

**The Harsh Reality of Life after the Verdict of Not Criminally Responsible on  
account of Mental Disorder**

By  
Nicole Marie Lefaive

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Approved: Dr. Jamie Livingston  
Associate Professor  
Department of  
Criminology

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**Abstract**

The finding of Not Criminally Responsible on account of Mental Disorder (NCRMD) is not a sentence, nor is it a finding of guilt or an acquittal. Rather, it is a disposition whereby the individual found NCRMD is found to be not criminally responsible for committing an offence. While the outlined objectives of the forensic mental health system are that of a rehabilitation and recovery centered around mental health treatment, the lived experiences of those in the forensic mental health system do not always reflect these objectives. Using a qualitative thematic analysis of interview transcripts of patients who were living in the forensic mental health system, this research sought to highlight similarities between the hardships experienced by those found NCRMD and those experienced by people in other carceral spaces. As a result, five themes were developed which highlighted the punishing experiences of those in the forensic mental health system: 1) Unheard and Ignored Voices; 2) Negative Interactions with Staff; 3) Loss of Identity; 4) Slow Moving Process; and 5) Unpleasant Environment. These themes were then analyzed against two different accounts of punishment: Hayes' (2017) Flew-Benn-Hart account of punishment and Sykes' (1958) conception of the pains of imprisonment to highlight the similar hardships between the prison system and the forensic mental health system.

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## Introduction

The Canadian criminal justice system is a vast and imposing force that approximately 300,000 people come in contact with each year (Crocker, Livingston, & Leclair, 2017, p. 28). Of those 300,000 people, a small population (approximately 1,000) are diverted away from the criminal justice system and enter what is called the Canadian forensic mental health system. Broadly, the forensic mental health system is partially comprised of individuals who have committed crimes but cannot be held criminally responsible for their actions due to suffering from a mental illness at the time of their offence. Currently, the expressed objectives of the forensic mental health system are that of treatment, rehabilitation, and risk management, not the administration of punishment for having committed a criminal offence. A major difference between the forensic mental health system and the criminal justice system is that people found Not Criminally Responsible on account of Mental Disorder (NCRMD) receive a forensic *disposition* instead of a criminal sentence. This is not a finding of guilt or innocence, but rather these dispositions act in a capacity to protect the individual from criminal prosecution, and protect the public from reoffending, while promoting therapeutic treatment and rehabilitation (Livingston, Crocker, Nicholls, & Seto, 2016, p. 6). While the outlined objectives of the forensic mental health system are holistically therapeutic, the subjective experiences of people living within the system are not always congruent with this.

The current literature surrounding the forensic mental health system largely highlights its successes regarding the treatment and rehabilitation of people found NCRMD. However, a gap exists within the literature with respect to how individuals found NCRMD can experience this system negatively and what types of experiences they encounter while navigating their disposition. In an effort to understand how people found

NCRMD can experience the forensic mental health system in ways that are contrary to its expressed objectives, this thesis will employ a thematic analysis to organize and categorize the lived experiences of people found NCRMD living in Canada. Also, this thesis aims to identify similarities between the hardships experienced by people found NCRMD and the hardships experienced by those living in other carceral spaces. My research seeks to provide an alternative perspective to the field of forensic mental health services while privileging the lived experiences of people found NCRMD.

The first section of this thesis explores the current literature surrounding the forensic mental health system, the idea of punishment as a construct, and how the notion of carcerality can be transferred from one institution to another. Next, the conceptual framework of this thesis – the pains of imprisonment – is discussed in detail. Then, the breakdown of the participants and their respective research projects are outlined, as well as the research design and the process of thematic analysis. Lastly, the findings of this thesis are presented and an interpretation of the data is explained within a detailed discussion section exploring their relation to the Flew-Benn-Hart account of punishment as well as the pains of imprisonment.

### **Literature Review**

#### **Not Criminally Responsible on Account of Mental Disorder (NCRMD)**

**What does it mean to be found NCRMD?** NCRMD is a defence used in court whereby an individual is adjudicated not criminally responsible for their actions on account of suffering from a mental disorder. The NCRMD defence is mainly concerned with the mental state of the accused at the time the offense was committed. The finding of NCRMD at the end of a trial is neither a finding of guilt or acquittal, “it is a pronouncement that the person did not possess the mental capacity to form criminal intent

at the time of the index offence” (Livingston et al., 2016, p. 1). It is a tool used by the court to divert the accused person into a more therapeutic stream of rehabilitation targeting their specific mental illness (Livingston et al., 2016, p. 8). Its main purpose is threefold: (1) it prevents the conviction of individuals suffering from mental disorders which render them incapable of making the autonomous decision to act freely, (2) it ensures the safety of the public by imposing restrictions on the freedom of liberty of those found NCRMD that are considered dangerous, and (3) it provides treatment opportunities to people with mental illness who have been found NCRMD (Verdun-Jones, 2014, p. 2).

The history of the defence of NCRMD is originally derived from the *M’Naghten* Rules established in England in 1843 (Verdun-Jones, 2014, p. 3). In 1842, Daniel M’Naghten shot and killed Edward Drummond under the pretense that he mistakenly believed Drummond was Sir Robert Peel, a British statesman who served as the Prime Minister of Britain twice and once served as the Home Secretary of Britain. M’Naghten believed that Peel had sent someone from his campaign to persecute him which lead M’Naghten to kill Peel first under this pretense. M’Naghten was tried on the charge of murder but was acquitted by a jury who used the special verdict of insanity to find him not guilty. As a consequence of the negative public outcry that this acquittal generated, the House of Lords developed what is known as the *M’Naghten Rules*; the most important statement found within the rules was as follows:

We have to submit our opinion that the jurors ought to be told in all cases that every man is presumed to be sane and to possess a sufficient degree of reason... and that to establish a defense on the ground of insanity it must be clearly proved that, at the time of the committing of the act that party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature

and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong. (Verdun-Jones, 2014, p. 3).

The basic elements of the *M'Naghten Rule* have been incorporated into our modern definition of the defence of NCRMD. The modern-day version of the rule is present in section 16(1) of the *Criminal Code*:

No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong (*Criminal Code*, 1985)

Section 16(1) is an essential element of the *Criminal Code* as it outlines in detail the circumstances under which someone cannot be found criminally responsible for a crime. This section serves as the foundation for the principles upon which the forensic mental health system is built. It clearly states that no person shall be found criminally responsible for a crime they committed due to mental illness, which thus implies that they should not be treated as though they are criminally responsible.

Before an accused person can be found NCRMD, the defence must first establish that the individual was, in fact, experiencing a mental disorder at the time the offense was committed. This was previously referred to as 'disease of the mind' in the *M'Naghten Rule*. The term 'disease of the mind' has been used and interpreted in Canadian courts for more than 170 years with regards to the culpability of offences (Verdun-Jones, 2014, p. 4). In the Supreme Court of Canada decision *Cooper* (1980), the presiding Justice of the Peace stated,

In a legal sense "disease of the mind" embraces any illness, disorder or abnormal condition which impairs the human mind and its function, excluding, however,



self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion (Verdun-Jones, 2014, p. 4).

This broad definition of the term encompasses virtually any mental impairment that a psychiatrist or psychologist would classify as a disorder (Verdun-Jones, 2014, p. 5). In practice, an individual who was suffering from a mental illness at the time of their offence and commits an offence as a result of that mental illness can be found NCRMD. For an accused to be found NCRMD, it must be established that the mental disorder manifested itself as a form of “psychotic symptoms” (Walvisch, 2016, p. 3). However, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) does not always work as well in application as it does in theory. As Walvisch (2016) states, the DSM and other similar manuals try to differentiate mental disorders from normal problems of living and ordinary social deviancy that occurs quite regularly (p. 4). With many mental disorders presenting in similar ways to typical human emotion, it is difficult to determine whether criminal behaviour was committed *because* of a mental disorder or because of average social deviancy which makes the job of the psychiatrist or psychologist more challenging (Walvisch, 2016, p. 4).

This problem relates directly to the earlier issue of moral culpability discussed in the *M’Naghten Rule*. If a practitioner is unable to determine whether a behaviour was caused by a mental disorder or from average social deviancy, it makes it very difficult to label an individual as having a mental disorder (Walvisch, 2016, p. 5). If it is difficult to justify the labelling of an accused person as having a mental disorder, it is difficult to justify the punishment or loss of liberties inflicted on people found NCRMD when under the jurisdiction of the forensic mental health hospital. Walvisch (2016) states, “[t]he conclusion to be drawn from this is that the category of ‘mental disorder’ is unnecessary

and harmful, and we should instead focus on the underlying problems of living” (p. 7). Therefore, punishment is not necessarily the answer for people found NCRMD. Rather, treating the mental illness and its causes would be more productive in reducing rates of reoffending. With regards to the defence of NCRMD, the diagnosis of a mental disorder provides the accused with treatment options that would not be available to them in the typical criminal justice system.

**What does the trajectory look like for someone found NCRMD?** The initial process whereby an individual is admitted to and moves through the forensic mental health system is fairly similar for most people found NCRMD. First, the person would go to trial where either a judge or judge and jury would adjudicate the person NCRMD. After a person has been found NCRMD, the court or a Review Board would meet where they render an appropriate disposition for the person found NCRMD. A Review Board is typically comprised of three people: a judge (or a qualified person appointed to a judicial office), a psychiatrist, and another qualified member with experience and training in the mental health field (Livingston et al., 2016, p. 1). Review Boards must consist of these three-essential people, but community members, legal counsel, treatment team members, victims, and family members of the person found NCRMD may all participate in the hearings.

At the Review Board hearing, one of three dispositions can be given to a person found NCRMD: a detention in hospital, a conditional discharge, or an absolute discharge (Livingston et al., 2016, p. 2). A detention in a hospital involves the person found NCRMD being detained within a forensic mental health hospital where they are placed under strict supervision and restrictions. The detention in hospital would occur until the Review Board has determined that the level of risk of the person found NCRMD has

dropped significantly enough to warrant a conditional discharge. However, the restrictions that the forensic mental health system can place on a person found NCRMD vary by case and the specific needs of the individual found NCRMD influence the restrictions imposed. In the circumstance of a conditional discharge disposition, the person found NCRMD is allowed back into the community with substantially more freedom than someone placed under detention, yet they are subjected to the restrictions imposed on them by the Review Board. These conditions can include anything from obtaining a secure place to live, gaining employment upon release, court-mandated counseling, and a host of other conditions aimed at keeping risk levels low (Livingston et al., 2016, p. 2). It is also important to note that a conditional discharge can be issued at the first hearing, bypassing a detention in hospital as the first step towards release.

The third disposition that can be imposed on a person found NCRMD is an absolute discharge. An absolute discharge means that the person found NCRMD is free from the restrictions of the Review Board and the forensic mental health system; however, this is only granted once the Review Board has found that the individual no longer poses a significant threat to public safety (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011, p. 3). If the person found NCRMD is deemed to no longer pose a threat to public safety, the Review Board *must* issue them an absolute discharge under section 672.54 of the *Criminal Code* (1991). After an absolute discharge has been granted, the person found NCRMD is no longer tied to the conditions imposed on them by the forensic mental health system or Review Board.

While under the jurisdiction of the Review Board either due to dispositions of custodial detention or conditional discharge, the person found NCRMD must abide by the conditions imposed on them. During this time, they are also granted periodic hearings

with the Review Board to reassess their progress. The provincial or territorial Review Board is under obligation to hold the first hearing for the person found NCRMD within 90 days of the initial verdict being rendered (Latimer, 2006, p. 13). At these hearings, the Review Board convenes to assess whether the person found NCRMD still poses a significant threat to public safety. Several other factors must be considered during these dispositions such as the clinical and rehabilitative needs of the person found NCRMD, as well as what would constitute the “least onerous and least restrictive” outcome for the person found NCRMD (Livingston et al., 2016, p. 2). The purpose of utilizing a variety of people in the Review Board process is to ensure that the system acts in an inquisitorial capacity as opposed to the adversarial model found in the criminal justice system.

After the initial Review Board hearing is held within 90 days, subsequent hearings will be conducted at regular intervals (at least annually if not more frequently) to determine whether the person found NCRMD still poses a significant threat to public safety. While the person found NCRMD is either spending time under detention or in the community on a conditional discharge, the forensic mental health system is tasked with monitoring their progress. The forensic mental health system and the Review Board have the authority to impose restrictions on the accused such as level of security, and the extent of their privileges inside the hospital or in the community, but they also have the authority to increase those restrictions if they believe the person found NCRMD is not adhering to them correctly (Jansman-Hart et al., 2011, p. 3).

**What is the forensic mental health system?** As stated previously, the forensic mental health system privileges the treatment for those who have been found by a court to be not criminally responsible instead of imposing sanctions that would otherwise be punishing. Its goals consist of providing treatment targeting the specific mental disorder,

and, in turn, addressing the underlying causes of criminal behaviour instead of exclusively addressing the criminal behaviour (Crocker, Livingston, & Leclair, 2017, p. 48).

Over the past 20 years, there has been a considerable increase in the demand for forensic mental health facilities that Crocker et al. (2017) refer to as *forensication* (p. 3). This increase has been attributed to factors such as changes to mental health acts and legislation, the downsizing of psychiatric institutions, lack of community based resources, the criminalization of substance use problems, increased media reporting of violence, and a general intolerance by the public of nonconforming and abhorrent behaviours (Crocker et al., 2017, p. 3).

The landmark ruling in Canada that outlined many of the unique goals of the forensic mental health system can be found in the Supreme Court of Canada case, *Winko v. British Columbia* (1999). In 1983, Joseph Winko suffered from a mental illness that included auditory hallucinations, leading him to hear voices from pedestrians he would pass on the street, eventually provoking him to attack them. Later in 1983, Winko was arrested for attacking pedestrians with a knife, subsequently being charged with aggravated assault, assault with a weapon, and possession of a weapon for dangerous purposes (*Winko v. BC*, 1998, p. 2). At trial, Winko was found NCRMD and was detained at the Forensic Psychiatric Institute in British Columbia (BC), Canada. In 1995, the Review Board directed that Winko be given a conditional discharge from the facility, but Winko appealed the decision seeking an absolute discharge (*Winko v. BC*, 1998, p. 2).

Winko was appealing on the grounds that a conditional discharge under section 672.54 of the *Criminal Code* was unconstitutional and violated section 7 and section 15

of the *Canadian Charter of Rights and Freedoms*. Section 672.54(a) of the *Criminal Code* states that:

where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or review board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely (*Criminal Code*, 1985).

This section of the *Criminal Code* states that when a verdict of NCRMD has been rendered, the presiding Review Board has the obligation to release the person found NCRMD on an absolute discharge once they deem that they no longer pose a threat to the public safety. This would mean that, if the Review Board did agree that Winko was no longer a threat to the safety of the public, they would have to order an absolute discharge on the grounds of section 672.54(a) of the *Criminal Code*.

The second element that Winko was appealing in his case was Section 7(1)(2) of the *Canadian Charter of Rights and Freedoms*. Section 7 of the *Charter* states that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice” (*Canadian Charter*, 1982), and section 15(1) and 15(2) of the *Charter* states:

15. (1) every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability, and;

15. (2) subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups

including those are disadvantaged because of race, national or ethnic origin, religion, sex, age, or mental or physical disability (*Canadian Charter*, 1982).

Winko was arguing that, if a Review Board deems a person found NCRMD is no longer a danger to society, they *must* grant an absolute discharge for the accused and any finding other than an absolute discharge would be unconstitutional under section 7 of the *Charter* by restricting their right to liberty.

Ultimately, the Supreme Court of Canada dismissed Winko's appeal on the grounds that section 672.54 did not violate Winko's *Charter* rights. However, the duties of the Review Board are interpreted in section 672.54 of the *Criminal Code* to ensure that the least onerous and restrictive provisions are placed on the accused, while also considering the needs of public safety. It was concluded in the court decision that, in order for the court to impose restrictive measures upon a person found NCRMD, a positive finding that the person *is* a significant threat to public safety is required, and the least onerous and least restrictive measures are to be consulted first without issuing an absolute discharge (*Winko v. BC*, 1998, p. 3). However, Winko's appeal was still struck down on the basis that restrictions can be placed on the accused if the Review Board believes that the evidence demonstrates that the person found NCRMD *may* pose a threat to the safety of the public, and that "any restrictions on the liberty of the NCR accused are imposed to protect society and to allow the NCR accused to seek treatment, not for penal purposes" (*Winko v. British Columbia*, 1999, p. 6).

These objectives of the forensic mental health system are not always congruent with the experiences of those found NCRMD, which may lead to the person found NCRMD being inadvertently punished through their disposition in the forensic mental health system. Within the current literature examined surrounding the defence of

NCRMD and the forensic mental health system, several articles were consulted which sought to highlight the positive experiences people found NCRMD had within the forensic mental health system, as well as the perspectives of forensic mental health staff such as nurses, doctors, and social workers. For example, Livingston (2016) provides insightful perspectives into how people found NCRMD and forensic mental health staff view a 'successful' life after receiving a forensic mental health disposition. The results indicated that people found NCRMD and forensic mental health staff have a broad range of outcomes and processes that they view as successes as opposed to thinking about it from a strict, public safety standpoint (Livingston, 2016, p. 1). Several articles provide a critical perspective on the experiences of people found NCRMD. For example, Livingston and colleagues (2011) sought to understand the levels of self-stigma felt by people who access mental health services, including 52 people who used forensic mental health services (p. 1). The study found that, qualitatively, people may perceive stigma from their access to forensic mental health services even though, quantitatively, levels of self-stigma are similar to others who access non-forensic mental health services (p. 1).

The existing literature has investigated the positive and negative elements of the defence of NCRMD and subsequent involvement in the forensic mental health system. Not only has this research privileged the experiences of people found NCRMD, but it also has taken into account the experiences of forensic mental health staff, family members, and community members who have been impacted by the forensic mental health system.

### **Objectives of NCRMD and the Forensic Mental Health System**

To conclude and summarize this section of the literature review, the objectives of the defence of NCRMD are outlined as being threefold: (1) it prevents the conviction of individuals suffering from mental disorders which render them incapable of making the



autonomous decision act freely, (2) it ensures the safety of the public by imposing restrictions on the freedom of liberty of those found NCRMD that are considered dangerous, and (3) it provides treatment opportunities to people with mental illness who have been found NCRMD (Verdun-Jones, 2014, p. 2). These functions were outlined in more detailed in the Supreme Court of Canada case, *Bouchard-LeBurn* (2011) where Chief Justice LeBel explained that,

that verdict [NCR] triggers an administrative process whose purpose is to determine whether the accused is a significant threat to the safety of the public, to take any necessary action to control that threat and, if necessary to provide the accused with appropriate care (Verdun-Jones, 2014, p. 4).

The *Winko v. British Columbia* (1999) Supreme Court of Canada ruling also states that the objectives of the defence of NCRMD are to “supplement the traditional guilt-innocence dichotomy of the criminal law with a new alternative...an alternative of individualized assessment to determine whether the person poses a continuing threat to society coupled with an emphasis on providing opportunities to receive appropriate treatment” (p. 2). That ‘appropriate’ treatment and care mentioned in the above quotations is available to the person found NCRMD in the form of the forensic mental health system and community resources.

The objectives of the forensic mental health system are also outlined in the Supreme Court of Canada ruling *Winko v. British Columbia* (1999). While Winko’s appeal was struck down on the grounds that it did not infringe upon his *Charter* rights, it still emphasized two of the major goals of the forensic mental health system which are not entirely congruent to the defence of NCRMD: “the NCR accused is to be treated in a special way in a system tailored to meet the twin goals of protecting the public and

treating the mentally ill offender fairly and appropriately” (*Winko v. BC*, 1999, p. 23).

Both these objectives—treating the person found NCRMD fairly while also protecting the public—are to be achieved through the treatment of the person found NCRMD in the least onerous and restrictive manner until the person found NCRMD is deemed to no longer be a risk to themselves or to the public (*Winko v. BC*, 1999, p. 28).

Therefore, both the objectives of the defence of NCRMD and the forensic mental health system work mainly in two ways: providing treatment to the person found NCRMD while also balancing the protection of the public. However, this raises the question: To what extent can the rights and liberties of a person found NCRMD be restricted in order to ensure the safety and protection of the public?

### **Punishment**

**What is Punishment?** While the Supreme Court of Canada ruled that the restrictions imposed on Winko’s liberties and freedoms were legally justified, the question of whether or not the courts were *morally* justified in the imposition of the disposition still stands. Cavadino (2008) states that punishment can be perceived as legitimate as long as it possesses a moral justification (p. 2). However, a major point of contention within the criminal justice system is the apparent lack of a moral justification for the infliction of pain through restrictive sentences (Cavadino, 2008, p. 2). Since punishment is almost always something that is harmful, painful, or damaging to the individual experiencing it, this begs the question: “what justifies the infliction of punishment on people?” (Cavadino, 2008, p. 2). There are two main schools of thought surrounding the moral and philosophical justification for punishment: reductivism and retributivism.

Reductivism attempts to justify punishment by looking at its potential future consequences, claiming that if punishment is inflicted, less crime will be committed as opposed to if no penalty of punishment was imposed (Cavadino, 2008, p. 3). This is a utilitarian way to perceive the institution of punishment; if punishment does indeed reduce the amount of crime people will commit, it will result in keeping more people safe. Therefore, the pain and harm that one offender endures is justified since it works to keep the rest of the population safe. However, reductivism becomes problematic when one tries to differentiate between managing risk and administering punishment.

If the needs of the many are privileged over the needs of the few, then punitive risk management strategies can be justified by protecting the majority of society while still harming the few who are subjected to it. This directly relates to an objective of the forensic mental health system as outlined by Verdun-Jones (2014), that the defence of NCRMD works to ensure the safety of the public by restricting the liberties of those found NCRMD (p. 2). While restricting the liberties of people found NCRMD may keep the public safer because the person found NCRMD is physically locked up and or legally restricted, the restrictions that are placed on the person found NCRMD as a tool of risk management may be more damaging to the individual than they are constructive in society. Restricting movement and association, forcing people to take medications or comply with other forms of treatment, and detaining them in forensic mental health hospitals are all tools used in risk management, yet, as it will be discussed in the subsequent findings of this thesis, these 'tools' can also be perceived as punishments. Thus, the risk management strategies imposed on people found NCRMD by the forensic mental health system work in a reductivist way to protect the masses of society while not considering the harms that are produced to the people subjected to it.

Retributivism, on the other hand, emphasises the logic that the people should receive punishment based on the fact that they have committed a crime that is morally condemned based on societies social contract (Cavadino, 2008, p. 10). Proportionality plays a direct role in retributive justice because, if punishment is justified as being a natural consequence of committing a crime, then the punishment should be proportional to the offence and the offender should get their “just deserts” (Cavadino, 2008, p. 10). One of the main problems that retributivism must contend with is how it seeks to justify punishment. At first glance, it shares similar undertones to vengeance, or the *eye for an eye* philosophy, in the sense that the offender must be punished simply because they did something wrong.

Some theorists have attempted to counter this notion by referencing the ‘social contract’, a theory that emphasizes that “all citizens are bound together in a sort of multilateral contract which defines our reciprocal rights and duties” (Cavadino, 2008, p. 11). In the social contract, retributive punishment is seen as restoring the balance in society by canceling out the wrongdoing through the enforcement of punishment. However, this social contract also highlights one of the major flaws with retributive justice: the idea that society has been conditioned by this social contract to believe that rule-breaking must be dealt with through the imposition of punishment. Due to this conditioning, society has been led to believe that sanctions such as restorative justice or therapeutic dispositions can only be used as *alternatives* to punishment instead of options in-and-of themselves.

This directly relates to the idea that punishment is a consequence of the logic that has become ingrained through this social contract: punishment must follow if a crime is committed since crime is an action that is morally condemned. Firstly, what society has

considered abhorrent, deviant, or illegal behaviour is defined within the constraints of this human-made social contract. What constitutes deviant behaviour is arbitrary in the sense that society governs what is considered right and wrong, and, thus, what is right and wrong is subject to change based on the popular opinions of the society. Also, it is the role of the lawmaker to assign a punishment that is both fair and equal to the proportion of the crime and to keep these punishments consistent across similar types of crime. However, this system becomes disrupted when mental illness becomes the driving force for the motivation of committing a crime because the individual no longer committed the criminal act due to their own free will.

If mental illness was the driving motivation behind a crime, and it is recognized that those who suffer from a mental illness at the time of their offence have a lowered appreciation for their actions, how can an equal and fair punishment administered to both a competent individual and also someone found NCRMD without being overly punitive? According to Cavadino, it cannot be imposed equally and fairly. Cavadino (2008) writes, “[o]ne serious difficulty is that the theory only applies if our society is a just one in which all citizens are genuinely equal; otherwise there is no equilibrium of equality for punishment” (p. 11). The justification that offenders must receive punishment on the sole premise that they committed an offence is unjust and contrary to the objectives of the forensic mental health system since not all individuals can be held to equal standards of responsibility.

If an individual is lacking moral culpability resulting from suffering from a mental illness, then it would be immoral to subject that individual to the same treatment administered to a person who is found to be morally culpable for their crimes. Although people with mental illness cannot be held morally responsible for their crimes the same

way that people not suffering from a mental illness are held responsible, people found NCRMD still experience pain and punishment similar to that of other offenders through the imposition of therapeutic dispositions in forensic mental health facilities.

**Hospitals as Carceral Spaces.** By exploring the notion that people found NCRMD experience punishment similar to that of people in jails or prisons, hospitals can then be viewed as institutions which act in ways that perpetuate the carcerality of the criminal justice system.

Firstly, the notion that hospitals are an extension of the criminal justice system will be explored through Erving Goffman's concept of the total institution found in his collection of essays in his book *Asylum*. For Goffman, total institutions can be described as, "[an] encompassing or total character symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant: locked doors, high walls, barbed wire, cliffs and water, open terrain, and so forth" (Goffman, 1957, p. 1). Goffman then says that the total institutions in our society can be placed in five "rough groupings" (p. 1). The first group consists of "institutions established to care for persons thought to be both incapable and harmless," which include places like orphanages and group-homes for persons with disabilities (Goffman, 1957, p. 1). The second group consists of "places established to care for persons thought to be at once incapable of looking after themselves and a threat to the community", which includes psychiatric facilities or sanatoriums (medical facilities mostly associated with tuberculosis) (Goffman, 1957, p. 1). The third type of total institution is "organized to protect the community against what are thought to be intentional dangers to it" (Goffman, 1957, p. 1). Examples of this third type of institution include jails, prisons, POW camps, and concentration camps. Next, total institutions include institutions "purportedly established to better pursue some technical

task and justifying themselves only on these instrumental grounds” such as army barracks, ships, boarding schools, labour camps, or compounds (Goffman, 1957, p. 1).

Lastly, total institutions include “those establishments designed as retreats from the world or as training stations for the religious” such as monasteries or convents (Goffman, 1957, p. 1).

Goffman then explains that the basic social arrangement in modern society consists of three spheres: sleep, play, and work. Each of these spheres is distinguished by existing in different places in society with a different set of co-participants, under a different authority and with different rational (Goffman, 1957, p. 3). Therefore, the central feature of the total institution can be described as a breakdown of those barriers which separate the three spheres (sleep, play, work) into one where all of these exist.

Goffman outlines the breakdown of those three spheres into four aspects of life within a total institution: the first aspect is that life is conducted in the same place under the same authority. The second aspect is that each phase of the participant’s daily life is carried out in the company of a large group of other participants who are treated alike. The third aspect states that all of the day’s activities are tightly scheduled, with one activity leading directly into another and the whole circle of activities being imposed on the people from a ruling body or officials. Lastly, the contents of the various activities are brought together as a part of a single, rational plan designed to fulfill the objectives of the institution (Goffman, 1957, p. 3).

While these characteristics can be found individually in a multitude of different organizations in society, many of the people who experience these characteristics in their daily life do so voluntarily and are able to move in and out of the separate spaces.

Goffman provides the example of a farm family, who may live the majority of their lives

in a small, fenced-in space of land, tending to the same patch of garden every day, however, these people are doing so voluntarily and are not “collectively regimented” like those who are confined to institutions (Goffman, 1957, p. 3). Another major difference between how people voluntarily interact with their surroundings versus those in total institutions is the split between the large group of people who must live within the total institution and the relatively small group of people who supervise those individuals. Goffman categorizes this split into inmates (the large group) and staff (the small group) (Goffman, 1957, 3). Goffman (1957) claims that this inmate-staff split is a central feature of total institutions, he says:

staff often see inmates as bitter, secretive, and untrustworthily, while inmates often see staff as condescending, highhanded, and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty. (p. 4)

This staff-inmate dynamic helps to perpetuate the punishing aspects of the total institutions while maintaining the hierarchy of superiority and subordination within the institution. This staff-inmate split can also be seen in the context of forensic mental health hospitals through the dynamics of the staff-patient relationship. This hierarchy of superiority is present among the forensic mental health staff and people found NCRMD who perceive the forensic mental health staff as having total and complete control over their lives. This can lead staff to feel superior and righteous and leave people found NCRMD feeling weak and inferior.

Applying Goffman’s concept of total institutions to forensic mental health hospitals, these institutions employ all the characteristics which are indicative of a total institution and, therefore, not only act spaces of treatment but also function in ways that



punish the people under their care. Central to this notion that forensic mental health hospitals share similar punishing aspects to other total institutions, like jails or prisons, is Michel Foucault's concept of *the carceral*. This concept posits a continuity of punitive criteria between institutions in society which strengthens and instills the rules of punishment within other institutions (Foucault, 1975, p. 301). This continuity has to do largely with the dissemination of power, or lack thereof, within these institutions. The role of the prison and jail in modern society was to focus the power of the state into one institution which would work to reform deviant behaviour through various forms of social control by restricting a variety of liberties. The social control functions of penal institutions has expanded by spreading to other institutions, such as hospitals, orphanages, and halfway houses.

The extent of the material framework of the prison is dispersed among other elements of our daily life in society, making it increasingly more difficult to escape the "invisible hands" of the criminal justice system (Foucault, 1975, p. 304). As a result of this dispersion among other institutions, a 'normalization' of power that works in a more subtle, nuanced way has found itself being employed in places like forensic mental health hospitals. These hospitals act in ways that administer punishment to the patients under the guise that it is part of their treatment.

Through this normalization of power, a significant shift occurred in the way that society viewed crime; it was no longer seen as an offence, but rather as an attack on societies common interests and public safety developed by the social contract. This has motivated the State to take the administration of punishment into its own hands; weakening the power that individual institutions have and applying that power more broadly across many institutions. Instead of designating prisons and jails as the

institutions in society that punish, the State has been able to use their power to disseminate punishment to other spaces such as forensic mental health hospitals. This has made it easier for the public to accept the idea that punishment is the natural response to criminal activity since it is seen as an attack on the person rather than a result of extenuating social factors. Foucault (1975) says that “[n]ot only is ‘the carceral’ a physical space, it is also an environment conducive to reaffirming already deviant tendencies, or creating new ones” (p. 293). Foucault (1975) goes on to write:

the carceral organizes what might be called ‘disciplinary careers’ in which, through certain processes, a whole process is set in motion. Through the play of disciplinary differentiations and divisions, the nineteenth century constructed rigorous channels which, within the system, inculcated docility and produced delinquency by the same mechanisms (p. 293).

Foucault is emphasizing that criminal behaviour is not only learned through our interactions in society, but the process of punishment and the construction of institutions dedicated to punishment further instills in society the normalized notion that punishment is necessary to maintain order. The original purpose of correctional institutions was to *correct* behaviour that was deemed deviant by society. This correction was meant to take place through discipline, deprivation, and changes in attitude and behaviour. Yet, as it has been noted throughout much of the literature, correctional institutions often serve to inflict more hardships onto those who experience it beyond their aim to correct abhorrent behaviour (Foucault, 1975, p. 296). In a similar fashion, hospitals, while meant to correct deficiencies in health through providing treatment and rehabilitative resources, also subject individuals to extraneous hardships according to Foucault.

While it is the purpose of jails and prisons to inflict punishment upon those deemed deserving of this, hospitals, due to the expansion of the criminal justice system and the 'invisible hands' of punishment, have also become institutions through which persons are subjected to various forms of deprivation and punishment. Medication and psychiatric treatment are used as a form of social control within hospitals to alter behaviour in a way that makes it more congruent with that of 'regular society'. Both prisons and hospitals then seek to change behaviour through the imposition of various social control methods which may or may not inadvertently cause harm to those subjected to these controls. This leads directly in Gresham Sykes notion of the *pains of imprisonment* which will be a central focus on the subsequent analysis of this thesis in order to understand the types of deprivations experienced by those in the forensic mental health hospital.

**Pains of Imprisonment.** The concept of the pains of imprisonment was first coined by Gresham Sykes in his seminal work *The Society of Captives* (1958). Here, Sykes outlined five types of deprivation that inmates experience while incarcerated: deprivation of liberty, deprivation of goods and services, deprivation of heterosexual relationships, deprivation of autonomy, and deprivation of security (p. 67).

Sykes defines the deprivation of liberty as inmates being restricted from exercising freedom due to their confinement within a cell. Sykes says that inmates experience this loss of freedom first by being confined *to* the institution, and second, being confined *within* the institution (Sykes, 1958, p. 68). This means that, while they are physically confined, they are also being socially confined to the broader criminal justice system, with experiences and labels that follow inmates long after they have been released into the community. Through the deprivation of liberty, inmates also experience

points of degradation which add another element of punishment on top of having their freedom of movement restricted. Sykes provides examples such as, “the anonymity of a uniform and a number rather than a name, the shaven head, [and] instances of subordination and respect when addressing officers” which all contribute to the degradation of inmates and further confine them to the prison system (Sykes, 1958, p. 69).

Next, the deprivation of goods and services refers to the standard of living that inmates experience within the institution which consists of consuming the absolute minimum of material goods (Sykes, 1985, p. 73). While incarcerated, inmates still want and need, not only the necessities of life, but also amenities which make life more pleasurable such as good food, leisure activities, and nice clothes. As Sykes highlighted, some inmates view this ‘material impoverishment’ not as a consequence of having committed an offence, but rather a product of the state using the inmate population as state labour (Sykes, 1958, p. 74). The inmate is then made to see themselves as being poor as a result of their criminal act without reaping the benefits of that act, and “the failure is his failure in a world where control and possession of the material environment are commonly taken as sure indicators of a man’s worth” (Sykes, 1958, p. 78). Therefore, this is not a typical punishment as Sykes has defined it prior (the punishment being a natural consequence of the criminal behaviour), but rather this punishment through the deprivation of goods and services is an extraordinary pain inflicted upon a vulnerable group who are unable to work themselves out of this impoverishment (Sykes, 1958, p. 78).

The third pain of imprisonment Sykes outlines is the deprivation of heterosexual relationships. Here, it is particularly important to acknowledge the historical context that

Sykes was writing in. During the 1950s, in North America, it was illegal to participate in non-heterosexual relationships and alternative forms of sexuality were seen as taboo. Strict gender roles were present and heavily enforced which undoubtedly influenced Sykes' ability to make observations beyond that of the typical heterosexual partnership. Keeping this in mind, Sykes' analysis only seeks to examine this pain through the divide of women and men that is present in prisons and jails, while it is more widely recognized today that intimate or sexual relationships can be experienced by people of a variety of sexualities in a variety of different contexts in society.

In speaking about this third type of pain, Sykes is not only referring to the obvious deprivation of sexual or intimate relationships between those of the opposite sex that inmates experience. Sykes is also referring to the psychological problems that can arise due to the lack of heterosexual relationships. Sykes says that a society composed entirely of men (which is the case for men while incarcerated) tends to create anxieties within that population regarding their masculinity (Sykes, 1958, p. 79). Due to the deprivation of intimate relationships, "latent homosexuality may develop in men which contribute to their marginalization and persecution inside of prison" (Sykes, 1958, p. 83). This may lead men to develop heightened feelings of anxiety, depression, and fear while incarcerated. Sykes also posits that, since many male inmates define themselves in part through the opinions and perception of others, the inmate's self-identity is in danger of becoming "half-complete" since interactions with half of his typical "audience" (females) are being denied to him (Sykes, 1958, p. 83).

Next, Sykes defines the fourth pain of imprisonment as the deprivation of autonomy: "power over the inmates is total and it is imposed" (Sykes, 1958, p. 84). Autonomy can be defined as the right to self-governance and freedom from external

controls. Therefore, to be deprived of autonomy means that the individual is lacking control over their life due to the imposition of external controls likely done through an authoritarian body. Within this fourth pain, there is a tension between the objectives of the institution and the objectives of the inmates: the institution's objectives do not make sense to the inmates and the inmate population is subjected to what Sykes calls "bureaucratic indifference". This 'indifference' is referring to those events that have great importance to people at the bottom of the institutional hierarchy which are viewed with an increasing lack of concern each step up the hierarchy (Sykes, 1958, p. 89). For example, the rationale for certain procedures within institutions is often withheld from inmates, only fueling the inmate's perception of bureaucratic indifference and may "reduce them [inmates] to a weak, helpless, dependent child" (Sykes, 1958, p. 89). Sykes provides further examples of how inmates are treated in child-like ways within institutions:

public humiliation, enforced respect and deference, the finality of authoritarian decisions, the demands for a specified course of conduct because, in the judgment of another, it is in the individuals best interest- all are features of childhood's helplessness in the face of a superior adult world (Sykes, 1958, p. 93).

Lastly, Sykes claims that inmates also experience a deprivation of security while incarcerated. Here, the term security is used to describe a type of emotional security where one feels stable, safe, and free from danger or threats in their everyday life. For Sykes, the deprivation of security consists of the "prolonged intimacy with men who in many cases have a long history of violent, aggressive behaviour" (Sykes, 1958, p. 94). This heightened threat of danger can provoke the inmate to develop feelings of anxiety or cowardice which may cause the inmate to call into question their masculinity, courage or nerve. Sykes also says that these inmates are accurately aware that:

sooner or later the inmate will be ‘tested’—that someone will push them to see how far they will go and they will have to fight for their safety and security. Thus, both the success and failure in defending oneself against the aggressions of fellow captives may provoke fresh attacks and no man stands assured of the future (Sykes, 1958, p. 98).

Overall, Sykes emphasizes that the pains of imprisonment cannot be limited to just physical pains; there is a significant amount of pain which lies in the frustrations felt by the inmates who are forced to experience the withdrawal of freedom, isolation from their community, and the withholding of desired goods and services (Sykes, 1958, p. 99). Sykes (1958) argues that these non-physical deprivations carry a more profound pain as they can be seen as “attacks which are directed against the very foundations of the prisoner’s being” which may lead the inmate to undergo a psychological withdrawal from the prison (p. 99). This withdrawal can take the form of renouncing goals, drives, or needs which may be impacted by their incarceration. It may also force the inmate into a fantasy-based world of memories, or it may cause the inmate to rebel against the institution if their frustrations are not addressed (Sykes, 1958, p. 102). In the subsequent section of this thesis, these pains of imprisonment will be applied to the forensic mental health system to highlight the similarities between the hardships experienced by inmates and those found NCRMD and detained in forensic mental health hospitals.

### **Research Objectives**

This research explores the tension between the expressed objectives of the forensic mental health system and the subjective experiences of people who have been detained in forensic mental health hospitals. Through conducting this research, my objective is to describe and categorize how people in the forensic mental health system

self-report their experiences as punishing and to illustrate how those hardships are similar to hardships found in other carceral spaces.

### **Conceptual Framework**

The conceptual framework that I will be applying through my thesis include the pains of punishment and of imprisonment, and how these pains are experienced in carceral spaces outside of jails and prisons. The pains of punishment can be defined as, “a personal experience of physical, mental, or emotional suffering by a penal subject, arising from their punishment by agents of a criminal justice system” (Hayes, 2017, p. 5). While this concept is typically employed to analyze the experiences of inmates in the prison system, I will be using the same concept to explore the experiences of people under the jurisdiction of the forensic mental health system.

As previously stated, the pains of imprisonment developed by Gresham Sykes in his work *The Society of Captives* that outlines five types of deprivations that inmates experience while incarcerated: deprivation of autonomy, liberty, goods and services, heterosexual relationships, and security (Sykes, 1958, p. 67). It will be argued that through the criminalization of disabilities and disorders like mental illnesses, the criminal justice system has created spaces outside of prisons and jails that act in similar carceral capacities. By designating forensic mental health hospitals as carceral spaces, individuals with disabilities receive punishment *because* of their disability. This is contrary to the rule of law that states if an individual is unable to appreciate or understand their actions they should not be held morally accountable for them (Verdun-Jones, 2014, p. 3). It is also contrary to the Supreme Court of Canada’s opinion in *Winko* that restrictions placed on people found NCRMD must be for treatment, not penal, purposes. It will argue that being found NCRMD does not free the individual from receiving punishment, rather it moves



the individual into an alternative space where they experience punishment in different forms (Steele, 2017, p. 7). Therefore, while the objectives of the forensic mental health system are treatment and rehabilitation—not punishment—this can differ greatly from the subjective experiences of people in the forensic mental health system.

## **Research Methods**

### **Research Design**

**Qualitative Research.** A qualitative approach was undertaken to conduct this research. Broadly, qualitative research is the method of observation used in gathering non-numerical based data including data in the form of words through different types of textual analysis. These different types of analysis can take the shape of content, conversation, discourses, and narrative analysis (Jackson, Drummond, & Camara, 2007, p. 4) This type of research tends to focus on understanding human beings' unique experiences and their perceptions or reflections about those experiences. A qualitative researcher relies on the participants to provide in-depth and meaningful responses to questions about how they form or understand their lived experiences. The overall goal of qualitative research is to develop an understanding of “human action by describing the inherent or essential characteristic of social objects or human experience” (Jackson et al, 2007, p. 4).

**Secondary Data Analysis.** This thesis has also used secondary data as the primary source. As discovered through the literature, there is no clear or distinct definition of what constitutes ‘secondary data analysis’ (Heaton, 2008, p. 2). However, a common theme across the majority of the literature was that a secondary data analysis consisted of the “re-use of pre-existing qualitative data derived from previous research studies” (Heaton, 2008, p. 2). Secondary data can be used for two main purposes: to

investigate new or additional research questions, or to confirm previous research findings. I have chosen to use secondary data in order to investigate a new research question through the process of informal data sharing. Informal data sharing may occur in several ways, but the process which most directly relates to this research consists of the primary researcher granting others access to their data set, “and lead or be part of the secondary analysis team” (Heaton, 2008, p. 3). The type of secondary data analysis that I will conduct is referred to as a supplementary analysis, which is “a more in-depth analysis of an emergent issue or aspect of the data, that was not addressed or was only partially addressed in the primary study” (Heaton, 2008, p. 7). Since the data was not collected to answer my intended research question, I will be exploring a new issue while recycling the same data as previous research projects.

Advantages of secondary data analysis are: it typically does not require an application to a Research Ethics Board (REB); there is no need to secure participants for the research; and time does not need to be spent creating, facilitating, and conducting the interviews, surveys, or questionnaires. Once the data has been secured, the researcher is able to immediately proceed with the interpretation and analysis of the data. Another advantage of using secondary data is that it allows the researcher to maximize the potential of pre-existing data. This allows for previous research findings to be reanalyzed, or the dataset can be reused for an entirely new purpose. This allows the secondary researcher to either confirm the previous research findings or create new findings from the already existing data.

## **Participants**

The data that was used for this thesis consisted of secondary data previously collected from five research projects conducted by my thesis supervisor, Dr. Jamie Livingston, and others. The total population of 137 ( $N=137$ ) are derived from the following data sources:  $N=18$ : Forensic Mental Health Success Stories (2017),  $N=24$ : Success in Forensic Mental Health (2018),  $N=29$ : Team PEER (2013),  $N=40$ : Patient Engagement Evaluations (2013), and  $N=26$ : Review Board (2016). All 137 transcripts were from people found NCRMD who were either detained in a forensic mental health hospital, or living in the community after being granted a conditional discharge or absolute discharge. Details of each study and its respective participants are discussed in the sections below.

The objective of the first project conducted by Livingston (2017) was to document and examine the stories of people who have achieved various forms of success after being found NCRMD. By gathering these stories, the goal was to learn more about the experiences of those found NCRMD and their journeys to success. This project consisted of the personal narratives of 12 people across Nova Scotia, Canada who were found NCRMD. By conducting in-depth interviews, Dr. Livingston documented each participant's history of mental illness prior to their arrest, their treatment within the forensic mental health system, and their experiences trying to find success after being released. Brief follow-up interviews were conducted with most participants several weeks following the initial interview. The participant's stories have been published in the form of videos, storybooks, and comic books which can be accessed through ResearchGate's online database.

The second study conducted by Livingston (2018) analyzed the perceptions of the forensic mental health system through the perception of those who live and work within it. Interviews were conducted with 18 people found NCRMD and 10 forensic mental health service providers to gather their views and personal experiences in the forensic mental health system and how they relate to the theme of ‘success’ (p. 1). Their interviews were analyzed using a qualitative descriptive design, specifically employing a thematic analysis to identify the dominant themes. Participants were asked about their conceptualization of ‘success’ and their responses were categorized into 6 distinct groups all pertaining to the forensic mental health system: (a) normal life, (b) independent life, (c) compliant life, (d) healthy life, (e) meaningful life, and (f) progressing life (p. 1). The results of this study indicated that the people who provide or use services accessed through the forensic mental health system conceptualize success in many ways apart from thinking about public safety.

Next, Livingston, Nijdam-Jones, and Team PEER (2013) conducted a study surrounding the perceptions of treatment planning in a Canadian forensic mental health hospital. This study consists of qualitative, participatory action research that examined treatment planning from the perspectives of 29 patients and 16 service providers at a Canadian forensic mental health hospital (p. 1). Most notably, this study employed the use of participatory action research through engaging with patients in the forensic mental health hospital and creating a research team call “Team PEER” (Patients Empowered and Engaged as Researchers) which consisted of individuals living with mental illnesses who had been adjudicated NCRMD and were detained in the forensic mental health hospital. Along with the researchers, Team PEER spent almost two years planning, designing, and carrying out their study. The PEER researchers were trained through lectures, role-

playing, and discussions relating to topics like research ethics, participant recruitment, how to conduct interviews, and so on. After the training had occurred, in-depth interviews were conducted and analyzed using a thematic analysis in order to examine how staff and patients perceived and experienced treatment planning in the forensic mental health system. Through this thematic analysis, six predominant themes were developed: “(a) *It’s all about the patient*; Involving patients; (b) *Other professionals at the table*: Including other professionals; (c) *Onward and upward*: Progressing through the hospital; (d) *Know me for who I am*: Understanding the patient; (e) *Keep me in the loop*: Sharing information with patients; and (f) *To trust or not to trust*: Openness, honesty, and trust” (Livingston, 2013, p. 1).

The next study used for this thesis was conducted by Livingston, Nijdam-Jones, Lapsley, Calderwood, and Brink (2013) and sought to support forensic mental health recovery by improving patient engagement within the forensic mental health hospitals.

The outlined objective of this study was to:

support patient’s recovery and improve their experiences of care in a Canadian forensic mental health hospital, [by launching] an intervention to increase patient engagement by establishing a peer support program, strengthening a patient advisory committee, and creating a patient-led research team (Livingston et al., 2013, p. 1).

Both quantitative and qualitative data was gathered from people found NCRMD and service providers twice during the span of 19 months by employing a “naturalistic, prospective, longitudinal approach” (Livingston et al., 2013, p. 1). Follow-up interviews were also conducted with 10 participants to assess whether or not they had been attending Team PEER meetings and what they liked or disliked about those meetings. The study

resulted in the conclusion that the intervention had minimal impacts on the internalized stigma, personal recovery, personal empowerment, service engagement, therapeutic milieu, and the recovery orientation of services, leading the researchers to conclude that patient engagement can contribute towards improving the experiences of care in the forensic mental health hospital, but has very limited effects on outcomes.

Lastly, a study conducted by Livingston, Crocker, Nicholls, and Seto (2016) used individual interviews from 26 people found NCRMD, 13 family members, and 3 professionals from 3 different provinces (BC, Ontario, and Quebec) to examine how Review Board processes were perceived. The interviews consisted of a combination of semi-structured and unscripted questions and generally lasted around 60 minutes. From these interviews, a thematic analysis was conducted which produced five themes: involvement of people in Review Board hearings (*constrained voice*), treatment of people during Review Board hearings (*respectful process*), diverse interests and agendas (*balancing interests*), Review Board decision-making (*[un]expected outcomes*), and time spent under the Review Board's jurisdiction (*feeling stuck*). The results of this study suggest that individuals directly involved with Review Boards perceive them to be working well, although the researchers acknowledge that improvements can be made.

### **Analysis of Data**

**Thematic Analysis.** A thematic analysis was employed to analyze the data. A thematic analysis works to identify predominant and reoccurring patterns within a particular data set. Thematic analysis is a form of pattern recognition whereby keys themes are extracted from the data through pinpointing, examining, and interpreting the information from the data set. This method privileges the lived experiences of individuals

working and living within the forensic mental health system since the findings of the thematic analysis are entirely the result of data gained through real-life participants. In general, I was searching for references made by participants that pertained to interactions they had with the forensic mental health system or staff which, according to their perception, negatively impacted their treatment or their recovery. These references included interactions with forensic mental health staff and family members, experiences with Review Board hearings or treatment team meetings, and anything else that the participant emphasized as having negatively impacted their time in the forensic mental health system.

The process of the thematic analysis process can be broken up into six phases as outlined by Nowell et al. (2016). I began phase one by familiarizing myself with the data and writing reflective thoughts about the data and the potential codes or themes that will emerge. After developing a general understanding of the material, phase two began which consisted of generating initial codes that were predicted to be found within the data set. It was during this stage of the analysis that I made a list of several codes that I thought would be present among the data. This list included the codes: lack of communication, lack of autonomy, restriction of movement, unpleasant environment, and hygiene. All of these codes did eventually emerge within the data, however, only two references were made to participant hygiene so that code was disregarded and the code 'lack of autonomy' was later changed to 'deprivation of autonomy'.

Once phase two was completed, phase three began whereby I thoroughly read through the data and began creating a more comprehensive list of codes identified within the data. This phase also involved sorting relevant codes into the early stages of what would become the overall themes of the research. Initially, the general theme of people

found NCRMD not feeling heard became very clear to me as codes such as ‘lack of communication’, ‘difficulty understanding’ and ‘miscommunication’ became prominent references made by the participants. Reviewing these themes then began in phase four where I reviewed the coded data and extracted common themes to create a coherent pattern among the data. While 40 initial codes were generated, some codes were collapsed during this process leaving the final coded data set with 34 codes.

The fifth phase then began whereby I reviewed and clearly outlined which aspects of each code related to its overall theme and why that information was of relevance to the greater research project. This process occurred twice; first, by reviewing the relevant individual references within each code to make sure that they fit the single code, then, I reviewed the relevance of the entire code to its assigned theme making sure that all the codes within that given theme shared common characteristics. Lastly, I began the final phase of this thematic analysis which was writing the report. This was done to provide a concise, coherent, and logical interpretation of the data as it related to the overall objective of the research project. The subsequent sections of this analysis detail those research findings and discussion surrounding the coded data and its relevance to the field of forensic mental health.

**Software.** The data was analyzed and coded using the Nvivo 12 software program. Nvivo is a qualitative data analysis software tool produced by QSR International (Nvivo 12). Its design is useful for researchers working with dense, text-based data, where in-depth analyses of the data are required. Nvivo 12 allows the user to store and organize data such as demographic information and qualitative open-ended questions in one platform. It automatically sorts themes and can be used in conjunction with SPSS for statistical analysis.



First, all relevant participant transcripts were uploaded to Nvivo and organized into categories according to their respective research project. Next, the Nvivo software program was used to identify relevant references within the text which were then organized into specific codes (or 'nodes' as they are referred to within the program) which allowed me to view the data more easily. While the I was conducting the initial analysis of the data, the memo function in Nvivo was used to write down important observations and thoughts about the data so that information would be easily accessible in the future. After the coding process was completed, Nvivo's memo tool was then used to organize the identified codes into themes based on shared characteristics. This allowed me to more easily see which codes were present in each theme and allowed for adjustments to be made to the organization of the codes. Lastly, powerful quotes were pulled from the references found within the codes to emphasize my findings which are outlined in the subsequent section of this analysis.

Within the software program, participants were broken down into their respective research project and were assigned a shared number-group, common to that group of participants. The Forensic Mental Health Success (2017) research project's participants were organized as Participant 101-118, the Patient Engagement (2013) project was organized as Patient Engagement Interview 201-230 (with follow-up interviews present from participants 201, 203, 208, 216, 217, 221, 222, 224, 225, and 228), the Review Board (2016) study was broken down into three categories: British Columbia Participants BC301-310, Ontario Participants ON301-309, and Quebec Participants QB301-307. Next, the Success Stories (2018) organized participants as 401-414 with follow up interviews being held for all participants except for participant 409, and lastly, the Team PEER (2013) study organized participants as PEER Study Participant 501-519.

### Limitations

Several limitations were present throughout the research process. Firstly, limitations arose due to the fact that the data was not originally collected for the purposes of this research project. This means that it was inevitable that some of the data would be irrelevant to my research project during the analysis process. This made it slightly more difficult to find relevant information pertinent to my research question instead of having a research project originally tailored to answer my question.

Also, since this research was collected through secondary data analysis, I had no control over the types of questions that were asked during the interview and the follow-up interviews that took place. This may have influenced the data in a way that did not assist me in answering my research question. Heaton (2008) referred to this as the “*problem of data fit*”: data collected for one primary purpose is re-used for another secondary purpose (p. 8). Due to the inherent semi-structured nature of qualitative data, datasets generally feature much depth and breadth in the coverage of their intended topic, so it is imperative to also ensure that the data will also meet the needs of the secondary researcher (Heaton, 2008, p. 8).

Heaton also outlines another limitation that was encountered during the process of interpreting the data: the “*problem of not having ‘been there’*” (2008, p. 8). This problem can arise when a new researcher tries to interpret the data that was collected by other researchers. Since I did not partake in any of the data collection throughout the five research studies used in this analysis, I was not able to experience the initial face-to-face interviews with the participants or listen to the nuances found in the conversations that were transcribed. Because of this, misinterpretation of the participant’s conversations was likely to occur since I was unable to experience the body language, tone of voice, and

emphasis on certain aspects of their story that would otherwise be interpreted by the initial researcher.

Lastly, a limitation was present due to the types of references I was seeking within my data set. Since this research project seeks to understand how participants experienced the forensic mental health system as punishing, the information I was searching for within the transcripts was inherently negative and critical of the forensic mental health system. This had the potential to create negative bias since I was not taking into account how participants experienced the forensic mental health system as helping them. Consequently, this research project has the ability to skew the reader's perception of the forensic mental health system as holistically negative and punishing which is not entirely true. It is important to acknowledge that, while this research was seeking to privilege the hardships that participants endured during their time in the forensic mental health system, the forensic mental health system also provided many positive resources and opportunities for people found NCRMD to which they would otherwise have not been exposed.

### **Research Findings**

After the initial analysis of the transcripts was completed, 40 codes were created. Those 40 codes were then analyzed for shared characteristics and were then grouped based on similar characteristics or general comments made by the participants. After several revisions to the organization of the codes and after collapsing several codes together, 37 codes and five distinct themes emerged that illustrate the hardships experienced by those found NCRMD in the forensic mental health system.

### **Themes**

**Unheard and Ignored Voices:** *“At times I feel like I’m totally in the dark.”*

Many of the participants spoke at length about a variety of difficulties they faced while trying to communicate with forensic mental health staff. Participants would often express that they feel like their voice did not matter or their opinions were ignored by doctors, nurses, social workers, and the like. Overall, this theme had the most number of references out of the four themes: 154 individual references across 6 codes made by 107 of the total participants.

An issue frequently raised by participants was the apparent lack of communication between themselves and their treatment team and other hospital staff: “they don’t go out of their way to talk to you” (Participant 112); and, “the lack of communication between medical team members [is challenging]. My social worker and my psychiatrist had completely different observations to make about my case, and I do not think that this is normal” (Participant QB305). This lack of communication caused delays with the processing of internal information within the forensic mental health hospital which in turn negatively affected the stay of the patients within the hospital. Other participants expressed that they had encountered miscommunications between themselves and hospital staff which resulted in feelings of anger and frustration: “there’ll be one nurse on one day and they’ll tell me one thing and the next nurse I talk to, like another time, will say something completely different” (Participant 205). This participant emphasized that this miscommunication proved to be a barrier to their recovery as it hindered their ability to access resources within the hospital in a timely manner. Another participant explained, “the staff will make up new rules and depending on which staff you talk to they’re, ah they’ll say different things about uh something, the same thing” (Participant 208). This miscommunication can cause confusion on the part of the patients who may become uncertain about how to act around particular staff, or they may become distrustful of the

system as Participant BC303 stated, “sometimes they [doctors] say one thing before going to the Review Board and as soon as they get in there they change their whole perspective of everything they said. I totally don’t trust them.”

Many participants also emphasized struggles they encountered when interpreting their treatment plan or medical or legal documentation when staff did not provide any assistance: “I find that a lot of the language that they use in the reports is hard to understand” (Participant BC309). The inability to interpret legal and medical documents also made participants feel alienated and uninvolved in their treatment planning and recovery: “...as a mental patient, it’s a kind of undermining, so I don’t feel good about it” (Participant 502). I was not surprised to encounter this hardship since many of the participants had only received a high school education or less, making it very difficult to unravel the nuances of legal documents like the disposition orders granted at Review Board hearings. While people found NCRMD have a right to access their legal and medical records, those records become useless if the individual is unable to understand them.

Another common sentiment among participants was feeling as though their thoughts and opinions were not being considered with regards to their treatment. One participant emphasized this by explaining their interactions with their treatment team:

I feel like um, the nurses that have more power over what I can do than what I would choose to do. And they’re um, like if I have a conversation with my treatment team, it’s usually what they say is what’s going to happen, not what I ask for. (Participant 205)

This opinion was also expressed on several occasions when participants were asked how they felt about their treatment team convening without them prior to a Treatment

Planning Committee (TPC) meeting or a Review Board hearing. Participant 509

explained their experience with waiting to join their treatment team for a TPC meeting,

I feel that it, it's they're talking behind my back and I guess they are, I guess they're trying to plan what they're going to, what's the things that are happen, that's happened in the last two weeks and need to discuss them, but for the most part I feel left out. (Participant 509)

Many participants acknowledged that it was necessary for their treatment team to meet without them present in order to discuss matters that the patient may not be privilege too, however, on several occasions, references were made such as “patients have very little say in what their treatment involves” (Participant 206) discussing how their treatment team and Review Board communicated with them. Being removed from discussions surrounding their treatment decisions lead people found NCRMD to feel disempowered or disheartened when it came to engaging in treatment planning or interacting with treatment team members. I think that these feelings can be summarized very well by Participant ON305's remark, “If they're [Review Board members] not going to talk to me then I don't wanna go.”

Overall, participants expressed that they felt excluded from their treatment decisions because of the lack of communication between themselves and their treatment team, their inability to understand the legal and medical documents without the help from staff, and being excluded from the Review Boards and treatment planning meetings left the participants feeling excluded and in the dark about what was going to happen.

**Negative Interactions with Staff:** *“They were putting me down, they were laughing at me”.*

In this theme, participants highlighted the negative interactions they had with forensic mental health staff while detained in hospitals and while under the jurisdiction of the forensic mental health system. Participants felt as though these interactions with staff had an adverse negative effect on their recovery, and frequently used words such as “condescending”, “abusive”, “insulting”, and “uncompassionate” to describe their experiences with staff. These experiences varied greatly, but included verbal interactions with staff, physical altercations, and general observations that participants made while the staff were performing their duties.

While outlining their experience with a recent Review Board hearing, one participant detailed their interactions with staff as being negatively influenced because of their position as a someone found NCRMD: “the lack of compassion and real in-depth, um—I don’t know just felt that—that because I was in this place, in this hospital, that I was treated as such and such a person” (Participant BC302). When speaking about Review Boards, Participant QB306 explained how they felt “insulted by the whole experience”:

I think it’s that they were prescribing to my character they seemed a bit too rash. It seemed to me that they should have stayed away from trying to blow up small issues. In a certain sense, I found, a certain amount of prejudice that was present. (Participant QB306).

Another participant shared a similar sentiment when asked how they felt they were viewed in the forensic mental health system: “When you’re in with the law and the forensic system it seems like they don’t give a shit really about how you’re feeling, whether or not, they just wanna know if you’re gonna be psychotic” (Participant 102). All

of these quotations share the common theme of feeling dehumanized and judged by forensic mental health staff whether those judgments were intentional or inadvertent.

Other participants felt like hospital staff would frequently belittle them or treat them childishly because of their mental illness: “I felt like I was being talked to like I’m a preschooler” (Participant 115); “I kind of feel like the patients of this hospital are treated more like children than like adults” (Participant 512); “I think a person should have insight, not be treated like a two year old and say, ‘Go to your room, you’ve lost everything that you’ve worked hard for.’” (Participant 519). I thought that this comparison to feeling child-like was particularly compelling given the earlier discussion regarding Sykes (1958) and his fourth pain of imprisonment: deprivation of autonomy. Deprivation of autonomy is characterized by “reduc[ing] them [inmates] to a weak, helpless, dependent child” (Sykes, 1958, p. 89). People found NCRMD detained in forensic mental health hospitals expressed perceiving themselves in the same way as inmates perceived themselves when their autonomy was curtailed. This draws a strong comparison between the hardships experienced by inmates and people found NCRMD.

Another prominent perception that participants expressed was the experience of stigma. Stigmatization associated with being found NCRMD was also evident in the interactions participants had with staff. When speaking about their experience with their most recent Review Board hearing, several participants shared that the most challenging part of the process was having to listen to the Review Board’s perception of them: “people [Review Board members] thinking I’m dangerous, when I’m not” (Participant ON306); “I think that the one thing the Review Board should change is that they should stop having to look all the way back and holding it against you...for the rest of your life” (Participant BC304); and,



I also do not like the demoralizing and stigmatizing nature of it [Review Board hearing]. Being monitored so closely, is very demoralizing for a human being and having to attend annual meetings, is just a constant reminder of that dark chapter in my life (Participant QB305).

This notion of Review Board hearings serving as a ‘constant reminder’ of the person found NCRMD’s past can act in ways that re-criminalize the individual years after the offence has been committed. All of the above participant quotations were organized into a code called “bringing up the past,” illustrating how bringing up past offences and behaviours of people found NCRMD negatively affects their self-perception and recovery; not unlike how a criminal record negatively affects people after they have been convicted and sentenced.

Another important element of the interactions between participants and staff was the perception that staff would manipulate patients or the system to impact the participants course of treatment: “They [staff] always use threats and bribes and other forms of pressure” (Participant 225); “there are a few staff out of the bunch that sometimes harass you and push your buttons to see how you react” (Participant 517); and “he [psychiatrist] will say one thing and manipulate my words into another thing, to what he believes is the truth” (Participant 519). This perception can lead people found NCRMD to develop a lack of trust or skepticism surrounding forensic mental health staff. This could, consequently, make the person found NCRMD more distrustful of, and less cooperative with, their treatment team, the Review Board, and the forensic mental health system as a whole.

Overall, participants expressed feelings of isolation and judgement by forensic mental health staff, and many believed that those negative interactions had a direct effect

on their treatment and recovery. Participants expressed that they felt labelled and judged by staff who had negative perceptions about the statuses of being found NCRMD and a forensic mental health service user. Participants felt as though they were treated like children, talked down too, and manipulated by forensic mental health staff and the system in general.

**Slow Moving Process:** *“I had no idea I was going to be here for two years”*.

This theme encompassed the participants’ experiences with the disposition and release process of the forensic mental health system. Participants stated that the indeterminate nature of forensic mental health dispositions caused them significant amounts of stress and had a negative impact on their recovery: “It’s undetermined, which is, I find, kind of stressful, because I never know when it’s going to end” (Participant BC310); “This is my third time here, I hope and pray it will be my last...I’m getting tired of being thrown in and out of the institution like this forever” (Participant 104); and, “[the] average day in this hospital is only suppose to be three years...Not ten, fifteen, twenty years just because a dude smoked marijuana” (Participant 228).

The indeterminate nature of forensic dispositions means that people found NCRMD can experience far longer periods of detention in forensic mental health hospitals and on conditional discharges compared with pursuing a conviction and sentence through the criminal justice system. When discussing this prolonged stay in the forensic mental health system, participants often compared their dispositions against the time they would have served had they not sought a finding of NCRMD: “over at jail at least you have a release date, right?” (Participant, 107). Another participant stated:

this system works so slowly that I’ve been in here for months and if I would have went to the jail side would have been out in thirty days or so, thirty to sixty days

and I would have maybe six months probation. I've already been here like seven and a half months (Participant 103).

The observations participants were making comparing the time they have spent in a forensic mental health hospital versus the time they would have spent in prison or jail was directly related to the issue of proportionality. Proportionality is the idea that a sanction must fit, or be appropriate to, the crime that was committed (Cavadino, 2008, p. 20). For example, if the Canadian government said that the appropriate sentence for a first-time shoplifter was five months' probation, they would be stating that that sentence of probation is proportional punishment for the offence of shoplifting. However, due to the indeterminate nature of the forensic mental health system, proportionality was not present in the dispositions given to people found NCRMD who participated in these studies. If the person found NCRMD shoplifted the same items at the same store, they could potentially spend years in the forensic mental health system as opposed to five months of probation that they would have received in the criminal justice system. This lack of proportionality created a sense of unease and hardship among the participants, one of whom described feeling "hopeless", "lost", and "like they [the Review Board] don't want me out of here" (Participant 218).

Another point of contention reported by participants were the mixed emotions regarding the process of their Review Board hearings: "at every single Review Board I go to, they say I have to stay here...I don't understand why, I'm not dangerous or anything" (Participant 205). Since the release of an individual found NCRMD is determined by the level of perceived risk to the public, individuals can spend relatively long periods detained in a forensic mental health hospital and under the authority of the forensic mental health system. Several participants expressed a similar sentiment stating that they

felt as though their Review Board hearings did not take place at a suitable frequency:

“have the Review Board [hearing] every forty-five days, not once a year. I mean you’re stable after six weeks and you sit there for a year waiting to get out” (Participant 114), and, “being involved with the Review Board it’s kind of like your life gets put on hold” (Participant BC309).

Another element of the Review Board process that participants outlined as having negatively affected their time in the forensic mental health system was receiving outcomes to their disposition which were contrary to their expectations. Common words used to describe these situations include “discouraged”, “frustrated”, and “unhappy”. One participant provided an example of experiencing a Review Board hearing that did not go as they had hoped:

when I went to my sixth month checkup or board hearing they didn’t give me an absolute discharge and I’ve heard before that I might get an absolute discharge, so it was somewhat disappointing. So, I kinda have a little bit, I’m a little bit skeptical of the whole thing. (Participant 111)

Another participant stated, “I was expecting that the order would be taken to effect immediately, what the Review Board order was, and then I learned there’s all these limitations that we have” (Participant BC308). Not only was the indeterminate nature of the forensic mental health system daunting to participants, but many participants also expressed negative attitudes towards the unpredictable nature of the forensic mental health system, especially Review Board hearings. When asked about their most recent Review Board meeting, one participant stated, “I had hoped to get an absolute discharge and was therefore disappointed on the outcome. I was also surprised at the testimony that my psychiatrist made as she did not give me a positive review” (Participant QB305). Not

only did this participant receive an outcome that was contrary to what they were expecting which was upsetting in-and-of itself, they sat and listened to members of his treatment team speak about him negatively which would also prove to be upsetting to the participant. Words such as “disheartened”, “upset”, and “lacking motivation” (Participant BC306) were also used to describe how this participant felt about Review Board hearings.

Overall, participants expressed that the indeterminate and unpredictable nature of the forensic mental health system increased their levels of stress while detained in hospital. Not having a fixed release or end date for patients made the process feel as though it was never-ending. The Review Board process only heightened this stress due to the large amount of time between hearings. The unexpected outcomes that people found NCRMD encountered at Review Board hearings left them feeling frustrated and disheartened.

**Unpleasant Environment:** *“It’s a hospital, it’s not a homely place”.*

Participants often spoke about how the environment of the forensic mental health hospital had a negative effect on their recovery. This theme incorporated the most of codes ( $n=9$ ) and included things such as being deprived of liberty, feeling as though the patients live in a prison-like environment, being exposed to violence, and experiencing a general lack of resources within the hospital. Not only does the term ‘unpleasant’ encompass the visual and surface-level aspects of the forensic mental health hospital, the ‘unpleasantness’ felt by people found NCRMD extended far beyond that into emotional discomfort, unease around other patients, and feeling psychologically restricted while in the hospital and community.

Comparing the forensic mental health hospital to a prison or jail was a common way for participants to describe their experiences living within the forensic mental health hospital:

They can call it a hospital all they want, but inside the hospital here is a jail.... all they do here is warehouse people. There's no treatment, seeing psychologist, and it's a warehouse. That I call medication a chemical straight jacket (Participant 107).

Some participants provided a comparison of the forensic mental health hospital and jails by drawing similarities between staff: "they've got prison guards here. With mace and taser you know" (Participant 219). Similarly, another participant stated:

We call it a hospital but yet we [are] forcing the law because you got security guards going around there that are jail guards that have been mixed with correctional centre, you got correctional guards mixing the bubble of hearing and all information of the patients which makes the patients uncomfortable. (Participant 102)

I found the above quotation to be particularly compelling because it is not only drawing on the fact that *seeing* prison guards walking around the forensic mental health hospital made them feel uneasy, but it also alluded to the carceral and prison-like nature of the forensic mental health hospital. Using prison guards to patrol the building would only work to reinforce the carceral elements already present within the hospital, such as locked bedroom doors, secure activity rooms, and high concrete ceilings. Having plain clothed or un-uniformed officers working in the forensic mental health hospitals may work to alleviate some of the distress caused by seeing a uniformed prison guard and may work to minimize some elements of carcerality.

Participants also commented on physical aspects of the forensic mental hospital like the general atmosphere: “Inviting and dignified? There’s no dignity in being locked up in a mental institution” (Participant 218); as well as the surroundings outside the hospital, “they have a whole bunch of fences now and before you could wander, you could wander away a little bit I think. They let you outside or something, and there were no fences or anything, in the old hospital” (Participant 226). The perimeter fences surrounding the forensic mental health hospitals not only physically restricted patients’ movement, but it also had a profound psychological effect on the participants: “we’re in here like a bunch of animals that we can let out for, to eat and stuff like that” (Participant 214). While the forensic mental health hospital was designated as a treatment facility, the fences, high concrete walls, and netted ceilings in outdoor spaces only contributed to the perception that the participants were living in their own type of prison. I thought that this participant’s comparison to feeling like an animal was quite poignant since it connoted feelings of dehumanization and degradation typically experienced in prisons and not often related to hospitals.

While many participants spoke about the physical aspects of the forensic mental health hospital that caused them discomfort, these physical aspects often presented in ways that produced psychological unease among the participants. One participant explained that it was other hospital patients that caused them increased levels of discomfort: “throw me in jail for eight months, don’t throw me in a mental hospital with like rapists, murderers, women beaters, and stuff like that right? I don’t need that in my life” (Participant 230). I found this quotation particularly interesting because many participants took the time to express how the forensic mental health staff made them feel uncomfortable, yet it was rare for participants to express that it was other patients who

made them feel uneasy. While forensic mental health hospitals do offer different levels of restriction for individuals depending on their perceived risk level, patients are not separated based on crime or seriousness of offence the way that prisons might classify offenders (e.g., provincial versus federal sentences). This means that someone found NCRMD for a very minor offence could end up in a housing unit with someone who was found NCRMD for first-degree murder. This could potentially increase levels of stress and anxiety when interacting with other people found NCRMD, also contributing to the unpleasant environment of the forensic mental health hospital.

Along with discussing the unpleasant nature of living within a forensic mental health hospital, many participants also detailed their traumatic experiences of being held in isolation or segregation cells. These spaces were often referred to as ‘side-rooms’, ‘TQ’ (therapeutic quiet) rooms, or ‘segregation’: “six months of not really talking to anyone. And sometimes I didn’t even get to shower every day. And at a certain point in time, they took away my clothes... fed me disgusting food” (Participant 225). The use of segregation as punishment within a forensic mental health hospital is contrary to the therapeutic objectives of the forensic mental health system, along with being incredibly psychologically challenging for even the most stable and healthy person. In October of 2011, United Nations Special Rapporteur on Torture, Juan E. Méndez, told the General Assembly dealing with social, humanitarian, and cultural affairs that “segregation, isolation, separation, cellular, lockdown, Supermax, the hole, Secure Housing Unit... whatever the name, solitary confinement should be banned by States as punishment or extortion technique” (“Solitary Confinement should be banned”, 2011). If the United Nations is pleading to stop using segregated isolation as punishment for inmates in prisons, then the use of segregation as punishment in forensic mental health



hospitals would seem to undermine the therapeutic aims of the forensic mental health system.

Not only was being forced into segregation traumatizing, participants also explained how they felt traumatized by being exposed to physical violence at the hands of other patients: “there’s a fight between the patients, that’s always very dangerous” (Participant 205); “people have gotten beaten up here, um, especially the guys” (Participant 208); and, “If he [patient] hit you hard enough, he could kill you, he was really powerful” (Participant 209). The threat of physical violence was not something I initially intended to code when I first began reading through the participant transcripts. However, after reading several of the participants encounters with other violent patients, I quickly realized that the lives of people found NCRMD detained in forensic mental health hospitals are fraught with routine instances of physical violence.

Overall, the unpleasant and threatening environment of the forensic mental health hospital was not only experienced through the physical aspects of the forensic mental health hospital, but also through psychological distress and emotional unpleasantness. The dull interior and high fences surrounding forensic mental health hospitals contributed to the visual unpleasantness of the facilities. The excessive security, threat of personal violence, and the use of segregation as punishment created an environment that was even more psychologically unpleasant for people found NCRMD. This unpleasantness was experienced by people found NCRMD through physical discomforts, emotional unease, and unjust punishments administered during their time in the forensic mental health system.

**Loss of Identity:** “*They call me a hardened criminal*”.

This theme highlights the losses of personal identity, social relationships, and physical property endured by people found NCRMD while under the jurisdiction of the forensic mental health system. Participants provided examples of losing external relationships and friendships while detained in hospital: “I ended up losing my children over it” (Participant 106); “I don’t have a lot of [family] support” (Participant 112); “I haven’t seen my wife and kids in seventeen years” (Participant 204); and, “I don’t have relationships at that moment... [the disposition] sort of limited my ability to maintain relationships” (Participant 227). Losing these important relationships that kept the person found NCRMD connected to what was going on in the community with regards to their family and friends, children, or parents left the person found NCRMD feeling “isolated” and “forgotten about” (Participant 402).

While many people lost relationships with those living in the community, many participants explained that they had difficulty making friends and maintaining relationships with individuals who were also found NCRMD living under the jurisdiction of the forensic mental health system: “you can’t pick and choose friends here. You have to be friends and mix together with the people you’re put with” (Participant 205); and,

I found it very difficult to make friends in there, I don’t think it is a place really to make friends. Friends are more like a utility, they have a purpose in there and I guess you could say the same maybe is in jail (Participant 412).

Several participants also expressed how difficult it was to maintain intimate relationships with other patients who were also detained in the hospital. Participant 208 explained, “well you’re not allowed to uh, have intimate relationships uh, to have sex in the hospital, but ah, if you do manage to have a relationship here, a dating relationship, staff make it really hard”. Another participant said,

I can't really talk about my sexual needs with another man. Right, and if I am talking about it with a woman, well, that's even harder...But it's affecting my relationships that way. I got nobody. I need somebody to hold me. I've been locked up for a long time, I need somewhere to put my head. (Participant 218)

This deprivation of intimate relationships not only caused physical loneliness for the individuals, but it was also psychologically harmful over extended periods of time. This lack of emotional and physical support can lead to people found NCRMD to feel "depressed" and "alone" (Participant 228). Such alienation can erode self-esteem and self-worth.

The inability to maintain external relationships coupled with the difficulties of making new relationships inside the forensic mental health hospital left participants feeling isolated and alone. This inability to maintain relationships was an extension of many of the participants' experiences surrounding the general lack of control over their lives while under the jurisdiction of the forensic mental health system:

I can't travel, I can't go anywhere, I can't do anything. You know? I can't live the, live the life that I want to live. It's always what they, what they say is right and wrong, which is not where I want to be. You know, I'm tired of being governed by people who don't know me, couldn't care less. (Participant 519)

The sentiment that forensic mental health staff didn't care or that they enjoyed exercising control over the people found NCRMD was a common theme expressed by participants: "I can never talk my doctor into doing the things that I want to do, it's always up to her" (Participant 205); "feeling like [psychiatrist] is gonna have control over my life is really scary" (Participant 212); and "I don't have any life choices when I'm in here...staff have all the control" (Participant 225).

Another aspect that contributed to participants feeling as though they had limited control over their lives arose due to their lack of privacy while detained in hospital. Several participants commented on the public nature of their Review Board hearings, “I didn’t have a choice about the people that sit in the back. But sometimes it’s a bit awkward if someone sits in the back... and they’re eyeballing you” (Participant BC303). Other participants gave examples of their diminished privacy while detained in hospital: “many people just walking into your room or people coming into your room to get you to play cards when you’re sleeping, and people taking your snacks that you’ve put in the fridge” (Participant 402).

This lack of control also extended to the goods and services they were afforded while detained in the forensic mental health hospital. When asked about any rules that hindered their recovery while detained in the forensic mental health hospital, many participants expressed that cigarettes and coffee were a point of contention between people found NCRMD and staff: “no smoking, no coffee [rules] are useless. Me, you know, waking up early. I don’t know, all this silly little rules” (Participant 209); “well I would have been out [released] earlier except I wanted to have a cigarette” (Participant 112); “I think it’d be nice to have the coffee- a cup of real coffee...and they should allow smoking...its really hard to quit [smoking] and it can be boring in here” (Participant 201); “the not smoking thing is out of hand, I don’t think they should have done that” (Participant 218); and, “I need money around here, and not with that smoking rule out, you know how much a cigarette goes for now? Five dollars” (Participant 206). While people living in the community may not give a second thought to their ability to smoke a cigarette or drink a coffee at their leisure, people found NCRMD were deprived of these small luxuries that many other people take for granted. Being deprived of these goods

was a significant hardship that was exacerbated by being prevented from taking part in activities that connected them to their life in the community or from which they previously derived pleasure.

Participants also explained how they felt like the stigma and labelling associated with being found NCRMD negatively affected their recovery and the public's perception of them as an individual, "The general opinion seems to be that once you're mentally ill, you're always mentally ill" (Participant BC305). Not only was this sentiment internalized by many of the participants, but they also emphasized that forensic mental health staff would reinforce these sentiments: they would treat people found NCRMD differently because of their disposition.

When speaking about barriers to recovery, participants explained how they felt like their restrictions while detained in the forensic mental health hospital limited their ability to progress within the system: "it's very disgusting the way people get treated when they're mentally ill. The stigma sets in, all of the, even – the staff here do it!" (Participant 219); and "people think I'm dangerous, when I'm not" (Participant BC306). This sentiment was echoed in the following quote:

it's very negative because not only are you dealing with the crime you committed, which was a vast surprise to me, it's because I hadn't come from a criminal background and dealing with not seeing my children and just being in the hospital. But then you've got these people saying, well these are all the things we want you to do and these are your risk factors. Not being able to do those because of my disease, the combination of my disease and my medication was really, it was kind of in added to the stress of the whole situation. (Participant 111)

Participants also spoke about how Review Board hearings evoked negative feelings and caused a negative self-perception: “there are just things from his report there are things that I do not like hearing. There are personality diagnosis I don’t like hearing” (Participant 115). When asked if there was anything the participant would like to see changed in the Review Board process, the participant explained, “More instruction from the doctor on the Review Board to the families and the public, that this is something that a person can recover from” (Participant BC305).

Overall, people found NCRMD experienced a loss of positive self-identity and personal security in the forensic mental health system. As illustrated by the participants, many people became removed from close family and friends who were living in the community and found it difficult to develop meaningful relationships while detained in hospital. Participants also spoke about the difficulties experienced from the lack of privacy given to their personal space and confidential records (medical or criminal), and the deprivation of goods they enjoyed while in the community contributed to the breakdown of their personal identity.

## **Discussion**

### **Flew-Benn-Hart Account of Punishment**

In studying the self-reported experiences of individuals in the forensic mental health system, several strong connections can be made to the punishing experiences of those in other carceral institutions. Firstly, similarities between the hardships experienced by people found NCRMD and those in jails and prisons can be examined through the Flew-Benn-Hart account of punishment as it is detailed in Hayes’ (2017) article, *Proximity, Pain, and State Punishment*. The Flew-Benn-Hart account of punishment established in the late 1950s and early 1960s outlines criminal punishment as consisting of five characteristics: it is a)

unpleasant, b) imposed for conduct that has breached legal rules, c) targeted against the individual responsible for that conduct, d) imposed intentionally by State agents other than the subject, who are e) acting under the authority of the breached law (Hayes, 2017, p. 2). As it will be explored thoroughly within this section, all five characteristics of punishment which are typically applied to the penal system can be applied to, and are clearly demonstrated as, punishments received by people found NCRMD under the jurisdiction of the forensic mental health system.

Firstly, punishment is unpleasant. While this characteristic is highly subjective and based on individual experiences with the environment, generally, people who are detained in forensic mental health hospitals experience their time accompanied with unpleasantness as was illustrated in the above theme *Unpleasant Environment*. The term ‘unpleasant’ not only refers to the unwelcoming physical aspects of the hospital, but also encompassed how the environment and experiences had within the forensic mental health hospital can lead to psychological discomfort and unease among people found NCRMD. Regarding the physical aspects of the hospital that an individual may find unpleasant, bedrooms and common rooms are starkly furnished with only essential items such as a bed, desk, and dresser all bolted to the floor. The common areas consist of minimal plastic furniture and bare, bland coloured walls, minimal visual art displayed, and very few recreational activities to participate in.

Not only is the hospital visually unappealing, but people found NCRMD are also required to live in small housing units (or ‘wedges’) with strangers, their time outdoors is limited, and when they are granted permission to use the outdoor space, the courtyard is enclosed with concrete walls and a netted ceiling. Also similar to a prison or jail, the forensic mental health hospital employs a system of locked doors and secure hallways

that restrict movement through the hospital, and a perimeter fence surrounding the institution restricts movement around the outside. All of these aspects, both visual and physical, render the forensic mental health hospital a physically unpleasant place, contributing to the overall punishing effect it has over the people who live there.

Psychologically, this unpleasantness resulted in participants being very mentally un-stimulated, feeling high levels of stress, and had the potential to cause unease among the people found NCRMD. Living in a threatening environment where physical violence was not uncommon left participants feeling anxious and unsafe while detained in the forensic hospital. The lack of mobility around the forensic mental health hospital due to the locked doors or privilege restrictions contributed to people found NCRMD feeling stuck and frustrated by this deprivation of liberty.

The second characteristic of punishment is that punishment is imposed for conduct that has breached legal rules. This directly relates to people found NCRMD because they would otherwise not be detained in a forensic mental health hospital had they not committed a crime and entered the court system. While the person found NCRMD was not found *criminally* responsible for committing a crime, they were diverted into the forensic mental health system in the first place is because they *physically* breached a legal rule. Since the person found NCRMD committed an act that was contrary to the behaviour accepted by the public, they are inadvertently being punished for committing the act through being detained and deprived of their liberties while receiving treatment. This seems counterintuitive since the goal of the forensic mental health system is to treat the mental illness, not punish the crime. Yet, participants report inadvertently experiencing punishment under the guise of treatment and risk management.



This is illustrated by the participants who spoke about the added stress and frustration of the indeterminate period of time in the forensic mental health system as opposed to a fixed sentence in the criminal justice system. The indeterminate nature of the forensic mental health system prolongs the time that the person remains under the jurisdiction of their given disposition, and, in turn, subjects them to extended periods of time under the restrictions, conditions, and mandated treatment programs imposed upon them by the forensic mental health system. While it is outlined in the Supreme Court of Canada case, *Winko v. British Columbia* (1998) that the role of the forensic mental health system is to provide the person found NCRMD with adequate mental health treatment while also protecting the public, the indeterminate nature of forensic mental health dispositions subjects people found NCRMD to unpredictable and disproportionate periods of detention which are arguably more psychologically harmful to the person found NCRMD than they are protective of society.

Next, the punishment that people found NCRMD experience is directly targeted to the individual based on their mental illness as well as the crime that they committed. A conditional discharge, for example, directly targets the individual's ability to associate with people, spend time in a given area, or use certain recreational substances, and these conditions are individualized according to the individual's needs and risk level. Treatment teams meet to discuss the best course of action for the person found NCRMD, so treatment options and restriction levels for people found NCRMD can vary widely within the forensic mental health system. However, while the person found NCRMD cannot be held criminally responsible for the illegal acts they commit, these restrictions directly targeting the individual found NCRMD are based entirely on the fact that they committed a crime in the first place. Even though the law outlines that people found NCRMD cannot

be held culpable of their crimes, imposing restrictions that act in punitive ways, in turn, punishes the individual for committing an act for which they are legally not responsible.

This also demonstrates how the fourth characteristic, punishment imposed intentionally by a state agent, relates to the experiences of people found NCRMD. The intentional aspect of the punishment which is experienced by people found NCRMD would be the restrictions on their liberties while detained in hospital or subjected to a conditional. The Flew-Benn-Hart account of punishment differentiates intentional from unintentional punishment as categorizing unintentional punishment as “fate, divine intervention, or self-punishment” (McPherson, 1967, p. 2). Therefore, for the purposes of this discussion, punishment imposed intentionally can be viewed as the disposition that has been imposed on the person found NCRMD by agent of the state (e.g., Review Board or forensic mental health authorities). For example, people on a conditional discharge have conditions imposed upon them intentionally by state agents based upon risk assessments. Restrictions on liberties are finely calibrated according risk levels according to the needs of the person found NCRMD. Participants found this experience to be punishing since these restrictions are often imposed by treatment professionals who are supposed to facilitating recovery and reintegration.

This leads into the last characteristic of punishment that Hayes (2017) outlines: those state agents are acting under the authority for the breached law and therefore acting in the interests of the system, not the individual (p. 2). This was the argument that Winko was making in his Supreme Court of Canada appeal: if the person found NCRMD no longer poses a threat to the safety of the public they *must* be granted an absolute discharge. While the Supreme Court of Canada clarified this point, many of the participants stated that they felt as though forensic mental health staff would manipulate

the patients' Review Board hearing or paperwork to paint the individual as a greater risk than they actually are. While the role of the treatment team and Review Board are to provide the person found NCRMD with the least restriction options given their perceived level of risk, people found NCRMD felt as though the restrictions placed on them were overly harsh, punitive, and unnecessarily. Striking examples can be found in participants' detailed accounts of spending time in segregation, and being degraded and discredited by staff.

### **The Pains of Imprisonment**

The findings indicate a clear connection between the hardships experienced by people found NCRMD and the deprivations outlined in Sykes' concept of the pains of imprisonment.

Firstly, people found NCRMD experience deprivations of liberty in many aspects of their daily lives. The most obvious way is being detained in hospital under an order of detention. This order of detention forces the individual to conduct every aspect of their lives confined within the walls of the forensic mental health hospital, restricting their movement to the same location, with the same people, doing the same activities every day. This is a direct example of the total institutions Goffman (1957) referenced in his work *Asylum*. Recall that total institutions are spaces where all three spheres of life (sleep, play, and work) are practiced in same location, with the same people, under the control of authority (p. 3).

Due to the wide variety of charges and risk levels presented by people found NCRMD detained in forensic mental health hospitals, many of the hospitals across Canada, such as the East Coast Forensic Hospital in Halifax, Nova Scotia, employ a system of privileges, which is a moniker for rights and liberties. These privileges are

afforded to individuals who are detained in the forensic mental health hospital based on their risk level, and people can work towards receiving greater privileges based on certain criteria. Similarly, the dispositions granted by the Review Board also grant privileges (i.e., liberties) based on risk level. Behaving good, complying with treatment, and following the rules can earn people more freedom. While this system of privileges can be beneficial in the sense that it affords freedom of movement around the hospital and community, the length of time at which it takes to be granted those freedoms was a major point of contention for people found NCRMD. As it was illustrated above, participants spoke at length about how slow they felt like their time progressed in the forensic mental health system. For example, many participants felt like the time spent between Review Board hearings was unnecessary and extended. They also felt like the speed at which applications for recreational and activities programs were processed was too slow. Requests to change to treatment team members or doctors could take months to process. Since these processes move so slowly, the amount of time that people are forced to endure unnecessary restrictions and unsatisfying situations is lengthy, making the overall experience in the forensic mental health system tedious and arduous.

Such experiences are exacerbated by the indeterminate and unpredictable nature of the forensic mental health system. As was stated by Justice Arbour in her report regarding solitary confinement and the Kingston Prison for Women:

the most objectionable feature of this lengthy detention in segregation was its indefiniteness. The absence of any release plan in the early stages made it impossible for the segregated inmates to determine when, and through what effort on their part, they could bring an end to that ordeal. This indefinite hardship

would have the most demoralizing effect. (*British Columbia Civil Liberties Association v. Canada [Attorney General]*, 2018)

Not only do people found NCRMD experience instances of segregation while detained within forensic mental health hospitals, but the entire nature of the system is also indefinite since they are never given a release or end date. So, unlike inmates who experience an indefinite sentence of segregation, someone found NCRMD experiences the entirety of their disposition fraught with the uncertainty of release. Moreover, the steps that can be taken to bring upon their release from the forensic mental health hospital are uncertain. Justice Arbour (2018) states that the most demoralizing aspect of segregation it is indefiniteness. This raises the question of whether forensic mental health dispositions are demoralizing since they are entirely based around this notion of indefiniteness. People found NCRMD experience deprivations that appears to be unlimited and, thus, even more punishing than a conviction and fixed sentence. This contributes greatly to the pains and hardships that people found NCRMD experience within the forensic mental health system.

The second pain of imprisonment that people found NCRMD experience is the deprivation of goods and services. As Sykes outlines, this refers to inmates existing with the absolute minimum number of personal items and additional services which are not essential to their life inside of the institution. People found NCRMD report experiencing this daily while detained in hospital. Participants outlined several goods that they had access to in the community, like cigarettes and coffee, which were not permitted in the forensic mental health hospital. Many participants expressed that the ban on cigarettes and coffee was unfair and harmful as some people enter forensic mental health hospitals with nicotine or caffeine dependencies and are unable to fulfill those craving. The

outrageous price of contraband cigarettes being sold in the forensic mental health hospital (five-to-ten dollars a cigarette) contributed to additional deprivations by depleting personal savings. While coffee or cigarettes are not necessities for survival, depriving people found NCRMD of comforts they enjoyed while in the community only serves to worsen their hospital experience. It also produces feelings of devaluation, frustration, and unfairness.

The third deprivation that is shared by both inmates and people found NCRMD is the deprivation of close intimate and non-intimate relationships. While Sykes defines the deprivation of heterosexual relationships as being completely deprived of physical and emotional contact with people of the other sex while incarcerated, individuals detained in forensic mental health hospitals can also experience a deprivation of romantic and intimate relationships with their partners living in the community or with friends and family members. Many participants referred to the fact that intimate relationships among people detained in hospital are heavily discouraged by staff which makes it increasingly more difficult for people found NCRMD to fulfil sexual and relational needs while detained in hospital. People found NCRMD who are detained in hospital are also isolated from their partnerships and intimate relationships with individuals living in the community. Many of the participants spoke about having to leave their spouse or partner because they were detained in hospital. This deprivation is not only experienced physically, but, as Sykes (1958) notes, the deprivation of these important intimate relationships can also have damaging psychological effects on individuals.

The deprivation of sexual relationships can lead to the inability to socialize with people of the opposite sex, and as Sykes noted, it can also contribute to the perpetuation of gender stereotypes and sexism (Sykes, 1958, p. 87). Since time spent in the forensic

mental health system is indeterminate, this deprivation of intimate relationships can occur for extended periods of time, triggering self-perceptions of being unlovable or unworthy of relationships. Parents found NCRMD face hardships when being forced away children, and sometimes losing custody of their children—producing feelings of anger and failure. Moreover, being kept from their own parents, siblings, or grandparents is challenging for many people detained in forensic mental health hospitals.

People found NCRMD are also subjected to the deprivation of autonomy while in the forensic mental health system. This is produced by legal dispositions as well as the practices and policies in the hospital. Similar to the tension felt between inmates and correctional staff, a strain exists between staff and patients in the forensic mental health system. As Sykes explains, within a prison, the objectives of the institution do not make sense to the inmates and inmates tend to challenge authority figures (Sykes, 1958, p. 89). People found NCRMD expressed similar sentiments when discussing their interactions with forensic mental health staff whom they felt abused their authority or manipulated procedures. For example, participants expressed that they did not like the types of medications they were forced to take, with many feeling that the medication took away their ability to make autonomous decisions, such as wanting non-pharmacological treatment plans. Tensions were heightened when patients refused to take medication, forcing staff to take disciplinary action. Regardless of the motivation behind why the person found NCRMD did not want to take medication, their refusal and the staffs' insistence creates a tension which, ultimately, is a hardship associated with forensic mental health hospitalization. Participants also frequently spoke about the treatment they received from staff to that of being treated like a child, which is comparable to the feelings that inmates develop towards staff while incarcerated.

Lastly, those found NCRMD also experience the deprivation of security while detained in forensic mental health hospitals. The violent nature of prisons makes it easy to understand how the daily lives of inmates are impacted by the threat to personal security and safety. Similar experiences were reported by participants who spent time detained within forensic mental health hospitals. Participants provided examples of threatening interactions with other patients who would yell, throw furniture, and or physically attack patients and staff. These interactions created feelings of fear and anxiety in people found NCRMD who felt like their personal safety was in jeopardy when violence erupted. The volatile and unpredictable nature of living within the forensic mental health hospital subverts the therapeutic objectives of the forensic mental health system, thus forcing people found NCRMD to live in an environment that threatens their personal security and causes distress since they are forced to endure such situations.

### **Conclusion**

The hardships that people found NCRMD experience while in the forensic mental health system are punishing in ways that are similar to the punitive experiences in other carceral spaces. While the expressed objectives of the forensic mental health system are to provide people found NCRMD with rehabilitation and treatment, while also protecting the safety of the public, the subjective experiences within this system are not always congruent with those objectives. This study has demonstrated that people found NCRMD describe their experiences with forensic staff, treatment plans, and the process of the forensic mental health system in ways that are consistent with being punished. My goal for this thesis was not to definitively state whether or not the forensic mental health system punishes people found NCRMD, rather, I was seeking to highlight how people found NCRMD can experience their time in the forensic mental health system



accompanied by hardships similar to that of people in other carceral spaces. Future research is needed to better understand how people found NCRMD experience their dispositions while detained in hospital and living in the community, and how to mitigate those negative experiences for people found NCRMD. Additionally, it may be useful to analyze the factors within the forensic mental health hospital or in the community that worsen or mitigate the punishing experiences of people found NCRMD, and how such experiences are associated with outcomes (e.g., recidivism).

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