

THE EXPERIENCE OF GOING THROUGH THE FORENSIC PSYCHIATRIC
SYSTEM FOR MENTALLY DISORDERED OFFENDERS: A PATIENTS' VIEW ON
WHAT HELPS AND WHAT HINDERS

by

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Abstract

This study examined helping and hindering factors that influence the experiences of forensic psychiatric patients in the forensic system, and describes implications for practice. A qualitative approach was used to delineate which factors patients report are helpful and which ones are reported as hindering within a forensic inpatient hospital. Ten participants were interviewed using Critical Incident Technique to elicit their experiences since coming to a Forensic Psychiatric Inpatient Hospital. Results indicated that the factors that were helpful were: talking with staff, programming and services, and taking prescribed medications. Hindering factors included: exposure to illicit drugs, exposure to violence, programming and services, stigmatism, living on a maximum security ward, lack of respect from the staff, and concerns involving prescribed medication. The results of this research are discussed in light of how this present research supports the extant research and theories. Implications and recommendations at both a clinician and system level within forensic psychiatric services are offered.

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CHAPTER ONE

Introduction

Canada has a unique population of mentally disordered offenders who require treatment in the forensic psychiatric system. While the focus with this population has generally been one of risk management and keeping the public safe, this focus is also balanced with rehabilitation of the offenders under hospital care. While under this care, the mentally disordered offenders face a number of challenges when “going through the system” that warrant attention. By “going through the system”, the author means being psychologically ill (as per *American Psychiatric Association 1994 Diagnostic and Statistical Manual of Mental Disorders.*), committing a crime, and then being arrested and placed in a psychiatric facility. This experience can be negative, such as experiencing violence on the wards, or positive, such as having a helpful relationship with the staff (Freuh, Dalton, Johnson, Hiers, Gold, Magruder, & Santos, 2000). It is valuable to examine these factors to improve the quality of care this population is receiving and to help appease the effects of negative experiences. If one examines the experience of offenders from their personal perspective, one can have guidance to strive toward the best quality of care in forensic facilities. This paper focuses on the effects of the arrest, ward life, relationships, and stigmatism on psychiatric offenders. It also focuses on other factors that came up throughout the research project that were not originally predicted by the writer, such as drug exposure, and services offered.

The term mentally disordered offender is used throughout the paper to keep in line with current publications, yet it is important to remember that this population is often

found not criminally responsible, and often are referred to as patients in the actual forensic hospital context. In going through the forensic system, there is generally a linear pattern. This pattern usually involves being arrested, being taken to jail, then being brought into a Forensic Psychiatric Hospital. More will be explained on the procedures later in the chapter. Since it is noted that many factors can be found very stressful for a person in this system, and some that appease the situation, this study looks at what are helping, and what are hindering factors that occur throughout this time.

After the crime and arrest, patients whose mental capacity is questioned are often committed to the Forensic Hospital. These patients spend the majority of their time living on wards with other patients and interacting with staff. They attend therapeutic programs throughout the day, and spend leisure time on their living units. How they experience this lifestyle plays a very large role in the patient's life, yet how they experience this life from their point of view, and what they find harmful or helpful, has a dearth of literature (for exception, see Verdun-Jones, Brink, Lussier, & Nicholls, 2006). This experience may extend to relationships with staff, hospital routine, patient to patient relationships (Johansson, & Eklund, 2003) treatment concerns, stigmatism experienced (Livingston & Balmer, 2006), and any other issues that are not touched on in the current literature.

Based on the aforementioned inquiries, a research project was designed. The current project aimed to enrich the current research by having an in-depth interview with a few patients about their experiences within the psychiatric correctional system from both a helping and hindering perspective. Because of the exploratory nature of the research topic, a qualitative approach was used to better capture their experience. Furthermore, since much of the published literature examines the negative experiences of

offenders' experience in the system, this project also aimed to capture what patients found positive and helpful.

Research Question

The research question is: "What is a patients' view on what helps or hinders the experience of going through a forensic psychiatric system for mentally disordered offenders?" By asking this question in a more general form, and then becoming more specific as the interview progresses, an enriched perspective can unfold, providing a plethora of information both on what helps, and what hinders the experience. The central research question was broken down to examine all areas of going through the system, both from a helping and hindering perspective. It started with a broad question on the participants experience overall, and then became more specific, asking about their experiences with the staff, their experiences on the ward, and any experiences with stigmatism, if they had not already been addressed. It was however, predicted that factors would come out of the interviews that were not reviewed, due to both the specific nature of the population (being mentally disordered offenders), and due to the lack of patient perspective research in the area.

Forensic Psychiatric Services in British Columbia, Canada

Before examining the experience of the offender, it is important to understand what "going through the system" means as all provinces in Canada differ slightly on how their Forensic Systems operate. British Columbia is a unique province because in 1974 it established an independent forensic body, The Forensic Psychiatric Services Commission. The vision was that as an independent body, the Commission could impartially express professional opinions regarding balancing protection of the public and

the rights of the accused. The Commission felt they could provide opinion regarding treatment needs of the offender, and his or her mental status. Furthermore, this commission conducts research and education about forensic patients, and provides services for those mandated to psychiatric evaluation, or held under the Criminal Code of Canada or Mental Health Act (Eaves, Lamb, & Tien, 2000).

The British Columbia forensic system where this study is conducted contains a 202 inpatient hospital, The Forensic Psychiatric Hospital, and has six partner community clinics in Victoria, Nanaimo, Vancouver, Surrey, Kamloops, and Prince George. The Forensic Psychiatric Hospital was built in 1997, and has maximum, medium, and minimum security beds for both males and females. Because of the increase in demands for court-ordered assessments, a separate Forensic Assessment Unit was established at the Vancouver Pre-Trial Centre in 1999. Under the Mental Health Act, many residential and community housing facilities have become available to forensic clients. This has led the Forensic Hospital to generally provide services to high-risk clients, while community facilities provide services for low-risk clients (Eaves, et al., 2000). Many patients move throughout this entire system, however, this study focuses only on those currently residing in the inpatient facility. Below is an introduction to the factors that may occur in this inpatient facility.

Experiences within the Forensic System

Arrest and Custody

Offenders often find events such as being arrested and taken into custody as a frightening experience (Frueh, et al., 2005). To date, the only study examining the effects of arrest on mentally disordered offenders was conducted by Frueh et al., which

examined arrest effects as part of a larger study examining harmful experiences within a psychiatric system. Arrest effects are extremely understudied in offender populations; therefore this study aimed to leave the interview open ended so that participants could speak to this issue.

Ward life

Once the patients are admitted to the psychiatric hospital, there are many experiences within ward life that can be examined. In the literature, type and severity of aggression on the wards is largely studied as part of ward life (for examples, see Binder & McNeil, 1994; Daffern, Ogloff, & Howells, 2003; Verdun-Jones et al., 2006). While this information is helpful for knowing the types of behaviour these patients are subjected to, information on the effects of the aggression on actual patients is often lost. While it is documented that there are adverse conditions on the ward, such as witnessing aggression or experiencing physical conditions such as restraint and seclusion (Frueh, et al., 2005) the psychological and emotional effects on the patients are often not documented. What is often lost is *how* the patient experiences these events.

One study that did ask the patients how they felt about aggression specifically was Verdun-Jones et al. (2006). This study found that the majority of patients generally reported feeling safe at the hospital, but were also still subjected to a high level of verbal and physical aggression from other patients. This study does not capture the subjective effect of the incidents experienced by the patients.

Relationships with Staff

Another aspect to hospital life is the relationships that the patients have with the staff. Some studies explored the effects that a positive experience with the staff can have

on the patients (Johansson, & Eklund, 2003). Johansson and Eklund found that patients in their study reported that the quality of the helping relationship between the patient and the staff, and feeling understood by the staff was of central importance in good care. Limitations of this study are that the authors used questionnaires to examine what patients find helpful with the staff. This method may not capture all the aspects of the relationship. Furthermore, many studies examine specific relationships (e.g. with nursing staff), while other areas may not be covered (e.g. with rehabilitation staff). By using a more open format, it may be possible to capture different types of relationships that the offender feels are important. The focus on relationships and therapeutic alliance as a major factor is promising, as the field of counselling focuses on the relationship as an important tool of care. Supporting the extant literature specifying how important patients find the relationship to be can have implications for future practices.

Stigmatism

When examining the patients experience in the forensic system, literature has pointed out that often one can encounter a lot of stigmatism once admitted to a forensic facility. After entering the forensic system, people in the offender's life may start to treat him or her differently, as there is a high association between stigma and mental illness (Livingston & Balmer, 2006). This population may firstly be stigmatized because of their mental illness, and then have the added burden of being involved in the criminal system. Stigma has been noted in the literature as causing distress in psychiatric patients, and studies have begun focusing on these effects (Livingston & Balmer, 2006; Livingston, 2007). For example, Livingston and Balmer (2006) in a quantitative study found that 21.4% of their sample of forensic psychiatric patients reported high levels of internalized

stigma, and 33% believed that others routinely discriminated against them. For these reasons, participants in this study were asked about their experiences with stigmatism to add depth to this literature.

Implications

Most data collected in this area is done with quantitative methods. This is very helpful in providing excellent data on forensic psychiatric patients; however, there is a lack of qualitative data collection in this area. Qualitative data can provide a rich perspective from the persons directly under study, which can offer a new way at guiding practice. Furthermore, much of the literature thus far examines the negative aspects of offender's experiences. While this information is important, it is also imperative not to overlook what is positive or helpful for the patients. Finally, emerging themes can come out of taking a qualitative approach, as an interview is not as limited in extracting spontaneous data as quantitative data collection. These new themes, combined with the targeted themes, can be used to improve care at the Forensic Hospital, and guide counsellors and other clinicians in future practice.

CHAPTER TWO

Literature Review

The purpose of this chapter is to provide a conceptual framework to exploring the literature in respects to the experience of mentally disordered offenders going through the correctional system. First, an overview of the forensic mental health systems in Canada is explored. Second, definitions of the main concepts involved in this research are defined (e.g. unfit to stand trial, not criminally Thirdly, this chapter outlines some of the experiences that mentally disordered offenders experience after committing their offence, and entering the forensic psychiatric system: the arrest or custody, life on the wards, the role of stigmatism, and interactions with staff. These factors are examined from a “what helps and what hinders” perspective.

Mental Health and the Criminal Justice System

When a mentally disordered accused is assessed and treated, the Criminal system and Mental Health system overlap. Mental health facilities, remand centers, and jails are often in charge of conducting assessments. This crossover between systems has resulted in concerns in the mentally disordered often being criminalized as a means to provide them with treatment (Swaminath, Norris., Komer, & Sidhu, 1993).

If upon assessment by a psychiatrist, a person is found to be unfit to stand trial, they are sent for treatment and detainment. After being treated, if a person becomes fit to stand trial, they are then tried for their crime. If there is evidence that a mental disorder is present, they may be found to be not criminally responsible for their actions at the time of the offence. In this case they may either be detained until fit for the community, or released if they are currently stable. While they are subject to annual review, there is the

possibility that the person will remain in the mental health system for an indeterminate period of time (Swaminath et al., 1993). If they are found criminally responsible, then they may be tried and found guilty and sent to jail (Swaminath et al., 1993).

Key Concepts for Mentally Disordered Offenders

Unfit to stand trial (UST): If a person is not fully capable of instructing counsel, or are not capable of understanding the consequences of a trial, then a person may be found unfit to stand trial (Criminal Code of Canada, 2002). There are two scenarios in this case. In the first scenario a judge sends the accused to a hospital, where they are assessed for fitness to determine if they are mentally ill. If they are found fit, then they go to trial. Furthermore, if the person is deemed fit while in custody, and there is the belief that that they may become UST if released, the court may rule that the person remain in custody of the hospital during the trial. In the second scenario, if the accused is still UST after 90 days, the case is reviewed annually by the Review Board, until the person is found fit to stand trial, or until it is decided by the courts to classify the person as NCRMD (Swaminath et al., 1993).

Not criminally responsible on account of a mental disorder (NCRMD): A verdict of NCRMD will result if the accused was suffering from a disease of the mind at the time of the offence that caused the accused to not understand that their actions were wrong (Criminal Code of Canada, 2002). This issue can only arise after it has been proven that the accused committed the crime in question. At this point the accused is either discharged subject to conditions, given a custody order for detention in a hospital, or given an absolute discharge (Swaminath et al., 1993).

Review Boards: The review board reviews the accused case every six months to one year, based on information from court systems, witnesses, and hospitals. While there are many things that the review board takes into consideration upon review, some of the main ones are: the charge, criminal history, results of assessments, risk assessment, hospital recommendations, and so on. Review Boards are mandated by the Criminal Code to appoint a minimum of five members, including one who is qualified to be a judge, and one who is qualified to practice psychiatry in the province (Criminal Code of Canada, 2002).

Index Offence: An index offence is defined as the *most recent* charge, conviction, or rule violation. Index offences can include numerous crimes perpetrated at different times because the offender may not be arrested when they first begin to offend. If this results in a single conviction, then all counts, regardless of the time frame, are considered part of the index offence (Phenix, Hanson, & Thornton, 2000).

Experiences within the Forensic Psychiatric System

Stress and Mental Illness

Stress is defined by Selye as, “the non-specific response of the body to any demand” (1984, p.74) and can be defined as either positive or negative stress. The present study examined the effects of stress on persons suffering from a mental disorder by looking at negative events within the forensic system. It has been shown that persons with severe mental illness not only suffer higher rates of traumatic / stressful events (Mueser, Goodman, Trumbetta, Rosernberg, Osher, Vidaver et al., 1999), but they also have a greater vulnerability to the effects of stressful events than people in the general population (O’Hare, Sherrer, & Shen, 2006). Furthermore, these stressors can lead to

exacerbation of psychiatric symptoms, increased risks for additional trauma, and emotional distress (Goodman, 2006; Mueser et al., 1999). It has also been shown that there exists a strong association between stressful events and substance use disorders (Brown, Stout, & Mueller, 1999). Due to the overwhelming and detrimental nature of all these results of stress, it is crucial to examine how this stress is perceived by the participants.

Stressful events were also of major concern as literature has shown that persons suffering from schizophrenia often have onset and / or relapse due to stressful events (Yank, Bentley, & Hargrove, 1993). It is believed that those suffering from schizophrenia may be lacking in coping skills, which would otherwise minimize the negative effects of a stressor on a person (Yank et al., 1993).

Arrest and Custody Effects

It has been noted in the literature that being handcuffed or transported in a police car can have harmful effects on patients (Frueh et al., 2000). Currently there is a dearth of information in the literature focusing on this area. Frueh et al. (2000) examined the frequency and associated distress of potentially harmful experiences within psychiatric settings. This study had 142 participants who completed self-report measures to assess harmful events that occurred during their lifetime, and the course of their mental health care. One of the measures used was the Psychiatric Experiences Questionnaire (PEQ). This questionnaire has 26 possible harmful items that may occur in a psychiatric setting. One of the items asked about was being handcuffed and transported in a police car. Sixty-five percent of the participants reported an incidence of this variable, and 51% of these felt the event was still distressing one week after the event.

To date this is the only study found that examines the effects of arrest on mentally disordered offenders. Based on the deleterious effects arrests have had on other populations such as soldiers who have been arrested and detained (for example, see Grieger, Cozza, Ursano, Hoge, Martiniez, Engel, et al., 2006), it is postulated that an arrest and custody may have a detrimental effect on other types of populations.

Experiences within a Psychiatric Setting

Since it has been argued that experiences within a psychiatric setting may cause or exacerbate stress (Frueh et al., 2000), it is important to examine what types of negative events might occur. The literature has documented that patients with mental illness are sometimes vulnerable to experiences that are considered traumatic or stressful within a psychiatric setting (Cohen, 1994; Frueh et al., 2000). It has furthermore been shown that some clinical procedures, such as restraint, may be highly distressing for some patients (Rogers, Gray, Williams, & Kitchiner, 1993). Thus far, not a lot of studies have examined these experiences occurring in psychiatric facilities (Frueh et al., 2000), and more knowledge is crucial in this area to understand and reduce these harmful effects. These types of events as aforementioned may also be exacerbating stress patients may be experiencing. Extant literature shows that residing in a psychiatric facility can have an effect on a patients' emotional well-being. For example, Roe and Ronen (2003) investigated the experiences of psychiatric patients. The authors interviewed 41 participants who were recently discharged from a psychiatric hospital. A narrative summary was taken of each interview, and conceptual labels were derived. Some of the findings relevant to this study were that living in a hospital, and having rules and expectations imposed on one was felt as traumatic by participants. The participants also

reported that their limited competence and independence threatened their self-concept. Furthermore, 87.5 % of the participants stated that the distribution in power between staff and patients led to a sense of hopelessness and helplessness.

Experiencing / Witnessing Aggression

Experiencing and witnessing aggression can be a major stressor on a psychiatric ward. As part of a larger scale study on inpatient aggression, 30 patients were interviewed to gain their perspectives of aggression on forensic psychiatric wards (Brink, Harabalja, & Nicholls, 2006; Verdun-Jones et al., 2006). Participants were asked about the nature and severity of violent incidents that they had been exposed to or involved in over the previous year (2004) by a researcher from the Forensic Psychiatric Hospital. The majority of the participants reported that they had been subject to verbal aggression (95%) and physically aggressive behavior in the past year. The majority of participants (87%) reported that the most serious incidence of violence or aggression involved an altercation between patients. None reported being the victim of inappropriate sexual behaviour. Furthermore, the majority of patients reported that they felt safe at FPH (68%) and stated that the staff deescalated incidents successfully 78% of the time. Sixty percent also reported having had safety concerns at some point during their hospitalization. This study is vital because it examines how the patients themselves feel, using semi-structured interviews. It shows that there is violence occurring on the wards, and that this may be important in regards to added stressors to the patients. Conversely, it does point out that while there is a high incidence of aggression, most of the patients reported feeling safe. This is an area that will benefit more exploration in the current study.

Other Harmful Events on Wards

Freuh, et al. (2005) examined 142 patients with severe mental illness from an adult psychiatric day hospital program. The study examined traumatic and / or harmful experiences in this psychiatric facility. Participants completed self-report measures (Psychiatric Experiences Questionnaire, Trauma Assessment for Adults-Self-Report Version, and the PTSD Checklist), to assess for harmful events that occurred during the course of their mental health care. The research examined the types of adverse events experienced by these patients, as well as the frequency of occurrence. The authors found that there were high rates of lifetime trauma within the psychiatric facility (63% for witnessing a traumatic event, 31% for physical assault, and 8% for sexual assault). Other areas that did not meet the DSM-IV criteria for trauma, but were still distressing to the patients, were events such as having medications used as a threat, being called names by staff, being around frightening patients, seclusion, restraint, and handcuffed transport.

Experiences with the Staff.

An imperative part of a patient's experience of going through the system is their interactions with the staff, as it is possible that this experience can appease or hinder their time in care. This can encompass many different relationships, and many different experiences within these relationships. For example, it has been pointed out the quality of patient and nursing interaction is a highly important factor in positive outcome for patients (Richmond & Roberson, 1996).

Johansson and Eklund (2003) investigated patients' opinion on what constitutes good psychiatric care. This study used both inpatient and outpatient samples of eleven patients, via an open-ended, in-depth interview. The questions asked were: "what was

your most important experience in receiving this psychiatric care?”, “what has this care meant to you and your life?”, and “how do you feel about the staff’s understanding of your psychiatric problems?” The main themes that came out of these questions were that the patients felt the main constitution of good psychiatric care was the relationship between the patient and the staff. More specifically, they wanted to feel understood by the staff, and felt the ‘helping alliance’ was the most crucial factor in the staff to patient interactions.

Koivisto, Janhonen, and Vaisanen (2004) examined patients’ experiences of being helped in an inpatient setting whilst they are psychotic. The study was a qualitative study which interviewed nine patients on acute psychiatric wards. The patients were asked to describe their experience surrounding their hospital care (e.g. “can you remember what happened when you came into the hospital?”), and themes were pulled out for analysis. The themes identified as helpful were: to feel safe, to feel understood, to be respected and trusted, to become conscious of one’s self (e.g. nurses telling them what is happening to them when they are psychotic), and to maintain integrity. This study is important because it utilizes the patient’s perspective on dignified care. It was predicted that the current study anticipated that similar findings would arise, as the majority of the patients at FPH suffer from psychosis.

Stigmatism of being a Mentally Disordered Offender

Stigma plays a role in the lives of many people who reside in psychiatric facilities (Roe & Ronen, 2003). Stigma defines people by accenting perceived negative characteristics. These characteristics can set a person apart from others, and can devalue them as a consequence (Crocker, Major, & Steele, 1998). Furthermore, research

continues to draw attention to the many problems associated with this stigma, as it can be the cause of much anxiety and stress in those being discriminated against (Crocker et al, 1998.).

Dinos, Stevens, Serfaty, Weich, and King (2004) examined the experiences and feelings of stigma of persons with mental illness. Forty-six participants were interviewed from day centers, hospitals, and mental health groups in London. The interviews lasted approximately one hour, and were transcribed to identify themes, participants' backgrounds and mental health problems. The themes were then content analyzed to build up categories, which were analyzed for frequency. Overall, 41 of the 46 participants expressed feelings of stigma. Out of these feelings, two distinct categories emerged. First, there were subjective feelings about stigma. This category pertained to feelings of stigma in the absence of any direct discrimination. Nineteen of the participants recalled feeling stigma when they received their diagnosis. Furthermore, 4 of the participants felt negatively about their treatment because of the stigma they felt were attached to it. Finally, 41 out of the 46 participants felt anxious about whether to disclose their illness to others. The second distinct category that emerged was regarding overt discrimination. Twenty-nine of the 46 participants spoke of verbal or physical harassment they had experienced due to their mental illness. Furthermore, 16 participants felt that others had severed contact with them because of their mental disorder. The consequences of this overt discrimination were depression, isolation, fear, anger, and embarrassment.

There are many negative consequences of being stigmatized against for having a mental disorder. Livingston (2007) was interested in if these findings in the extant literature were also comparable to a compulsory-based mental health center. He

hypothesized that adding a label of criminality to a person with a mental illness might increase stigma. He interviewed twenty-seven patients one month following their discharge into the community, examining stigmatization, quality of life, symptoms, and service utilization. He found that 14.3% of subjects reported high levels of stigma *feelings*, and had an average of 3.8 stigmatizing experiences. Furthermore, the level of stigma *experienced* was significantly correlated with psychological well-being, symptoms, quality of life, and general satisfaction.

Summary of Literature

Past literature has uncovered a number of factors that can cause stress for mentally ill offenders. The identification of stress may facilitate appropriate treatment, reduce the risk of suicide, and allow the patient to begin rehabilitation promptly. It has been noted that stress can be detrimental to mental illness, and it is hoped that examining how participants cope will lead to future ways to assist them.

The literature has also revealed that patients with mental illness are sometimes vulnerable to experiences that are considered stressful within a psychiatric setting. Past research studies show that factors such as an arrest, aggression on the wards, medication threats, and other routine ward procedures can cause significant stress on the patients. It has also been shown that the patients relationship with the staff can either ameliorate or exacerbate this effect. Finally, it has been shown that stigma can also play a role in adding to stress. Based on the current literature, there are a lot of conditions that can lead to stress in mentally ill offenders. As a result of the need for more knowledge around these conditions, participants were asked to share their experience on these factors, and any other factors not already been identified in the literature.

CHAPTER THREE

Methodology

This chapter provides the rationale for the application of a qualitative approach to this research. Particularly, it explains the use of the critical incidence technique (CIT) as the qualitative method employed (Flanagan, 1954). Next, the chapter provides a step by step methods section. Finally, it discusses and provides a framework for data analysis.

Role of Researcher

I have worked in the area of forensic psychiatry for six years interacting with mentally disordered offenders through various positions. In this experience, I have come to know many of the patients quite well, and have heard some fascinating life stories from them. The lesson I have learned from this work is that most of them simply want to be heard and understood, and that a great deal of them have useful information on how they should be treated within the forensic system.

I have also seen ward life as being a major aspect of the patients' lives, as this is where they essentially spend their lives. Sadly, part of this experience and as recognized in the literature, is that there is often a lot of violence occurring on these wards. Many patients I have talked to have said this is a major concern for them, so will be explored in this study.

Once they are on the wards, interaction with staff plays a large role in the patient's lives. Their lives are under the care of psychiatrists, case managers, social worker, nurses, etc. Therefore, the relationships the patients have with staff have always stood out to be important to me. This has led to my assumption that how the staff and patients interact plays a large role in the patients' lives and stress levels.

Finally, I have seen the role that stigmatism can play in the patients' lives. Not only are people discriminated against because they are mentally ill, but there is the added component of being a forensic population. These patients are often turned away from job sites, boarding homes, and treatment programs, because of who they are. Based on this information, my assumption is that many patients would express being discriminated against, not only in the aforementioned areas, but also from friends, family, and strangers.

Research Design

This study used a qualitative approach with participants in a forensic psychiatric facility to examine the aforementioned areas of patient experience, and any other areas not identified in previous literature. The data were collected at the Forensic Psychiatric Hospital with one female and ten male participants. Ethical approval was obtained from both the Forensic Psychiatric Hospital (Appendix A), and the University of British Columbia (Appendix B). The participants were told of the nature of the study, and consent was taken (Appendix C). Furthermore, before obtaining consent from the patients, due to the participants being in a psychiatric facility, assent was obtained from the psychiatrists (Appendix D). A CIT interview method was used to explore the various areas of "going through the system", and finally the interviews were transcribed, and themes pulled out of the data for analysis. Following the system of Buterrfield, Borgen, Amundson, and Maglio (2005) eight of nine data analysis checks of the interviews were conducted.

Critical Incident Technique (CIT)

CIT is a qualitative technique first coined by Flanagan (1954) to collect observations of human behavior and develop psychological principles. Flanagan described an incident as “any observable human activity that is sufficiently complete in itself to permit influences and predictions to be made about the person performing the act” (1954). Flanagan’s work principally consisted of employing the technique to analyze job duties and performance within the air force to determine who might be successful. It was shortly thereafter utilized by Andersson and Nilsson (1964) as they found the technique to have good reliability and validity.

Over the years, the method has been used in numerous other areas, one being that of counselling research (McCormick, 1997), and has been utilized in many studies looking at helping and hindering factors in an experience (Butterfield et al., 2005). This method has also been used numerous times within the University of British Columbia’s counselling psychology department, where a number of credibility checks have been established, and mark it as a “good” research method (Butterfield et al., 2005).

This method works well with the proposed research, as it is a flexible way to examine a patient’s journey through the forensic system, while pulling out the incidents that are critical in helping or hindering. This approach works well in eliciting the participant’s subjective view of their experience, while upholding scientific rigor. More on the actual technique will be described in the procedures section.

Participants

Ten participants from a forensic psychiatric hospital were interviewed on their experiences in the hospital system (Appendix E). A sheet containing demographics (Appendix F) was also completed by each participant.

Inclusion Criteria:

1. Be a patient in a forensic psychiatric hospital
2. Be willing to participate in the study, and give consent
3. Be given assent to participate by their psychiatrist
4. Be able to discuss their experience of going through the forensic psychiatric system
5. Have lived in the forensic hospital for at least 3 months to capture a full experience

Exclusion Criteria:

1. Are actively psychotic and not able to complete an interview
2. Are unwilling to participate
3. Cannot speak or understand English

Measures

Demographics Sheet. Each participant was asked to fill out a short demographics questionnaire.

CIT qualitative interview. This study used a qualitative approach, utilizing an interview to elicit the lived experience of the offenders.

Compensation

Participants in this study were offered a \$10.00 gift card to the hospitals canteen to thank them for their time. This was given to participants immediately after their interview.

Rationale for Design

The voices of forensic patients are barely heard in the literature. Instead, the lives of forensic patients are often described primarily in terms of expert opinions (Sullivan, 2005). One goal of qualitative research design is to remedy this by documenting the subjective experiences of participants in a way that reflects the diversity of their lived experiences (Polkinghorne, 2005; Silverstein & Auerbach, 2006). Qualitative methods offer an opportunity to deepen the understanding of the experience of mentally disordered offenders going through a forensic psychiatric system. Because it generates such a rich description of local contexts and individual subjective experiences, it is particularly suited to improving clinical practice (Silverstein & Auerbach, 2006).

Since it was not possible to interview every patient at the Forensic Hospital due to time and funding for this study, ten participants were interviewed via a semi-structured interview, exploring critical incidents. Some advantages of this method are that it can overcome poor response rates of a questionnaire, explore attitudes and beliefs, and allow for observation of non-verbal behavior (Barriball & While, 1994). Critical Incident Technique is a widely used qualitative method, and has been utilized in studies looking at helping and hindering factors. It has been shown as very useful in collecting observations of human behavior to develop broad psychological principles (Flanagan, 1954).

A list of questions were drafted (Appendix E), which were asked in a standardized way to ensure responses were due to differences among the participants rather than the way the questions were asked (Barriball & While, 1994). Probing questions were also used in the interview to help participants recall information involving memory since this interview partially asks the participants to go back in time (Smith, 1992).

Recruitment Procedure

1. *Initial meeting*: The researcher formally presented the research proposal to the psychiatrists at a forensic psychiatric hospital (Appendix G). This was a letter of introduction via email and mailboxes, with a delay of at least one week for psychiatrists to have enough time to contact researchers with questions. This was an opportunity for the psychiatrists to ask questions about the study, and to gain an understanding of the nature of the project for when they were to give assent. A copy of this letter was also attached to all assent forms.
2. *Advertising*: Posters were put up around the hospital (on wards and in program areas) asking for volunteers to participate in the project (Appendix H). The study was also advertised via word of mouth. Volunteers were asked to contact Devon Harabalja via a password protected in-house telephone number.
3. *Screening*: Once participants signed up, assent forms were sent to the psychiatrists to screen out any participants who were not able to participate in the study due to their mental illness, and for appropriateness for participation.
4. *Initial meeting with participant*: Participants were met with to fully explain the nature of the study, and to go over the consent form in detail. More explicitly, it was made clear that all information would be kept private and confidential. At this point the limits of confidentiality were outlined to participants as per APA standards (APA, 2002). They were told that the only times that confidentiality would be broken were under the following conditions: if they reported that they thought a child or children were being abused or neglected, if there was a threat of harm to self or others, if there was a medical emergency, or if there is ever a subpoena from the courts. This was told to the participant

before the interview, and outlined on the consent form. Consent was obtained on the patients unit, in a private room. It was also made explicitly clear to participants that anything said during the interview would not go to their treatment team. The consent form was then left with the participant for 24 hours. At this time a second meeting was scheduled for the actual interview.

5. *Interview*: At the scheduled time, participants were met with to conduct the actual interview in a meeting room at the hospital. They were reminded that it would take about one hour, and that audio taping was necessary for research purposes. It was made clear that that no one but the interviewer and supervisor would listen to the tape and that it would be kept safely stored, then later erased. Because of the overlapping roles of the interviewer, it was stressed that this research is separate from their treatment, and that confidentiality would only be broken as per APA (2002) guidelines (see appendix C for more details). After participants agreed to these conditions, they were asked to sign the consent form to participate. At this point the interview tapes were started and participants were invited to talk about their journey through the forensic psychiatric system via a structured interview. The interviews were semi-structured to permit the interviewees, as far as possible, to describe the course of events freely. Supplementary sub-questions were asked to elucidate the interviewee's story if all the details did not already arise.

Interview Questions

Orienting Question (1st question asked)

I am interested in hearing about your overall experience of going through the forensic psychiatric system. Now over this time, you may have experienced some things that you felt were helpful, and some that may not have been helpful to you. Can you

describe any events you may have experienced like this, starting with either helpful or unhelpful experiences?

Sub-questions if not mentioned already:

- ◆ What has your experience been like living on the wards?
- ◆ What is your experience of interacting with staff at the hospital?
 - What has been helpful?
 - What is not helpful?
- ◆ Do you feel people treat you any differently because of where you are (FPH)?
- ◆ What advice would you give to the hospital staff on helping improve your care?
- ◆ Any further comments you would like to mention about your experience that we haven't covered?

Data analysis

Once the interviews were complete, the interviews were transcribed and analyzed for thematic connections. A final analysis was written based on the incidents found in the interviews. Furthermore, before transcribing the data, the situation of text production was examined, as Schilling (2006), states that it is important to take context into consideration. This means that the following questions were examined: who are the interviewees, what is the relationship of the subjects and interviewer, under what circumstances were the interviews conducted, and were there any disturbances or outstanding reactions from the participants. These were all examined in advance of text analysis to give a context to the interviews. None of the participants reported any events or moods that may unjustly have influenced their interview content.

Information was then pulled from the transcripts using the CIT data analysis check (Butterfield et al., 2005). This involved the following eight out of nine validity checks:

- A. Audio-taping was used to ensure the participant's stories were accurate: this ensured that there was descriptive validity.
- B. After the first interview was completed, a person familiar with CIT listened to the tapes for fidelity: this was to ensure the researcher was following the CIT method.
- C. Extracting the critical incidents: incidents were put into piles that were all related on some frame of reference. Once these were selected, short definitions were constructed, and any additional incidents were put into them. While going through this process new categories and definitions were derived.
- D. It was ensured that incidents were tracked the point to which exhaustiveness was reached: when only two or three critical behaviors emerge from every 100 incidents gathered, it was noted that redundancy was achieved. This step was not necessary as there were 99 incidents.
- E. Once the incidents were categorized, participation rates were calculated for at least a 25% rate: this was done by determining the number of people who cited an incident, and then dividing that number by the total number of participants.
- F. Next an independent judge placed randomly drawn incidents into these categories. This was done by another graduate student familiar with CIT. They pulled out 30% of critical incidents from the transcripts to calculate the

level of agreement with the researcher. Some of the definitions were slightly modified to clarify, and final inter-rater was 96%.

- G. Expert opinion was then sought by submitting tentative categories to two experts in the field to see if they agreed. These categories were sent to a Forensic Psychologist, as well to a Senior Forensic Researcher. Both experts independently examined the themes, and supported the conclusions of the study.
- H. Theoretical agreement was checked, comparing the study's underlying assumptions to the existing literature. This is examined in the discussion chapter of this document.

The ninth validity check, taking the results back to the participants for review was not completed. This check was decided against due to the population used. It was felt that participants would likely not be open to a second interview based on past research done in this setting.

Demographic information was also used to supplement the interviews and give a snapshot of the population under investigation. Participants were asked to complete these forms before beginning the interview.

Validity

As outlined above, the CIT method can demonstrate credibility and trustworthiness by following the nine steps of data analysis checks (Butterfield et al., 2005). By extracting incidents by independent coders, having independent judges place incidents into categories, tracking the point to which exhaustiveness was reached, eliciting expert opinions, calculating participation rates for at least a 25% rate, checking

theoretical agreement stating the study's underlying assumptions and comparing to the existing literature, taping the interviews, and having an expert in CIT listen to tapes all strengthened the credibility of this study.

Sharing Results

A letter providing the study's findings was sent to all participants six months after completion of the study. Results were also presented to the Forensic Psychiatric Hospital Research Committee within six months of completion of the entire study. Results have also been presented at the Forensic Psychiatric Conference in April 2008. Future publications submissions hope to further disseminate results.

Ethical Considerations

As the researcher was asking for information of a personal nature (e.g. their personal experiences since entering the forensic system), there was the risk of emotional discomfort. This risk was judged to be minimal due to the voluntary nature of the participation, as well as the participants' freedom to decline answering questions that caused them discomfort. Furthermore, the participants in this study had the opportunity to withdraw from the study at any time. Finally, if needed, participants were informed they could obtain counselling services from Pastor Tim Fretheim, who was contacted and agreed to provide support throughout, and up to six months after study completion. As well, patients were reminded they could receive support from nursing staff. This enhanced trustworthiness as it is recognized that the participants may be vulnerable, and that a researcher has a responsibility to guard against harm (Haverkamp, 2005).

It is recognized that conducting interviews with a sensitive population can also lead to boundary concerns. When one is conducting research around a topic that is

sensitive, it is important to maintain the role of a researcher in the face of intimate disclosure and strong emotions (Haverkamp, 2005). Haverkamp points out that one does not consent to a counselling session, but rather to a research interview. This was monitored by having another person listen to the tapes. In cases where the patient's involvement posed a risk to themselves or others, the researcher was prepared for the point where the researcher role will have to be abandoned, and a shift in roles may have to ethically occur (Haverkamp, 2005).

Another ethical consideration was that of competence (Haverkamp, 2005). Since the researcher in this case is embedded in the system of forensic psychiatry, competence in this area is strengthened, and possible harmful experiences were thought through in advance as best as possible. One potential risk identified in this area was conflict of interest due to the dual roles of the researcher at the hospital. To combat this concern, it was decided that the researcher needed to be very transparent and clear about these roles. Patients were given the following information regarding conflict of interest on the consent form: "Devon Harabalja is the researcher conducting the interview in this study. She is also an employee of the hospital. As per ethical guidelines, she cannot disclose any information from the interview in other areas of your treatment. If you are uncomfortable with this situation, you may feel free to decline to participate with no consequences. You may also contact Norm Amundson at any point if you would like information about this research from a source outside of FPH."

A final ethical consideration was that of researcher bias. In qualitative research individuals are working collaboratively to construct a reality and requires that the researcher to be self-reflexive. The researcher must examine researcher bias, and monitor

the dynamic interaction between participants and researcher (Silverstein & Auerbach, 2006). Since using an interview approach, the researcher is the main tool in the study, so therefore cannot disengage from the process. Krieger (1991) postulates that since the investigator cannot remain neutral and leave their personal history behind, it is important to recognize the nature of their participation. It is imperative to be aware that one cannot separate the researcher from the research process, and be aware of what biases one might bring to the process. Seeing as the researcher comes from an area where they have strong opinions about patients' lives, it is imperative to recognize these biases. To combat this bias, the author took all precautions to not ask interview questions in a way that was leading. The questions were also pre-screened by the research committee. It was also important to separate any opinions from the data when doing analysis, and all precautions necessary to give an authentic account from the patients' perspectives were taken.

Limitations of qualitative methods

Using a qualitative interview does not come without cautions. Since experience is not directly observable, data is subject to the participant's ability to reflect, and communicate the experience (Polkinghorne, 2005). There may also be concern inquiring if the interview questions capture the variations and richness of the experience. Polkinghorne asks that researchers to ensure that the interview questions have construct validity. Furthermore, Polkinghorne postulates that reflection on experience may serve to change the experience. He states that if one is in a state of anxiety at the time of the interview, they may reflect the experience as more anxiety provoking than it actually was. While it may be impossible to control for these aforementioned influences, they were kept in mind when analyzing the data and drawing conclusions. The author

considered if there was any overt behavior by the participant that would lead to the belief that they appeared in a state that may alter findings, or if there were any unusual circumstances present (e.g. patient spoke of just being released from the side-room). This was further monitored on the demographics form by asking the patients if there were any unusual circumstances in the past seven days that may be influencing their opinions in the interview.

CHAPTER FOUR

Results

This chapter focuses on the results of the in-depth interviews conducted with patients at the Forensic Psychiatric Hospital, Coquitlam, BC, Canada. Specifically, this chapter reports the demographic data of the participants (Tables 1, 2, and 3), as well as an analysis of the critical incidents (tables 4 and 5), along with examples of quotes.

Participant Demographics

The population at the Forensic Psychiatric Hospital is usually around 170. Twelve patients signed up to participate in this study, and assent was granted from the psychiatrists to ten of these patients. Of these ten, the average age was between the 26-35 year age category (range: 19-77). Of these ten 70% identified as Caucasian, 10% as Native, 10% as Norwegian, and 10% as Euro-Asian. For living units, 50% of the participants lived on the maximum security wards, 30% on medium security, and 20% on minimum security wards. The average length of stay for these participants was 74.4 months at the time of interview (range: 5-228). The most common index offence of the participants was arson (30%), followed by uttering threats (20%), and then 2nd degree murder, drunk in public, aggravated assault, mischief, and not reported, all falling at 10% combined. All participants reported an Axis I Disorder: schizophrenia (40%), schizoaffective disorder (40%), drug-induced psychosis (20%), bipolar disorder (20%), and substance use disorder (10%). The combined total is over 100% as some had multiple diagnoses (though all reported psychosis as at least one of their disorders). Ten percent

reported an Axis II Personality Disorder of Narcissistic Personality Disorder (these are self reports, not collaborated by chart review).

All of these patients completed the demographics questionnaire, as well as a taped interview. Nine of the participants were male, and one was female. All patients reported on the demographics form that there were no unusual circumstances in the past seven days that they felt would affect how they might feel during the interview (e.g. if they had spent the week in seclusion, recent review board, etc.).

Table 1

Demographic Data of Research Participants (A)

<u>Age Category</u>	<u>Gender</u>	<u>Ethnicity</u>	<u>Marital Status</u>	<u>Highest Grade</u>
26-35	Male	Norwegian	Single	12
35-50	Male	Euro-Asian	Single	12
20-25	Male	Caucasian	Single	12
26-35	Male	Caucasian	Single	College
35-50	Male	Caucasian	Single	10
> 50	Male	Caucasian	Single	12
> 50	Male	Caucasian	Single	10
26-35	Male	Caucasian	Single	11
26-35	Female	Native	Single	12
26-35	Male	Caucasian	Single	9

Note: Age categories: 20-25, 26-35, 35-50, and > 50. Ages range from 22-53 years old

Table 2

Demographic Data of Research Participants (B)

<u>Legal Status</u>	<u>Months Admitted</u>	<u>Security of Living Unit</u>
NCRMD	60	Medium
NCRMD	84	Maximum
NCRMD	5	Medium
NCRMD	10	Minimum
NCRMD	48	Maximum
NCRMD	156	Maximum
NCRMD	228	Medium
NCRMD	36	Minimum
NCRMD	36	Maximum
NCRMD	81	Maximum

Note. NCRMD equals not criminally responsible due to mental disorder.

Table 3

Demographic Data of Research Participants (C)

<u>Index Offence</u>	<u>Year of Offence</u>	<u>Psychiatric Diagnosis(s)</u>
2 nd Degree Murder	2003	Drug-Induced Psychosis
Uttering Threats	2001	Schizophrenia
Drunk in Public	2007	Bipolar Disorder
		Schizoaffective Disorder
Aggravated Assault	2001	Drug-Induced Psychosis
		Narcissistic Personality
		Schizoaffective Disorder
Arson	2004	Schizoaffective Disorder
		Borderline Personality
Arson	1995	Paranoid Schizophrenic
Arson	1989	Substance Use Disorder
		Schizoaffective Disorder
Uttering Threats	2005	Schizophrenia
Mischief	2002	Bipolar Disorder
NA	2001	Schizophrenia

Note. NA indicates the participant did not report information on the demographics form.

Critical Incident Analysis

A total of 99 incidents were identified from the 10 interviews conducted. These incidents were broadly classified into positive and negative events which either helped or hindered the participant's experience in the forensic psychiatric system. From the classifications, 20 categories were formed, into which all 99 incidents were classified. Those incidents without at least a 25% participation rate (85 incidents) or more were dropped, and eleven themes were kept. All remaining incidents were put into these themes, and definitions of the themes derived. Four of these themes were classified as helpful and 7 as unhelpful. The four incidents without 25% participation were dropped. The remaining themes are described in tables 4 and 5. Following the tables these themes are described. A complete rank order listing of all categories is contained in Appendix I.

Table 4

Helpful Critical Incidents

<u>Category</u>	<u># of Incidents Reported</u>	<u># of Participants Per Category</u>
Talking with staff	13	8
Programming & services	8	5
No experience with stigma	4	4
Taking Prescribed Medication	5	4

Table 5

Hindering Critical Incidents

<u>Category</u>	<u># of Incidents Reported</u>	<u># of Participants Per Category</u>
Exposure to drugs	7	7
Violence Exposure	13	7
Programming & Services	9	7
Stigma	10	6
Maximum Security Ward	6	5
Lack of Respect From staff	7	4
Taking Prescribed Medication	3	3

Helpful Critical Incidents

Definitions of positive critical incidents follow, supplemented by quotes from the transcripts to enrich the description.

Talking with staff at FPH

In this category 80% of patients talked about how helpful it is when staff talked with them. This category captures patients' experiences of finding it helpful to talk with staff about their personal concerns as well as to receive input on their treatment. An important part of these experiences that patients highlighted was the importance of receiving respect from staff. They stressed the importance of respectful and caring communication.

The following quotes were taken from the transcripts of the participants reporting critical incidents that highlighted the importance of talking with the staff at the hospital:

"...there's quite long bouts of depression and the nursing staff talked to me and helped me throughout it, so..."

"And talking with Pastor _____. And I really look forward to talking with my addiction counsellor, _____."

``So, you know, interacting with ____ and _____ and all the staff kind of thing, like, I'll sit and talk to them and stuff like that. Because -- you know, I wanted to come in here. And I find that, you know, I can have a decent conversation with some of the staff in here.``

``She (staff) always asks, you know, how am I doing, every shift, and she's always there for me if I need to talk to her or anything. Whenever I needed to talk to somebody. ``

`` But, yeah, it was actually helpful to talk to my primary nurse to kind of get things off my chest, because I do have stuff, right? And I know that. ``

``... think about it, we are the ones that are in this place, I think you should have the patients' views on things. Hey, how do you feel about that? Find out what we want or what we need. ``

Programming and services at FPH are helpful

Fifty percent of patients interviewed found the programs and services to be helpful both in terms of giving their day some structure and reducing boredom, as well as teaching them new skills and coping strategies.

The following quotes further describe this category:

``And a lot of the good experiences is, you know, just all the programs and stuff that they have here. And people should take advantage of them when they come in here. ``

``...the LEAP program that I'm taking is really helping me. You know, I wanted to change, like I want to change my lifestyle and it's just the perfect opportunity that I got into this group. ``

``Q: So would you say that programming generally is helpful or unhelpful? A: Helpful, helpful. Because it gets the guys off the ward in the day time. When you get stuck in the ward the time just drags badly in here, you know. ``

`` The assertiveness training really, helped a lot -- -- in life. Q: Really? What was helpful about it? A: It gave me practice to be more assertive in life. Before I wasn't. I probably didn't understand it that fully. ``

``Working in the canteen was helpful, giving me customer service skills. I can translate those to the community, transfer those to the community. If I decide to go back to work ``

“Also they help us do our income tax check, the staff help us, have a chance, I think it's somewhere in the hall, set up a place to help us do our income tax, because a lot of us don't know how to do it and I don't know how to do it.”

No experience with stigma since admission to FPH

In this category, 40% of patients stated that they have had no perceived negative experiences as a result of stigma from the community, from friends outside of FPH, or family members since coming to FPH.

The following quotes describe this category:

“I think they're pretty accepting, as long as – you know, I've been asked by like cab drivers, you a patient here, you work here, what's going on. I'm a patient here, I'm okay saying that. Their reaction is pretty good.”

“Family and friends have somewhat treated me differently in the respect that I'm actually getting help for myself and they're really happy that I'm here.”

Benefits of Taking Prescribed Medication

In this theme, 40% of patients named having the right medication prescribed for them to be helpful in terms of their mental health stability. Many felt that this was one benefit of the care they receive at FPH. The following quotes from the transcripts further describe this category:

“Um, the medication has been helpful. That's one thing I'm very thankful for.”

“Well, at first, when I first came here, I had very paranoia, very paranoid, you know, thinking everybody was trying to hurt me and everything, and then as they got the right medication for me, now I feel much better and I'm more relaxed.”

“...as soon as I'm on the meds I think a lot clearer. The medication helps. Yeah, made a big difference. (Q M'mm-hmm. So was that different, you weren't on those medications before?) Oh, yeah. Yeah, I wasn't on those medications before and it helps a lot. (Q And what has that been helpful for?). The memory, my mood. Keeping me more chipper than usual.”

“...you know, it all depends on how well I'm doing on my medication. If I'm not balanced on my medication, and I'm not chemically, psychologically, psychiatrically balanced, then nothing is going to make any difference.”

Hindering Critical Incidents

Definitions of hindering critical incidents follow, supplemented by quotes from the transcripts to enrich the description.

Exposure to drugs

Seventy percent of patients found all the exposure to illegal drugs at the hospital to be unhelpful. Many patients talked about how they would like more drug searches and wished the hospital would do more to reduce drug use and exposure.

The following quotes from the transcripts further describe this category:

``I think that's a really good thing. I think that they should increase security in the hospital, increase the -- take further steps to increase the drugs, the drug use. To decrease the drug use. Take further steps to increase the -- not increase the drug use, to -- I think I did say increase the drug use. Probably a slip of the tongue. ``

`` Drugs are unhelp -- recreational drug use is not helpful here.There's a pattern whereby a person will come in to the system and they'll start using drugs, and not get caught, they'll move onto another ward and they'll get caught and they'll move back again, and this just keeps on going on..... Drug abuse. That is the major problem with this place, there's more drugs in here than there are on the street. ``

``...you know, for a while it was so bad that we had to move the nurse 2 from this ward down to A1, the handling. Well, there was so much dope smoking you could smell it in the office. These guys were just sitting in the smoking room, you know, toking. And then there wasn't control in any event, so she was moved out, and I think _____ was moved in. ``

`` It's more of the things -- -- of drugs on the ground and a lot of people try to get me to bring in drugs to the grounds and after a while you get tired of that. Most of the guys that approach me I tell them, no, I'm not comfortable doing that. ``

Violence at FPH

Patients in this category talked about how they were often subject to direct or indirect verbal or physical violence at FPH. Seventy percent of the patients interviewed stated they wished that known violent patients would be on separate wards from the other patients. Patients in this category reported the violence as having a negative effect on their quality of life.

The following quotes from transcripts add further meaning to this category:

`` People that are less likely to be violent or people that are more prone to the freak-outs should be on lower wards and the less violent people should be on higher wards, in the sense that that doesn't seem to exist right now. ``

`` Just, there's several people on the ward that I am on that are constantly getting into fights and getting thrown in the side room, just very big agitation. And I -- I'm assuming at the level that I'm at there would be less of that.``

`` Somebody had left their chair and somebody else sat in it and then they got over -- got into a confrontation about it. Took away or stopped the outing, but neither of these two people had had to do with the outing, they just got in a fight and ruined it for the rest of the people. ``

`` And we had to role play kind of thing and I was role playing with this one guy and he thought I was serious at the time. I had been eating a piece of orange and I had the orange peel. Here, get rid of that, it's yours. And he totally got defensive, eh, and the staff had to say, no, it's just role playing, right? ``

`` It drives you nuts, because they do stupid things, they're stealing your things and they're -- they're making inappropriate comments at you. It drives you nuts, you know. ``

`` Let's see, _____, when he first came in, was very paranoid. He was worried about his drug past and, he was a dealer, he had a couple of drops and when he first got here he was, you know, I'm the heavy, I'm the big guy here. And he got into a fight with _____ in the lunch room. And then he went to power hour and he punched the wall and broke his hand. ``

“ I was working out and -- I forget what I was doing, I was on the treadmill or something -- no, no, I was working on the puzzle that we have, right. And I was like ho hum, whatever, and I was listening to music on channel 35, and this chick comes over and she's like, I'm going to turn the channel, and I'm like, no, I'm watching it until four. Watch TV. all day, she got up and turned the channel. What are you doing, get up and turn the channel back. And I thought, you know what? I'm just going to turn it off. So I turn it off and walked away. She turns it back on. So I go up to her, like, what's your problem, she goes, what is your problem, and she pushed me. And I'm going to go tell the staff, no, no, no, so she threw a shot at me, but I ducked her shot, and I gave her one. So we were in the side room, like both of us, for like five hours. ”

Programs and service at FPH are not meeting patient needs

This category speaks to the struggles that 70% of patients found with the current programming and services provided by the various departments at the hospital. These struggles include the programs not being sophisticated enough, not providing enough pay, or not providing skills transferable to the community.

The following are quotes from transcripts that further describe this category:

“ As symptom management, I have that course, and it's not the staff, it's more of the content in the class that I kind of find dull. The course is going to last up to five weeks and it feels like it could be covered in two hours or less. ”

``...they won't even give me an opportunity to go to school or go to work so I can improve myself, but you know, if I'm, you know, getting provisions for day leaves or whatever, so I can go to school or work, and prove to them what I'm gonna do, and I feel that I am remaining stagnant here, and they don't offer any programs for people that are, that are high functioning. I mean like, like what am I supposed to do in the real world? Wash milk cartons and uh you know, make pasta? ``

``The possibility of work in the community for these guys should be addressed as well. I think that, you know, once they've gotten through the system they should be trained to do something, even if it's washing a car by hand, and then when they're kicked out into the community it will help with that.``

``... programs like welding, or like an electricians ticket, those are the things that are valuable to me in the outside world. You know, washing out milk cartons isn't too valuable.”

``...dishes and wiping down the tables and putting away all the food, because it's like half an hour after every meal and I think they only pay like two bucks.``

`` They don't pay enough. We get \$1.50 an hour for work in OT and whatnot. I get two bucks a day for doing the tables in the kitchen. And the criminal justice system pays \$3.50 a day for the same job. So that is a bit of a drawback. I don't like – I find that to be not helpful. I refuse to work for a buck and-a-half an hour. So basically that's not enough. So I think that that should be addressed. ``

Experiencing Stigma since admission to FPH

In this category 60% of patients talked about how they have had problems with stigma due to how they look and / or because of residing within the forensic system (specifically since admission to FPH). This stigma has come from the community, staff, friends and family. For example, some patients talked about the struggles of losing friends since coming to FPH.

The following quotes from the transcripts refer to this category and provide further description:

`` And people in general, just, um, trying to show who my true friends are. People that are trying to find -- they consider me crazy. And will have nothing to do with me anymore aren't a true friend..... Well, definitely (hard to maintain old friends), because there's not a lot of outside contact -- well, it's hard, other than the internet. ``

`` Well, you know, like, I was doing drugs and stuff like that, and, you know, the core group that I grew up with and went to high school with, there was only one of those guys that kind of stuck with me a lot of stuff and after coming in here and stuff. ``

“Family and friends and -- I lost all my friends from the outside. It's hard making new friends and stuff have. I had a friend that I've had for 20 years tell me to stop calling her.
”

“The people from the outside know that I'm here and people always treat me different when they know I'm from here. ”

“My friends, I don't tell them. You know, because most of my friends are from the Okanagan and I talk to them. Like my sister, my sister has kids, my niece, and we hang out. So I was like -- my niece's birthday party was on like Saturday. And I'm, oh, Norma's here, do you want to talk to her? Sure. Man, that's how -- we were hammered, right? She's like, what are you doing down there, I'm just chilling, taking it easy, I couldn't say I'm in the hospital, she'd think it was all weird, right? (Q: So some people you don't want to tell them?) Right. I don't think it would be so complicated, well, okay, I'll be like talking for two hours about it and they wouldn't understand, so I just kind of keep it to myself.”

“Since he is a nice person and he doesn’t look like me he got taken every week!! Twice a week!! And that really bothered me because you know, because maybe it’s the way I look, or I don’t know, I don’t know what it is but it’s against me. It keeps me wondering what did I do. And I’m just trying to figure out why I get treated differently than other people do.”

“Well yeah I remember that my case manager wrote on my chart that I shaved my head and like that lots of people shave their head not like I shaved it bald but real short but he said that I was intimidating I mean what’s that got to do with oranges and apples I mean he sent that to the review board I mean what the hell’s that got to do with my treatment or anything of how I keep my hair, I mean as long as there’s not lice crawling all over my head or anything. I mean I just shaved my head that’s how I like to do my hair. You know. It’s, I don’t know what it is. You shouldn’t judge based on what’s on the cover.”

“...in one situation I got some money from my brother and they’re accusing me of it’s drug money and I said well you know why don’t you go check the bank statements and I can prove where it came from and I believe that I got treated like based on how I appear cause I wear jewellery a few gold rings or whatever. You know. It’s my opinion I don’t know.”

“...some -- there's particular nurses that don't like the way I wear my clothes, but that's -- -- but that comes with anywhere, I suppose. Oh, I wear my pants quite low and they always reprimand me and say that it's offensive.”

Challenges of living on a maximum security ward

In this category 50% of patients spoke about the struggles of living with other maximum security patients. Particularly, participants reported that they found it difficult living on the maximum security wards due to mentally unstable patients, more confinement, and the lack of privileges that come with a higher security ward.

The following quotes from the transcripts further describe this category:

``Um, maybe, you know, being in the A building is -- it's tough, because of the privileges that you don't have and stuff like that. ``

`` Well, in the A building there's -- the people are a lot sicker, right? So the cleanliness of, like, the bathrooms and, you know, just the -- it's hard to find a patient on your level sometimes to talk to, have a conversation with, or, you know, taking over the TV. Or being isolated inside the ward there, not getting fresh air, gym time or something like that. ``

``Ashworth 4 is too -- too many hard-nosed cases there. Too many antisocial types there. It's not that it's tougher; it's that they're antisocial there. The patients there, they tend to put more antisocial patients there. ``

``...don't about Ash, you feel like you're always shut in. And then they give you a small yard, it's not a very big yard and it's all concrete and everything, it's not very comfortable. ``

Perceptions of staff members' displays of respect toward patients

Patients in this category stated they wished that the staff would be more respectful and understanding towards the patients. Forty percent of patients mentioned feeling disrespected themselves by staff, or witnessing staff being disrespectful to other patients.

The following quotes from the transcripts illustrate this category:

``So I drank a couple of cups of water, and she's like, so what are you drinking all the water for? Like kind of like seeing that I wanted to have a clean urine and stuff like that. And I'm like, thirsty, it's hot out, you know, and then I kind of told the supervisor of the ward and, you know, I kind of felt disrespected kind of thing, and I stand up for myself.``

``There was a guy on Elm North there, someone was having a problem climbing the stairs and they made a joke about it. And I'm in the same position; I can't do stairs very well. So I couldn't even live at Hawthorne because I can't do stairs. But, yeah, it was a comment that was made. So the staff needs to be more sensitive towards patients. Yeah, a little more accepting. ``

``But, you know, if it wasn't for working in the canteen I get to see a lot of people, I notice their illnesses, not totally, but kind of. Kind of, you know, and the staff could be a little more caring towards the really bad ones because it's not their fault, they are just messed up. ``

``...it sounds kind of weird but the guy is pretty uh...like he will put down, down patients, and he will find fault with some of the less functioning guys you know to put himself up on a pedestal, you know and make them feel like crap because like, they don't know how to play volleyball very well. And I don't think that's very cool. ``

Concerns about taking prescribed medications

This category highlights patient views around taking prescribed medications. In this category 30% of the patients talked about the struggles they have had with both not wanting to be on medications, and their concerns around side effects.

The following quotes from the transcripts further describe this category:

“I'm worried if I get another doctor they're just gonna put me back on medication I don't need. And you know. It causes a bunch of mental problems, you know, they're neural optics. That's not good for someone that doesn't have a brain disorder. ``

``Q: You didn't like your injections before? A: And she was not willing to work with me on it at all. Q: Why didn't you like it? A: It really made me gain a lot of weight and made me feel really just -- I don't know, I can't explain it, I just didn't like the medication. I'm not much into pills. I like putting things into my body that really knows about. No, like some sort of experiment or something. You put me on medications and kind of monitor and watch them, but the long-term effects of medication, nobody knows about. That's what kind of scares me. ``

CHAPTER FIVE:

Discussion, Implications and Recommendations

This section evaluates and interprets the results and their implications. Specifically it examines the results with respect to the original hypotheses, specifically providing support or non-support for original hypotheses. Theoretical consequences of the results are also examined. Finally, limitations and recommendations derived from the current results are provided.

General Themes

In general, patients described more hindering experiences of going through the forensic system than helpful experiences. This is not surprising since this is an incarcerated population, and treatment at the hospital is coerced through the legal system. However, despite this coercion, participants were still able to name many positive aspects of being in this system. The themes in this study were consistent with those found in the extant literature, and as well, new themes emerged that were not previously identified.

Demographic Data

The demographics are similar to other forensic psychiatric populations. Due to the higher male to female ratio at the facility, it is not surprising that the participants were 90% male. Of particular note, many of the patients had lived in the forensic hospital for an average of 74.4 months. Thus the participants had lived at the hospital for an adequate amount of time to provide an account of a lived experience. Long, Mclean, Boothby, and Hollin (2008) examined quality of life of forensic psychiatric patients finding that they did not find that life satisfaction changed with length of stay. Therefore, it is not expected

that participants in this study would report more negative events than other patients based on their length of stay.

All participants suffered from a disorder that involved psychosis. This is supported in the current literature (Long et al., 2008). One limitation of this study is that diagnosis is not corroborated with file review. Due to this fact, the author postulates that there is underreporting of Axis II disorders. Axis II disordered offenders tend to have a more negative view of the world, which could lead to reporting of more negative events. More research which conducts file review is necessary to determine if this is in fact the case.

In terms of index offences, it was surprising that the majority of the participants were charged with arson (30%). However, there is no known reason this may have influenced results of this study. One limitation of forensic psychiatric patients who commit arson found in the literature is that this population is more prone to suffer from a learning ability (Enayati, Grann, Lubbe, & Fazel, 2008). However, there were no obvious disabilities seen by the interviewer that would limit the information provided. As well, there were no identified concerns by the psychiatrists when they provided assent.

Patient and Staff Interactions

The patients identified four helpful experiences in the forensic system. Not surprisingly the patients spoke most about how helpful it is talking to the staff (80%) and how unhelpful it is when they are disrespected (40%). This is consistent with Johansson & Eklund (2003) who found that patients who felt understood by the staff found this to be of central importance. Patients in this study stated that the quality of the helping relationship between the patient and the staff is a key factor in treatment. The current

study supports these findings, and suggests the importance of staff taking extra time to speak with patients regarding their concerns and treatment. This supports the notion that often in mental health care, the relationship between staff and patients can be a key contributor to positive outcomes. Another similar study found the quality of patient and nursing interaction was an important factor for positive outcome for patients (Richmond & Roberson, 1996). The main themes that came out of this study were that the patients thought the main constitution of good psychiatric care was the relationship between the patient and the staff. More specifically they wanted to feel understood by the staff, and felt the 'helping alliance' was the most crucial factor in the staff to patient interactions. As counsellors and clinicians, these results imply that one should not under-estimate the value of creating a therapeutic alliance with forensic inpatients. Furthermore, this population is usually more prone to isolation due to the nature of their illness (i.e. negative symptoms of schizophrenia), and thus often harder to engage. However, the voice of this population reports that this is exactly the type of engagement that they would like from the clinicians.

Of particular concern is that 40% of patients felt disrespected by staff. As noted, an important part of a patient's experience of going through the system is their experience with the staff, as it is possible that this experience can appease or hinder their experience. However, when 40% state they have been subject to disrespect or have seen disrespect to others by the staff, this raises concern. As Koivisto, Janhonen, and Vaisanen (2004) point out, a respectful, empathetic relationship helps the patients to feel safe, understood, respected, and trusting. Future efforts are recommended to target staff awareness of respect toward patients. Lack of respect should not be tolerated from staff in any setting,

especially one where there is a sensitive population. Forensic Psychiatric institutes should raise awareness to this issue, and make efforts to train staff on how to develop a therapeutic alliance. Efforts could be made by offering staff training in motivational interviewing, and other techniques that teaches empathy building skills. Furthermore, disrespect by staff towards patients should not be tolerated by management. Continuations of existing training programs such as respectful workplace should be continued.

Services Provided

The second highest ranked helpful theme was that of being provided with programming and services at the hospital. Past literature (Harabalja & Sanderson, 2005) has shown that patients value programming at the forensic hospital. The current study is consistent with this previous data. There are few studies that have looked at this factor, and more literature on the specifics of this claim is recommended in future studies. What emerges from this study is that 40% of patients found programs to help with daily boredom, provide them with structure, and teach them new skills. Seventy percent of patients found the current programs were not helpful. This implies that efforts should be made to increase the positives present in current programs, and decrease negatives. Some of the recommendations from patients were to increase the pay of the programs, offer programs for higher functioning patients, and provide programs that teach skills transferable to community work. Long et al. (2008) support this claim, showing that higher quality of life is associated with the presence of leisure activities in forensic patients.

It is recommended that the institution conduct future research in this area. Efforts are currently underway to bring rehabilitation programs up to evidence-based practice. The results of this project will be helpful in aiding to re-write programs, to ensure they are meeting patients' needs. Patient satisfaction with programs should be revisited after completion of this program.

Stigma

Livingston and Balmer (2006) found that 21.4% of their sample of forensic psychiatric patients reported high levels of internalized stigma, and 33% believed that others routinely discriminated against them. Findings of this study found elevated rates of patients who reported experiences with stigma (60%). Efforts at reducing this stigma should be targeted by clinicians in the field. This may reduce shame felt by patients, and well as ease reintegration back into the community. Efforts could also be made on educating the community on forensic psychiatric patients, and reaching out to family and friends of those who come into forensic services. Many patients stated they had lost friends they had previously to entering the system. Efforts at educating friends and family at an education series at the hospital, and conducting outreach work may limit this stigma. By bridging this gap, patients could experience more social support, thus providing them with more protective factors against risk to self, and others (Webster, Martin, Brink, Nicholls, & Middleton, 2004).

Furthermore, it is noted that 40% of the stigma experienced by patients in this study came from staff at FPH. This is alarming, especially in light of aforementioned results that speak to the importance of staff treating patients with respect. All efforts should be made to raise staff awareness and sensitivity to this matter.

Medications

Medication adherence was not previously identified as a potential helping or hindering factor in this study but was reported in the interviews. Results showed that 40% of participants in this study stated they found medications helpful, 30% stated they were unhelpful, and 30% did not mention medication at all. What stood out was that many patients found medications helpful in terms of stabilizing their mental health. This is encouraging as adherence to medications can be a challenge in this population (Pyne, McSweeney, Kane, Harvey, Bragg, & Fischer, 2006). These findings are also consistent with Long et al., (2008) who found that those with the least amount of medication side-effects, and a decrease in symptom severity reported higher life satisfaction. Also, those who stated the negatives of medications, such as side-effects, may be able to be targeted for education around the benefits around medications. Two particular programs at the hospital, Symptom Management, and Medication Management target this concern. The current study supports the need for programs like this to be running at the hospital. Understanding the patients accounts of medication concerns is also important, because it has been shown to substantially increase both functioning and quality of life in psychiatric patients (Lehman, Carpenter, Goldman et al., 1995).

Drug Exposure

Exposure to drugs at FPH was pointed out as hindering by 60% of the patients. This was not examined in the literature previously to the study. However, drug use has implications on the mental health of those who are mentally ill, as it is associated with aggression, problematic anger, persistent offending, and criminal activity (Lumsden Hadfield, Littler, & Howard, 2005). It is also identified that those with concurrent

disorders are more likely to engage in violence than those with mental illness alone (Monahan, Steadman, Silver, Appelbaum, Robbins, & Mulvey, 2001). Substances are also shown to exacerbate psychotic symptoms in those with pre-existing disorders (Wheatley, 1998). Wheatley also suggests that substance use may contribute to stress, which then increases harm to self or others. Based on all these negative consequences of drug use in this population, efforts should be made to lower drug use and exposure at the hospital. Patients in this study spoke about how hard it is to stay clean when they often exposed to drugs from other patients. It is recommended that there be more thorough drug searches by the staff. It is also recommended that as these drug searches will likely not eliminate all drugs, more services should be provided for patients on how to deal with substance concerns. This can be done by providing more concurrent disorder services, such as counselling and group therapy.

Counsellors and clinicians may also use methods such as motivational interviewing in their everyday practices. Motivational interviewing has shown promising results as an effective intervention for psychiatric patients (Chanut, Brown, & Dongier, 2005). Future research efforts should be made on the best interventions for working with forensic patients specifically on substance use. These methods can be employed to help patients refuse drugs, and lessen the effects of triggers in their environment.

Violence Exposure

Seventy percents of participants in this study stated they are regularly exposed to violence. Experiencing and witnessing aggression can be a major stressor to patients on psychiatric wards. Patients in the current study spontaneously talked about violence at FPH, describing the types of violence, and giving specific accounts of incidents of

violence. These findings support and Brink, Harabalja, and Nicholls (2006) research where the majority of the participants reported that they had been subject to verbal aggression and physically aggressive behavior in the past year.

Verdun-Jones, et al. (2006) asked 40 patients about their experience with aggression on the wards. Patients in this study reported that witnessing or being subject to this violence caused them to feel anger (35.5%), fear, (16.1%) and anxiety (12.9%). This is consistent with the current study where participants talked about the difficulties and irritation they felt around violence exposure. The high levels of aggression, combined with the negative emotional states it produces in patients causes concern. Furthermore, stressors have been shown to lead to exacerbation of psychiatric symptoms, increased risks for additional trauma, and emotional distress (Goodman, 2006; Mueser et al., 1999). It has also been shown that there exists a strong association between stressful events and substance use disorders (Brown, et al., 1999). Therefore, it is recommended that future studies take a more in depth examination of the effects aggression has on this population. Preliminary effects seen in this study are that it agitates patients and negatively affects their quality of life. Further recommendations are that all efforts should be made at offering patients a safe environment to talk with counsellors or other clinicians about their experiences with aggression. From an institution perspective, recommendations from the Verdun-Jones, et al. (2006) study should be implemented. These recommendations cover things such as new violence de-escalation training models for staff, updating risk management forms etc.

Maximum Security Ward Life

Another theme that emerged is the struggle of living on a maximum security ward. A recent study by Long et al., (2008) found that patients who live in low security wards reported a higher level of satisfaction with their living situations. As well, Daly (1999) found lesser restricted conditions led to higher quality of life. Sixty percent of patients in the current study described the challenges of living with mentally unstable patients, being confined, and their lack of privileges. This is consistent with Daly (1999) findings that comfort, privacy, personal control, and freedom of choice influences life satisfaction. This is especially highlighted in the quote, “you always feel shut in. And then they give you a small yard, it’s not a very big yard, and it’s all concrete and everything, it’s not very comfortable”. Patients from different security wards talked about maximum security ward challenges, even participants who had moved on to less secure wards at the time of the interviews. Maintaining maximum security wards is a necessity to balance risk in the forensic system, thus it is unclear what could be done to reduce the negativity. Future research could be helpful in examining how and if one could improve this factor.

Stress and Forensic Psychiatric Populations

It is not inconceivable that a patient may find being in a psychiatric facility traumatic (Frueh et al., 2000). In this study, patients did not specifically describe their experience as traumatic, but they did list a number of negative events as being stressful. As previous research shows, stress can lead to exacerbation of psychiatric symptoms, increased risks for additional trauma, and emotional distress (Goodman, 2006; Mueser et al., 1998). Therefore, reducing the number of hindering experiences, and increasing the helpful

incidents may improve the mental health of patients. Efforts at expanding access to counselling services and other avenue of stress reduction may appease conditions for patients.

Arrest and Custody

A few studies stated that being handcuffed or transported in a police car can have harmful effects on patients (Frueh et al., 2000). In the Frueh study, 51% of participants felt distressed by handcuffing and being taken into custody, even up to one week after the event. This was not reported in the current study. It is postulated that a limitation of this study is the construct validity of the interview questions in addressing this issue. It was difficult to examine this area without using leading questions, so it was hoped that leaving the interview open would allow participants to spontaneously bring up this event. Since it was not mentioned in any interviews, it is unclear if this is because participants had no negative experiences with this matter. It is also possible this was not mentioned as a result of patients having resided at the hospital for many years. It is recommended that future research find ways to revisit these areas.

Summary of Implications and Recommendations for Counselling

Many recommendations were made throughout the discussion section, and it was noted that there are implications where counselling can be helpful for patients in a forensic hospital. The most helpful incidents patients reported were that of being able to talk to staff, and of feeling heard and respected. Patients' spoke of aggression, medication struggles, interpersonal struggles, drug exposure, and programming as all affecting their lives. Counselling can provide patients with a safe space to explore all these concerns, thus striving to improve their mental health. Counselling would allow patients a place to

feel heard and respected by staff. This would also likely increase the patients' feelings of respect from staff. Counselling would also serve as an environment where patients could be in control of their treatment, and learn coping skills to translate into this potentially stressful environment.

Furthermore, patients are asking for a more therapeutic stance from the staff, stating that they find this to be very valuable. Therefore, it is recommended that forensic psychiatric staff aim to adopt a more therapeutic stance. This can be a challenge, as one must balance this stance in relation to the context. It is not always easy to be client-centered in an environment that is treating "criminals". It is also difficult to work from this perspective with a population that needs to balance risk, and a population that has many personality disordered individuals, who may exploit and manipulate. However, with taking context into consideration, one should still aim to adopt this therapeutic stance as the benefits can often outweigh the negatives. The power of the therapeutic relationship has been shown time and time again to serve as a protective factor against many negative behaviors.

Limitations and Suggestions for Future Research

One limitation of this study is that of sample size. It is recommended that future studies should use a larger sample. Previous studies with this populations found that interviews with this population tend to yield shorter interviews than other populations (Verdun-Jones et al., 2006). By expanding the number of participants, more information can be gathered with shorter interviews. It would also be helpful to obtain file review information to supplement and corroborate interviews. Finally, each of the factors identified should be examined in more depth to add to the extant literature.

Conclusions

In support of previous literature of psychiatric patients experience in the forensic system, the present investigation demonstrated a number of variables associated with reported quality of their provided experiences. These findings indicate a number of individual and situational factors that help or hinder the experience within the system. Clinicians in the field of forensic psychiatry need to take account of the existence of the nature and variability of factors that influence this population. As with this present study, future research should focus on how experience is hindered or helped by factors within the forensic system. This can be done by looking at individual patient characteristics, as well as addressing systemic gaps.

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APPENDICES

Appendix A



BC Mental Health & Addiction Services

An Agency of the Provincial Health Services Authority

November 30th, 2007

Dr. Norm Amundson
Department of Educational and Counselling Psychology, and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. V6T 1Z4
Phone: (604) 822-8229 Fax: (604) 822-3302

Dear Dr. Amundson:

Re: Resubmission of Proposal “The Experience of going Through the Forensic System for Mentally Disordered Offenders: A Patients’ View on What helps and What hinders”

The FPH Research Committee has received all requested documents outlined in our letter to you of November 23rd, 2007 pertaining to the re-submission of the above noted research proposal.

The approval to conduct this research is now effective immediately.

Congratulations, and please do not hesitate to contact me for further information.

Sincerely,

J. Brink, MB ChB BA Honours, FCPsych (SA) FRCPC
Scientific Director
Forensic Psychiatric Services Hospital
B.C. Mental Health & Addictions.

Cc: Lynda Bond, Tracey Brickell, Devon Harabalja

Appendix B

THE UNIVERSITY OF BRITISH COLUMBIA**Research Ethics, Office of Research Services***Suite 102, 6190 Agronomy Road**Vancouver, B.C. V6T 1Z3**Phone: 604-827-5112**Fax: 604-822-5093*

Our File: H07-01978

October 23, 2007

Dr. Norman E. Amundson, Educational & Counselling Psychology, and Special Education

Dear Dr. Norman E. Amundson,

RE: Your proposed study: **The Experience of Going through the Forensic System for Mentally Disordered Offenders: What Helps and What Hinders?**

The University of British Columbia Behavioural Research Ethics Board has reviewed the protocol for your proposed research project. The Committee found the procedures to be ethically acceptable and a Certificate of Approval will be issued upon the Committee's receipt of written agency approval from the Forensic Psychiatric Hospital.

If you have any questions, please call me at 604-827-5112.

Sincerely,

Shirley A. Thompson
Manager, Behavioural Research Ethics Board

Appendix C



The University of British Columbia

Department of Educational and Counselling Psychology, and Special Education

Faculty of Education

2125 Main Mall

Vancouver, B.C. V6T 1Z4

Phone: (604)822-8229 Fax: (604)822-3302

CONSENT FORM

Title of project: The Experience of Going Through the Forensic Psychiatric System for Mentally Disordered Offenders: A Patients' View on What helps and What Hinders?

Principal Investigator: Dr. Norm Amundson, Educational and Counselling Psychology, Department of Education. Phone: 604-822-6757.

Co-Investigator: Devon Harabalja, MA Student, Educational and Counselling Psychology, Department of Education. Phone: 604-524-7730.

Co-Investigator: Dr. Colleen Haney, Educational and Counselling Psychology, Department of Education.

You are invited to participate in a research study as a part of Devon Harabalja's Masters in Counselling Psychology Thesis paper.

Purpose of the research

This study examines the experience of persons going through the forensic psychiatric system.

Study Procedures

If you agree to participate in this research, you will be asked to meet with a researcher in order to complete a one hour interview. During the interview you will be asked the following question: I am interested in hearing about your overall experience of going through the forensic psychiatric system. Now over this time, you may have experienced some things that you felt were helpful, and some that may not have been helpful to you. Can you describe any events you may have experienced like this, starting with either helpful or unhelpful experiences?

The interview will be done at a time that is convenient for you. You will receive monetary compensation of a \$10.00 gift certificate to use in the Forensic Psychiatric Hospital Canteen for answering the questions. You must complete the entire interview to receive compensation. Compensation will be issued immediately after the interview.

Potential Harms

If the interview causes distress at anytime, you may talk to nursing staff at FPH. You may also call Pastor Tim Fretheim to set up an appointment if you feel you need additional support. You also have the right to refuse to answer the questions of your choice, and stop at any time.

Potential benefits

This research can potentially benefit clients in the future by providing clinicians information that can help patients journey through the forensic system.

Participation and alternatives

Your participation is voluntary and you can refuse to participate at any time. Whether you decide to participate or not, you will continue to receive all the social, community and health services you already have access to. If you decide to participate and change your mind later on, you can quit the research at any time.

Confidentiality

All the information you will give in the interviews will stay strictly confidential and will only be used for this study. No information revealing your identity will be disclosed. In order to protect your confidentiality, a number will be used for data entry, instead of your name. The list of names associated to the numbers will be kept in a locked safe that only the researchers will be able to consult. This list of names will be destroyed five years after the end of the study.

The use of an audiotape will also be used, and will only be listened to by the above mentioned researchers. After the study is complete the audiotapes will be destroyed five years later. During the duration of the study, the tapes will be locked at UBC, and only be accessible by the researchers.

In terms of information given during the interview, all information will be kept private and confidential. The only times that confidentiality will be broken is under the following conditions: report that you think a child or children are being abused or neglected, if there is a court order, or if you report you might harm yourself or others.

Publication

When the results of this study are published, no identifying information will be used. Only themes will be pulled out of all the interviews combined.

Commercialization and conflicts of interest

Devon Harabalja is the researcher conducting the interview in this study. She is also an employee of the hospital. As per ethical guidelines, she cannot disclose any information from the interview in other area of your treatment. If you are uncomfortable with this situation, you may feel free to decline to participate with no consequences. You may also contact Norm Amundson (listed above) at any point if you would like information about this research from a source outside of FPH.

Consent

This study examines the experience of going through a forensic psychiatric system, from a “what helps and what hinders” perspective. By signing below, you are agreeing to participate in this study. It is important that you understand what the research is and that all your questions have been answered to your satisfaction. Take the time to ask questions about the project before signing, so you are sure that you understand what the study’s about. If you have further questions or if you find the information that you have received vague or unclear, you can contact:

**Dr. Norm Amundson, Educational and Counselling Psychology,
Department of Education. Phone: 604 822 6757.**

**Devon Harabalja, M.A. Student UBC, Education and Counselling
Psychology Phone: (604) 524-7730**

If you have questions or concerns pertaining to your rights as a participant in research, you can contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598

If you decide to participate, you can keep a copy of this document.

Your participation

I declare:

- 1) That I have read and understood the information about this research;
- 2) That I understand that I can ask questions at anytime in the future;

3) That I freely consent to participate to this research by signing this document.

4) That I have received a copy of the 4 pages of the consent form.

I therefore give my consent to participate in this research and to use the information obtained for science or for improving the services that I receive.

Participant's signature

Participant's name (print)

Date

Appendix D



The University of British Columbia

Department of Educational and Counselling Psychology, and Special Education

Faculty of Education
2125 Main Mall
Vancouver, B.C. V6T 1Z4
Phone: (604)822-8229 Fax: (604)822-3302

Psychiatrist Assent Form

The Experience of Going through the Forensic Psychiatric System for Mentally Disordered Offenders: A Patients' Opinion on What Helps and What Hinders?

Principal Investigator: Dr. Norm Amundson, Educational and Counselling Psychology, Department of Education. Phone: 604 822 6757.

Co-Investigator: Devon Harabalja, MA Student, Educational and Counselling Psychology, Department of Education. Phone: 604-524-7730.

Co-Investigator: Dr. Colleen Haney, Educational and Counselling Psychology, Department of Education. Phone: 604-822-4639.

I, _____, am the physician responsible for the care and treatment of _____ [date of birth:

____/____/____] while this individual is under the care of the Forensic Psychiatric Services Commission. Having assessed the above-named individual, I am of the clinical opinion that s/he is capable of providing consent to participate in a research project. Further, as a voluntary research participant who is able to withdraw at any time or to refuse to answer questions that are distressful or upsetting, I do not believe that s/he will experience undue harm or distress as a result of this research participation.

I assent _____

I do not assent _____

Signature: _____ Date: _____



Appendix E
The University of British Columbia

Department of Educational and Counselling Psychology, and Special Education

Faculty of Education
2125 Main Mall
Vancouver, B.C. V6T 1Z4
Phone: (604)822-8229 Fax: (604)822-3302

INTERVIEW QUESTIONS

Title of project: The Experience of Going through the Forensic Psychiatric System for Mentally Disordered Offenders: A Patients' View on What helps and What Hinders?

Orienting Question (1st question to be asked)

I am interested in hearing about your overall experience of going through the forensic psychiatric system. Now over this time, you may have experienced some things that you felt were helpful, and some that may not have been helpful to you. Can you describe any events you may have experienced like this, starting with either helpful or unhelpful experiences?

Sub-questions if not mentioned already:

- ◆ What has your experience been like living on the wards?
- ◆ What is your experience of interacting with staff at the hospital?
 - What has been helpful?
 - What is not helpful?
- ◆ Do you feel people treat you any differently because of where you are (FPH)?
- ◆ What advice would you give to the hospital staff on helping improve your care?
- ◆ Any further comments you would like to mention about your experience what we haven't covered?

Appendix F



The University of British Columbia

Department of Educational and Counselling Psychology, and Special Education

Faculty of Education

2125 Main Mall

Vancouver, B.C. V6T 1Z4

Phone: (604)822-8229 Fax: (604)822-3302

Demographics Form

Patient ID #: _____

Today's Date: _____ (YYYY) _____ (MM) _____ (DD)

What unit do you currently live on: _____?

IDENTIFYING INFORMATION

1. Legal status: _____

(Not criminally responsible; Unfit; Remand; Temporary absence; other, unknown)

2. Gender: _____

3. Date of birth: _____ (YYYY) _____ (MM) _____ (DD)

4. Ethnicity: _____

5. Marital Status: _____

6. Highest grade completed: _____

7. Date of most recent admission to FPH: _____ (YYYY) _____ (MM) _____ (DD)

8. Date of Index Offence (most recent charge): _____ (Year)

9. Type of Index Offence(s) (what the charge was for): _____

CURRENT MENTAL HEALTH STATUS

1. Psychiatric Diagnosis: _____

CIRCUMSTANCES

Have there been any unusual circumstances in the past 7 days that you feel may affect how you are currently feeling? (E.g. review boards, seclusion, visit, etc.)

Appendix G



The University of British Columbia

Department of Educational and Counselling Psychology, and Special Education

Faculty of Education

2125 Main Mall

Vancouver, B.C. V6T 1Z4

Phone: (604)822-8229 Fax: (604)822-3302

LETTER OF INTRODUCTION

Title of project: **The Experience of Going Through the Forensic Psychiatric System for Mentally Disordered Offenders: A Patients' View on What helps and What Hinders?**

Principal Investigator: Dr. Norm Amundson, Educational and Counselling Psychology, Department of Education. Phone: 604-822-6757.

Co-Investigator: Devon Harabalja, MA Student, Educational and Counselling Psychology, Department of Education. Phone: 604-524-7730.

Co-Investigator: Dr. Colleen Haney, Educational and Counselling Psychology, Department of Education.

*This Project is a part of Devon Harabalja's Masters in
Counselling Psychology Thesis*

Purpose of the research

Canada has a significant population of mentally disordered offenders who require treatment in the forensic system. While going through the forensic system, patients may encounter a variety of situations that can cause stress and a variety that appease stress.


Study Procedures

Based on the need to understand the experience of being a patient in the forensic system, this project was designed. The project will use a one hour interview to give voice to the offenders asking them to describe their experience, focusing on what they find helpful, and what is not helpful in going through the forensic system. The data will be collected at the Forensic Psychiatric Hospital with approximately 10-12 male and / or female participants. The interviews will be transcribed, and themes will be pulled out of the transcriptions.

Ethical approval for this study has been granted through both the UBC ethics board, as well as the FPH Ethics committee.

If you have anymore questions, please feel free to contact researchers at the numbers above.

Appendix H

	<p>The University of British Columbia</p> <p>Dr. Norm Amundson</p> <p>Department of Educational and Counselling Psychology, and Special Education</p> <p>Faculty of Education 2125 Main Mall Vancouver, B.C. V6T 1Z4 Phone: 604 822 6757</p>
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Would you like to Participate in a Research Study?

Title of project: **The Experience of Going Through the Forensic Psychiatric System for Mentally Disordered Offenders: A Patients' View on What helps and What Hinders?**

You are invited to participate in a research study as a part of Devon Harabalja's Masters in Counselling Psychology Thesis paper.

This study aims to examine the experience of persons going through the forensic system asking what has been helpful, and what has been unhelpful.

If you agree to participate in this research, you will be asked to meet with a researcher in order to complete an interview that will take approximately one hour. The interview will be done at a time that is convenient for you. Approval to participate must be approved by your psychiatrist.

You will receive monetary compensation of a **\$10.00** gift certificate to use in the Forensic Psychiatric Hospital Canteen for answering the questions. **You must complete the entire interview to receive compensation. Compensation will be awarded immediately after the interview.**

If you are interested in participating in this study, please contact Devon Harabalja at (604)524-7730.

Appendix I

Helpful and Hindering Critical Incidents

Helpful Critical Incidents

<u>Category</u>	<u># of Incidents Reported</u>	<u># of Participants Per Category</u>
Talking with staff	13	8
Programming & services	8	5
No experience with stigma	4	4
Taking Prescribed Medication	5	4
Are treated with Respect by staff	1	1
Drug & Alcohol Services	3	2

Appendix I-2

Helpful and Hindering Critical Incidents

Hindering Critical Incidents

Category	# of Incidents Reported	# of Participants Per Category
<u>25% or more participant agreement:</u>		
Violence Exposure	13	7
Programming & Services	9	7
Exposure to Drugs	7	7
Stigma	10	6
Maximum Security Ward	6	5
Lack of Respect From staff	7	4
Taking Prescribed Medication	3	3
<u>Less than 25% participant agreement:</u>		
No Conjugal Visits	1	1
Do not Like the Food	2	2
Lack of Control Over Own Treatment	2	2
Inconsistency of Rule Enforcement by Staff	2	2
Too Long in Custody Of Hospital	1	1
Frustration with Other Patients	1	1
Hard to get a hold of Team Members	1	1

Appendix J

Sample Interview

Q Okay. So I'm interested in hearing about your overall experience in going through the forensic psychiatric hospital. Now, over this time you may have experienced some things that you felt were helpful and some that you felt were not helpful to you. Can you describe any events that you may have experienced like this during, either a helpful or unhelpful experience?

A Well, well, I've had a lot of helpful ones, different people here helped me out. The people, when you get to know the people that live here, once you get to know them.

Q Yeah?

A Sometimes it's nerve-racking getting to know everybody new that comes in, it's kind of nerve-racking. Same as the staff, like, until you get to know them.

Q M'mm-hmm?

A And then you feel more comfortable with them.

Q Okay, good. So you feel comfortable with them now?

A Yeah.

Q Yeah. And what's been helpful about feeling comfortable with them?

A Well, at first, when I first came here, I had very paranoia, very paranoid, you know, thinking everybody was trying to hurt me and everything, and then as they got the right medication for me, now I feel much better and I'm more relaxed.

Q Oh, good.

A I don't think everybody is talking about me or saying things or going to hurt me or something.

Q M'mm-hmm. So has there been anything specifically, like, that a certain staff member has done that's been especially helpful?

A Yeah, my doctor, especially my doctor, my ^^ are very, very helpful to me.

Q Yeah. What did they do that's helpful?

A Well, they always try to give me an out, a work detail, go to the ^^ and stuff, something better, something better, always something better for me.

Q Okay, good.

A When I cooperate, but sometimes I don't cooperate 'cause just I feel stubborn or something.

Q M'mm-hmm. So they've been helpful in that way. What about in terms of any other staff?

A Yeah, my primary nurses, we have primary nurses in these wards here that look after us.

11 Q Yeah?

A And she's really helpful too, Barb, the primary nurse.

Q Okay. What does she do that's helpful?

A She always asks, you know, how am I doing, every shift, and she's always there for me if I need to talk to her or anything.

Q Oh, okay. So she's been there to talk to you?

A Yeah, whenever I needed to talk to somebody.

Q Okay, excellent. Anything else that any of the other staff have done that has been helpful?

A Well, they're pretty fair, with the smoking bothering and all that, pretty well, giving me gum, with the changes and everything.

Q Oh, a substitute for your stress?

A Yeah, ^^.

Q Gotcha, gotcha. Okay. Anything else that – with regards to the staff that you found has been helpful?

A Well, when you get to know them they're very easy-going.

Q Yeah?

A Yeah.

Q Good.

A Yeah.

Q It sounds like you've had a fairly positive experience with the staff.

A Yeah.

Q Would you say that there's been anything that's been unhelpful about the staff?

A Not really, no, I can't, honestly.

Q Good. That's nice to hear.

A Yeah.

Q So nothing that they could do differently or --

A No.

Q No, okay. In terms of living on the wards, like, and it can be any ward, like the Ash building or the Elm building, I see you've been in a few wards.

A Yup.

Q Is there anything that -- what's your experience been like living on the different wards?

A I don't about Ash, you feel like you're always shut in.

Q Yeah?

A And then they give you a small yard, it's not a very big yard and it's all concrete and everything, it's not very comfortable.

Q M'mm-hmm?

A In the A building, that is.

Q M'mm-hmm.

A But here right now, we've got a huge smoke pit out back for walking around, we can walk around, and we've got more grounds here, we have more access to grounds.

Q Okay.

A So every step of the way it gets easier and easier for you.

Q M'mm-hmm. So it's been helpful then, I guess, in coming to --

A Yeah, it is, in the A building, yeah.

Q Because of the less secure --

A And you've got more privileges to go to programs, if you want to, or go the library or...

Q M'mm-hmm?

A Yeah.

Q Okay. And in terms of living on the wards with the other patients, what's that been like?

A Well, sometimes it seems like everybody is in your space, but then that's if you're having a bad day --

Q Yeah.

A -- you might think that, but then some days you think, well, there's not very many people here today, and then you think, well, there's lots of people here, but they just don't seem that close, though.

Q Right.

A It's so big here.

Q Oh, okay, like actually in your physical space?

A Yeah.

Q Yeah, okay.

A And when I want to be by myself I just go to my room and have a sleep or something. That's a good thing too.

Q So you're able to do that on this ward?

A Yeah.

Q Anything else that's been helpful in terms of living on the wards or other patients?

A Well, I've visited all of the wards before. Hawthorne was very nice, but I didn't last very long there because I didn't have my medications and I didn't do so well without medications, but it was nice at Hawthorne, it was really nice.

Q Yeah. What did you like about Hawthorne?

A I liked those comfortable chairs, new chairs, couches, and you got your own room with carpeting and everything.

Q Yeah.

A And plus at Hawthorne you can plug things in in your room. We don't have no plugs in our rooms here.

Q Oh, okay. So it's a pretty nice, like, building then at Hawthorne?

A Yeah, yeah.

Q Yeah.

A And in ^^ San Jose, I've been there for a year, but you know from before that they're still there, working there, the building's getting older too.

Q Oh, okay. So a continuation of –

A Yeah.

Q Good. Has there been anything about living on the wards or any interaction with the other patients that's been not helpful?

A Yeah, sometimes some people get in a bad mood or else you're in a bad mood and then you say something just to bug them, and then it doesn't go over very well.

Q Oh, okay.

A Yeah.

Q Is there an example of that you can remember?

A Well, I try to keep away from arguing too much, but then I argue too with a lot of people. Sometimes I tell the staff or just they'll tell the staff, or else you'll tell the staff and they'll talk to the person.

Q Right. So has there been an incident where you've had that in the last little while?

A Not in the last little while, no.

Q Okay. So this is from a while ago?

A Yeah.

Q Can you remember any time where you had that --

A I think someone was bothering me or teasing me or something like that and it was bothering me.

Q Yeah, someone was teasing you?

A Yeah.

Q One of the patients?

A Yeah.

Q Okay. And what happened with that?

A Well, I think I told the staff on him and they talked to him and that was the end of it.

Q Oh, okay, good. So the staff sort of intervened?

A Yeah.

Q Good, good, okay. You've been here for a little while now?

A Yeah.

Q Have you felt that since you've been at the hospital that people have treated you any differently, in terms of, either out in the community when you go out?

A No, no. Well, not really, no.

Q Okay, good. What about in terms of any of the people that you used to know before you came in here?

A I don't see them that often, people.

57 Q Yeah.

A Yeah. Usually I'm just with my dad or else I'm -- I don't go anywhere.

Q Oh, okay. So your dad comes out and takes you out then?

A He used to see me since Christmas, but then he stopped taking me, because he got mad at me for selling this watch he bought me for Christmas for cigarettes.

Q Oh, okay.

A Yeah. He drops off parcels for me every week and that's about it.

Q Okay. Anything else at all about the hospital, the whole system, that you thought was either helpful or unhelpful?

A Well, it seems helpful that they always assign a lawyer for you and everything for your review board, so they can talk for you.

Q A which, sorry?

A A lawyer for you, for your review board.

Q Oh, okay.

A That's helpful, because I don't know what to say to them. The lawyer usually does the talking for me.

Q Oh, okay.

A That's helpful, having him around. Also they help us do our income tax check, the staff help us, have a chance, I think it's somewhere in the hall, set up a place to help us do our income tax, because a lot of us don't know how to do it and I don't know how to do it.

Q Oh, yeah. That's great. I imagine anyone would find that helpful.

A Yeah.

Q Myself included. Yeah, that's great. They help you with, like, the sort of day-to-day

--

A Yeah.

Q M'mm-hmm, okay. Anything else that's been helpful?

A Well, right now I'm not in programs, but if I do want to go to programs I got to think about it, because I always change my mind at the last minute about program.

Q Oh, okay.

A So I don't know what -- because I was thinking about going back to school again, taking my GED in here.

Q Oh, really?

A Yeah, because I never finished it. They were just going to test me and then I quit, yeah.

Q So what's your experience been like in programs so far?

A Well, it's ^^ good.

Q Yeah, you enjoyed them?

A Yeah.

Q So how come you stopped going to them?

A I think I was -- I ran away from the hospital one time ^^, so I didn't finish it.

Q Oh, so you got your privileges taken away for a while?

A Yeah.

Q Okay. So would you say that programming generally is helpful or unhelpful?

A Helpful, helpful.

74 Q Yeah?

A Because it gets the guys off the ward in the day time. When you get stuck in the ward the time just drags badly in here, you know.

Q Yeah?

A When you have nothing to do until three o'clock. That's what I like, three o'clock, when you can go outside and get fresh air and see your friends.

Q Oh, okay, yeah. So you go out and socialize --

A Yeah.

Q -- with the other patients at that time then?

A Yeah.

Q Good. Now, if you had to give advice to the hospital staff on how to improve things around here or improve your care, would you have any advice on that?

A I would just say, just listen to what the patients are saying to you.

Q Yeah.

A Yeah. ^^ at the end they get happier or it could help them.

Q Right.

A I don't know, but they are doing a good job in here, it's pretty good. I like it here.

Q Yeah?

A Some guys say they would like to go to Auburn, I like it here better.

Q Yeah. What do you like about this place?

A It's more relaxed. The staff are always joking around, they're laid back, they are not really strict.

Q Oh, okay, yeah.

A Yeah. If they are too strict it makes you feel like more confined.

Q Yeah. That's good. That's been a positive then, being here with the relaxed staff, people to talk to?

A Anytime you want to, yeah. They always help you, out, like, sometimes they'll go to the banking window for me and everything too.

Q Oh, good.

A That's very good of them.

Q Yeah, that is nice.

Q Yeah, okay. Excellent. Anything in specific you want them to listen about?

A Maybe just when the patients are having big problems.

Q Okay.

A There's a lot -- it's a pretty big hospital, there's a lot of people confined here. You know how short-tempered people get.

Q M'mm-hmm.

A And they just quit smoking and making it easier to quit too.

Q Oh, you just quit smoking, yeah.

A Yeah.

Q True, yeah. Anything else that you would like to mention?

A No, that's about it. That's all I can think of right off the top.

Q That's been helpful, okay. So nothing else that's been helpful or nothing else that's been unhelpful?

A Not that I know of.

Q Nothing you can think of right now?

A No.

Q Okay. Well, that's no problem then. I'll just stop the tape unless you have anything to add?

A No, that's fine.

Q Okay, thank you.