his relationship with his family and that his whole life was dramatically changed after his offending behaviour:

“Well it’s not just staying at the FPH that’s affected my relationships, it’s my index offence destroyed my relationships with my family. I was married, I had a family, I had [a great] job, and you know, just everything, I lost it all. So it’s not just staying at the hospital that’s done that, but it’s

me getting sick ... I do have support from my mother and my brother, but my mother's aging ... it's made my recovery very lonely." (Participant 17)

This speaks to forensic inpatients' need to recover both from their mental illness and the impact of their offending behaviour (Corlett & Miles, 2010; Simpson & Penney, 2011). The above participant may have realized that it was his mental health crisis which made him commit his index offence, but he appears to still struggle with what he did while attempting to move forward in his life.

The stigma associated with inpatients' index offences even influences relationships between peers in the hospital, as demonstrated in the quotes below:

"Some of the guys ... they're all sickos in my mind, or whatever you want to call them. I just don't like some of the guys in here because [of] their charges." (Participant 10)

"I did make friends but [sighs], it's easier to make friends among staff than patients because the patients, some of them have no regret for what they've done." (Participant 12)

These quotes reflect the fact that being involved in a forensic mental health hospital is stigmatizing even among the individuals who receive care there, and presumably understand the meaning of NCRMD. Although the courts have found the forensic inpatients not criminally responsible for their index offences due to their mental state at the time of the offence, individuals with the same disposition differentiate between how guilty people actually feel.

Commitment: "If I did nothing then I kinda only have myself to blame for who I would be"

Of the four components to social bonding theory, commitment was the least saturated in the forensic inpatient narratives. Commitment is the extent to which an individual has invested time and energy into participating in conventional activities (occupational or academic) and lifestyles. An individual obeys rules and norms of society in order to avoid the negative costs of engaging in deviant or socially unacceptable behaviour. The stronger the bond to conventional activities and lifestyles, the less likely an individual would risk their hard-earned efforts pursuing conventional activities by behaving in a deviant manner.

As discussed earlier, involvement in programs and activities was important for the study participants as it gave them the opportunity to engage in meaningful activities, build connections with others and contend with boredom. Several of the participants ($n = 8$, 26.7%) referred to being dedicated to therapeutic programs at the hospital. Committing and dedicating their time and energy to learning new skills was perceived as a way to connect with the community, both inside and outside of the hospital, as well as a means to an end in their quest for autonomy as reflected in the quotes below:

“Taking my courses has also affected my attitudes towards myself ... because [before] I came in here I took two courses and I had to drop both of them, so here, I’m actually completing [courses]. I’ve regained that faith in myself to do the other two courses ... Here, I’ve regained that confidence so I can do something like that.” (Participant 01)

“I involve myself in the peer group [and] PAC [Patient Advisory Committee], and I think those are efforts that engage me in activities that have potential to enrich others. Whether it be PAC Committee or something that might impact and affect all the patients.” (Participants 17)

This next quote emphasizes the importance of investing the time and energy into new skills or activities for the participants. The participant below expressed how what he had learned in the woodworking shop had been a key factor to his reintegration into the community and that not being involved in this occupational activity would have had a negative effect on his recovery:

“If I did nothing then I kinda only have myself to blame for who I would be. I would probably feel sorry for myself a lot more often. But since I’m taking time to learn more about the trades and woodworking ... at least I’m doing something to be productive. To learn skills ... And I’m out in the community now working as a result of it.” (Participant 28)

Participants placed importance on the time and energy that they dedicated to learning vocational skills. Research indicates that engaging people with mental illness in activities that are both satisfying and fulfilling contribute toward building self-esteem and confidence, supporting recovery (Anthony, 1993; Jacobson & Greenley, 2001; Roberts & Hollins, 2007). Providing programs that teach people skills that they can then apply in the community opens doors for their recovery and their successful return into the community. This was reflected in the following quote:

“Well the doctors that have been here have performed minor miracles with these guys [patients at FPH], they come in here and they’re unhappy, they’re mad, they’re sick, they’re sick and tired of being sick—and they leave less than two years generally. They’re happy here ... They kinda turn things around within a couple of years ... it’s programs and medications, the two go together. These people, for the most part haven’t worked for a long period of time, they’ve had extensive involvement in a legal structure and they see this as a hope of getting out of that, getting away from [it].” (Participant 09)

The reason why this element of social bonding theory may be less saturated than the other components may be because of the restricted and controlled access forensic inpatients have to conventional activities such as work or school. Although programs do exist for forensic inpatients to access school or work, both within the hospital and in the community, it all depends on the forensic inpatient’s privilege level. This fact may influence the extent to which forensic inpatients can meaningfully commit to conventional activities and is reflected in the narratives where the participants addressed adhering to hospital rules in order to not regress in their privileges. As listed in the above section on Belief, the potential consequences of breaking rules were identified by participants as a motivating factor for adhering to the rules and norms of the hospital. This suggests that many of the participants consider the risks associated with engaging in deviant behaviour (i.e., fights or drugs) prior to breaking hospital rules or norms.

“I feel like a lot of people who come here don’t really recover they just have a relapse and then they come back”

After coding the data and looking at the codes and themes in relation to social bonding theory, one theme did not fit naturally into the categories defined by Hirschi. A subsample of the participants identified staying too long at the hospital as an impediment to their recovery. Recovery literature speaks to the negative impact of long-term institutionalization on elements of recovery that may cause feelings such as hopelessness and helplessness (Hillbrand et al., 2010). Hope is an important component of recovery (Jacobson & Greenley, 2001). Feelings of hopelessness and despair were reflected in participant narratives ($n = 8, 26.7\%$) if they felt they had been in the system for too long or had committed too serious of an index offence and were therefore unlikely to ever be released.

In the following quotes, the participants described how they felt that long stays discourage hope in an individual's recovery:

"The system here is too slow [for recovery]. I've been at this hospital since two thousand and three." (Participant 05)

"I'm looking at [recovery] in a more pessimistic way because a lot of people who leave here on conditionals come back, so I feel like a lot of people who come here don't really recover they just have a relapse and then they come back or they come back for some other reason."
(Participant 08)

Other participants identified the uncertainty around their stay at the hospital, often not understanding what criteria they need to meet in order to return to the community:

"I don't know how long I'm going to be here so... It's a grey area. Yeah, I feel like I'm in a limbo." (Participant 14)

"Some of us, some of them have been here for a very long time. And nobody's really ever told me what's required to exit this hospital and I don't believe they tell anybody that because most of the guys have no idea how long they would be here." (Participant 02)

This next participant indicated that he believed he would never be given an absolute discharge because of his past offences. This again reflects the complexity of recovery in a forensic mental health setting, in which the individual must come to terms with the impact of their offending behaviour. In the following quote, the participant believed that the severity of his index offences, despite the finding of NCRMD, is what will keep him in the hospital permanently:

"... I don't think I'm ever gonna get out of here, right? And it [is] understandable. I've done some heinous things, right? But I think I deserve another chance. And it's gonna be really hard for me to get one."
(Participant 18)

Lastly, in this final quote, the participant stated that he felt he was just too sick to ever recover, especially since he had not recovered yet. In reaction to this thought, the participant indicated that he planned to stay in the hospital as long as possible. This once again reflects the complexity of recovery in a forensic mental health setting, and the internalized stigma that it may cause:

“I don’t believe in recovery anymore. I just believe in being in this hospital for as long as possible. And that’s not really recovery, that’s maintenance ... I don’t believe that I ever will recover. I’m just too mentally ill ... I don’t have faith in myself anymore. I don’t have faith in my ability to go about my day-to-day decisions. Just the fact that I’ve been here for so long, and there’s no talk of discharging me or anything.” (Participant 25)

Although staying at the hospital for long periods was discouraging and promoted feelings of hopelessness for many participants, needing time to work on one’s recovery has been noted in other forensic mental health literature (see Mezey et al., 2010). Interestingly, a few of the forensic inpatients noted that time was necessary to work on their recovery:

“I think recovery means it takes time to get well, it takes time to do better ... it takes improvement over the years from maybe hiding or doing better.” (Participant 24)

“Just to have the facility here and be able to contact people and stuff ... the other patients [are] really nice and just having some time to heal and grow and stuff.” (Participant 29)

Summary

There were several core themes that emerged from the interviews with forensic inpatients. Consistent with the literature on personal recovery, participants identified recovery as reintegration into the community, returning to a state of normative behaviour, and becoming or remaining abstinent from drugs and alcohol. Although the four components of social bonding theory were reflected in the participants’ narratives, the importance of social relationships, involvement in activities and belief in norms and rules were more saturated in the narratives than commitment. This might be because forensic inpatients have limited opportunities to invest time and energy in participating in conventional activities due to the nature of their confinement in the forensic mental health setting.

Participants spoke of how involvement in meaningful activities and a feeling of productivity gave structure to their day, keeping them busy and away from engaging in deviant behaviour. The benefit of involvement in meaningful activities and hobbies is also reflected in much of the literature on recovery (Anthony, 1993; Davidson, O’Connell,

et al., 2005; Jacobson & Greenley, 2001; Ridgway, 2001; Roberts & Hollins, 2007; Smith, 2000; Young & Ensing, 1999).

Participants also addressed the rules around their stay in the hospital, and although they did not agree with all of them, the narratives spoke to the participants' belief that the rules were in place for their safety and benefitted them by providing a climate that fosters routine and aids in their recovery. Participants spoke of following the rules as a sign of respect for both the staff that care for them at the hospital as well as the institution that is there to help them. Another reason why participants maintained that adhering to the rules was important was reinforced by their fear of consequences, such as seclusion or loss of privileges. This speaks to the commitment of the participants who must weigh the costs and benefits of behaving well and their desire not to risk impeding their progression through the system.

Lastly, attachment to peers and staff appeared to play a large role in the participants' recovery. Positive relationships and role models have been identified in the literature as important elements of the recovery process (Corlett & Miles, 2010; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Mezey et al., 2010; Pouncey & Lukens, 2010; Smith, 2000). Although participants perceived that not all the staff at the hospital were supportive and caring, it appears that most of the forensic inpatients had one or two staff members that they trusted and looked to for support and encouragement. Fellow inpatients in the secure setting were also considered to have made an important impact by providing support for some of the patients who participated in this study. Family members and friends outside of the hospital were also viewed as supportive, but the participants spoke of the distance and physical separation from family and friends as having a negative impact.

Although participants indicated that many components of their care at the hospital supported their recovery, several potential impediments to recovery were also identified. The most prominent themes that emerged from the narratives included the power differentials between staff and patients, lack of activities and access to the community, and feelings of being in the system too long.

Inversely, in relation to the importance of relationships with staff and peers in strengthening an individual's bond to society and aiding in their recovery, a common theme that emerged was that some staff do not consistently treat the inpatients kindly, leaving the inpatients feeling powerless and belittled. Participants also identified feelings of not being involved in treatment decisions. A lack of involvement in activities and feelings of being stuck in a unit were identified as hindering recovery. Despite this recognition, several participants spoke about understanding the need to manage risk and safety for both them and the community and they viewed these restrictions as important components to their care at the hospital. Lastly, participants spoke about feelings of hopelessness after being stuck in the system for too long.

Chapter 6.

Discussion

The aim of this thesis was to examine the qualitative data collected from a mixed-method study at the BC FPH in light of four specific research objectives:

- (a) To understand the perspectives of patients on recovery at the BC FPH;
- (b) To investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients;
- (c) To examine the extent to which forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory; and
- (d) To identify the strengths of a forensic mental health hospital as well as the areas that patients believe could be improved in order to make their recovery experience more successful.

This chapter will summarize and interpret the findings of this study as they relate to the four objectives.

A. What are forensic inpatients' perspectives on recovery?

The participants of this study spoke of three main themes in relation to what recovery meant to them. For the forensic inpatients, recovery involved reintegration into the community, returning to a state of normative behaviour, and becoming or remaining abstinent from drugs and alcohol.

Reintegration

Reintegrating into the community involved not only being discharged from the hospital, but also being accepted by society, making future plans concerning relationships or careers, fitting in and making positive and meaningful contributions.

Forensic inpatients also indicated that recovery meant fitting in and being like others, as opposed to being different. This may speak to the self-stigma that is associated with receiving forensic mental health services (Livingston et al., 2011). Another core component of recovery for the participants of this study has also been documented in the literature on civil and forensic inpatients was to be discharged from the hospital and return to the community (Mezey et al., 2010; Piat et al., 2009). Participants also discussed the importance of returning to a safe community in order to foster their recovery, which reflects the fact that forensic inpatients often come from socially disorganized areas prior to admission in forensic mental health services (Coid et al., 2001).

The theme of returning to the community is also common in the literature on recovery in terms of making meaningful contributions to the community (Mezey et al., 2010). This part of recovery speaks to reconnecting with the social world and stresses the social aspects of recovery in which the individual goes from being isolated within their illness to becoming part of the social world again through establishing and maintaining relationships with others (Schrank & Slade, 2007). Returning to the community may also be a very important factor of recovery for individuals living in the forensic system, owing to their limited access to the community while receiving forensic mental health care.

Participants spoke about recovery involving having a career and rebuilding relationships with other people. This may reflect forensic inpatients' limited access to work, friends and family, depending on the level of their privileges in the secure forensic mental health hospital. By being able to provide for themselves and their family, the patients are addressing their need for autonomy and self-management while also fostering positive personal relationships (Jacobson & Greenley, 2001). In speaking of future plans, the study participants referred to the need to be in control of their lives and move forward. This aligns with other research findings on recovery in forensic mental health settings (Mezey et al., 2010).

Normative Behaviour

The study participants also defined recovery at a more individualized and personal level in relation to changing their behaviour. For over half of the participants, recovery meant a transformation of their behaviour that would allow them to fit into societal norms. Participants suggested this could be done by either learning how to manage and live with the symptoms of their illness or by returning to the same, or an improved, level of functioning than where they were before their mental illness brought them into contact with the justice system. Speaking of recovery in terms of feeling normal or achieving goals similar to those who do not live with the challenges of mental illness is a common theme in the literature on personal recovery, often from the perspective of consumers (Deegan, 1988; Leete, 1989; Walsh, 1996; Young & Ensing, 1999).

The participants spoke of living satisfying lives within the constraints of their mental illnesses and maintaining a similar quality of life to individuals that do not live with a mental illness, something that involves symptom reduction, but also goes beyond it. Meanings of recovery that go beyond simply symptom reduction is common in the recovery literature (Andresen et al., 2003; Anonymous, 1989; Anthony, 1993; Campbell-Orde et al., 2005; Corlett & Miles, 2010; Corrigan & McCracken, 1999; Deegan, 1988; Hillbrand et al., 2010; Leete, 1989). However, it is also common for mental health consumers to define recovery as the cure or cessation of symptoms or returning to their former selves (Piat et al., 2009). This indicates individuals' need for autonomy and desire of "reclaiming who they were before mental illness struck" (Piat et al., 2009, p. 32) and returning to basic state of functioning.

Abstinence from Drugs and Alcohol

Over half of the participants self-reported a history of substance abuse, and this was reflected in the forensic inpatient narratives. For some, recovery meant being able to manage their addiction issues and take control of their lives once again. For several of the participants in this study, the importance of moving past their alcohol or drug addiction was a key factor to their understanding of what recovery meant to them. As substance abuse can have a debilitating and catastrophic effect on an individual, abstinence may be a way for individuals to regain power and autonomy in their lives.

This may also reflect the strict regulations of alcohol and substance use in a forensic mental health setting, and how violations of such hospital rules may hinder the individual's opportunity to return to the community.

B. Do conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients?

The participants' discussions around recovery were aligned with the current literature on recovery. However, there were several components of their understandings of recovery that appear to be unique to forensic mental health settings.

The participants' discussion of reintegration may reflect the internalization of a secure forensic setting's mandate, as safe community reintegration is often one of the final steps towards an individual's rehabilitation (BC Mental Health & Addiction Services, 2010; Ontario, 2002). In the forensic system, successful reintegration has been operationalized to mean that the individual does not reoffend and is not readmitted into the hospital (Viljoen et al., 2011). Pursuant to section 672.54 of the *Criminal Code*, an individual shall not be released to the community unless they are "not a significant threat to the safety of the public". Participants demonstrated insight and understanding that there is a strong need for them to learn skills to prevent deviant or dangerous behaviour, something that is unique to forensic inpatients. Although individuals living with mental illness may pose a risk of violence during acute stages of the illness, forensic inpatients are unique in that their past risk has manifested in a criminal or violent act, and in humanely diverting the individuals for treatment at a forensic mental health hospital (as opposed to punishment through incarceration), the forensic system must constantly assess their risk of future violence before they can return to the community. For forensic inpatients, the need to not be a significant threat to the safety of the public was an important component in their successful reintegration into the community.

Similarly, forensic inpatients' understandings of recovery also reflected the desire to be "normal", or like everyone else. Although the desire to return to one's state of being prior to the onset of their mental illness is common in the recovery literature, advocates

for the personal recovery paradigm discuss how one's illness should be incorporated into the person's identity, as often they become stronger individuals by overcoming the challenges. Forensic inpatients do talk about returning to the same, or an improved state of functioning, but the emphasis on being "normal" was more saturated in the forensic inpatient narratives than what is discussed in the civil mental health recovery literature. This could symbolize forensic inpatients' desire to lead lives that fit in with societal norms, that are not defined by criminal, violent, or potentially unsafe behaviour.

Another important component of recovery in a forensic mental health setting is being abstinent from drugs and alcohol. Forensic inpatients are prohibited from consuming drugs or alcohol, or smoking cigarettes on hospital grounds (due to provincial legislation that bans smoking). Individuals are subjected to urinalysis to ensure that they are not using illicit substances, and if it is found that they are, it may affect the speed at which they may leave the hospital. Additionally, many individuals on conditional discharges are released on the condition that they must abstain from illegal drugs and alcohol and are submitted to urinalysis (Latimer & Lawrence, 2011), and may be removed from the community and returned to the forensic mental health hospital if it is discovered that they broke their conditions.

There were also many parallels between forensic inpatients' narratives around recovery and constructs identified in forensic risk assessments. This may reflect the internalization of rules and assessments in forensic mental health settings. Risk and safety was a common theme in the forensic inpatient narratives, as the participants were aware of the impact maintaining safety has on their recovery. Maintaining safety and containing risk were perceived to impact the forensic inpatients' interactions with other patients and access to activities and the community. For example, items that are identified in the START as strengths or risk factors, such as attitudes, substance use, social support, relationships, social skills, occupation activities, recreational activities, rule adherence and self-care, were also identified in forensic inpatient narratives as components that can support or define one's recovery.

Individuals' index offences impacted their recovery process as well. Participants described how their offending behaviour impacted relationships with their family and forensic inpatients' index offences were often stigmatized by fellow inpatients. This

speaks to forensic inpatients' need to recover both from their mental illness and the impact of their offending behaviour (Corlett & Miles, 2010; Simpson & Penney, 2011). Several participants realized that it was their mental illness which made them commit their index offences, but it was still something that they needed to resolve or come to terms with before they could move forward with their recovery.

C. To what extent do forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory?

Forensic inpatient narratives on recovery were aligned with the four central tenets of Hirschi's social bonding theory, including: (a) involvement in programs; (b) belief in the structure and rules as well as social norms; (c) attachment to other individuals, such as supportive staff, family and friends; and finally, (d) commitment to education and skills that might lead to work in the community. However, the first three themes were much more saturated in the forensic inpatients' narratives than commitment. This may be owing to the fact that forensic inpatients have limited access to conventional activities such as work or education.

Involvement

In the social bonding theory, involvement refers to being actively involved in conventional activities. Being involved in meaningful activities or hobbies is addressed as a key component to recovery in the literature (Anthony, 1993; Barsky & West, 2007; Davidson, O'Connell, et al., 2005; Jacobson & Greenley, 2001; Ridgway, 2001; Roberts & Hollins, 2007; Smith, 2000; Young & Ensing, 1999). The forensic inpatient narratives were saturated with discussion on how important involvement in programs was to them. The forensic inpatients spoke about how involvement in programs and therapies provided structure, kept them busy and gave them a sense of accomplishment. Programs also provided individuals with education that helped them on their path to recovery by learning new ways to manage their challenges. These privileges to attend meetings and be active in work programs empowered patients to feel in control with respect to their lives and their recovery.

Forensic inpatients also discussed how *not* being involved in activities hindered their recovery and promoted problematic behaviour. Although some participants identified the need to manage risk and safety for both the patients and staff, it was suggested that as soon as possible, patients, especially in the high security units, should have access to a variety of programs as it prevents them from being bored and less agitated, which may prevent deviant behaviour or getting into trouble.

Belief and Adherence to Social Norms and Rules

In relation to social bonding theory, the concept of belief refers to the extent to which an individual believes in conventional norms, morals and rules of a society and internalizes them. Individuals follow the rules because breaking them would show a lack of respect for others that they care about. The narratives about the rules and structure at the forensic mental health hospital varied. Participants did not agree with all of the rules (e.g., no smoking on hospital grounds), but it seems that many individuals agreed with the rules and believed that having them in place was for their benefit and aided in their recovery. Several of the themes that emerged from the patient narratives included believing that the rules were reasonable and made sense and provided structure, that breaking the rules were not worth the risks and that participants followed the rules in order to show respect for staff.

Several participants spoke about how they believed the rules were appropriate due to the forensic nature of the hospital. According to Hirschi, if an individual has a weakened or non-existent belief in social norms and rules, the likelihood that the individual will break them increases. In the case of several of the participants, their narratives about expectations and hospital restrictions for their behaviour suggest that they share the social values and beliefs of both other patients and staff at the hospital. For example, the forensic nature of the institution was brought up by several participants during discussions about the norms, rules and expectations of the hospital. One individual suggested that the rules might be restrictive, but that such restrictions are expected owing to the fact that they are in a forensic institution.

Rules also provided the forensic inpatients with routine and structure, which was perceived as aiding their recovery or improving one's life. Rules at the hospital, although

more restrictive than in the community, aided in internalizing normative behaviour and improved interactions with others. It appears that the external rules of the hospital can be internalized by forensic inpatients as they come to believe that adhering to conventional norms and rules aid in their recovery by providing routine and structures for interactions with other and their daily activities.

Adhering to hospital rules was also perceived by the forensic inpatients as an important component of their recovery as it prevented the loss of their privileges. Participants stated that breaking the rules led to them losing their privileges or access to the community, which decreased the speed to which they could be discharged to the community. Breaking the rules meant that the forensic inpatients might lose privileges, be relocated to a more secure unit in the hospital, or be put into seclusion.

The way in which patients weighed the risks and benefits of breaking the rules undoubtedly reflects the secure nature of a forensic mental health hospital. The participants are involuntarily detained in the hospital and may only access the community at the discretion of the hospital director who is granted authority by the Review Board to make decisions concerning visit leaves and access to the community. Although it is the Review Board which determines whether an individual is a significant threat to public safety and is inappropriate for management in the community (Eaves et al., 2000), the hospital director may make decisions concerning supervised access to the community or day leaves where the individual may enter the community alone for set periods of time. It appears from the forensic inpatient narratives that they feel that following the rules leads to receiving more privileges, and thus provides greater access to the community. By following the rules in order to avoid the negative consequences, the patients demonstrate that they value social norms and may internalize them as a means to their independence and autonomy.

The participants of this study also spoke about feelings of respect for staff and others as one of the motivating factors for adhering to conventional norms and the rules of the hospital. This may be due to feelings of personal attachment and friendship with the staff. Hirschi (2002) describes the relationship between an individual's belief and adherence to rules and bonds with others as a "more or less straightforward connection between attachment to others and belief in the moral validity of rules" (p. 29).

Participants' adherence to societal rules and expectations is likely based on their desire to show respect to others that they trust.

Attachment to Supportive Individuals

According to Hirschi's social bonding theory, attachment is the extent to which individuals have close affectional ties to others and care about their expectations because they admire and identify with them. It is attachment to others that determines an individual's adherence or violation of social norms and normative behaviour. Similarly, the literature on recovery identifies the concept as a social process which involves "rejoining the social world" (Jacobson & Greenley, 2001, p. 483). In this recovery process, larger social support networks have been correlated with their recovery, feelings of hope and perseverance towards success (Corrigan et al., 1999; Corrigan & Phelan, 2004; Hendryx et al., 2009). The participants' narratives on their experiences of recovery at the forensic mental health hospital identified social relationships with staff, friends and family as key components of support for their recovery (Smith, 2000).

Relationships with Staff

Patients at the forensic hospital have reduced access to the community, and are often limited to building relationships with other patients and staff. Many of the participants spoke about both supportive and unsupportive staff at the hospital. In other words, some staff were perceived as contributing to the forensic inpatients' personal recovery, whereas others' attitudes and behaviours were perceived as hindering the forensic inpatients' recovery. Almost all of the participants referred to staff as being, overall, supportive and caring. In contrast, participants also indicated that some staff were disengaged, uncaring, or burnt out. The majority of participants at least mentioned once throughout the interview that power differentials existed between staff and patients.

Other qualitative research done in secure forensic settings has produced similar findings (Barsky & West, 2007; Mezey et al., 2010). It is common for patients in secure forensic settings to describe staff negatively, often emphasizing feelings of power differentials and being treated like a prisoner. It is also common for some staff members to be referred to as being unengaged with patients, uncaring and only there to earn a

living (Barsky & West, 2007; Mezey et al., 2010). Just as supportive and caring staff can support an individual's recovery in a secure setting, insensitive or intolerant staff negatively impact forensic inpatients' recovery (Mezey et al., 2010).

However, despite perceiving a few staff as unsupportive, many participants spoke about connecting with certain staff members, and that a majority of the staff they interact with on a day-to-day basis were helpful, encouraging, caring and supportive. Several participants described their relationship with staff as unique and special, as more like friends than like a patient and service provider. This may reflect the forensic inpatients' desire to be more like "normal" non-forensic individuals. It has been suggested that individuals who are detained in secure forensic mental health settings place a great deal of importance on the friendships they develop within the hospital (Mezey et al., 2010). This can be attributed to being confined to the hospital for long periods of time, not having other positive or affirming relationships in the community, and connecting with others who have shared similar experiences. It is also a common theme in the literature on recovery that an individual's recovery can be fostered when someone believes in them, helps them realize their own self-worth, and provides persistent support even in the face of challenges (Kelly & Gamble, 2005).

While the participants of this study spoke positively about the many ways in which staff supported and encouraged their recovery, some interactions were also a source of stress and conflict. The most prominent theme that emerged from the narratives included the power differentials between staff and patients. Although many participants had good relationships with the service providers at the hospital, some patients described how staff had left them feeling powerless and in little control over their own lives. Another concern that the participants perceived as potentially hindering their recovery was their lack of involvement in treatment decisions. Participants spoke about being uninvolved in the treatment planning process, and not being listened to when it came to their medication dosages.

Under the British Columbia Mental Health Act, forensic inpatients can receive involuntary treatment for their mental illnesses (Eaves et al., 2000). It is the hospital director who authorizes such treatment and as long as they are under the care of the forensic mental health hospital, the patient has no option to refuse care or treatment.

The forensic inpatient narratives reflected the participants' wishes to have more input into the dosages of their medications and controlling the side effects, as opposed to having wanted to desist from using medication altogether. Feeling listened to and involved in treatment decisions is an important component to an individual's recovery. It provides the individual with input and control over their treatment as well as the management of their own symptoms (Davidson, O'Connell, et al., 2005). Procedural justice principles should be implemented in coercive treatment situations to improve long-term therapeutic outcomes (McKenna et al., 2000).

Relationships with Friends and Family

Participants in this study had mixed responses as to how their stay at the hospital had affected their relationships with friends and family. In regards to relationships with fellow patients, over a quarter of the participants spoke about their relationships at the hospital with other patients as being a source of support and acceptance, because they were all going through the same emotional and physical challenges which gave the participants a feeling of not being alone.

Relationships with peers and peer support are key factors that aid in an individual's recovery and influence changes in a patient's emotions, behaviours, and perspectives (Bouchard et al., 2010). Mutual and peer support can increase an individual's feelings of acceptance and community, while increasing hope and promoting change (Davidson et al., 1999; Johansson & Lundman, 2002; Mead & Copeland, 2000). In the secure forensic setting of this study, the patients found hope and encouragement in the interactions they had within the hospital. In a previous study, Mezey and colleagues (2010) found that a hospital provides a safe space where patients are protected from an aggressive and uncomprehending public.

Relationships with family and friends outside of the hospital were important to several participants in this study. Although the literature suggests that mental health service providers and peers may be the leading support networks for individuals living with the challenges of mental illness, family support still plays an important role (Corrigan & Phelan, 2004; Smith, 2000). Several participants spoke about the importance of having contact with their partners, children and parents.

Another barrier to the support of family and friends for inpatients in secure settings is the stigma and social isolation associated with receiving treatment services in hospital. Although participants spoke about friends and family being supportive, the distance put between them during their stay at the hospital added a stress on their relationships and their recovery. Participants of this study also spoke about their friends and family moving on without them, and not being able to maintain contact with their loved ones on a regular basis owing to geographical distance. Separation from family and friends often elicited feelings of frustration, loneliness and sadness.

From the forensic inpatient participant narratives, it seems that relationships with family were different from how they spoke about their relationships with staff and peers. Although relationships with family were mentioned as supportive, participants' stay at the hospital was viewed as a barrier to maintaining contact with family members. It is unclear whether this is because of the nature of the individual's index offence, as NCR-accused persons often offend against family members, or whether it was due to the physical distance between the hospital and the individual's family. This lack of clarification may be due to the fact that the semi-structured interview was intended to evaluate patient-centred care at the hospital, and therefore, many of the standardized measures that elicited comments from participants were worded around staff and fellow patient interactions. However, the limited role of family in an individual's journey towards recovery is consistent with the literature that has examined the role of social support networks. Research has found that peer and professional supportive social networks are more associated with improved recovery than family support (Corrigan & Phelan, 2004; Smith, 2000). This does not mean that family supports are unimportant in an individual's recovery, but instead it may reflect the circumstance that friendships and mental health professional networks have more "relative plasticity" and can expand and grow more than an individual's family network (Corrigan & Phelan, 2004, p. 521). In relation to the forensic inpatient narratives indicating more staff and peer support in secure settings, this may be the result of the continuity of contact that staff and fellow patients have, which may make them more dominant in patient narratives on recovery than family members.

There is a great amount of stigma associated with mental illness and forensic services. Recovery for forensic patients must extend beyond recovering solely from the

effects of their mental illness, but also from the impacts of their offending behaviour. Participants of this study spoke about how their mental illness and index offences negatively affected their relationships with family and interactions in the community.

Commitment

Of the four components to social bonding theory, commitment was the least saturated in the forensic inpatient narratives. Commitment is the extent to which an individual has invested time and energy into participating in conventional activities (occupational or academic) and lifestyles. An individual obeys rules and norms of society in order to avoid the negative costs of engaging in deviant or socially unacceptable behaviour: the stronger the bond to conventional activities and lifestyles, the less likely an individual would risk their hard-earned efforts pursuing conventional activities by behaving in a deviant manner.

As discussed, involvement in programs and activities was important for the study participants as it gave them the opportunity to engage in meaningful activities, build connections with others and contend with boredom. Committing and dedicating their time and energy to learning new skills was viewed as a way to connect with the community, both inside and outside of the hospital, as well as a means to an end in their quest for autonomy.

Participants placed importance on the time and energy that they dedicated to learning vocational skills. Research indicates that engaging people with mental illness in activities that are both satisfying and fulfilling contributes toward building self-esteem and confidence, supporting recovery (Anthony, 1993; Jacobson & Greenley, 2001; Roberts & Hollins, 2007). Providing programs that teach people skills that they can then apply in the community opens doors for their recovery and their successful return to the community.

The reason why this element of social bonding theory was less saturated in the data than the other components of social bonding theory may be because of the restricted and controlled access forensic inpatients have to conventional activities such as work or school. Although programs do exist for forensic inpatients to access school or work both within the hospital and in the community, it all depends on the forensic

inpatient's privilege level. This fact may influence the extent to which forensic inpatients can meaningfully commit to conventional activities, and is reflected in the narratives where the participants spoke to adhering to hospital rules in order to not regress in their privileges. As listed in the above section on Belief, the potential consequences of breaking rules was identified by the participants as a motivating factor for adhering to the rules and norms of the hospital. This suggests that many of the participants consider the risks associated with engaging in deviant behaviour (i.e., fights or drugs) prior to breaking hospital rules or norms.

How Social Bonding Theory did not Explain Recovery

Although social bonding theory could be used to explain many components of the forensic inpatients' narratives and understanding of recovery, it did not perfectly describe all of the themes that emerged from the interviews. Similarly, the theory was too simple in its separation of elements. In the narratives, recovery was identified as a complex phenomenon that involved the integration of involvement, belief and attachments. Although Hirschi does speak of how attachment and commitment, commitment and involvement, and attachment and belief are all related components of the theory that vary together, he did not empirically analyze the relationships between the four elements of his theory, and therefore does not explore the possibility that the four components of the theory may work together to explain delinquency (Empey, 1978, as cited in Wiatrowski et al., 1981). For example, the forensic inpatient narratives suggest that their belief in and adherence to the rules is greatly related to their involvement in activities (and the potential of losing such privileges and freedoms).

Although belief was a significant component of forensic inpatients' adherence to norms and rules in the forensic mental health hospital, it was not strongly related to the literature of recovery. Social bonding theory could also not explain the forensic inpatients' narratives on length of stay at the hospital. A subsample of the participants identified staying too long at the hospital as an impediment to their recovery. The recovery literature speaks to the negative impacts of long-term institutionalization on elements of recovery that may cause feelings such as hopelessness and helplessness (Hillbrand et al., 2010). Feelings of hopelessness and despair were reflected in the participants' narratives if they felt they had been in the system for too long, or had

committed too serious of an index offence and therefore were unlikely to ever be let out. At the same time that some forensic inpatients felt that they had been in hospital too long, other participants identified time as a factor that benefited their recovery as one needs time to recover.

Social bonding theory is only a sociological perspective that explains normative behaviour and deviance. Therefore, it can only provide a sociological examination of recovery and does not attend to other components such as the success of medication adherence and other psychological interventions that may aid in an individual's journey of recovery in a forensic mental health setting.

D. What are the current strengths of a forensic mental health hospital and what are the areas that could be improved to aid in forensic inpatients' recovery?

The participants in this study identified several core strengths to the care that they received at the hospital as aiding their recovery such as involvement in activities, supportive staff and peers, and rules and structure which provided healthy routines. Involvement in a diversity of programs, such as school and the workshop were identified as key components that facilitated forensic inpatients' recovery by providing meaningful activities which enhance their skills to return to the community. Relationships with peers and staff at the hospital were viewed as helpful, encouraging, caring and supportive. Building friendships between forensic inpatients and staff may aid in the inpatients' recovery through providing role models and positive support that encourage change.

Rules were also perceived as helpful in the forensic inpatients' recovery, as they were perceived to provide structure that not only promoted daily routines in the forensic inpatients' lives but also aided in internalizing normative behaviours and keeping the hospital inpatients, staff and community safe. Although the forensic inpatients did not agree with all of the rules and did not want to lose their privileges, the participants recognized the importance of managing risk and the need to limit access to certain activities at times.

In consideration of the need to manage risk, participants identified the need for forensic inpatients to have access to activities as soon as it is safe and possible. Several of the participants identified the need for more activities on the secure units of the hospital, as they felt that having nothing to do promoted problematic behaviours. As activities are also a way to build connections with staff and peers, providing safe programs for individuals on the secure units may improve the speed to which an individual begins to work on their recovery by providing conventional activities to occupy an individual's time.

Additionally, interactions with staff that were negative also were perceived to hinder an individual's recovery. To improve attachment to others, staff must be more aware of how their actions are perceived by forensic inpatients. Not only did some of the forensic inpatients feel that staff were inconsiderate towards their mental illness, the participants discussed the power differentials and feeling uninvolved in their treatment decisions. Although medications and treatment are mandated under the *British Columbia Mental Health Act*, forensic inpatients should be involved in the discussion of treatment so that they feel empowered in the decisions that shape their lives.

Summary

The data analysis of the qualitative interviews with forensic inpatients revealed that forensic inpatients' narratives around recovery are similar to conventional understandings of recovery in the literature. Three main themes emerged around recovery, which included: reintegration, normative behaviour and abstinence from drugs and alcohol.

In relation to whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients, the participants' narratives suggest that the forensic mental health settings influence how the forensic inpatients define recovery. Safe community reintegration, a return to "normal" behaviour, and abstinence from drugs and alcohol appear to be more emphasized than in non-forensic inpatient populations.

As to the extent to which social bonding theory may be used to understand recovery in a forensic mental health setting, the forensic inpatient narratives on recovery were aligned with the four central tenets of Hirschi's social bonding theory, including: (a) involvement in programs; (b) belief in the structure and rules as well as social norms; (c) attachment to other individuals, such as supportive staff, family and friends; and finally, (d) commitment to education and skills that might lead to work in the community. However, the first three themes were much more saturated in the forensic inpatients' narratives than commitment. This may be owing to the fact that forensic inpatients have limited access to conventional activities such as work or education. The theory also does not speak to the effect of time as perceived by forensic inpatients, as long stays in the forensic mental health hospital led to feelings of hopelessness.

Lastly, the participants in this study identified several core strengths to the care that they received at the hospital as aiding their recovery such as involvement in activities, supportive staff and peers, and rules and structure which provided health routines. Lack of involvement in activities in the more secure units and negative interactions with staff where the forensic inpatients felt like they were not being listened to or felt like they were being jailed as opposed to hospitalized also impacted their experiences of recovery.

Chapter 7.

Conclusion

Both the recovery framework and social bonding theory address the importance of social relationships in developing and supporting normative behaviour. The specific aims of this research study were to: (a) to understand the perspectives of patients on recovery at the BC FPH; (b) to investigate whether conventional conceptualizations of recovery coincide with how it is perceived by forensic mental health inpatients; (c) to examine the extent to which forensic mental health inpatients' understandings of recovery reflect the elements of social bonding theory; and (d) to identify the strengths of a forensic mental health hospital as well as the areas that patients believe could be improved in order to make their recovery experience more successful.

Forensic mental health inpatients identified reintegration, normative behaviour and abstinence from drugs and alcohol as what recovery meant to them. Although this is similar to the current understandings of recovery in the literature, the forensic inpatient narratives highlighted the internalization of the many rules and procedures of a secure forensic setting's mandate, as reintegrating into the community safely and to be "normal" and like others were very dominant in the forensic inpatient narratives. This may reflect the fact that the individuals are in the forensic system as result of conflicts with the law and involvement in the legal system.

The findings of this study also suggest that strengthening social bonds in a forensic hospital may benefit recovery. In accordance with social bonding theory, participants spoke of supportive relationships with staff and peers, involvement in activities, and adherence to hospital rules as components as important components which aid in their recovery at the hospital. Although other factors such as medication and education about their illness were identified as important contributors to an individual's recovery, participants also discussed the importance of supportive relationships,

involvement in activities, and the routine provided by structure and rules. Participants' responses reflected several components to recovery spoken about in the literature such as having meaningful activities (Anthony, 1993; Barsky & West, 2007; Davidson, O'Connell, et al., 2005; Jacobson & Greenley, 2001; Ridgway, 2001; Roberts & Hollins, 2007; Smith, 2000; SAMHSA, 2011; Young & Ensing, 1999), attachment to supportive staff and peers who promote feelings of hope and encouragement (Corrigan et al., 1999; Corrigan & Phelan, 2004; Davidson et al., 1999; Hendryx et al., 2009; Kelly & Gamble, 2005, p. 249; Mead & Copeland, 2000; MHCC, 2009; SAMHSA, 2011) and the importance of structure and routine in their daily activities (Smith, 2000). Similarly, the findings of this study complement the MHCC's strategic direction to transform and improve mental health services across Canada, which specify the need to offer diverse social supports and engagement of individuals living with mental illness.

The findings of this study suggest that supporting and building social bonds for inpatients in forensic settings can be beneficial to their recovery and the promotion of normative behaviour. The narratives highlighted several strengths of the services that are provided at the forensic hospital. Patients indicated that current programs and activities are meaningful and aid in their recovery. Likewise, several patients discussed a strong attachment to supportive staff and an appreciation for the hospital as it supports them through their recovery in a forensic mental health setting.

The patient narratives also reflected areas for strengthening recovery-oriented care at the hospital. Involvement in meaningful activities promotes social behaviour, and participants in this study identified programs and hobbies as an effective method to keep them engaged, occupied and out of trouble. Forensic mental health hospitals must balance safety concerns with recovery—a concept that several participants in this study recognized. Therefore, providing meaningful programs and activities as soon as safely possible is an important step to support forensic inpatients' recovery. Participants also spoke of reintegration into the community, as well as work programs as other factors were viewed as constituting positive components of their recovery.

Participants in this study discussed the importance of rules, structure and routine in their daily lives. Although participants indicated that they may not agree with all of the rules they were required to follow at the hospital, overall, they found them to be

reasonable and they followed them because doing so aided in their progression through the hospital, and therefore through their recovery. They also discussed how following rules was a way to show respect for the supports provided by service providers and the hospital.

A motivating factor for participants adhering to hospital rules and expectations was related to their desire to not move back in the progression of their recovery and their journey through the hospital. Commitment to meaningful activities, an individual's freedom (i.e., staying in the open units and not being put into seclusion) and maintaining their privileges were all important motivations for participants to follow the rules, as the risks of losing their privileges and activities often outweighed any benefit of breaking the rules.

Finally, participants spoke at great length about the importance of supportive, encouraging and positive attachments to staff, peers and family in their journey of recovery. Although the participants identified unsupportive, patronizing staff as an impediment to their recovery, positive relationships with select staff gave patients hope, encouragement, and support in their recovery from both mental illness and the impacts of their offending behaviour. A hospital environment that promotes an atmosphere in which patients feel that they are being listened to, cared for and respected by staff helps to build their feeling of self-worth and determination not to give up in the face of challenges. Promoting respect between patients and staff may also aid in encouraging patients to adhere to hospital rules, as some participants mentioned that they do not like to break them because they do not want to show disrespect for the staff that care and support them.

Strengths and Limitations

There are several methodological limitations to this thesis. Patients self-selected to participate in this research project, and although advertisements and recruitment posters were thoroughly distributed throughout the hospital, it is possible that the more engaged eligible patients signed up to participate, thereby potentially biasing the interviews toward more empowered and engaged patient narratives.

The contextual nature of this study must also be considered (Kuper, Lingard, & Levinson, 2008). When assessing this research and considering the transferability of the findings to other contexts, one must remember the unique circumstances of the forensic mental health setting in this study. For example, this study examined perspectives of forensic inpatients in both low and secure units in British Columbia, Canada. If this study looked at the perspectives of recovery from participants in other secure settings elsewhere, the responses may have been different.

Owing to limited time and resources, the author was unable to employ triangulation to allow for cross-comparison of the results. Only the author of this study coded and identified themes from the qualitative data. If this study were to be replicated, it would be beneficial to include multiple coders in order to reduce investigator bias and to ensure interrater reliability. While the author was not able to use triangulation or to enlist the services of more than one coder, there were several methods employed to ensure the quality of the research analysis such as consulting with experienced qualitative researchers during the coding process and reporting the preliminary findings back to participants.

As this study examined self-report data collected through interviews with individuals receiving treatment services in a forensic hospital, the findings are based on the personal experiences and perspectives of the participants and may not take into account other factors that would influence their interpretation of the circumstances. Tong and colleagues (2007) suggest returning transcripts to participants to allow for comments and corrections on information they may not agree is represented accurately, but this was not a possibility in this study due to the confidential nature of the hospital setting. Printed copies of the transcript could not be distributed to participants at the risk of breaking confidentiality. In order to counter this concern, member checking was employed with a subset of the participants early on in the data analysis.

As the original data was collected in a mixed-method interview, gathering the quantitative data was a lengthy process that took up a majority of the interview and was prioritized at the cost of the depth of qualitative data that could be collected from the participants. Future research could involve examining quantitative and objective

measures using scales of recovery and social bonding theory to further examine the relationship between the two constructs.

Finally, this thesis also only explored the sociological factors towards recovery and did not look at the impact of other factors that may improve an individual's recovery. This thesis was also unable to complete a gendered analysis of the forensic inpatient perspectives and experiences. The female participants varied greatly in age, most were single or divorced, and only two participants mentioned their children in the interviews: therefore there were no common themes found in their narratives specific to their gender. Additionally, analysis based on gender in such a small study in a contained population would risk the possibility of participants being identified. Future studies may want to employ intersectionality to examine the role of gender in perspectives on recovery in a forensic mental health setting.

To conclude, this study's findings suggest that social bonds are an important component of the participant's personal recovery in living with mental illness. Social bonding manifested through relationships with staff and peers, involvement in activities and programs, and adherence to hospital rules, and was identified by participants as having improved the prospects for their recovery and as having provided them with sound reasons for adhering to normative rules and expectations. Therefore, supporting and building social bonds for inpatients in forensic settings is clearly very beneficial both to recovery and to the promotion of normative behaviour.

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Appendices

Appendix A.

Patient Participant Recruitment Poster



PATIENT-CENTRED CARE IN THE BC FORENSIC PSYCHIATRIC HOSPITAL: A RESEARCH STUDY

How do you feel about the care you receive at this hospital?

- *Are the services consistent with your needs and preferences?*
- *Do the services make you feel engaged and empowered?*

Tell us about your experience!

We would like to invite you to participate in a research study on patient-centred care at the BC Forensic Psychiatric Hospital. Your participation will include answering questions about your care experience at FPH in two 90 minute, confidential interviews. You will receive **\$10** for participating in each interview. Please note that your psychiatrist will be contacted to approve your participation in the study. Contact Alicia for more information: 604.524.7768.

Funding provided by the Canadian Health Services Research Foundation.

Patient Version 1.0

07MAR11

Patient-Centred Care
Contact Alicia for Info
604.524.7768

Appendix B.

Patient Participant Consent Form



PATIENT PARTICIPANT INFORMATION AND CONSENT FORM

Patient-Centred Care in the BC Forensic Psychiatric Hospital: An Exploratory Study

Principal Investigator:

Johann Brink
BC Mental Health & Addiction Services
University of British Columbia
604.524.7700

Co-Investigator:

Jamie Livingston
BC Mental Health & Addiction Services
604.524.7725

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine the concept of 'patient-centred care' within the context of the BC Forensic Psychiatric Hospital (FPH). Patient-centred care is an approach to providing health care that is personalized to meet a patient's individual needs and is consistent with their preferences in order to engage and empower them in their own recovery.

WHO IS CONDUCTING THE STUDY?

The study is being conducted by researchers from the BC Mental Health & Addiction Services and the University of British Columbia. The study is funded by the Canadian Health Services Research Foundation.

WHO CAN PARTICIPATE IN THE STUDY?

You can participate in the study if you: (1) are at least 19 years of age; (2) can speak and understand English; (3) are diagnosed with a mental illness; (4) are receiving treatment services for at least one month at the BC Forensic Psychiatric Hospital; and (5) have been approved by your psychiatrist to be part of this study.

WHAT DOES THE STUDY INVOLVE?

This study involves taking part in two in-person interviews that will each take approximately 90 minutes to complete. The first interview will take place as soon as you agree to participate in this study. The second interview will take place approximately 9 months later or prior to your hospital discharge (which ever comes first). As part of this interview, you will be asked questions about your experiences and perspectives of patient-centred care at the BC Forensic Psychiatric Hospital.

WHAT ARE THE BENEFITS OF PARTICIPATING?

At the end of each interview, you will receive \$10 for your participation. From participating in this study, you may enjoy telling us about your experiences and being part of a study that listens to your views in order to help others. There are no other direct benefits to you from participating in this study.

WHAT ARE THE POSSIBLE HARMS OF PARTICIPATING?

While there are no serious risks associated with participating in this study, it is possible that you may experience some emotional distress or discomfort disclosing your attitudes, feelings, and beliefs regarding your experiences of patient-centred care within the BC Forensic Psychiatric Hospital.

DO I HAVE TO PARTICIPATE IN THIS STUDY?

Your participation in this study is entirely voluntary. If you want to participate, you will be asked to sign this form. If you do not wish to participate, you do not have to provide any reason for your decision and you will not lose the benefit of any medical care to which you are entitled or are presently receiving.

You may decline to answer questions or withdraw from this study at any time. There will be no penalty or loss of benefits to which you are otherwise entitled, and your future mental health treatment or services will not be affected. The study investigators may decide to discontinue the study, or withdraw you from the study, at any time, if they feel that it is in your best interest not to continue.

WILL INFORMATION THAT I PROVIDE IN THIS STUDY BE KEPT CONFIDENTIAL?

Information that we gather for this study will be kept strictly confidential to the full extent permitted by law. Only authorized members of the research team will have access to your personal information. All study documents will be stored in a locked office at the BC Forensic Psychiatric Hospital. All computer-stored information will be password protected. No participants will be individually identified in reports, papers, or presentations of this study without your explicit written permission.

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

WHAT WILL HAPPEN TO THE INFORMATION GATHERED IN THIS STUDY?

Information is being collected in order to produce a report that will be distributed and presented to academic, professional, or community audiences. Additional written academic articles will also be produced from this information. As a participant in this study, you will receive a written summary of the research findings upon completion of the project.

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, please contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598, or, if long distance, e-mail to RSIL@ors.ubc.ca. If you have any questions or desire further information about this study, please contact Alicia Nijdam-Jones at 604.525.7768.

FUTURE RESEARCH PARTICIPATION

It is possible that we would like to get in touch with you again later to ask if you want to participate in other research related to this project. Your participation in this study does not mean you have to participate in other research studies, and you may change your mind about participating or not in these future studies at any time. The information you provide on this form regarding your interest in being contacted about participating in future studies related to this project will be retained only until the completion date for this study (i.e., December 31, 2012).

Please indicate below whether or not you want to be contacted for future research:

- YES, I wish to be contacted about participating in other research studies**
- NO, I do not wish to be contacted about participating in other research studies**

CONSENT TO PARTICIPATE

**Patient-Centred Care in the BC Forensic Psychiatric Hospital:
An Exploratory Study**

My signature on this form means that I was given a copy of this consent form that tells me about what will happen in the study, the risks and benefits of the study, that I have been given enough time to think about the information, and that I voluntarily agree to participate in the study. I understand that I do not have to participate and can leave the study at any time without any consequences to me or the mental health services that I receive. The consent form has been reviewed with me and I have had the opportunity to ask questions.

Participant printed name	Participant signature	Date
Investigator/Designate printed name	Investigator/Designate signature	Date

Appendix C.

Psychiatrist Approval Form



PSYCHIATRIST APPROVAL FORM

Patient-Centred Care in the BC Forensic Psychiatric Hospital: An Exploratory Study

Principal Investigator:

Johann Brink
BC Mental Health & Addiction Services
University of British Columbia
604.524.7700

Co-Investigator:

Jamie Livingston
BC Mental Health & Addiction Services
604.524.7725

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine the concept of 'patient-centred care' within the context of the BC Forensic Psychiatric Hospital. Patient-centred care is an approach to providing health care that is personalized to meet a patient's individual needs and is consistent with their preferences in order to engage and empower them in their own recovery.

WHO IS CONDUCTING THE STUDY?

The study is being conducted by researchers from the BC Mental Health & Addiction Services and the University of British Columbia. The study is funded by the Canadian Health Services Research Foundation.

WHAT DOES THE STUDY INVOLVE?

In this study, participants who are receiving treatment services at the BC Forensic Psychiatric Hospital will take part in two in-person interviews (9 months apart) that will each take approximately 90 minutes to complete. During the interview, participants will be asked questions about their experiences and perspectives of patient-centred care at the BC Forensic Psychiatric Hospital. Individuals will receive \$10 for each interview in which they participate.

WHAT ARE THE POSSIBLE HARMS OF PARTICIPATING?

There are no serious risks associated with participating in this study. It is possible that participants may experience some emotional distress or discomfort disclosing their attitudes, feelings, and beliefs regarding their experiences within the BC Forensic Psychiatric Hospital. To minimize this risk, participants will be informed that (1) participation in this study is voluntary; (2) they do not have to participate in parts of the interview about which they feel uncomfortable; and (3) they may withdraw from the study at any time. They will further be informed that declining to answer certain questions or withdrawing from the study will not have

Appendix D.

Patient Interview Guide

STUDY ID: INTERVIEW DATE: START TIME:

INTRODUCTION

During this interview, I'm going to ask you some questions about your experiences at the BC Forensic Psychiatric Hospital. I'll start by asking you questions about yourself, and then you'll be asked several general questions about your experiences at the hospital. Do you have any questions before we begin?

A. BACKGROUND INFORMATION

SOCIODEMOGRAPHIC INFORMATION

1. What is your gender? *(circle one)*
 - 1 Male
 - 2 Female
 - 99 Declined

2. What is your date of birth? *(dd/mm/yy)* _____

3. Were you born in Canada? *(circle one)*
 - 1 Yes
 - 2 No *(specify)* _____
 - 99 Declined

4. What is the primary ethnicity or culture that you identify with? *(circle one)*
 - 1 Aboriginal *(e.g., Inuit, First Nations, Metis)*
 - 2 Asian *(e.g., China, Japan, Korea, Malaysia, Philippines, Vietnam, India, Pakistan)*
 - 3 Black *(e.g., Canadian, American, Africa, Caribbean)*
 - 4 Latin American *(e.g., Argentina, Chile, Brazil)*
 - 5 Middle Eastern *(e.g., Egypt, Iran, Israel, Afghanistan)*
 - 6 White *(e.g., Canadian, American, European)*
 - 7 Mixed background *(specify)* _____
 - 8 Other *(specify)* _____
 - 99 Declined

5. Is English your primary language? *(circle one)*
 - 1 Yes
 - 2 No *(specify)* _____
 - 99 Declined

6. Did you graduate from high school or obtain a GED? *(circle one)*
 - 1 Yes
 - 2 No
 - 99 Declined

7. Did you attend college or university? *(circle one)*
- 1 Some college, did not complete
 - 2 College graduate
 - 3 Some university, did not complete
 - 4 University graduate
 - 5 No
 - 99 Declined

PSYCHIATRIC INFORMATION

8. What is your current mental health diagnosis?
- 1 Schizophrenia
 - 2 Schizoaffective Disorder
 - 3 Bipolar Disorder
 - 99 Other _____
9. Do you have a history of problematic alcohol or drug use? *(circle one)*
- 1 Yes
 - 2 No
 - 99 Declined
10. How old were you when you were first diagnosed with a mental illness by a professional? _____ yrs
11. In your lifetime, how many times have you been admitted to the BC FPH? _____
12. How long has your most recent stay been at the BC FPH? (# months) _____

SERVICE INVOLVEMENT INFORMATION

13. In the past year, have you been involved in any programs at the BC FPH that focus on empowering patients to take the lead on the services and supports they receive? *For example, peer support program, the Patient Advisory Committee, Team P.E.E.R., unit based community meetings, peer mentoring at the woodshop, etc.*
- 1 Yes
 - 2 No
 - 99 Declined/unknown

IF 'Yes':

Indicate program name

B. PATIENT-CENTRED CARE

Now I'm going to ask you to describe your experiences with, and perceptions of, patient-centred care at FPH. By 'patient-centred care', I mean the way in which services are personalized to meet your individual needs and are consistent with your preferences. 'Patient-centred care' also refers to the therapeutic qualities of an environment that promote and support wellness and recovery.

1. Do you feel that your choices and preferences regarding treatment decisions are valued and taken into account by the people who provide care at the BC FPH? *[Prompt – Input sought and listened to with respect to defining your care needs; Making health care treatment decisions; Selecting and implementing treatments]*

- 1 Yes
- 2 No
- 99 Declined/unsure

If 'Yes', please explain why and how? (describe examples) If 'No', please explain why not (describe examples)?

2. In what ways do you think that the BC FPH does a good job at involving patients in the services and supports they receive? Describe and provide examples. *[Prompt – Respecting and listening to you; Courteous and supportive staff; Shared decision making; Getting needed information; Self care management and support; Receive education and support to take an active role in managing your own illness and take care of yourself]*

3. In what ways do you think that the BC FPH does a poor job at involving patients in the services and supports they receive? Describe and provide examples. *[Prompt – Respecting and listening to you; Courteous and supportive staff; Shared decision making; Getting needed information; Self care management and support]*

4. What are your recommendations for improving patient involvement and participation in services and supports at the BC FPH? Describe and provide examples.

C. PATIENT ENGAGEMENT

SINGH O'BRIEN LEVEL OF ENGAGEMENT SCALE¹

I am now going to ask you questions about your perception of the services you have received, or are receiving, at the BC Forensic Psychiatric Hospital. Please rate from 0 to 10 your agreement with the following statements.

	Not at all										Entirely
1. I attend all appointments with the members of my treatment team	0	1	2	3	4	5	6	7	8	9	10
2. I need to see the members of my treatment team regularly.	0	1	2	3	4	5	6	7	8	9	10
3. I find seeing the members of my treatment team helpful. <i>Please tell me more about why you find seeing members of your treatment team helpful or unhelpful.</i>	0	1	2	3	4	5	6	7	8	9	10
4. I need to be involved with mental health services.	0	1	2	3	4	5	6	7	8	9	10
5. I have benefited from mental health services. <i>Please tell me more about why you feel that you have or have not benefited from mental health services.</i>	0	1	2	3	4	5	6	7	8	9	10
6. I have a mental health problem.	0	1	2	3	4	5	6	7	8	9	10
7. I find my psychiatrist helpful.	0	1	2	3	4	5	6	7	8	9	10
8. I need to take psychiatric medication.	0	1	2	3	4	5	6	7	8	9	10
9. I find psychiatric medication helpful.	0	1	2	3	4	5	6	7	8	9	10
10. I always take my medication.	0	1	2	3	4	5	6	7	8	9	10
11. I feel I get enough practical support from mental health services.	0	1	2	3	4	5	6	7	8	9	10
12. I feel I get enough emotional support from mental health services.	0	1	2	3	4	5	6	7	8	9	10
13. I can cope by myself without contact from mental health services. ²	0	1	2	3	4	5	6	7	8	9	10
14. Admissions to hospital have been helpful.	0	1	2	3	4	5	6	7	8	9	10
15. I feel listened to by health professionals.	0	1	2	3	4	5	6	7	8	9	10
16. I can get help from mental health services when I need it.	0	1	2	3	4	5	6	7	8	9	10

¹ O'Brien, A., White, S., Fahmy, R., & Singh, S. P. (2009). The development and validation of the SOLES, a new scale measuring engagement with mental health services in people with psychosis. *Journal of Mental Health, 18*, 510-522.

² The score on question 13 is reverse scored.

D. PATIENT EMPOWERMENT

MAKING DECISIONS EMPOWERMENT SCALE³

Now I am going to read you several statements relating to one's view about life and having to make decisions. As I read each statement, please think about how you are feeling now and rate your level of agreement or disagreement.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I can pretty much determine what will happen in my life.	1	2	3	4
2. People are limited only by what they think is possible.	1	2	3	4
3. People have more power if they join together as a group.	1	2	3	4
4. Getting angry about something never helps.	4	3	2	1
5. I have a positive attitude toward myself.	1	2	3	4
6. I am usually confident about the decisions I make.	1	2	3	4
7. People have no right to get angry just because they don't like something. (<i>Explain without double negative</i>)	4	3	2	1
8. Most of the misfortunes in my life were due to bad luck.	4	3	2	1
9. I see myself as a capable person.	1	2	3	4
10. Making waves never gets you anywhere.	4	3	2	1
11. People working together can have an effect on their community.	1	2	3	4
12. I am often able to overcome barriers.	1	2	3	4
13. I am generally optimistic about the future.	1	2	3	4
14. When I make plans, I am almost certain to make them work.	1	2	3	4
15. Getting angry about something is often the first step toward changing it.	1	2	3	4
16. Usually I feel alone.	4	3	2	1
17. Experts are in the best position to decide what people should do or learn.	4	3	2	1
18. I am able to do things as well as most other people.	1	2	3	4
19. I generally accomplish what I set out to do.	1	2	3	4
20. People should try to live their lives the way they want to.	1	2	3	4
21. You can't fight the decisions made by hospital management.	4	3	2	1
22. I feel powerless most of the time.	4	3	2	1
23. When I am unsure about something, I usually go along with the rest of the group.	4	3	2	1
24. I feel I am a person of worth, at least on an equal basis with others.	1	2	3	4
25. People have a right to make their own decisions, even if they are bad ones.	1	2	3	4
26. I feel I have a number of good qualities.	1	2	3	4
27. Very often a problem can be solved by taking action.	1	2	3	4
28. Working with others in my community can help to change things for the better.	1	2	3	4

³ Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services*, 48, 1042-1047. (Response options have been reversed to provide consistency with other measures).

E. RECOVERY

1. Please describe, in your own words, what "recovery" means to you. *[Prompt – wellness, hope, self-determination, empowerment, personhood not pathology, ability - A way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness]*

RECOVERY SELF ASSESSMENT – REVISED: PERSON IN RECOVERY VERSION⁴

For the following statements, please think about the services that you are receiving at FPH and rate your level of agreement or disagreement.

	Strongly Disagree				Strongly Agree	N/A	Don't Know
2. Staff welcome me and help me feel comfortable in this hospital.	1	2	3	4	5	N/A	D/K
3. The physical space of this hospital (e.g., the units etc.) feels inviting and dignified.	1	2	3	4	5	N/A	D/K
4. Staff encourage me to have hope and high expectations for myself and my recovery. <i>Please tell me more about why you feel that staff do or do not encourage you to have hope and high expectations for yourself and your recovery.</i>	1	2	3	4	5	N/A	D/K
5. I can change my clinician or case manager if I want to.	1	2	3	4	5	N/A	D/K
6. I can easily access my treatment records if I want to.	1	2	3	4	5	N/A	D/K
7. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.	1	2	3	4	5	N/A	D/K
8. Staff believe that I can recover.	1	2	3	4	5	N/A	D/K
9. Staff believe that I have the ability to manage my own symptoms.	1	2	3	4	5	N/A	D/K
10. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	1	2	3	4	5	N/A	D/K
11. Staff listen to me and respect my decisions about my treatment and care.	1	2	3	4	5	N/A	D/K
12. Staff regularly ask me about my interests and the things I would like to do in the community.	1	2	3	4	5	N/A	D/K
13. Staff encourage me to take risks and try new things.	1	2	3	4	5	N/A	D/K

⁴ O'Connell, M., Tondora, J., Kidd, S., Stayner, D., Hawkins, K., & Davidson, L. (2007). *Recovery Self-Assessment*. Retrieved, December 7, 2010 from http://www.yale.edu/PRCH/tools/rec_selfassessment.html

	Strongly Disagree				Strongly Agree	N/A	Don't Know
14. This hospital offers specific services that fit my unique culture and life experiences.	1	2	3	4	5	N/A	D/K
15. I am given opportunities to discuss my spiritual needs and interests when I wish.	1	2	3	4	5	N/A	D/K
16. I am given opportunities to discuss my sexual needs and interests when I wish.	1	2	3	4	5	N/A	D/K
17. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	1	2	3	4	5	N/A	D/K
18. Staff help me to find jobs.	1	2	3	4	5	N/A	D/K
19. Staff help me to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.	1	2	3	4	5	N/A	D/K
20. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).	1	2	3	4	5	N/A	D/K
21. Staff introduce me to people in recovery who can serve as role models or mentors.	1	2	3	4	5	N/A	D/K
22. Staff offer to help me connect with self-help, peer support, or consumer advocacy groups and programs.	1	2	3	4	5	N/A	D/K
23. Staff help me to find ways to give back to my community, (i.e., volunteering, community services).	1	2	3	4	5	N/A	D/K
24. I am encouraged to help staff with the development of new groups, programs, or services.	1	2	3	4	5	N/A	D/K
25. I am encouraged to be involved in the evaluation of this hospital's services and service providers.	1	2	3	4	5	N/A	D/K
26. I am encouraged to attend agency advisory boards and/or management meetings if I want.	1	2	3	4	5	N/A	D/K
27. Staff talk with me about what it would take to complete or exit this hospital.	1	2	3	4	5	N/A	D/K
28. Staff help me keep track of the progress I am making towards my personal goals.	1	2	3	4	5	N/A	D/K
29. Staff work hard to help me fulfill my personal goals.	1	2	3	4	5	N/A	D/K
30. I am/can be involved with staff trainings and education programs at this hospital.	1	2	3	4	5	N/A	D/K
31. Staff listen, and respond, to my cultural experiences, interests, and concerns.	1	2	3	4	5	N/A	D/K
32. Staff are knowledgeable about special interest groups and activities in the community.	1	2	3	4	5	N/A	D/K
33. Staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	1	2	3	4	5	N/A	D/K

MENTAL HEALTH RECOVERY MEASURE⁵

Now I am going to read you several statements relating to your views about life and having to make decisions. As I read each statement, please think about how you are feeling now and rate your level of agreement or disagreement.

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
34. I work hard towards my mental health recovery.	0	1	2	3	4
35. Even though there are hard days, things are improving for me.	0	1	2	3	4
36. I ask for help when I am not feeling well.	0	1	2	3	4
37. I take risks to move forward with my recovery.*	0	1	2	3	4
38. I believe in myself.	0	1	2	3	4
39. I have control over my mental health problems.	0	1	2	3	4
40. I am in control of my life.*	0	1	2	3	4
41. I socialize and make friends.	0	1	2	3	4
42. Every day is a new opportunity for learning.	0	1	2	3	4
43. I still grow and change in positive ways despite my mental health problems.	0	1	2	3	4
44. Even though I may still have problems, I value myself as a person of worth.	0	1	2	3	4
45. I understand myself and have a good sense of who I am.	0	1	2	3	4
46. I eat nutritious meals everyday.	0	1	2	3	4
47. I go out and participate in enjoyable activities every week.	0	1	2	3	4
48. I make the effort to get to know other people.	0	1	2	3	4
49. I am comfortable with my use of prescribed medications.	0	1	2	3	4
50. I feel good about myself.	0	1	2	3	4
51. The way I think about things helps me to achieve my goals.	0	1	2	3	4
52. My life is pretty normal.	0	1	2	3	4
53. I feel at peace with myself.	0	1	2	3	4
54. I maintain a positive attitude for weeks at a time.	0	1	2	3	4
55. My quality of life will get better in the future.	0	1	2	3	4
56. Every day that I get up, I do something productive.	0	1	2	3	4
57. I am making progress towards my goals.	0	1	2	3	4
58. When I am feeling low, my religious faith or spirituality helps me feel better.	0	1	2	3	4
59. My religious faith or spirituality supports my recovery.	0	1	2	3	4
60. I advocate for the rights of myself and others with mental health problems.	0	1	2	3	4
61. I engage in work or other activities that enrich myself and the world around me.	0	1	2	3	4
<i>Please tell me more about why you do or do not engage in work or other activities that enrich yourself & the world around you.</i>					

⁵ The MHRM[®] was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
62. I cope effectively with stigma associated with having a mental health problem.	0	1	2	3	4
63. I have enough money to spend on extra things or activities that enrich my life.	0	1	2	3	4

64. What has helped you with your recovery at FPH? (*Probes: programs; relationships*) What has interfered in your recovery at FPH?

65. How has staying at FPH affected your relationships? (*Probe: relationships outside of the hospital; relationships within the hospital; positive relationships; negative relationships*) How has this affected your recovery?

66. How has staying at FPH affected your views around recovery? [*Prompt – concept of recovery, attitudes and behaviours*] How and why do you think your attitude and behavior has changed?

67. How do you feel about the rules you are expected to follow during your stay at FPH? What affect do these rules have on your recovery?

68. Can you tell me some reasons that you choose to follow the rules at FPH? (e.g. getting in trouble; what others might think; to get out of hospital; personal values) Have you ever broken the rules at FPH? If so, can you give me a recent example and tell me about why you did it? Has this affected your recovery?

F. THERAPEUTIC MILIEU

ESSEN CLIMATE EVALUATION SCHEMA⁶

Now I am going to read you several statements relating to the environment at the BC Forensic Psychiatric Hospital. As I read each statement, please think about how you are feeling now and rate your level of agreement.

	I agree...				
	Not at all	Little	Somewhat	Quite a lot	Very much
1. This hospital has a homely atmosphere.	0	0	0	0	0
2. The patients care for each other.	0	1	2	3	4
3. Really threatening situations can occur here.*	4	3	2	1	0
4. In this hospital, patients can openly talk to staff about all their problems.	0	1	2	3	4
5. Even the weakest patient finds support from his fellow patients.	0	1	2	3	4
6. There are some really aggressive patients in this hospital.	4	3	2	1	0
7. Staff take a personal interest in the progress of patients.	0	1	2	3	4
8. Patients care about their fellow patients' problems.	0	1	2	3	4
9. Some patients are afraid of other patients.	4	3	2	1	0
10. Staff members take a lot of time to deal with patients.	0	1	2	3	4
11. When a patient has a genuine concern, they find support from their fellow patients.	0	1	2	3	4
12. At times, members of staff are afraid of some of the patients.	4	3	2	1	0
13. Often, staff seem not to care if patients succeed or fail in treatment.	4	3	2	1	0
14. There is good peer support among patients.	0	1	2	3	4
15. Some patients are so excitable that one deals very cautiously with them.	4	3	2	1	0
16. Staff know patients and their personal histories very well.	0	1	2	3	4
17. Both patients and staff are comfortable in this hospital.	0	0	0	0	0

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G. STIGMA

INTERNALIZED STIGMA OF MENTAL ILLNESS INVENTORY⁷

Below are several statements about stigma. Stigma is the negative attitudes, feelings and beliefs people have towards mental illness (e.g. prejudice, discrimination). Please indicate whether you strongly disagree, disagree, agree, or strongly agree with each statement as they apply to you.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I feel out of place in the world because I have a mental illness.	1	2	3	4
2. Mentally ill people tend to be violent.	1	2	3	4
3. People discriminate against me because I have a mental illness.	1	2	3	4
4. I avoid getting close to people who don't have a mental illness to avoid rejection.	1	2	3	4
5. I am embarrassed or ashamed that I have a mental illness.	1	2	3	4
6. Mentally ill people shouldn't get married.	1	2	3	4
7. People with mental illness make important contributions to society.	4	3	2	1
8. I feel inferior to, or less than, others who don't have a mental illness.	1	2	3	4
9. I don't socialize as much as I used to because my mental illness might make me look or behave "weird."	1	2	3	4
10. People with mental illness cannot live a good, rewarding life.	1	2	3	4
11. I don't talk about myself much because I don't want to burden others with my mental illness. (Explain without double negative)	1	2	3	4
12. Negative stereotypes about mental illness keep me isolated from the "normal" world.	1	2	3	4
13. Being around people who don't have a mental illness makes me feel out of place or inadequate.	1	2	3	4
14. I feel comfortable being seen in public with an obviously mentally ill person.	4	3	2	1
15. People often patronize me, or treat me like a child, just because I have a mental illness.	1	2	3	4
16. I am disappointed in myself for having a mental illness	1	2	3	4
17. Having a mental illness has spoiled my life. (e.g. ruined)	1	2	3	4
18. People can tell that I have a mental illness by the way I look.	1	2	3	4
19. Because I have a mental illness, I need others to make most decisions for me.	1	2	3	4
20. I stay away from social situations in order to protect my family or friends from embarrassment.	1	2	3	4
21. People without mental illness could not possibly understand me.	1	2	3	4
22. People ignore me or take me less seriously just because I have a mental illness.	1	2	3	4
23. I can't contribute anything to society because I have a mental illness.	1	2	3	4
24. Living with mental illness has made me a tough survivor.	4	3	2	1
25. Nobody would be interested in getting close to me because I have a mental illness.	1	2	3	4

⁷ Ritsher, J.B., Ollingam, P.G., & Grajales, M. (2003). Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*, 121, 31-49.

	Strongly Disagree	Disagree	Agree	Strongly Agree
26. In general, I am able to live my life the way I want to.	4	3	2	1
27. I can have a good, fulfilling life, despite my mental illness.	4	3	2	1
28. Others think that I can't achieve much in life because I have a mental illness.	1	2	3	4
29. Stereotypes about the mentally ill apply to me.	1	2	3	4

30. Is there anything else that you would like to add?

END TIME: