DESCRIBING THE RECOVERY EXPERIENCES OF NOT CRIMINALLY RESPONSIBLE CLIENTS LIVING IN THE COMMUNITY

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Abstract

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This study describes the recovery experiences of persons who have been found not criminally responsible on account of a mental disorder (NCRMD). A qualitative descriptive methodology was used to elicit the recovery experiences of five participants. The overarching theme that arose from the data was '*Experiencing and understanding recovery in the forensic mental health system (FMHS) as a dynamic process of change*,' and the major themes that emerged out of the overarching theme are: 'Recovering in the FMHS,' 'the Critical Role of Medication,' 'the Significance of Relationships,' 'the Importance of Helping Yourself,' and 'Navigating Challenges.' The results of this inquiry reveal that the participants' experiences of recovery are greatly influenced by their involvement in the FMHS. This study offers a preliminary understanding of how recovery is experienced by NCRMD clients who reside in the community and suggests implications for clinical practice and education, as well as future research and theory.

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CHAPTER NULLA: PROLOGUE

MY EXPERIENCES

Introduction

I remember the first time I summarized these experiences, identifying the salient moments and connecting them meaningfully across time. It was through this process of interpreting and succinctly describing my experiences that I began to comprehend and appreciate their impact on me. These experiences provided me with the opportunity to recognize the significance of the clients' perspective as specifically distinct from my own, inspired my curiosity, and lead me to ask the question: "How do clients who are not criminally responsible on account of a mental disorder (NCRMD) understand and experience recovery?" Finally, gathering, identifying, interpreting and describing these experiences motivated me to propose this qualitative descriptive study.

Experiences leading to Insight

Part One

The five of us left the unit together, the three clients, cameras in hand, and the occupational therapist (OT) and me, a registered nurse. As we took the elevator down to the ground floor the OT and I conversed with the clients about the purpose of our community outing, which was to take photographs of things that inspired them to work for their recovery. Usually we spent this time together talking about recovery on the unit, and the change from our routine came with a sense of excitement.

We stepped outside into a day that was warm and sunny. We left the hospital grounds and walked along the busy downtown street towards the park. We stopped frequently, as the clients,

enjoying the benefits of digital technology, took many pictures. After taking more pictures at the park we walked back towards the hospital, making detours as needed when photo-worthy subjects were spotted.

I was intrigued by the things the clients stopped to photograph, and was even more intrigued by the reasons they provided when asked why they were taking a picture of this or that thing. One client, for example, took a picture of the hospital, explaining, “When I live in the community, this is where I’ll come for treatment”.

Part Two

Two weeks later I was in the activity room with the three clients from the outing and two other clients who had similarly had the opportunity to take photos of things that inspired their recovery. Each client had been given a piece of Bristol board, a glue stick and prints of the pictures he had taken, and on the table we sat around was a tin box full of coloured markers, a few pairs of scissors and a stack of old magazines. The plan was that each client would make a collage about what inspired his recovery.

I watched the clients sort through the many images they had taken, setting some aside for the collage and dismissing others. I observed a few clients flip though magazines to find additional images or printed words of relevance. The collages came together quickly; the clients focused on the task at hand, their quiet concentration tempered by the occasional sharing of a humorous image or recollection from the outing when the photos were taken.

When the collages were complete I asked each client to show his collage to the group and explain why each image was used and how it was relevant to his recovery. In making such a request I knew not every client would feel comfortable sharing in this way, however, what I did not know was how profoundly those who did share would change my understanding of recovery.

Part Three

My interest in recovery was first ignited when I was as nursing student, though at the time, I did not endeavour to understand recovery per se. What I understood was that I was entering into a profession that conferred upon me the responsibility of supporting persons in responding to the experiences of illness and disease and I inherently understood this to mean supporting persons in their recovery. As Grace and Powers (2009) explain, "although human responses and meaning contexts are unique for each individual and situation, nurses have a body of evidence for practice that assists them in recognizing the range of possible human responses and contexts" (p. 27). I was fascinated by the multiplicity of ways nurses could work to support people in this manner, and intrigued by the profession's commitment to providing this support in ways that embraced the unique experiences the individual.

When I started my career, working as a nurse in the forensic mental health system (FMHS), I came to learn more about recovery. First, as a primary nurse I learned that I could only do so much to support clients in their progress through the system because, at some point, they needed to want to engage in their recovery. Second, I had assumed the responsibility of running a symptom management group, an education-based group that focused primarily on teaching about the uses medication in the treatment of psychiatric disorders, and I learned that this information could only be useful if it was understood in the context of the life of the person who might use it.

I learned more formally about recovery when the OT and I began to co-facilitate a recovery-oriented treatment group on the unit. The contents of this new treatment modality, which replaced the symptom management group and better addressed the needs of the clients,

took holistic, life-management, goal-oriented approach to recovery in serious mental illness, and I came to understand recovery as it was framed in the context of this group.

Part Four

It was more than a year after we started running the recovery-oriented treatment group that we broke away from its structured sessions for a few weeks to engage in the group members in the recovery photo collage project described in Parts One and Two. I had become quite comfortable with the treatment modality and felt I had a working understanding of the concept of recovery. However, what I failed to recognize until that afternoon in the activity room, was how indoctrinated I had become, my understanding of and dialoguing about recovery so heavily dominated by the framing and language of the group that I had forgot to listen for the unique ways the clients might experience, and thus understand, recovery.

Consequently, when we were liberated from the confines of the structure of the treatment modality and the expected rhythms of the group on-goings, the clients, in describing their collages, were free to explain themselves and their personal understandings of recovery, and I, listening to them, was able to perceive their experience of recovery in ways I had never comprehended before. What I understood was that the clients' understandings and perspectives of recovery were very personal, contextualized by their individual life experiences and expressive of their particular hopes and dreams. For example, one client, in explaining his selection of a specific picture, described with evident pride his experiences owning his own business, and then, with darkened face, identified the feelings of sadness and frustration he continued to experience as a consequence of having lost that same business coming into the FMHS. At this moment the client paused, seeming to have forgotten why he was speaking about the picture. Then finally, with face brightening, he began speaking excitedly about how much he

would, upon returning to reside in the community, like the opportunity to re-establish himself as an entrepreneur.

Afterward

In summary, the difference in the way the clients spoke about recovery in the absence of the context of the treatment group session was remarkable. The afternoon I spent with the clients making collages and talking about their recovery experiences made me realize that I wanted to further explore and discover more about how clients in the FMHS understand and experience recovery, and to do so by asking them about their experiences in a context that was free from the framing influences of treatment group teachings or conceptual models. Moreover, I understood to gain insight into their understandings of recovery meant listening to them and then explaining, from their perspective, their experiences of recovery.

Reflexivity

I think it is important to acknowledge that I bring to this inquiry an influential informal and personal perspective that is informed by my professional experiences. Specifically, it is a consequence of these experiences that I endeavoured to conduct this study. This awareness of the influence of my subjectivity on the research process, known as reflexivity in the qualitative research paradigm, is considered a fundamental criterion when assessing the ethical quality of an inquiry (Lincoln, 1995). Consequently, in an effort to identify the importance of reflexivity in this study, I recognize that while my identity as a registered nurse and the experiences I had in this role working with NCRMD clients have irreversibly altered the way I think about and understand the topics I write about, in authoring this thesis I have made an effort to by mindful of their impact on my orientation to and position within the research process.

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CHAPTER I: INTRODUCTION

IDENTIFYING THE STUDY

Introduction

Mental health recovery is a complex and multifaceted concept, described by the Mental Health Commission of Canada (MHCC) (2012) as a process of: finding, maintaining and restoring hope and optimism for the future; re-establishing a positive identity; regaining a meaningful and satisfying life despite the presence of mental illness; as well as taking responsibility for and feeling control over one's life and one's illness. This conception of recovery was developed out of the field of psychosocial rehabilitation and the advocacy of people living with mental health issues (Anthony & Liberman, 1986; Deegan, 1988; Leete, 1989; MHCC, 2012). Importantly, these two influences distinguish between "what helpers do to facilitate recovery," which is to provide support and rehabilitative, recovery-oriented care, and what clients do, which is the work of recovery (Anthony, 1993, p. 15; Livingston, Nijdam-Jones & Brink, 2012; MHCC, 2012; Simpson & Penney, 2011).

Comprehending this distinction is relevant to appreciating the importance of recovery for persons who are receiving care in the forensic mental health system (FMHS) and who have the legal designation of not criminally responsible on account of a mental disorder (NCRMD). The primary goal of the Canadian FMHS is to support the rehabilitation of clients by improving their mental health and providing opportunities for successful reintegration into society (Bettridge & Barbaree, 2008; *Criminal Code*, 1985, s. 672.54). Therefore, accomplishing this rehabilitative goal requires that health care providers offer recovery-oriented care and support clients to engage

in the work of recovery. Moreover, how NCRMD clients understand and experience recovery is germane to the success of the forensic mental health system.

Despite the prominence of recovery in the Canadian national mental health strategy (MHCC, 2012), as well as the fact that rehabilitation is an expressed goal of the FMHS, it is striking that there is minimal Canadian literature which addresses the recovery experiences of forensic clients generally, or NCRMD clients specifically (Viljoen, Nicholls, Greaves, Ruiter & Brink, 2011). There is, however, some relevant theoretical literature which discusses the "unique rehabilitative needs" of forensic clients (Simpson & Penney, 2011, p. 301). Specifically, this literature highlights the need for clients recovering in the FMHS to manage their offender status, legal oversight and the consequent accountabilities (Simpson & Penney, 2011). Further, they must deal with public fear and discrimination, social isolation and the dual stigma of being "mad and bad" (Quinn & Simpson, 2013, p. 570; Simpson & Penney, 2011). There are also two publications that discuss the implementation of the Tidal Model (a recovery-oriented care model), in an Ontario hospital, of which one of the piloting programs was the forensic program (Brookes, Murata & Tansey, 2006; Brookes, Murata & Tansey, 2008). These articles, while indicating that recovery oriented care principles are being implemented in forensic care settings in Canada, are of limited relevance because the forensic clients' experiences with the implementation of the Tidal Model and/or of recovery were not discussed. The most germane empirical literature examined an intervention aimed to increase clients' engagement in the receipt of care in an inpatient forensic care setting (Livingston, Nijdam-Jones, Lapsley, Calderwood & Brink, 2013). This study is relevant because, to evaluate this intervention, participants (forensic clients) were asked to complete a variety of outcome measures, one of which assessed changes in recovery. Moreover, the study found there was a positive correlation

between engaging in peer support (one aspect of the intervention) and in recovery. However, the recovery measure used, the Mental Health Recovery Measure (Bullock, 2005, as cited in Livingston et al., 2013), is not specific to the recovery experiences of forensic clients, nor did the study specifically discuss the forensic clients' understandings or experiences of recovery. Other studies also discuss forensic client recovery, but in the context relevant to their specific line of inquiry (Livingston, 2012; Livingston et al., 2012; Viljoen et al., 2011). Significantly, no Canadian studies were located that considered the forensic clients' understandings, experiences, or perceptions of recovery.

There is slightly more international scholarly literature addressing forensic clients and recovery. This theoretical literature identifies the inherent challenges of and contradictions in supporting recovery principles, specifically the principle of self-determination, in the care of forensic clients (Dorkins & Adshead, 2011; McLoughlin, 2011; Moore & Drennan, 2013; Pouncey & Lukens, 2010). Also discussed is the implementation of a recovery-oriented care model in a forensic setting (Gill, McKenna, O'Neill, Thompson & Timmons, 2010), and the possible benefit of music therapy on forensic clients' recovery (Walker & Paton, 2015). Some peripherally relevant empirical literature was located that addresses the provision of care as it relates to recovery in forensic settings. One study examined and validated a set of structured professional judgment instruments, the DUNDRUMs, one of which assesses recovery in forensic settings (Davoren et al., 2012; O'Dwyer, Davoren, Abidin, Doyle, McDonnell & Kennedy, 2011). Another study evaluated the effectiveness of the Recovery After Psychosis (RAP) programme, which was developed to assist forensic clients in high security settings manage depression, improve self-esteem, develop self-compassion, and reduce feelings of shame by teaching clients about the process of recovery (Laithwaite et al., 2009). However, while the study

found the RAP programme to be effective in addressing: depression, self-esteem, ratings of self compared to others, and shame, the clients' experiences of recovery were not discussed. Finally, yet another study analyzed the therapy notes from a group in which inpatient forensic clients from "black and ethnic minorities" discussed their experiences with stigma and discrimination (Williams, Moore, Adshead, McDowell & Tapp, 2011, p. 197). The results of the analysis revealed one of the three themes discussed by participants in the group was 'emergent recovery styles'. However, despite the identification of this theme, William et al. did not explicitly discuss the concept of recovery or describe the experiences of forensic clients in that context. In summary, although these primarily quantitative studies do not directly address client perspectives of recovery, they do highlight the need to understand the clients' experience of recovery to support the development of effective recovery oriented interventions.

Regardless, relevant international studies that do explore forensic clients' perspectives on recovery and rehabilitation were also located. For example, one study explored clients' understandings of the inclusion of recovery principles in community outings (Walker, Farnworth & Lapinski 2013), while another study explored clients' perspectives on the impact of a motivational program on their experiences of recovery (Skinner, Heasley & Stennett, 2014). Further, relevant studies were located which specifically described how forensic clients perceive, experience and/or understand recovery. One of these studies explored clients' perceptions of their ability to engage in the work recovery in a medium-secure compared to a high-secure setting, and found that participants perceived the medium secure setting to be more conducive to recovery (Barsky & West, 2007). Another study collected and examined inpatient clients' perceptions and understandings of recovery to create a forensic-specific measure of recovery (Green, Batson & Gudjonsson, 2011). A third study explored how inpatient forensic clients with

violent offending histories experience and understand their engagement in recovery (Olsson, Strand & Kristiansen, 2014), and a fourth study explored how inpatient forensic clients perceive their experiences of recovery in an effort to determine whether recovery is uniquely experienced in the context of medium-secure forensic settings (Mezey, Kavuma, Turton, Demetriou & Wright, 2010). Finally, one study was located that explored how forensic clients residing within a hospital setting perceived and understood their experiences of rehabilitation (Barnao, Ward & Casey, 2015). In summary, these five studies, which specifically address inpatient forensic clients' perceptions of their experiences of recovery, and of rehabilitation, are the most pertinent to exploring the recovery experiences of community residing NCRMD clients.

Problem Statement

Five studies exploring forensic clients' recovery experiences were identified, none of which were conducted in Canada. All of these qualitative studies involved analyzing data collected from interviews with participants; however, these studies focused almost exclusively on exploring clients' perceptions and experiences of recovery within inpatient forensic care settings. Therefore, there is a need to explore the experiences and understandings of recovery from the perspective of NCRMD clients who have lived in a secure inpatient setting but who are now residing in the community.

Study Purpose

The purpose of this study, using the qualitative descriptive methodology as described by Sandelowski (2000), was to develop an increased understanding of the recovery experiences of individuals who had been found NCRMD, previously received treatment on a secure inpatient unit, and were currently residing in the community in a large urban centre in Ontario under the supervision of the Canadian forensic mental health system.

Research Question

How do NCRMD clients who have a history of detention on a secure inpatient unit and are currently residing in the community, understand and experience recovery?

CHAPTER II: BACKGROUND, CONCEPTUAL DEFINITION & LITERATURE REVIEW

SITUATING THE STUDY

Introduction

In this chapter the topics germane to the recovery of forensic clients are explained more thoroughly. Part One provides reviews the literature pertinent to those persons with a legal designation of not criminally responsible on account of a mental disorder (NCRMD) and the forensic mental health system (FMHS). Part Two discusses the concept of mental health recovery in more depth. Finally, Part Three explores the extant literature that specifically addresses how forensic clients understand and experience recovery.

PART ONE: BACKGROUND

Introduction

This section of this chapter provides a review of the literature pertinent to NCRMD clients and explains briefly the structure and function of the forensic mental health system. The purpose of this is to provide background information relevant to the circumstance of potential participants.

Not Criminally Responsible on Account of a Mental Disorder

In Canada, every individual with the legal designation of NCRMD has a mental illness that has, in a court of law, been identified as a mediating factor in the commission of an unlawful act (*Criminal Code*, 1985, s.672.34). Specifically, the majority of the offenses committed in Canada by those with an NCRMD designation are committed against other people (64.9%), with property offenses (16.9%) and other Criminal Code violations (18.2%) making up the remainder

(Crocker, Nicholls, Seto, Charette, Côté & Caulet, 2015). The range of severity of the offenses committed against others varies dramatically, with assault and making threats being the most common (Crocker, Nicholls, Seto, Charette, et al., 2015). Notably, despite mass media coverage, murder and attempted murder account for less than seven percent of the offenses in cases that result in an NCRMD finding (Crocker, Nicholls, Seto, Charette, et al., 2015). However, beyond this common experience of having committed an offense, NCRMD clients are a diverse group. These clients have differing mental health and substance use issues, unique psychiatric histories, and varying degrees of risk for future violence and criminality (Crocker, Nicholls, Seto, Charette, et al., 2015). Consequently, the NCRMD population has a wide variety of health care and living needs (Crocker, Nicholls, Seto, Charette, et al., 2015). Presently, this population is comprised of adults between the ages of 18 and 64 years, the vast majority of whom are men (Crocker, Nicholls, Seto, Charette, et al., 2015). The most common psychiatric diagnoses are schizophrenia, substance use, as well as mood and personality disorders, with many clients having multiple mental health needs (Crocker, Nicholls, Seto, Charette, et al., 2015).

The Forensic Mental Health System

The FMHS is uniquely situated within every Canadian province or territory, created at the intersection of the health care system, the mental health care system and the criminal justice system. The FMHS provides care to this heterogeneous group of NCRMD clients, and aims to address the various and complex needs of each individual in each of the aforementioned systems (Bettridge & Barbaree, 2008; Kent-Wilkinson, 2011; Latimer & Lawrence, 2006; Livingston, 2006). In order to provide each NCRMD client with the most fitting, individualized care, provincial review boards (RBs) assess each individual's mental health, reintegration and/or other psychosocial needs, as well as his or her risk to public safety, and make a determination about

where and how best to support that client (*Criminal Code*, 1985, s. 672.54). The most restrictive decisions made by RBs involve detention and require clients to reside in a psychiatric hospital at the level of security (maximum, medium or minimum) deemed most appropriate by the board (Bettridge & Barbaree, 2008; *Criminal Code*, 1985, s. 672.54). These decisions are imposed when NCRMD clients are considered to pose a significant threat to public safety (Bettridge & Barbaree, 2008; *Criminal Code*, 1985, s. 672.54). As clients' mental health improves and they are able to meet reintegration goals, as well as demonstrating decreased risk to public safety, they are given increasing access to the community (Bettridge & Barbaree, 2008; Crocker, Nicholls, Seto, Charette, et al., 2015). To facilitate the rehabilitative trajectory described immediately above, RBs regularly review and revise detention decisions to include, when deemed appropriate, the option of community residency, or change detention decisions to conditional discharge decisions, which similarly allows clients to reside in the community (Bettridge & Barbaree, 2008). The rationale for reintegrating NCRMD clients back into the community is based on the following evidence: the recidivism rates for NCRMD clients residing in the community on a conditional discharge or following a release from provincial RB purview are low, and are notably lower in clients with violent offense histories than for others (Crocker, Seto, Nicholls & Cote, 2013; Crocker, Nicholls, Seto, Charette, et al., 2015; MHCC, 2013).

Finally, between 1992 and 2004 approximately 6800 people in Canada were found NCRMD (Latimer & Lawrence, 2006). However, the number of people being found NCRMD has been increasing as the result of a number of landmark cases and parliamentary bills which have changed the way mentally disordered accused persons are handled in the judicial system and the FMHS (Crocker, Nicholls, Seto, Charette et al., 2015; Latimer & Lawrence, 2006; Penney, Morgan & Simpson, 2013). The increased number of NCRMD clients is relevant to this

study because, as the number of NCRMD clients in Canada increases, so too does the need to build capacity of healthcare professionals working within the FMHS. Specifically, these care providers can support NCRMD clients to actualize their personal recovery goals, and in so doing, assist them to concurrently fulfill the rehabilitative and reintegration aims of the FMHS. Moreover, the diversity of the NCRMD population suggests that achieving these goals will not be accomplished by assuming the same recovery approach with each client. Therefore, engaging in Canadian research that explores NCRMD clients' experiences of and perspectives on recovery, which is ultimately intended to encourage reflection, insight, and practice change, is reasonable and justified.

PART TWO: CONCEPTUAL DEFINITION

Introduction

Chapter One defined mental health recovery and identified that it developed out of the field of psychosocial rehabilitation in conjunction with the advocacy of people living with mental health issues. Further, it was pointed out that these influences have led to a distinction between recovery, which is what clients do, and rehabilitation, which is what helpers do. This section of this chapter expands on that definition of mental health recovery. Specifically, the development of the concept is described, and the context in which recovery is currently understood is explained more thoroughly. Finally, the application of the concept of recovery in FMHS is discussed.

Mental Health Recovery

Mental health recovery is defined as a process that centres on attaining hope and optimism, developing a positive sense of self, and finding meaning and purpose within the

context of mental health challenges (MHCC, 2012). This understanding of recovery is the result of a century of conceptual evolution that began when Dr. Emil Kraepelin first described an illness phenomenon with the symptoms and behaviours that are understood today to be associated with schizophrenia (Brennaman & Lobo, 2011; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Piat, Sabetti & Bloom, 2009; Stickley & Wright, 2011; Watson, 2012). In the early twentieth century, consequent to Kraepelin's description, psychosis was deemed to be an "incurable mental infirmary", which framed our understanding of mental health recovery until the 1970s and 1980s, when the consumer-survivor movement began to challenge this pessimistic view (Brennaman & Lobo, 2011; Kraepelin, 1913, p. 28; Watson, 2012). As those living with mental illness found their voice, often by sharing personal experiences, it became anecdotally evident that recovery was possible, even in spite of on-going symptoms (Deegan, 1988; Leete, 1989). This realization that recovery was possible was further backed up by empirical research which indicated that people with serious mental illness could and did improve over time (Engelhardt, Rosen, Feldman, Engelhardt, & Cohen, 1982; Glynn & Mueser, 1986; Harding, 1988; Vaillant, 1978). Specifically, these studies demonstrated that when recovery was understood as the attainment of an improved quality of life, it became not only possible, but also common, for the majority of people with mental health issues to engage and progress in recovery.

As a result of this historical understanding, the current conceptualization of mental health recovery is described as a "deeply personal" and idiosyncratic process that encompasses: attaining hope and optimism, developing a positive sense of self, and finding meaning and purpose (Anthony, 1993, p. 15; MHCC, 2012; Simpson & Penney, 2011). Recovery is experienced uniquely by each individual and can and does occur even when the symptoms of

mental illness persist (Anthony, 1993; MHCC, 2012). It involves focusing on the possibility of recovering one's life without the necessity of being cured of illness, and is enabled when people engage in autonomous decision-making and self-determination, as well as aspire to attain self-actualization (Anthony, 1993; Brennaman & Lobo, 2011; Frese & Davis, 1997; MHCC, 2012).

Recovery in Forensic Mental Health

The concept of recovery applied in forensic care environments is distinctly influenced by the inherent contradictions between the notions of autonomy that are fundamental to recovery and the restriction of liberty imposed by the FMHS (Simpson & Penney, 2011; Skipworth & Humberstone, 2002). Specifically, managing security and maintaining public safety while facilitating rehabilitation may appear to restrict the capacity of NCRMD clients to engage in recovery. However, it is actually this exact paradox that reinforces the importance and possibility of recovery in the care of forensic clients (Simpson & Penney, 2011). As Simpson and Penney (2011) state: "one cannot attain a 'life worth living' and continue to offend" (p. 304).

Forensic Client Recovery

Individuals recovering in forensic care settings have rehabilitative needs that are specific to their circumstance as persons with mental health issues under legal supervision (Simpson & Penney, 2011). Specifically, forensic clients need to manage having an offender status and being under the purview of provincial RBs (Simpson & Penney, 2011). Therefore, recovery for NCRMD clients involves accommodating their legal oversight and the consequent accountabilities along with addressing all the aspects of mental health recovery already identified above (Simpson & Penney, 2011). Notably, these issues are specifically challenging to the capacity of forensic clients to engage in the kind of autonomous decision-making that is considered of major importance to, and necessary for, recovery (Simpson & Penney, 2011).

Furthermore, for those NCRMD clients who reside in the community, there are even greater challenges inherently in their recovery process. Specifically, these clients need to also deal with public fear and discrimination, social isolation or exclusion, and the dual stigma of being perceived as being "mad and bad" (Quinn & Simpson, 2013, p. 570; Simpson & Penney, 2011). These factors, particularly public fear and stigma, may further limit the ability of NCRMD clients to engage in recovery because they perpetuate the perception that these individuals are more seriously ill and are less likely to succeed at recovery than their non-forensic counterparts (Simpson & Penney, 2011).

In summary, the concept of recovery, with its focus on supporting personal autonomy and self-actualization, may at first seem incompatible with the imposition of involuntary legal oversight and various restrictions on people's liberty that exist in forensic care settings. However, when applied in this care context, the concept of recovery has the potential to support forensic clients and healthcare providers in achieving these clients' rehabilitative and recovery goals. Specifically, restricting the liberty of NCRMD clients and limiting their autonomy can actually facilitate their recovery. By requiring, but also supporting, the progression from offending to reintegration, through the provision of guidance and care, the FMHS is both prescribing and providing a clear path to recovery (Simpson & Penny, 2011).

PART THREE: LITERATURE REVIEW

Introduction

This section of this chapter reviews the extant literature to identify what is currently known about how people in forensic care settings understand and experience recovery. The search strategy used to identify the germane literature is described and a synopsis of the findings

from each of the identified pertinent articles is provided. A summary of these findings is also provided. Finally, the importance of this study and how it might add to what is currently known is reiterated.

Literature Search Strategy

The articles discussed in the literature review below, which was undertaken to identify what is currently known about how people in forensic care settings understand and experience recovery, were located using the following search strategy. The initial search was conducted to provide an overview of Canadian studies prior to undertaking a more focused search and as such, used the 'search everything' function on the Ryerson University library website. This search limited the results to those from peer-reviewed sources, and used the term 'recovery' in combination with the phrase 'not criminally responsible' which is used in the Criminal Code of Canada, and consequently was determined to be the most accurate method of identifying relevant Canadian articles. The search located 65 articles, and after reading through their titles and/or abstracts to determine further relevance, a total of 14 articles were identified that were somewhat germane or even tangentially relevant to identifying or describing NCRMD clients' experiences, understandings and/or perceptions of recovery. A more extensive search was then undertaken using the CINAHL, Medline (OVID), ProQuest Nursing Journals, and PsychINFO databases, however no additional articles were located. Of the 14 articles located five have been referenced at a previous point in this thesis (Crocker, Nicholls, Seto, Charette et al., 2015; Livingston, 2012; Livingston, Nijdam-Jones, Lapsley, Calderwood & Brink, 2013; Simpson & Penney, 2011; Viljoen, Nicholls, Greaves, Ruiter & Brink, 2011). Most notably, the Simpson and Penney (2011) article has been referenced extensively in the preceding discussions about the application of recovery principles in forensic settings. However, because none of the 14 articles located

specifically addressed the perceptions, experiences or understandings of recovery of NCRMD clients in the FMHS they have not be included in the discussion below. Consequently, a further search of the literature was required.

Given the lack of relevant literature, a subsequent search was undertaken using the 'search everything' function on the Ryerson University library website, with results limited to those from peer-reviewed sources. The broader range of germane search terms included those used in forensic mental health literature to describe the recipients of care: client/criminal/ individual/offender/patient/people/service-user, and to describe the care setting itself: forensic/ secure. However, a preliminary Boolean search using these terms in combination with the term 'recovery' turned up more than a million results. Therefore, a second search was conducted in which the term 'recovery' was augmented with the addition of the terms: mental health/mental illness/psychiatric/psychiatry. Using the following Boolean search string: (client OR criminal OR individual OR offender OR patient OR people OR service-user) AND (forensic OR secure) AND ((recovery AND "mental health") OR (recovery AND "mental illness") OR (recovery AND psychiatric) OR (recovery AND psychiatry)) the search located over 15 thousand results. To increase the specificity of the search, these results were limited to those with 'forensic OR secure' in the title, and excluded book reviews. This search located 328 articles. An extensive search was then undertaken using the CINAHL, Medline (OVID), ProQuest Nursing Journals, and PsychINFO databases, but no further articles of relevance were located.

As above, the titles and/or abstracts of these 328 articles were reviewed for relevance to the topic of how people in forensic care settings understand, perceive or experience recovery. A total of 312 articles were excluded because they were editorials, commentaries or opinion pieces, or considered the recovery paradigm in the provision of care, service provider perspectives on

recovery, or clients' perspectives but did not specifically as they relate to recovery. Additionally, one previously located article of relevance by Green, Batson and Gudjonsson (2011), was not located in the above search because the title does not include the words 'secure or forensic', referring instead to 'mentally disordered offenders'. To ensure other potentially relevant articles were not missed, the above search was repeated but limited the results to those with 'mentally disordered offenders' in the title. Eleven articles were located, and when titles and abstracts were read for relevance, the aforementioned article and one further article were identified as germane to the topic of interest. Therefore, a total of 18 articles were located and deemed relevant for further review because they directly or indirectly solicited client perspectives, and in so doing, made a direct reference to 'recovery'.

The texts of these 18 articles were reviewed more thoroughly to determine in which manner they addressed recovery. Thirteen of these 18 articles were eliminated from further consideration because they solicited clients' perspectives in relation to: a specific aspect of care or client experience, or the implementation of care approaches or treatment modalities, and in so doing made at least one direct reference to 'recovery', but did not specifically elicit clients' understandings, perceptions, or experiences of recovery. In total, five articles remained; four that explicitly studied experiences of recovery from the perspective of clients (Barsky & West, 2007; Green, Batson & Gudjonsson, 2011; Mezey, Kavuma, Turton, Demetriou & Wright, 2010; Olsson, Strand & Kristiansen, 2014) and one that explicitly studied the experience of rehabilitation from the perspective of clients (Barnao, Ward & Casey, 2015). This last article was preserved for review because much of what its participants reported as being either a part of and significant to their rehabilitation was remarkably similar to what the participants in the four recovery studies described. Moreover, including this study highlights the inherent connection

between recovery and rehabilitation. Consequently, it is these five articles will be discussed in the literature review below. Finally, the lack of literature explicitly addressing recovery in forensic mental health services should not be unexpected, given the limited amount of research with regard to forensic clients' perspectives (Coffey, 2006; Corlett & Miles, 2010).

Literature Review

As described above, after an extensive search of the available peer-reviewed literature, a total of four articles germane to forensic clients' understandings, perspectives and experiences of recovery and one related to their perceptions of rehabilitation were located. Three studies were conducted in the United Kingdom (Barsky & West, 2007; Green, Batson & Gudjonsson, 2011; Mezey, Kavuma, Turton, Demetriou & Wright, 2010), one in Sweden (Olsson, Strand & Kristiansen, 2014) and one in New Zealand (Barnao, Ward & Casey, 2015). All of the studies were conducted in the past ten years and solicited the perspectives of participants detained in hospital-based forensic mental health settings. Given the small number of studies under review, each study is discussed separately, in order of their perceived relevant to the topic of interest. Lastly, a summary of what is similar and distinct in the studies' findings is provided.

Synopses of Identified Studies

Mezey et al. (2010) conducted the study that is the most relevant of the five studies that will be discussed as part of this literature review. This study explored the perspectives of clients from different specialized care settings: eating disorders, dual diagnosis, and forensics, for the purpose of developing insight into recovery across various care settings. Specific to this discussion, ten forensic clients detained in a secure inpatient environment were asked open-ended and semi-structured questions during face-to-face interviews to discover their perceptions of recovery. The purpose of this was to identify if, and in which ways, their understandings of

recovery were distinct from non-offending clients. Mezey et al. identified, 'the Recovery Approach,' as the context for the study, which is described as "the guiding principle for mental health service delivery in the UK" (p. 683). A grounded theory approach was used to analyze the data, and findings focused exclusively on identifying client definitions and understandings of recovery, including what they perceived as being helpful and hindering to recovery.

The germane findings in the Mezey et al. (2010) study reveal that forensic clients understand recovery in ways that reflect a general understanding of mental illness recovery. For example, participants expressed that experiencing: a reduction in illness symptoms; positive and accepting relationships with oneself and others; hope for the future; and support for autonomous decision-making were important for recovery. They also indicated the importance in recovery of finding employment, finding housing, and feeling as though they were making a contribution. However, participants also identified that their experience of recovery was uniquely influenced by their experience as offenders. Specifically, they indicated that not re-offending, and being socially accepted by those that were hurt by their actions were vital for recovery.

Finally, the participants in the Mezey et al. (2010) study also identified that their understanding and experiencing of recovery was contextualized by their detention in a secure environment. They expressed feeling that detention provided a safe place for engaging in recovery, as it afforded them the time required for recovery as well as the opportunity to develop strong relationships with staff and peers, all of which gave the participants a sense of acceptance, belonging, companionship. Interestingly, the participants also identified detention as a deterrent to recovery because it was a reminder of the stigma of having mental illness and a criminal history. In addition, participants identified that caregiver attitudes were not always positive and the detention environment, being small and overcrowded, was unpleasant. Lastly, these

participants expressed dichotomous feelings about the recovery and the possibility of discharge. Discharge was considered to be an indicator of recovery success but was often anticipated with fear of the unknown and of possible failure, as well as feelings of loss regarding the safety and security of the detention environment. In summary, these findings clearly identify that the participants in this study understood recovery and viewed the recovery process as being influenced by their mental health, their status as offenders, and their detention within a forensic setting.

Green et al. (2011) conducted a study with participants who were detained on a secure inpatient forensic unit for the purposes of creating a tool to measure forensic client recovery: the Recovery Journey Questionnaire (RQJ). In the first stage of this study, two focus groups, each with six participants, were held to identify factors of relevance to the participants' recovery, as well as to identify the types of interactions and staff behaviours participants felt would support their recovery. A qualitative content analysis method was used to identify themes relevant to forensic clients' experiences of recovery.

The second stage of the Green et al. (2011) study consisted of in-depth interviews with four individual participants and was conducted to authenticate the five identified themes in stage one. The first theme, 'working together,' identified the importance to participants of having interactions that developed and encouraged their autonomy and supported them in solving their own problems. The second theme, 'support and preparation,' identified the importance of having relationships with care providers that provided hope for leaving hospital, and that assisted participants in defining and working for rehabilitation goals, and making links in the community. The third theme, 'empowering service-users,' described the importance to participants of being involved in their care plans and being encouraged to develop their own plans for the future. The

fourth theme, ‘providing good role models,’ identified that currently detained clients perceived a benefit from knowing what behaviours had helped others cope and succeed in making progress in recovery. The fifth and final theme, ‘things to do,’ identified the importance to participants of having numerous opportunities to engage in purposeful activities.

In the third and final stage of this study, a pilot of the RQJ was drafted based on the themes identified in the focus groups and authenticated during the interviews. This RQJ was given to 69 additional participants who were asked to identify whether it reflected their understandings of recovery. The RQJ was found to be a “psychometrically robust measure for assessing [forensic] service-users’ subjective experience of recovery” (Green et al., 2011, p. 262), and thus further validated the forensic-specific recovery themes identified in this study. Lastly, the findings from this study further indicate that clients receiving care in a forensic mental health setting uniquely conceptualize recovery and perceive recovery as inherently connected to the experience of the care they receive.

Barsky and West (2007) conducted a study using semi-structured interviews and thematic content analysis to explore six participants’ perceptions of recovery. Participants in this study were recruited from a medium secure forensic setting and all had experiences residing in high-secure settings. The purpose of this study was to identify if these participants perceived differences in the viability of engaging in the work of recovery in medium-secure as compared to high-secure settings. No specific recovery framework was identified within the context of the study. However, Barsky and West identify that many of their findings corresponded to Jacobson and Greenley’s (2001) conceptualization of recovery, which focuses on describing recovery as involving internal factors, for example, feelings of hope and connectedness, and external conditions, for instance, a culture of healing and access to recovery-oriented services.

The results attained by Barsky and West (2007) demonstrated that participants perceived recovery as a more realistic proposition medium secure settings as opposed to higher security settings. The reasons participants gave for this included the following: medium secure settings present increased opportunities to make choices and exert personal control; increased access to more activities; and an atmosphere that is more conducive to recovery. Specifically, participants identified medium secure settings as more stable, less violent milieus, with increased opportunities for developing relationships with peers compared their experiences residing in higher secure settings. Additionally, participants identified that interactions with caregivers on medium secure units involved greater engagement, friendliness, trustworthiness, and helpfulness, as compared to those experienced in higher secure settings. Finally, participants felt medium secure settings supported recovery by providing more freedom on the unit and increased community access.

Consequent to these findings, Barsky and West (2007) conclude that medium secure units are more favourable for recovery because they are perceived by participants to provide higher quality of life, as defined by the characteristics identified above, compared to the quality of life available in a higher security setting. Finally, the findings from this study supports the understanding that forensic mental health clients come to understand recovery in the context of being detained as offenders, and further suggests that as they progress to increasing levels of freedom with lower levels of security, they may perceive recovery as increasingly attainable.

Olsson et al. (2014) conducted a study that aimed to discover how detained inpatient forensic clients with a historically high risk for violence come to understand and experience recovery. To this end, Olsson et al., using open-ended questions, interviewed ten participants with experiences of receiving forensic care at multiple levels of security. A qualitative method of

inquiry was used to gather information pertaining to the "experiences and emotions related to the turning point process" and a thematic content analysis method was used to analyze the data (p. 586). To explain recovery Olsson et al. refer to Anthony's (1993) conceptualization of recovery, which they identified as being the preferred explanatory framework based on its pervasive presence in the literature on mental health recovery.

The findings from this study revealed three phases in the data collected from participants, which represent the participants' progress from initial detention to being in recovery (Olsson et al., 2014). The first phase involved a period of high risk for participants, who described experiencing intensely negative emotions pertaining to being detained within a forensic setting. Specifically, participants experienced challenging feelings related to being detained and the coerciveness of treatment, as reflected by the use of restraint, seclusion, and involuntary medication compliance. Further, based on what the participants reported, moving from the first phase to the second was captured by the theme, 'transition from violence to recovery,' which occurred when participants perceived stability in their environment, in themselves, and in their relationships with healthcare providers. The second phase was identified as a turning point, a process of self-reconceptualization in which participants described trying to be hopeful along with believing in the potential of having a better life. The participants that embodied this phase also report being more capable of dealing with negative emotions and experiences, as well as having better relationships with family and with healthcare professionals. The third and final phase described by Olsson et al. (2014) was the recovery phase. Based on the information collected from participants, this phase involved: feelings of self-confidence and self-acceptance; the attainment of new coping methods; managing potential relapses in illness; and having trusting relationships with others. Participants in this phase also identified the importance of

having things to do to keep themselves occupied. Moreover, these participants perceived that a change in circumstance, such as moving to somewhere unknown or the loss of a favoured care provider or other beneficial relationship, could be potentially disruptive or detrimental to recovery. In summary, the findings from this study suggest that forensic clients come to understand recovery as a result of progressing through three phases that are contextualized by the participants' circumstance, such as being detained in a forensic mental health setting.

Finally, Barnao et al. (2015) conducted a study that endeavoured to discover the participants' perspectives on the lived experiences of rehabilitation in forensic settings. The study was included in this literature review since it highlights the inherent connection between recovery and rehabilitation; identifying that forensic clients understand, perceive, and experience rehabilitation as distinctly complementary to the way in which they experience recovery. In this study, Barnao et al. assumed a phenomenological approach and, using open-ended and semi-structured questions, conducted interviews with 20 participants residing on either a medium or general forensic unit or in hospital-based transitional housing. The interview questions were developed in the context of Ward and Maruna's (2007) theory of rehabilitation and guided by a framework that applied rehabilitation principles in forensic settings (Robertson, Barnao & Ward, 2011, as cited by Barnao et al., 2015). Notably, participants were not given any definitional reference for understanding the term 'rehabilitation' in an effort to ensure that the collected data reflected client understandings and perspectives.

An analysis of the study findings was undertaken using thematic analysis and revealed how participants perceive rehabilitation in forensic mental health settings. Specifically, three internal themes of 'self-evaluation,' 'agency,' and 'coping mechanisms,' and four external

themes of ‘person-centered approach,’ ‘nature of relationships with staff,’ ‘consistency of care,’ and ‘awareness of rehabilitation pathway’ were identified (Barnao et al., 2015).

The results of this study highlighted that participants wished to feel respected as individuals and be included in decisions about the care they would receive. Specifically, participants expressed the importance of care providers having knowledge of their personal rehabilitative treatment goals, as well as a willingness to work collaboratively in pursuit of those goals. Notably however, participants also voiced feeling that this approach was not always reflective of their actual experience of receiving care. Participants also identified the need to be treated as people. Further, participants wished to have the opportunity to develop quality, trusting relationships with care providers, which was a challenge when staff changed frequently. The participants also expressed concerns about the variations and inconsistencies in the care that they received, which made them feel powerless and confused, and ultimately vulnerable. Inversely, participants reported that strong consistent relationships with care providers, along with the capacity to predict their care, made them feel confident and optimistic. Participants also expressed the importance of knowing how to move forward successfully, but reported feeling that the way forward this was not always clear to them.

Within the context of their rehabilitation experiences, participants also spoke about perceiving themselves as having mental health issues, which required medication, as well as identifying offenders. Participants also made references to meaningful personal circumstances and their hopes for the future. Some participants also expressed a range of feelings arising from their detention, including: feeling unable to trust their own judgment; feeling dependent on caregivers for decisional assistance; and feeling a lack of control over their circumstances as a

consequence of their detention. This lack of control was experienced along with feelings of sadness, frustration, resentment, and powerlessness.

Finally, participants reported a variety of strategies for addressing their perceived lack of agency. For example, some reported doing what was expected of them, cooperating with staff, and following unit rules and policies, while others reported distancing themselves from staff except in the context of needing something specific. Participants also reported strategies for setting and meeting their own rehabilitation goals, including: self-study; personal recreation activities; using medication; and maintaining a positive perspective. In summary, the findings from this study reveal that participants experience rehabilitation as contextualized by forensic care setting in which it occurs. Moreover, these findings highlight that forensic mental health clients endorse experiencing recovery and rehabilitation similarly.

Summary of the Identified Studies' Findings

The findings from all five studies reveal that forensic mental health clients experience recovery, and rehabilitation, as contextualized by but not distinct from their involvement in the receipt of forensic services. Specific examples of the role of receiving care in the forensic system are present in each of the five studies. For example, participants identified positive and rewarding relationships with care providers and peers as important in their recoveries (Barnao et al., 2015; Barsky & West, 2007; Green et al., 2011; Mezey et al., 2010; Olsson et al., 2014). It was also evident that the relationships with care providers were important, especially with regards to having hope (Mezey et al., 2010; Green et al., 2011); specifically, hope pertaining to leaving hospital or attaining lesser levels of detention (Olsson et al., 2014). The significance of having good relationships was further reinforced by participants' reports that their experiences of recovery were negatively impacted when relationships with care providers were inconsistent

(Barnao et al., 2015); when care providers had negative attitudes (Mezey et al., 2010); and when good relationships were lost, often as a consequence of making progress in recovery and moving to another level of service provision (Barnao et al., 2015; Mezey et al., 2010). This final point highlights two more general aspects of engaging in the work of recovery in the context of receiving forensic care. One, recovery progress and detention restrictions are perceived as being inversely related (Barsky & West, 2007), and two, participants report that progress in recovery generally was seen as a desirable, yet positive outcomes were also approached with fear and apprehension due to the uncertainty incurred as a result of that progress (Mezey et al., 2010; Olsson et al., 2014). Participants' perception of mental illness stability was also seen as important for making progress in recovery (Barnao et al., 2015; Mezey et al., 2010; Olsson et al., 2014), but treatment may be experienced negatively when it was enforced coercively or compliance was mandated (Olsson et al., 2014). Finally, it was evident across studies that participants in forensic care settings identified the importance of having agency in (Barnao et al., 2015), and control over (Barsky & West, 2007), the making of autonomous decisions (Mezey et al. 2010). Moreover, participants identified the importance of being supported in the making of autonomous decisions and the need for being involved in making treatment decisions (Green et al., 2011). However, participants simultaneously described that these important aspects of recovery and rehabilitation were not always experienced in the context of receiving care as a forensic client (Barnao et al., 2015).

In concluding this summary, the examples identified demonstrate the inextricable link between forensic clients' experiences of recovery and the context in which it occurs, namely forensic mental health services. However, despite the fact that these five studies are rich sources

of information about the perceptions and understandings of forensic mental health clients' experiences of recovery, there remains an overall paucity of literature addressing this topic.

Conclusion

There is a dearth of research addressing forensic clients' understandings, perceptions and experiences of recovery. None of the extant literature is Canadian, and the experiences of recovery from the perspective of forensic clients currently residing in the community have not been studied. Therefore, the novel approach assumed in this study will uniquely add to what is currently known about the forensic clients' understanding and experiences of recovery and has the potential to inspire new ways of thinking about this phenomenon.

CHAPTER III: PHILOSOPHICAL INFLUENCES & THEORETICAL FRAMEWORK

VIEWING THE STUDY

The act of engaging necessitates the assumption of a certain perspective, an orientation to that with which one is engaged, and the role of the qualitative researcher is to be mindful of the influence this orientation has on that which is perceived but also on him or herself as perceiver.

Introduction

The formal philosophical, as well as the theoretical perspectives and underpinnings assumed in this study, are described in this chapter. Specifically, the prevailing philosophical influences in the qualitative research paradigm are described, and the role of theory in qualitative description is discussed. This chapter concludes with a discussion of the theoretical framework selected for use in this study, Spaniol and Wewiorski's (2012) phases of the process of recovery from psychiatric disability.

The Qualitative Research Paradigm

The purpose of conducting research is the attainment of knowledge, and consequently, of understanding. The philosophical underpinnings of the many methodologies used in the pursuit of knowledge exist on a continuum, the extremes of which represent two very distinct epistemological ideas (Guba & Lincoln, 1998). On the one hand is the positivist perspective, which assumes knowledge acquisition to be the product of a deductive process of measuring and analyzing phenomena (Streubert & Carpenter, 2011). This paradigm encompasses quantitative research methodologies, and has dominated our recent conceptions of what it means to know

(Guba & Lincoln, 1998). At the other end of the continuum is the constructivist or interpretivist perspective, which embraces the idea that knowledge generation is fundamentally an inductive process and encompasses qualitative research methodologies (Rolfe, 2006; Streubert & Carpenter, 2011). This philosophical perspective accepts that it is possible to know and understand immeasurable phenomena, and is particularly relevant in the context of healthcare research because human phenomena, which inherently involve the subjective and the interpretative, cannot be understood without reference to meaning and purpose (Guba & Lincoln, 1998; Streubert & Carpenter, 2011). However, in embracing induction as a method of attaining knowledge there is an inherent abandonment of certitude; no inductive process can lead to the formulation of understanding that is without render (Clandinin & Connelly, 2000; Guba & Lincoln, 1998). Additionally, in the promotion of successful induction, the qualitative research paradigm supports the attentive but flexible application of theory within the research process, which affords qualitative researchers the freedom to develop knowledge in ways that best represent the data (Sandelowski, 2000; Sandelowski & Barroso, 2002).

Consequent to this understanding of constructing knowledge about human phenomena, this study makes use of the epistemological perspective assumed by the qualitative research paradigm. Accordingly, qualitative description, an inductive method of exploration, will be used to generate knowledge about the phenomenon of interest in this study, namely the recovery experiences of persons who have been found not criminally responsible on account of a mental disorder (NCRMD). This methodological approach, along with Braun and Clarke's (2006) method of thematic analysis, will support the collection, analysis and representation of a rich description that explicates specifically significant and meaningful themes pertaining to this phenomenon (Sandelowski, 2000; Streubert & Carpenter, 2011).

Description in the Qualitative Paradigm

The intention of describing qualitative data is to present "data near interpretations" of the phenomenon under study (Sandelowski, 2010, p. 78). Specifically, this means descriptively summarizing the informational contents of that data such that the meanings ascribed to the facts presented about the phenomenon are directly based on those identified by the participants (Sandelowski, 2000; Sandelowksi, 2010). Accomplishing this entails limiting the interpretative influences of formal theories and perspectives, while recognizing that any act of describing does involve some interpretation and therefore requires researchers to attend to what and how they are describing, and for which reasons (Sandelowski, 2000; Sandelowski, 2010). Expressly, this involves the researcher acknowledging his or her preconceptions and applying theory carefully, in such as way as to enhance the representation of the data within the description, not overwhelm it (Sandelowski, 2000; Sandelowski, 2010). This is important because descriptions that intend to be without any theoretical or conceptual influences are "decontextualized to the point that" they become "almost devoid of human subjectivity", and therefore are unable to adequately answer questions about experiences of health and illness (Thorne, Kirkham & MacDonald-Emes, 1997, p. 170).

In summary, the intention of any qualitative description is to develop knowledge about specific phenomena. Specifically, descriptive methodologies collect, analyze and interpret data for the purposes of presenting data-near descriptions of phenomena. Through the prioritizing of data, insight and understanding are developed. Further, within the qualitative descriptive approach, germane theoretical and conceptual understandings can also be simultaneously embraced and effectively utilized to ensure the descriptions presented are meaningful. Descriptions of this kind are able to develop knowledge of health and wellness experiences,

stimulate debate, and encourage reflection by researchers and consumers of research findings alike (Clandinin & Connelly, 2000; Streubert & Carpenter, 2011; Thorne et al., 1997).

The Use of Theoretical Frameworks in Qualitative Description

One of the central tenets of qualitative description methodology is the commitment to collecting, analysing, and representing full and rich descriptive information using a process that is theoretically informed, but not theoretically bound (Sandelowski, 2010). Particularly, this requires researchers using this methodology to: utilize theory in the manner most appropriate for the needs of their particular inquiry; be transparent about the presence, role and influence of theory in their inquiry process; and be willing to move away from theories if or when they are not longer useful or applicable (Sandelowski, 2010). Consequently, throughout this study I have attended to the influence of theory on my perceptions and understanding of the phenomenon of interest.

Selecting a Theoretical Framework

The phases of the process of recovery from psychiatric disability (Spaniol & Wewiorski, 2012) was selected to be the theoretical framework for use in this study for three explicit reasons. First, although the framework is not specific to the forensic experience, it takes a perspective on mental illness recovery that assumes recovery is an individual experience and not specific to a particular diagnosis or circumstance, and therefore is a useful way to think about the recovery experiences of NCRMD clients. Second, the qualitative descriptive methodology values using suitable, theoretically informed ways to think about phenomena (Sandelowski, 2000). Finally, it resonates with the way the MHCC (2012) conceptualizes mental health recovery as a process of growth and change that is uniquely accomplished and experienced by individuals over time (Anthony, 1993; Simpson & Penney, 2011).

The Phases of the Process of Recovery from Psychiatric Disability

The concept of mental health recovery discussed in Chapter Two is based on Canada's mental health strategy (MHCC, 2012) and contextualized by Simpson and Penny's (2011) perspective on the use of the recovery paradigm in the Canadian forensic mental health system (FMHS). This distinctly Canadian perspective provides a background for understanding the context in which persons who have been found NCRMD may experience recovery. However, the concept of mental health recovery as described earlier provided a relatively straight forward overview of a phenomenon that is remarkably complex when explained in much greater detail, as it is by Spaniol and Wewiorski's (2012) framework: the phases of the process of recovery from psychiatric disability.

The phases of the process of recovery from psychiatric disability (Spaniol & Wewiorski, 2012) describes serious mental illness recovery as a process that occurs as people develop and change over time, and identifies that this change process occurs in four phases; specifically: 'overwhelmed', 'struggling', 'living with', and 'living beyond'. Spaniol and Wewiorski (2012) further specify that these changes occur neurobiologically, psychologically, developmentally and spiritually, and can be either positive or negative depending on the influence of presiding internal and external factors. The purpose of their framework is to provide an understanding of recovery that makes it is possible to understand how people change during the course of their recovery.

According to Spaniol and Wewiorski's (2012), the four phases of their framework are not distinct, but instead are overlapping and can be cyclical. However, a linear progression through the phases represents the general trajectory of mental health recovery. Each phase consists of important turning points that are influenced by internal and external contextual factors, and result in either positive or negative shifts in attitudes and/or behaviours. Accordingly, people in

recovery may proceed or regress through these phases or stagnate in one particular phase, and consequently in their recovery, based on a wide variety of potential influences.

Phase One: Overwhelmed

The first phase, '*overwhelmed'*, is the initial onset of illness and its consequent disabling symptoms, which may last for many months or years. During this phase people experience distress; they feel confused and powerless, and are unable to manage the impact the illness and symptoms on their lives. The significant turning point in this phase is the attainment of stability in illness symptoms, which provides an opportunity for people to regain their capacity to function successfully and regain a sense of self. Importantly, this stability affords people the opportunity to develop some insight into their experiences, and consequently, a perspective for understanding themselves in the context of their illness. This renewed perspective then enables some measure of self-confidence to be established, allowing people to begin to act in their own self-interest. As stated by Spaniol and Wewiorski (2012) "people begin to develop a preliminary explanatory framework for understanding their experience" (p. 5).

As people begin to transition into the second phase, 'struggling', they may continue to experience and perceive their illness as dominating and debilitating, and their self-confidence may waver. They may accept medication willingly but struggle to accept that their symptoms may persist. They also begin to address the impact of their illness experience on the circumstances of their life; for example, by attaining gainful employment if they are able or coming to terms with their disability if they are not. Finally, it is during this transition that people often question whether they are able to live in the context of their illness.

Phase Two: Struggling

The second phase, '*struggling'*, is depicted by the persistent challenge of learning to live with mental health related disability. Additionally, this phase is characterized by the experience of and need to address discrimination, prejudice, and stigma related to the presence and impact of mental health issues, as well as the accompanying feelings of loneliness and hopelessness. During this phase people move backwards and forwards in their recovery as they make progress in certain domains (neurobiological, psychological, developmental or spiritual) and lose ground in others. Importantly, each of these moves represent small turning points in the process of recovery. The significant turning point in this phase is acceptance. People learn to tolerate the experience of living in the context of mental health challenges and develop increasingly comprehensive explanations for understanding their experience that are specifically meaningful to them. Notably, these explanatory frameworks are highly individual, and representative of people beginning to understand their recovery experience as unique to them. This facilitates an enhanced sense of ownership in the process of recovery and supports individuals' further progression.

As people begin to transition into the third phase, 'living with', they may struggle to engage in new activities, fearing that they will destabilize and therefore jeopardize their recovery progress. Developing coping strategies for dealing with this uncertainty, as well as for managing possible relapse, become the focus of this transition between phases. Finally, it is when people have developed the necessary confidence in their ability to manage stress that they become able to begin to participate successfully in activities, while also addressing what is require to maintain stability or progress in their recovery.

Phase Three: Living With

The third phase, '*living with'*, is realized when people have attained: an understanding of their disabilities; the confidence to manage their lives and their recovery; and the coping skills necessary to address both persistent and unanticipated challenges. People in this phase of their recovery are engaged in a variety of meaningful activities and feel they have some measure of control over their lives and their circumstance. Additionally, they experience some satisfaction related to accomplishments that have been achieved in learning to live successfully in the context of their disabilities, and having an increased sense of security and stability. The ownership they assume over their own circumstance allows them to begin to feel a part of their communities, and it becomes possible to rebuild family relationships that may have been disrupted in the previous phases. The significant turning point in this phase is the finding of a personal, meaningful niche. This involves the recognition that illness management may be a prerequisite for, but cannot in and of itself, result in a satisfying, meaningful existence. People accept and assume greater responsibility for creating the life they want to live. They successfully assert control over their circumstance; attending to and making progress in multiple domains (neurobiological, psychological, developmental or spiritual) based on what they perceive to be important and/or necessary.

Phase Four: Living Beyond

The fourth phase, '*living beyond'*, is attained as a consequence of successfully living with mental illness when the presence of disability has receded such that it no longer dominates the recovery experience. People who are able to transition into this phase have a strong sense of self. They feel well connected to others and to whatever else is most meaningful to them in the broader world; for example, their work or their community. Moreover, their lives are

characterized by meaningful engagement and a deepening sense of personal satisfaction. People feel empowered and as though they are making a contribution. They are able to take risks because they feel confident in their ability to respond effectively in the context of the unknown, and have trust in their ability to solve problems effectively. Ultimately, the recovery process culminates when people successfully begin living in this fourth phase.

Additional Information and Summary

Additional information pertinent to understanding Spaniol and Wewiorski's (2012) phases of the process of recovery from psychiatric disability includes the assumption that periods of change are significant; for example, transitioning between phases and navigating the turning points within each phase. Because transitions and turning points result in feelings of instability, these transitory phases increase the potential for relapse in recovery and/or a period of regression within or between phases. Yet, these transition points also present opportunities for people to learn about themselves and their recovery, and to further develop the explanatory frameworks they have created for understanding themselves in the context of living with mental illness. Finally, there is recognition that the factors that influence, either positively or negatively, the transition between phases, as well as the progression or regression within phases, are both internal and external. Examples of internal factors include: peoples' inner drive; their willingness to accept responsibility for themselves; and alternately, their willingness to accept help from others; their level of hopefulness; having a sense of empowerment and personal satisfaction; the presence of self-stigma; and the feeling of being a contributing community member. Examples of external factors include: the effectiveness of medication on reducing symptoms; the presence of medication side effects; the effects of previous trauma or substance use; having access to work

and/or other meaningful roles; the presence of helpful, supportive healthcare professionals, service providers and peer support; as well as the extant level of prejudice and discrimination.

To summarize the explanation provided above, the Spaniol and Wewiorski (2012) framework describes serious mental illness recovery as a process that occurs as people develop and change over time, and in four phases: 'overwhelmed', 'struggling', 'living with', and 'living beyond'. Important to this understanding of recovery is the idea of turning points, which are influenced by various internal and external factors and result in positive or negative shifts in attitudes and/or behaviours, which can either motivate or inhibit recovery progression. Further, the recovery process involves developing an explanatory framework that provides people with an understanding of their experiences, and ideally supports them in moving forward in life. Finally, the phases of the process of recovery from psychiatric disability further explains the understanding and process of recovery that has been previously described. Specifically, it explains in greater detail the inherently personal nature of recovery, and addresses the importance of attaining hope, being optimistic, developing a positive sense of self, and finding meaning and purpose in the process of recovering. Furthermore, it embraces the idea that recovery can and does occur even when the symptoms of mental illness persist, and explicitly identifies the importance of autonomous decision-making and self-determination as prerequisites for attaining self-actualization in mental health recovery.

The Phases of the Process of Recovery from Psychiatric Disability in this Study

The phases of the process of recovery from psychiatric disability (Spaniol & Wewiorski, 2012) has been used during the analysis and representation of the data to support the description of data that expresses "the meanings participants give" to their experiences of recovery (Sandelowksi, 2000, p. 336). Specifically, this framework was used to support the

conceptualization of the collected data, the identified themes, and consequently, the composition of the descriptive summary.

Conclusion

In this chapter the philosophical influences germane to this qualitative descriptive study have been explicated. The theoretical framework the phases of the process of recovery from psychiatric disability (Spaniol & Wewiorski, 2012) was also identified as a useful way to think about the recovery experiences of NCRMD clients. Finally, by explicitly identify these influences this chapter affirms my commitment to being cognizant of the influences philosophy and theory have had on this study.

CHAPTER IV: METHODOLOGY, STUDY DESIGN AND RESEARCH PROCESS

UNDERSTANDING AND DESIGNING THE STUDY PROCESS

Introduction

In this chapter the qualitative descriptive methodology (Sandelowksi, 2000) is explicated and the study design and research process are explained in detail. The role of reflexivity is discussed and, finally, the four factors that have been used to establish rigour in this study are described.

PART ONE: METHODOLOGY

Qualitative Description

In this section an overview of the qualitative descriptive methodology is provided, its development is explained, and finally, its philosophical foundations are discussed.

Overview of Methodology

This study used qualitative descriptive methodology, as described by Sandelowski (2000), which is based on the tenets of naturalistic inquiry (discussed in detail below). Accordingly, the act of inquiry in qualitative descriptive studies is guided by the desire to understand the phenomenon, as it exists naturally, and not by the use of prescribed or prescriptive strategies, techniques, or theories (Sandelowksi, 2000). This does not imply that theory does not play a role in qualitative description. Instead, researchers must utilize theory in the manner that is most appropriate for the needs of their particular inquiry, keeping in mind the need for transparency regarding the presence, role, and influence of theory in their research process. Moreover, researchers using this methodology must make an effort to acknowledge their

pre-conceptions regarding their theoretical and conceptual leanings, and be explicit if, when, and how formal theories are being used during the inquiry process (Sandelowski, 2010). Ultimately, researchers must be willing to move away from theories when they are no longer useful or applicable (Sandelowski, 2010). As such, qualitative description is a particularly useful approach for providing descriptive information about phenomena for which little is known, as well as answering research questions that require straightforward, unspun answers (Sandelowski, 2000).

According to qualitative descriptive methodology, knowledge is developed when the facts about a specific phenomenon are described in everyday terms (Sandelowski, 2000). Consequently, the goal of any qualitative descriptive study is to collect as much data relevant to the phenomenon under study as possible and to analyze, organize, describe, and comprehensively summarize that data in straightforward explanatory language that represents the accounts of the phenomenon provided by participants (Sandelowski, 2000).

Finally, staying true to the descriptive intentions of this approach can be a challenge because the meanings ascribed by participants to the "facts" about the phenomenon under study are always context specific (Sandelowski, 2000, p. 335). Therefore, researchers must make every effort to be unbiased, and in so doing, endeavor to make choices and decisions to describe the data in ways that capture the context of participant descriptions in order to lessen the unavoidable influence of interpretation (Sandelowski, 2000).

Development of Qualitative Description

Qualitative descriptive methodologies evolved as an alternative to the quantitative descriptive research tradition (Sandelowski, 2000). The need for an alternative methodology arose primarily due to the fact that quantitative description was considered to be the "crudest form of [quantitative] inquiry"; specifically, it was not experimental and did not involve any

manipulation of the phenomenon under study (Thorne, Kirkham, & MacDonald-Emes, 1997, p. 170). Moreover, because quantitative description is constrained by the philosophical assumptions of the positivist paradigm, the data produced in these studies is considered by some qualitative researchers to be "decontextualized" and "devoid of any human subjectivity"; and thus lacking the capacity to adequately address questions pertaining to human experience (Thorne et al. 1997, p. 170). Consequently, qualitative researchers have been apprehensive about utilizing qualitative description as a method of inquiry, fearing that it would be deemed similarly limited, and instead have embraced phenomenology, grounded theory, ethnography, and narrative (Sandelowksi, 2000; Thorne et al., 1997). Traditionally, the aforementioned methodologies have been considered philosophically well-grounded and epistemologically sound compared to qualitative descriptive methodology and therefore more scientifically defensible (Thorne et al., 1997). However, it was observed that researchers were challenged when attempting to use these four methodologies to address a range of qualitative questions, with the resulting studies aligning with what could be more accurately described as descriptive studies that encompassed some specific methodological leanings (Sandelowski, 2000).

It is with the evolution of qualitative methods in mind that Thorne, Kirkham, and MacDonald-Emes (1997), and Sandelowksi (2000) put forth related qualitative methodologies; specifically, interpretive description and qualitative description. These authors reasserted that qualitative description was methodologically valuable since this method could effectively address questions pertaining to the human experience and, in particular, the subjective experiences of health and wellness. Moreover, as Thorne, et al. and Sandelowksi point out, contrary to earlier held beliefs that qualitative methods must be based on specific philosophical underpinnings, the lack of a theoretical orientation is actually the strength of the qualitative

descriptive methodology. These authors emphasize that an atheoretical focus allows for the flexible involvement of theory within the inquiry process, as well as the timely selection and adoption of conceptual frameworks that are most suitable and responsive to the purposes of the inquiry and to the data (Sandelowksi, 2000; Thorne et al., 1997). Finally, and perhaps most importantly, this commitment to the appropriate use of relevant theories in qualitative description allows for the data to drive the inquiry process; ultimately producing qualitative representations that are close to the data and most illustrative of the phenomenon under study: namely the experience of participants (Sandelowksi, 2000; Thorne et al., 1997).

Influences of the Naturalistic Paradigm

The most prominent philosophical influence in qualitative description has been derived from the naturalistic paradigm of inquiry (Sandelowski, 2000). This conceptual orientation asserts a commitment to studying phenomena as they occur naturally (Sandelowski, 2000). More specifically, despite the pragmatic application of relevant theories, the aim of any naturalistic research endeavour is to minimize the influence of the act of inquiring on the phenomena being studied (Sandelowski, 2000). Consequently, qualitative description studies aim to comprehensively describe phenomena using everyday language and terms particular to the phenomenon itself (Sandelowski, 2000).

Naturalistic inquiry and constructivism/interpretivism, (the epistemological foundation of the qualitative research paradigm), share a view of the world that: includes multiple conceptions of reality, values the subjectivity of experience, and identifies the attribution of meaning as contributing factors to the construction of those multiple realities (Krauss, 2005). Consequently, these paradigms recognize the context and time dependence of the knowledge developed studying the world from their shared philosophical perspective (Krauss, 2005). Moreover, it

follows from this philosophical orientation that it is nonsensical to use objectivity to establish the truth and validity of the findings produced using this type of inquiry, since objective measures are based on the incompatible assumption that a reality external to our perceptions exists (Trochim, 2006). Instead, the quality and truth-value of the knowledge obtained using qualitative description should be determined in the following two ways: by consensus, specifically of the local community, about what is real, useful, and meaningful; and in consideration of the intentions of the particular inquiry (Denzin & Lincoln, 2011).

PART TWO: STUDY METHOD AND RESEARCH PROCESS

Introduction

In this section the design of this study is explicated. The recruitment process, consent process, and the processes used during data collection and analysis are explained. Subsequently, the implications of data are discussed. Finally, reflexivity, rigour, and the ethical considerations relevant to this study are addressed.

Study Method

Location

Recruitment and data collection in this study occurred at a large, urban psychiatric mental heath facility in Ontario. Data collection involved two points of contact between the researcher and each participant; first, a face-to-face interview, which occurred in a private room at this facility and second, during a process of member-checking, which was conducted via telephone ten to fourteen days after each interview.

Sample

Sampling method. This study used a method of purposive, criterion-based sampling, in which participants were intentionally selected based on a specific set of criteria (Patton, 1990; Sandelowski, 2000). This sampling method is recommended for use in qualitative descriptive studies because it supports the identification of participants who are "information rich" examples of the phenomena under study (Patton, 1990, p. 40; Sandelowski, 2000).

Selection criteria. The criteria for participation in this study included the following:

INCLUSION CRITERIA:

- Presently under the jurisdiction of the Ontario Review Board (ORB) with the legal status of Not Criminally Responsible on account of a Mental Disorder (NCRMD);
- Presently residing in the community, proximal to the study location;
- A history of receiving care in hospital on a Medium or Maximum security unit in the forensic mental health system in Ontario;
- Be comfortable verbally communicating in English;
- Have an interest in speaking about his/her recovery experiences;
- Be willing to participate in research in the form of an interview;
- Be willing to be audio-taped during the interview.

EXCLUSION CRITERION:

- A pre-existing professional relationship with the researcher.

Notably, participants' verbal endorsement was accepted as sufficient confirmation that they meet the selection criteria because it was deemed improbable that potential participants would purport to have an NCRMD designation when they did not. Moreover, because none of

the participants were suspected of falsely identifying as an NCRMD client, there was no need to question any participant about his or her legal status. However, the inability to know for sure that the participants met the inclusion criteria regarding their NCRMD status is a limitation of this study design.

Sample size. In this study I collected the experiences of recovery from five participants. Sandelowski (2000), in describing qualitative description, does not identify a specific or typical sample size appropriate for use with this methodology, or provide any guidelines for determining when an adequate sample size has been attained. However, a seminal article on the selection of appropriate sample sizes in qualitative research indicates that the sample should be sufficiently large as to allow for the identification of new understandings, but small enough to permit the in-depth analysis of experience (Sandelowski, 1995). Additionally, Sandelowski (1995) indicates that an adequate sample is attained when data saturation occurs. However, data saturation is "particularly difficult to achieve in qualitative description" because the methodology aims to explore the participants' distinct experiences, and consequently, during each interview in this study participants were invited to, and did, describe their unique experiences (Milne & Oberle, 2005, p. 415). Therefore, data saturation was not used to determine the adequacy of the sample size in this study.

Recruitment. Recruitment was accomplished using flyers (Appendix A) placed at the facility where potential participants received care. The recruitment flyer briefly explained the study, identified the main inclusion criteria and invited interested individuals to contact the researcher by telephone or by email. Following this, regardless of the method used to initiate contact, I spoke with each interested person on the telephone to discuss the study. A script was used to guide this conversation (Appendix B). Potential participants who remained interested in

participating were sent by mail or email a copy of the Consent Agreement (Appendix C). Finally, after reviewing the Consent Agreement, potential participants contacted me by telephone if and when they had questions about the study, and to schedule a time for the interview. Participants were accepted into the study based on the order that they initiated contact.

Participation incentive. Participants received a 30-dollar cash incentive in recognition of their time commitment. The amount of this incentive was appropriate since it conveyed a level of respect regarding the time commitment of participants, taking into consideration participation in the interview process, as well as telephone interactions between participants and researcher (Latterman & Merz, 2001). Additionally, an amount of 30-dollars did not unduly influence potential participants (Grady, 2001). Finally, a cash incentive was selected because the participants could decide how to make use of the money.

Consent Process

Immediately prior to the commencement of the interview two copies of the Consent Agreement were signed. I retained one copy, which had on it the numeric code that was used to identify that particular participant in all subsequent research documents. The second copy, which did not have a numeric code, was given to the participant for his or her records.

Data Collection

Data collection in qualitative description aims to acquire full and rich data about the target phenomenon as it exists naturally (Sandelowski, 2000). The data collected included the audio recordings of individual participant interviews, and the digital transcriptions of these recorded interviews.

The interview. Each participant was invited to engage in a one-on-one conversation to ascertain information about the "who, what and where" of his or her recovery experiences

(Sandelowski, 2000, p. 338). It has been suggested that asking open-ended questions, rather than closed-ended ones, is more effective in eliciting relevant data in qualitative description (Sandelowski, 2000). As such, open-ended interview questions were constructed to stimulate discussion about how participants understand and experience recovery. Please refer to Appendix D for the full Interview Guide. This Guide was used only as needed during each interview to ensure that data collection remained focused on gathering inquiry-relevant participant experiences, while allowing a level of responsiveness to each conversation as it unfolded.

Each interview was audio-recorded. In order to protect the participants' identities, participants selected a pseudonym to be used during interview, prior to the commencement of the audio-recording. Each audio-recording was transcribed verbatim as soon as possible after each interview, with all the personally identifying details removed. The de-identified transcriptions were saved into password-protected digital documents located on a password-protected USB key to ensure the security of the information they contain.

The member-checking process. Approximately ten to fourteen days after the date of the interview I contacted the participants by telephone to review the data collected from their individual interviews (Appendix E). Four of the five participants participated in this process; one participant was not reached successfully by telephone and therefore did not participate in this portion of the study. These telephone conversations involved discussing with each participant the preliminary themes identified from his or her transcribed interview. Participants were asked to share their thoughts about the identified themes and were given the opportunity to remove, add, or change any details contained within the information they shared during the interview. All participants endorsed the identified preliminary themes and did not make any requests to change the interview content. This process confirmed the accuracy of the information collected and also

ensured the transcriptions did not contain details that participants felt uncomfortable with or that they perceived to be compromising their confidentiality.

Data Analysis

Braun and Clarke's (2006) method of thematic analysis was used to identify the significant and important themes in the data and to develop "a rich thematic description" of the recovery experiences of NCRMD clients (p. 83). Thematic analysis describes the data by adopting a low level of interpretation (DeSantis & Ugarriza, 2000; Vaismoradi, Turunun & Bondas, 2013), which makes it congruent with the intentions of the qualitative descriptive methodology (Sandelowski, 2000).

Overview of Braun and Clarke's (2006) Thematic Analysis. Braun and Clark's (2006) thematic analysis method is an interpretive process that involves engaging in six phases of analysis, described below, that focus on identifying patterns of meaning, or themes, within the collected data. This method embraces the active role of the researcher in exploring the data, discovering patterns, selecting themes, and reporting themes of significance and interest. Specifically, thematic analysis is an iterative process that requires moving back and forth between the components and the entirety of the data set and the constant consideration of what is currently being analyzed in the context of what has already be analyzed and vice versa. Important themes are identified by the researcher based on prevalence, both within and across the data, and in the context of the purpose of the research study. Once themes have been identified, this method of analysis can be used to provide a specific description of one aspect of the data or to richly describe the entire data set. Describing the entire data set allows for the identification of preponderant themes, and is an appropriate approach to data analysis when the

intention of the study is, as it was in this one, to describe a phenomenon about which not very much is known.

Finally, like qualitative description, Braun and Clark's (2006) thematic analysis method is theoretically informed, but not theoretically bound. Specifically, thematic analysis is a flexible approach, which uses current understandings of the phenomenon under study to guide the analysis process (Braun & Clarke, 2006). The authors indicate that the literature is best used after the analysis process for inductive studies, while the literature should be reviewed before the analysis process for theoretically-driven studies (Braun & Clarke, 2006). Additionally, themes can be identified semantically by using the contents of the participants' words and expressions, or latently, which requires researchers to look for patterns in the underlying assumptions in the data (Braun & Clarke, 2006).

Implementing Braun and Clarke's (2006) Thematic Analysis. In this study themes were identified inductively and semantically, and the entirety of the data was described. Additionally, my thesis supervisor participated throughout this data analysis process in order to substantiate the identification and organization of the coded data segments into relevant themes.

Phase one: Familiarizing yourself with the data. The purpose of this phase of analysis was to gain a familiarity with the content, the breadth and depth, of the data. To accomplish this I actively engaged with the data: first the data were transcribed verbatim, and then the transcripts were read and the audio-recordings listened to repeatedly to identify patterns of meaning (Braun & Clarke, 2006). During this process I made notes of my initial impressions and thoughts, before beginning to formally identify any codes (Braun & Clarke, 2006).

Phase two: Generating initial codes. Executing this phase of analysis involved identifying the smallest segments of significant information within the data and organizing these

data segments, or codes, into meaningful groups. The data were approached as the source of meaning, and the entirety of the data was used to drive the coding process.

To accomplish this, a variety of methods including multi-coloured digital text highlighting and track change comment boxes, were used to collect, identify, and organize the coded data segments. First, I created as many themes as were needed to ensure every meaningful segment of data was identified. In so doing, I also maintained the context of the coded segments, and represented each segment in as many organizational categories as it fit (Braun & Clarke, 2006).

Phase three: Searching for themes. This phase commenced once all the data segments were identified and collated, and involved sorting the entire list of differentially coded data into broader, overarching themes. To accomplish this I thought about the connections and relationships between and within codes and themes, drafted thematic maps, and tried a variety of ways of thematically organizing the coded data. Finally, I developed an organizational strategy in which each data segment had a place in one of the identified themes or subthemes.

Phase four: Reviewing themes. This phase of analysis involved reviewing, revising, and refining the candidate themes and subthemes created in the previous phase. This was accomplished by considering the internal homogeneity and external heterogeneity of each candidate theme and subtheme, and making the necessary changes to the thematic organization of the data to ensure each theme and subtheme were internally consistent and distinct from other themes.

In order to systematically review the themes, segments of coded data within each theme or subtheme were reviewed to determine if there was consistency between the theme and the representative segments of data. In instances of incongruence, a further assessment was

conducted to determine if the theme itself was problematic or if certain data segments simply did not fit within that particular theme. The data segments were then rearranged and alterations were made to the identified themes and subthemes until each theme contains only relevant data segments and each data segment was contained within a relevant theme. Finally, the relevance and appropriateness of each identified theme and subtheme was considered in the context of the entire data set. Specifically, the data were re-read in their entirety to ensure each candidate theme fit with the whole of the data, and to determine if the themes and subthemes could be reorganized to enhance their congruence with the data set.

Phase five: Defining and naming themes. In this phase, each of the candidate themes and subthemes were defined, further refined, and each thematic idea was named. The process of defining and refining each theme involved considering how the overall theme contributed to the data as a whole, and then identifying the essence of each theme and subtheme by creating descriptive composites of data segments contained within each theme that specifically identified what was significant and meaningful. Following this, based on these definitions, each theme and subtheme was given a "concise, punchy" name (Braun & Clarke, 2006, p. 93).

Phase six: Producing the report. This final phase of analysis involved the composition of the representation of the findings, and is discussed in the next section of this chapter.

Data Representation

Study findings. The study findings, organized based on the themes and subthemes identified during data analysis, are inclusive of the relevant information collected about the phenomenon and are presented using straightforward, everyday language (Sandelowski, 2000). The story told by the data represents the complexities within and between each theme and subtheme (Braun & Clarke, 2006). Furthermore, the findings include example segments of the

coded data, as evidence of the prevalence, value, and significance of each theme (Braun & Clarke, 2006). Finally, the decision was made to organize the data thematically because this was the best way to present data accurately and comprehensively, and additionally, was considered suitable for the intended audience (Sandelowski, 2000).

Discussion and descriptive summary. The goal of this qualitative descriptive study is to present a comprehensive and descriptive summary (Sandelowski, 2000) of the recovery experiences of NCRMD client residing in the community. However, in advance of presenting this summary, each theme was discussed in the context of what is currently evidenced in literature on forensic clients' understandings and experiences of recovery (Braun & Clarke, 2006). Following this discussion, the theoretical framework selected for use in this study, the phases of the process of recovery from psychiatric disabilities (Spaniol & Wewiorski, 2012), was used to further understand the significance of the study findings within the broader context of recovery. The data were considered in the context of this framework to determine how the identified themes and subthemes were conceptually related to the current understandings of serious mental illness recovery, and to support the creation of a meaningful, contextualized description that expressed "the meanings participants gave" to their experiences of recovery (Sandelowksi, 2000, p. 336). This a posteriori application of theory is consistent with the method of Braun and Clarke's (2006) thematic analysis used in this study, in which themes were identified inductively and/or semantically, but not theoretically.

Data Implications

Finally, the last aspect of data development involved the reflective examination of the analyzed data to determine if the identified themes had broader meanings and/or implications (Patton, 1990). Therefore, I considered how current, relevant literature connects to the themes

identified in the descriptive summary, and pondered, in the wider context of the forensic mental healthcare, how the composite findings linked with issues germane to practice, education, and future research and theory. Specifically, although a rigorous representation of the data in a qualitative descriptive study is an end in and of itself, I identified what further questions, hypotheses and conceptual beginnings follow from this study's findings, and considered how the findings may motivate and inspire further study (Sandelowski, 2000).

Reflexivity

Researcher reflexivity, first introduced in the prologue, is important in the conduct of any qualitative study (Creswell, 2013). Specifically, being reflexive requires researchers to have an awareness of themselves as an integral part of, and not separate from, the inquiry (Lincoln & Guba, 2003), and allows researchers to recognize, acknowledge, and manage their multiple influences on the inquiry process (Streubert & Carpenter, 2011).

In order to support the process of reflexivity in this study, I maintained a research diary, "a self-critical account of the research process", in which I reflected on my position in and orientation to the research process (Rolfe, 2006; Tobin & Begley, 2004, p. 392). Specifically, I asked myself questions about who I am, and with this in mind, considered my impact on the research process (Trainor & Graue, 2014). Developing this awareness of self was important in order to identify and understand my motivations for engaging in this research study. Further, I used this self-understanding to clarify and clearly articulate the reasoning behind the decisions I made regarding the why and the how of the study (Sandelowski, 1993). In addition, I maintained meticulous records as evidence of my decision-making process, which further demonstrates my reflexive process. Evidence of my reflexivity is also present in the study findings, and is presented in this thesis (Rolfe, 2006; Tobin & Begley, 2004). These actions, in addition to

emphasizing the importance of being reflexive, increased the rigour of this study (Vaismoradi, Turunun & Bondas, 2013).

In addition to the aforementioned benefits of being reflexive, engaging reflexively in this study was beneficial to the process of inquiry for the following reasons. It promoted a heightened sense of awareness about the experience of others, which is of particular importance in the context of the researcher-participant relationship (Lincoln, 1995). It facilitated the comprehension of otherwise obscured ethical issues (Clancy, 2011), and in the context of using a method of thematic analysis, facilitated the identification of themes that were not initially or immediately apparent (DeSantis & Ugarriza, 2000).

Finally, reflexivity must also be congruent to the methodology used, and the associated philosophical and theoretical commitments (Trainor & Graue, 2014). It is for this reason that I have explicitly identified and discussed my philosophical, conceptual and theoretical leanings, and the philosophical and theoretical foundations of this study (Sandelowski, 2000).

Methodological Rigour

Rigour is the quality or goodness in qualitative research, and is present if the study findings are an accurate representation of the phenomenon under study as described and experienced by the participants (Streubert & Carpenter, 2011). The presence of rigour indicates that the results are sufficiently trustworthy to support actions based on the research findings (Creswell, 2013; Denzin & Lincoln, 2011; Streubert & Carpenter, 2011). According to Sandelowski (1986), there are four factors that establish rigour in qualitative studies: truth-value, applicability, consistency, and neutrality. These factors are based on those originally identified and explained by Guba and Lincoln (1981), and have been identified as appropriate since they are conceptually congruent with the qualitative descriptive methodology.

Truth-Value

The truth of study findings in qualitative research studies is based on the successful presentation of information that is determined to be accurate from the perspective of participants (Lincoln & Guba, 1985; Sandelowski, 1986). According to Sandelowski (1986), the truth-value of a study is evaluated using the criterion of credibility, which is present if the researcher has direct access to the phenomenon of interest, for example in a one-to-one research-participant interview. Assessing credibility, which can establish truth-value, involves confirming with those who have experienced the phenomenon that the presented description resonates with them as truthful (Sandelowski, 1986).

Establishing truth-value and credibility. Credibility was attained in this study in three ways. First, I established a relationship with each participant that gave me access to his or her experiences. Second, the member-checking process, which improves the trustworthiness of the findings (Onwuegbuzie, Leech & Collins, 2008), enabled each participant to verify the truth of the data he or she provided during the interview and to make the necessary changes to improve its accuracy. Third, by keeping a research diary I attained insights into my position within the research process. Specifically, I was able to reflect on my position in relation to the participants and to the phenomenon under study, both of which enhanced my ability to represent the data as participants experienced it, not as I experienced it during the study in my role as researcher.

Applicability

Applicability in qualitative research is the extent to which the study findings can be applied in contexts outside those that are particular to the inquiry, and if they are identified as meaningful and relevant by readers (Sandelowski, 1986). The applicability of any given research study's results is determined by the criterion of fittingness, which evaluates the applicability of

the data in more than one contextually-defined construction of reality. Developing fittingness requires the recognition and appreciation of the inherent influence context has on the phenomena under study and on the research process, as well as identifying typical and atypical aspects of the phenomena (Sandelowski, 1986). Establishing fittingness therefore involves providing information about the context of the study, using purposive sampling, which ensures participants have experience with the phenomena, and identifying how those participants represent the larger group of persons with experience of the phenomenon (Sandelowski, 1986).

Establishing applicability and fittingness. Fittingness was established in this study in three ways. First, the use of purposive sampling ensured the participant representativeness of the phenomenon (Sandelowski, 1986). Second, during data analysis I iteratively checked the representativeness of the coding (Sandelowski, 1986) and attained confirmation of this by having my thesis supervisor review my work. Third, the representation of the data provided a rich and full description of the data, specifically identifying the contexts in which the phenomenon was experienced, as well as the typical and atypical aspects of that experience (Sandelowski, 1986). Finally, keeping a research diary ensured that I had an awareness of the influence of context on the process of inquiry.

Consistency

Consistency in qualitative research is present when there is evidence of an enduring commitment to describe and interpret the uniqueness of the experience, as well as giving priority to determining the subjective meaning of experience over its empirical understanding (Sandelowski, 1986). The criterion for evaluating consistency, auditability, is the presence of a "decision-trail" that describes the rationale used to make decisions throughout the study, from the study design to the transformation of raw data into research texts (Sandelowski, 1986, p. 33).

The transparency of this decision-making process means that another researcher could follow the logical flow of ideas and understand how the conclusions of the study were reached, but also that readers can follow the logical progression of the study (Sandelowski, 1986).

Establishing consistency and auditability. The criterion for evaluating consistency and auditability is the presence of clear and logical explanations of how and why each decision in the study was made (Sandelowski, 1986). Auditability was established in this study in a variety of ways. I provided my reasons for initiating this study and described my orientation to it. I also identified the purpose of the study and described how and why I recruited the participants. I explained my relationship with the participants and provided details regarding the data collection process. I also described the data analysis process in detail, including my coding practices, and maintained meticulous records as evidence of my decision-making process. Finally, I identified the specific strategies used to establish the truth-value and applicability of the data.

Neutrality

Assessing neutrality in qualitative research involves considering the study findings. Specifically, neutrality exists when there is evidence of *impartiality* in the findings. It is established when the subjective is valued and there is a focus on the meaning of experience (Sandelowski, 1986). Qualitative neutrality is assessed using the criterion of confirmability, which is attained when credibility, fittingness, and auditability are extant (Sandelowski, 1986).

Establishing neutrality and confirmability. I achieved neutrality in this study by performing the strategies identified in the preceding paragraphs that established credibility, fittingness, and auditability. These actions ensured the quality and therefore the trustworthiness of the study findings.

Ethical Considerations

It has been necessary to attend to ethical considerations in this study since it was first conceptualized. These issues greatly influenced the design of this study and have been identified and addressed in one way or another throughout this study and in this thesis.

Research Ethics Board Approval

The protocol for this study was submitted to and approved by the Ryerson University Research Ethics Board (REB) and by the REB at the facility where the participants were recruited from and data collection occurred.

Potential Risks

The most significant risk was to participants' confidentiality. Specifically, this was the case because participants were recruited from a relatively small number of NCRMD clients who reside in the community in Ontario. Therefore, this study was designed to effectively protect their confidentiality. Specific strategies implemented to protect participant confidentiality included the recruitment strategy, the use of numeric codes and pseudonyms as participant identifiers, and the removal of personally-identifying details from the data transcriptions. Finally, and perhaps most importantly, the conscientious representation of the study findings reduced the risk of the participants being identified by those who may be familiar with their recovery experiences.

Other strategies, present in the design of this study to manage risk included the following. Deception was not used, and the recruitment and consent processes did not involve coercion. Furthermore, consent was informed and on-going. Specifically, participants were provided with the Consent Agreement in advance of meeting for the interview to ensure they had as much time as they needed to consider participating, as well as the opportunity to ask questions about the

study. Further, their willingness to participate was reiterated and confirmed verbally prior to the commencement of the interview and member-checking process. Similarly, the voluntariness of participation, as it related to the study itself and specific interactions, was explained to participants. Throughout the study I also attended to the balance of power that existed between me and the participants. Additional aspects of the study design that address ethical sensitivities included the selection of interview location, which was a location that was familiar to the participants and where their privacy could be maintained. Moreover, the location was located proximally to where they receive care, should they have requested or required additional support. Finally, the inclusion of a member-checking element in the design further mitigated risk.

In addition, to manage risks related to data security in this study, access to the study data was limited to me, my thesis supervisor and the identified site principal investigator (a senior psychiatrist with a research appointment at the facility where participants receive care). Additionally, the transported data were secured in locked briefcases, and the stored data were, and will be, maintained in a secure environment for the legally-mandated amount of time of seven years (i.e. in locked cabinets that keep separate the data with personal information from that which is coded). Finally, the saved digital data exists only in password-protected files on encrypted USB keys, and the timely destruction of the data has been guaranteed.

Potential Benefits

Practical and social benefits. The goal in completing this study was to describe the ways NCRMD clients' experience of recovery, and in so doing to contribute to what is currently understood about this phenomenon. However, because the impact of the findings of this study cannot be anticipated, it is not possible to determine if any group, community, and/or societal benefits will be achieved.

Participant Benefits. The participants may have found it beneficial to be asked about and open up about their individual recovery experiences. As a result of having participated in the interview process participants may also have benefitted from recognizing how far they have come in their recovery. Additionally, participating in this study may have given participants a voice, and indirectly implied that they are not alone in addressing the challenges of recovery in the forensic mental health system (Ahern, 2012).

Conclusion

In this chapter I explained qualitative descriptive methodology (Sandelowski, 2000), the study methods, and the research process. I also discussed issues of data quality and identified the ethical considerations. In the subsequent chapters the study participants and study findings are described and discussed, the descriptive summary is presented, and finally, implications of the findings are considered.

CHAPTER V: STUDY FINDINGS

RESULTS OF THE STUDY

Introduction

This chapter begins by describing, in general terms, the participants in the study. This is followed by a detailed description of the study findings. The overarching theme that arose from the data is, '*Experiencing and understanding recovery in the forensic mental health system (FMHS) as a dynamic process of change'*. Further, the major themes that emerged within the context of this overarching theme included: 1) Recovering in the FMHS; 2) The Critical Role of Medication; 3) The Significance of Relationships; 4) The Importance of Helping Yourself, and 5) Navigating Challenges.

Throughout the presentation of the major themes specific participant quotes have been selected to exemplify each theme and subtheme. This importantly brings the voices of the participants into the study (Creswell, 2013). However, in the interest of maintaining participant confidentiality and anonymity, (a fundamental aspect of this study), the source of the quotes has intentionally not been provided. Nevertheless, to provide a balanced representation of the participant voices, the selected quotes fairly represent the experiences of each participant.

The Participants

This study was designed to maintain the confidentiality and anonymity of the participants and as such, participants were not asked to report specific demographic data. In order to afford some context for the study findings, I have provided a general overview of participant characteristics based on my interactions with study participants.

To begin, the participants as a group were representative of the ethnic and cultural diversity present in the urban centre in which they currently reside. The sample included both male and female participants that ranged in age from early twenties to late forties. As per the specified selection criteria, all the participants identified: having a legal designation of not-criminally responsible on account of a mental disorder (NCRMD); spending time in a secure inpatient setting; as well as residing in the community under the purview of the Ontario Review Board (ORB) at the time of the study. The length of involvement in the FMHS (which included inpatient hospitalizations) described by participants varied, from approximately two years to longer than 12 years.

In addition, all participants explicitly identified or alluded to having been diagnosed with a psychotic disorder. A few participants spoke about their current substance use. Participants also reported living in a variety of living situations, including: a group home, alone, or with family. None described having current employment. A few participants spoke about receiving government social assistance, while others did not make reference to their current financial circumstance. A few participants described being engaged in college programs, while others did not express having any current plans or express any interest in educational pursuits. Most participants identified that they were single or intimated they were unattached.

Finally, the participants identified themselves as being in recovery, and expressed an interest in speaking about their recovery experiences. Consequently, participants spoke specifically and extensively during the interview about their experiences of recovery and as such, the focus on the participants' experiences of recovery is very evident in the study findings.

Recovery as a Dynamic Process of Change

"I have recovered but I am still in the process of recovering, it doesn't stop."

Without exception all participants in this study experienced and described recovery as a process of dynamic change. Accordingly, this theme is identified as the predominant, overarching theme and is evident across all of the five major themes discussed below. In the first theme*, Recovering in the FMHS*, participants described how their circumstances changed as they progressed through their recoveries, within the FMHS. In the second theme, the *Critical Role of Medication*, participants described the changes they experienced as a consequence of taking medication. In the third theme, the *Significance of Relationships*, change was apparent in the way participants described how various relationships contributed either positively or negatively to their recovery progress. In the fourth theme, the *Importance of Helping Yourself*, the participants described how they had experienced and contributed to their own positive change during their recovery. In the fifth theme, *Navigating Challenges*, the notion of change is evident as participants described addressing, and whenever possible managing or overcoming, the many things that were identified as challenging to their experiences of recovery. Finally, this experience of change has been distinctly influenced by the participants' involvement in the FMHS, and accordingly, the influence of the FMHS is evidenced in each theme as well.

Recovering in the Forensic Mental Health System

"They took me to be a danger… they thought it's better for me to be locked up in the hospital until they see some changes, after they saw that I have well recovered everything is okay."

"I will never forget like what year I came here… that year basically saved my life."

As illustrated by the quotes above, all participants identified the significant influence of the FMHS on their experience of recovery. Specifically, each participant spoke about their

experience in the FMHS, as it unfolded, particular to their experiences of: *being in jail*; *hospitalized*; *being in the community*, *experiencing unique challenges*; as well as their *expectations for future recovery*. Finally, the idea of change figures prominently in this theme in the way participants describe their progress through the FMHS.

First a Stay in Prison

For all five participants, their experiences immediately prior to coming into the FMHS involved a period of incarceration, and it was evident that this experience impacted the way in which virtually all of the participants experienced recovery. Specifically, participants invariably reported being in jail as a negative experience, and identified these experiences as something that they felt motivated not to repeat. For example, one participant stated: *"My experience with jail, I don't want to go through that again,"* while another participant reported: *"I'm never gonna do anything to cause somebody, to justify somebody, doing that to me again, right. It was hellish."* However, for some participants their experiences of being in prison were more than just negative; being in jail was experienced as highly distressing because, as a person with mental illness, they felt unsafe. As one participant describes:

> *In jail… you can't just talk to your inmate, certain things… they might just think you're weird, they can snap on you, they can hit, they could… crash you off the range or anything… they could just basically just treat you like you're not… human, and fully take advantage of you, so it's not really a safe place to be.*

Overall, participants recognized that *"Jail's not the place for no body with mental illness, its not the right place for them, there's no recovery in there,"* and in so doing concluded, *"I knew I didn't need to be in jail for my crime, I needed to be in [the hospital], 'cause I was just deteriorating in [jail]."*

A Period of Hospitalization

In stark contrast to their experiences in jail, the experiences participants had in hospital were more positive. Generally speaking, at least retrospectively, the participants expressed feeling that their recovery had greatly benefitted from the time they spent in hospital. One participant expressed this feeling, saying: *"When I dealt with [the hospital]… I felt like I was in a home, I always knew I needed a place where I could relax, and just feel… that's where I'm supposed to be at the moment."* Additionally, participants identified that there were individuals who wanted to help, as evidenced by the following quote:

> *In the hospital... you are dealing with people who really wants to help you out, they want to see positive outcomes from you, they are not there to, to make you suffer, no, they are there to help you out so that you can… be somebody who is… respecting themselves and loving other people and not thinking of hurting anyone.*

However, not every appraisal of the participants' experiences in hospital was positive. Many of the participants commented on the harsh reality of being in hospital and the inaccessibility of even the most basic freedoms, identifying that:

> *It's very hard… it's not pretty, you're dealing with people… that are very sick, you're dealing with the nurses, you're dealing the doctors, you're dealing with the environment, you know. It's very hard, you can't, you… don't get to go outside.*

Also in accordance with this perspective, participants made comments about the quality of the air, the food, and the inability to meet their own needs while in hospital. For example, one participant noted that *"You can't even, you can't cook for yourself on most of the units."*

However, these negative feelings were tempered by the realization that being in hospital *"Was better than jail, but at the end of the day it still wasn't freedom."* Participants seemed to come to terms with their experiences of being hospitalized, and seemed to affirm the important

role being hospitalized had on their recovery progress, reflecting that *"It's not easy to be hospitalized for more than one year, but when I look back I look at it as a positive thing because of what I am right now, the respect that I am getting from people."*

Currently in the Community

At the time of the study all the participants were residing in the community under the purview of the ORB and they spoke about their current recovery in this context. Some participants identified that living in the community was preferable to living in the hospital. As exemplified in the following statement, the emphasis appears to on the increased capacity to move freely and choose how to spend one's time: *"It's better 'cause like I could go, I could go on the streetcar, I can go anywhere I want in the city, you know, I could go to the movies, I could go to a baseball game… ."* However, for some participants, this idea that the community residency was better than being hospitalized was nuanced by the awareness that:

> *My life isn't my life totally right now. I mean, I'm, I'm in the community which is great, it's a lot better than hospital, but I'm only one signature away from hospital, you know, from being re-institutionalized, and that's unnerving.*

In some of the statements made by participants, the perceived influence of being under the purview of the ORB on their experiences of recovery was more explicit. However, participants uniquely experienced and consequently appraised this experience of being under the ORB differently. For example, one participant, in identifying the importance of attaining an absolute discharge, described how he was currently working towards that end, explaining that he was:

> *Just trying to be absent from stuff, not doing anything, you know, check in everyday on time, you know, uh, just doing my thing you know, uh, just being… you know, planning on going to school, do stuff that look good in the review board.*

This statement reflects a willingness to act in such a way as to appear favourable to the ORB while also acknowledging those actions are contextualized by the limitations and expectations put forth by the ORB. For another participant the influence of the ORB on his recovery was also acknowledged, however for him the authority of the ORB was seen as exclusively limiting to his ability to act, as he explains it: *"I'm under the detention order for the next year, there's nothing I can do. The ORB has said what I have to do, you're not allowed to smoke cannabis, you can't do this, you can't do that… ."*

The participants also contextualized their current experiences of recovery by reflecting on how far they felt they had come since they first experienced the symptoms of mental illness. For example, one participant stated:

> *I used to think totally differently, I was in a different world, that every little detail was different, I wasn't violent even though I was sick, but like I was just different like, the stuff I would say would be unordinary for a person like me.*

Finally, in this quote this participant makes a direct reference to violence, which is an indicator of risk. This suggests that for this participant, even when he is not making any direct reference being involved in the FHMS, his understanding of recovery has been influenced by his experience as an offender in the FMHS.

Unique challenges. The participants described that their current and on-going recovery experience was influenced by three unique challenges, each of which is discussed below.

Feeling constrained and dehumanized. First, participants expressed feelings of being confined by and trapped within the FMHS. As one individual explains, making reference to the annually held ORB hearings: *"As it stands right now I'm doing life on the [the hospital] yearly installment plan."* For this participant, the feeling of being contained has resulted in the perception that the FMHS is more akin to a prison than to a *"therapeutic environment."* As he

explains, *"I feel more like an inmate that I do a patient."* The sentiments expressed by this participant suggest that just being in the FMHS, even as an outpatient, is a challenge to recovery, which he explains succinctly, stating, *"the NCR designation is a massive hurdle for recovery."* However, he is not alone is the perception that the FMHS is not a place where one enjoys recovering. As another participant explains, *"I don't like being in the system... I wanna move on with my life and go forward from there".* An additional challenge of recovery in the FMHS is the struggle to remain positive in the face of being dehumanized. As one participant explains:

> *They felt that there is something that I am hiding, maybe I have, I am using somebody's urine, not my own urine, but I had to be patient and I just say to myself let me work with them, though I know that there is nothing that I am doing I'm not using anybody's pee so they started watching me when I am peeing, they will make sure that I am in the toilet and I don't close the door and they make sure it's my urine.*

The use and disuse of substances. Another challenge described by participants relates to the use of prohibited substances in the community while under the purview of the ORB. For example, for some participants, the fact that the ORB required abstinence was approached with feelings of frustration. As one participant explains: *"I understand some people… can't smoke weed because they could get psychotic, but like there's a lot of people here that doesn't, it doesn't effect them,"* and, *"You can't have a little get-together with your friends, have a beer once in a while, you have to be abstinent from it, you can't do nothing."*

The participants also described finding it challenging to navigate social situations where substances were available. For example, one participant found it difficult to explain the need to abstain to others. As he explains:

> *Some of your friends that, they're not mentally ill, and they're like 'you wanna a beer?'... and you, you're, holly, I'm gonna tell, I have to tell them I can't have it because of so and so and so and so.*

In other situations participants report the presence of peer pressure relating to the use of substances. For example, one participant explicitly identified, *"peer pressure… hanging with certain people and they wanna like get me involved in stuff I don't wanna be involved with,"* as a challenge in the context of his recovery because such an experience might *"get in my way."* Another participant expressed similar concerns relating to the existence of peer pressure as it relates to substance use, explaining, *"I just gotta watch out for people that does hard drugs… it's the main thing I think… watch out for those people that wanna… put you in their state, you know, in that low state."* Finally, the need to abstain from substances is a challenge in the context of experiencing peer pressure because it is hard to overcome the desire to fit in and not be seen as different. As this participant explains, *"When he brings friends over it's kinds hard to say no, sometimes I even drink sometime, I'm not gonna lie to you… I don't want to be left out, I don't wanna seem like I'm all weird."*

To address these challenges one participant explains her strategy for not succumbing to the negative influences of peer pressure, stating: *"…right now I don't even have a friend who drinks… if I try to make friendship with you and I see that you are drinking I stop it, 'cause you are not the right person to be around me… ."* This participant adds that this is helpful for her, *"'cause I don't want anybody to come and tempt me and make me drink alcohol."* Another participant has a different idea about how to support community residing persons under ORB purview. For him substance use presents as a challenge that should not be resolved with hospitalization. As he explains:

> *I think they should… tell them to go to groups, instead of locking them up… you know encourage them and say 'You know what you have a problem you know, like, you shouldn't be doing this because, hey, you could get psychotic blah, blah, blah'… like you know, go to a group and try to figure out things,*

> *you know, instead of saying oh 'I'm gonna put you in the hospital if you do this,' or 'you're not gonna get your absolute [discharge].'*

This quote alludes to an additional challenge experienced by participants in the context of choosing whether or not to use substances. Specifically this participant describes the fear and uncertainty that may be associated with knowing that the choice to use substances may result in being *"locked up"*. This particular challenge is discussed below in greater detail in the fifth major theme, Navigating Challenges, in the 'Presence of Fear and Uncertainty' subsection.

The index offense and the offender. The majority of the participants spoke, with varying degrees of specificity, about their index offense, frequently to explain their involvement in the FMHS. For example, two participants specifically identified experiencing delusional thinking prior to their index offense, which suggests that their state of mind during the commission of the index offense has influenced how they came to understand themselves in recovery. Furthermore, a few participants spoke about the challenges of over overcoming self-perceptions of being someone who had hurt others. For example, participants made references to thinking, *"Like right now, before I talk to somebody, I think first, 'Am I going to hurt this person?',"* and trying not to act *"in a violent nature."* For another participant, the challenge was not about what he might do, but in recalling what he had done. As he describes: *"sometimes I, it, it just gets to me man, like I just can't forget about what happened."* Finally, one participant describes the challenge of trying to overcome the confusion he experienced in the context of thinking about committing his index offense:

> *In the back of your head is just running through your mind, that like you didn't even mean to do what you did or, sometimes when you're mentally ill, whether you did it or not 'cause you can't remember too much about it, or you could have been delusional at the time, and you could still be delusional to think that you had the right to cause what you did even though it was wrong.*

What of the Future?

One of the main ideas that presented when participants spoke about their future recovery was the attainment of an absolute discharge, further highlighting the significant impact of the ORB and the FMHS on the ways NCRMD clients reported thinking about recovering. However, of notable interest was the observation that not all the participants valued the attainment of an absolute discharge in the same way. For example, one participant expressed concerns about receiving on-going support after receiving an absolute discharge: *"If I get an absolute discharge, they shouldn't just leave me on my own, they should make some connections for me that will help me out, throughout my life."* While another participant stated that getting an absolute discharge was *"very important, everybody wants to get outta here. Nobody likes being here, I don't want stay here forever."* Interestingly, these contrasting views allude to the fact that for some in the FMHS getting an absolute discharge is an endpoint, a way to exit the system, while for others it evokes the need to find new ways of attaining support.

Participants also expressed differing motivations for their recovery moving forward. One participant stated, *"I just have to do what is right for me to do, to make [the ORB] see that I have moved on with my life,"* which indicates the assumption of some personal ownership in what this participant considers to be important for recovery while also acknowledging the importance of acting in a manner that will be seen favourably by the ORB. Another participant described feeling motivated to engage in recovery in the following way: *"I don't wanna stay here 10 years, 15 years, 20 years, in this system, I wanna get out, I wanna move on, I wanna have my life back, and I don't have my life back."* Compared to the sentiment expressed in the previous quote, this participant's motivation for recovery seems to be more heavily influenced by a desire to attain an

absolute discharge, which suggests that acting in a way that will be evaluated favourably by the ORB is a priority for this participant is his recovery.

Finally, some participants discussed their plans for their recovery after having received an absolute discharge. One participant reported that he wanted to get an absolute discharge so that he could *"move on with my life and go forward from there"*, but then explained that being aware of the need for an absolute discharge would not necessarily have a specific influence on his recovery behaviours, because these are things that he did anyway. As he states, *"I think things will be the same. I'll be on my meds, I won't abuse substances, and um, I'll keep my, my friends… ."* These statements seem to suggest that even though there is an evident connection between the attainment of an absolute discharge and the way the participants experience recovery, there is some understanding that recovery will continue even after one's involvement in the FMHS has ended.

Summary

The major theme *Recovering in the FMHS* describes the participants' experiences of recovery in the FMHS, making explicit the significant influence that FMHS involvement has had on the participants' experiences of recovery. Moreover, the overarching theme of change was clearly conveyed in this theme; specifically in the way participants described their experiences of recovery in the FMHS.

The Critical Role of Medication

"It's all about taking your meds, medication is the key. If you are not taking meds you cannot function… It really helps to stabilize the mind and it works with even the mood and all that… if you are not on meds, it's something different."

"I'm what I am right now because I'm taking my medications."

The majority of participants spoke extensively about the impact medication has had on their experiences of recovery and described the changes they experienced as a consequence of taking medication. As the bolded quotes above identify, participants credited medication with being the key to their recoveries. Specifically, they explained that medication was important for *reducing the symptoms* of their mental illness and that it was because of the use of medication that they were able to *develop insight into and an understanding* of their circumstance. Participants also expressed the intention to *continue to use medication* in the course of their recovery. Finally, a few of the participants discussed the occurrence and management of *medication side effects*.

Returning to Reality: Symptom reduction

The majority of the participants spoke about their experiences with the symptoms of mental illness, indicating that this had an influence on their experiences of recovery. Four participants spoke of their experiences being delusional. One participant endorsed hearing voices and another reported having paranoid thoughts. Unambiguously, participants experienced their mental illness symptoms as putting them *"outta touch with reality."*

It was in the context of experiencing these symptoms and feeling disconnected from reality that participants reported the importance of medication in their experiences of recovery. For example, two participants, identifying the impact of medication on reducing their delusional symptoms, made the following statements: *"When medication started working, I got back to normal senses,"* and, *"I'm able to become sane again… due to the fact of the medication… ."* As these comments suggest, the participants expressed that reducing their mental illness symptoms was important to their recovery because it lead to a return to normalcy. Two participants explain this idea clearly. One stated, *"After taking my medication I stopped being delusional… and I*

started connecting with reality and started thinking well, and things started working out for me," while the other said, *"I feel normal. I won't have an… unordinary conversation with someone or something like that, like I feel normal and I know what's going on around me."* Participants also expressed the connection between taking medication and symptom reduction in simpler terms. As one participant answered, when asked directly how he reduced his symptoms, *"I take my medication."*

Finally, participants identified the importance of taking medication and staying in touch with reality as a way to prevent being in the state of mind that precipitated their index offense. As one participant explains: *"I wouldn't know what I am doing when I'm sick... I have to make sure that I take my medications and make sure that nothing happens."*

Enabling Insight and Facilitating Understanding

As the previous discussion indicates, participants felt the benefits of taking medication because it reduced their mental illness symptoms and brought them back to reality. However, the benefits of taking medication extended beyond this, as participants expressed the feeling that medication also lead to clearer thinking and a better understanding of their circumstance. As one participant explained: *"When the medication started kicking in I started my, my way of thinking started changing, the way I do things started changing,"* and, *"when I got better I had a better understanding of what happened."* Importantly, this improved capacity for understanding was identified as beneficial to the participants' experiences of recovery. As another participant explains, *"My medication, it's been helping me a lot… and I've felt myself change and [I'll] never go back to the person I used to be, while I was sick."*

Plans for Continuance

Participants expressed value in continuing to take medication, specifically as a way to support themselves in their recoveries. For example, one participant stated, *"There is nobody who can stop me from taking my meds. Hmm. Because I don't want to see myself back in the hospital, it's not a good thing."* Another participant, reflecting on the on-going role of medication in his recovery, made the following statement: *"I'm just gonna keep taking my medication but uh, the difference is… I'm like way better now."* Finally, this participant stated succinctly about his understanding of the importance of medication to his recovery: *"At the end of the day, you need your medication."*

Interestingly, despite understanding the purpose of medication and expressing the best intentions to continue taking medication, some participants reported periods where they forgot to take their medication, and also identified, with some regret, the consequences of forgetting: *"I forget my medication sometimes, and… end up getting ill, and… end up back [in the hospital]."* However, acknowledging the possibility of experiencing a relapse in mental illness symptoms seemed to only further affirm the participants' commitment to the continued use of medication. As one participant stated: *"If you don't take your meds… you can relapse because you are not helping yourself with meds."*

Medication Side Effects

Some of the participants identified experiencing side effects from medication, and spoke very specifically about their experiences. Participants identified feeling *"tightness in my neck and like my spinal area sometimes,"* of feeling *"like woozy"* and *"sleepy,"* and of living with *"tardive dyskinesia."* These participants also spoke about how they are managing, or hoping to manage, their medication side effects. For some participants, their approach was very active.

This was explained by one participant: *"I try to come in early… I start pushing myself... and I keep on pushing myself…"* and, in the context of feeling tired all the time, *"I'm gonna have to try to deal with that, that's why I'm in the… sleep group."* However, for other participants a more passive approach was assumed: *"I'm just waiting... I'm just hoping that my side effect will go away or [the hospital] can help me some way."*

Finally, although not every participant spoke about experiencing medication side effects, for those who did their commitment to taking medication seemed to remain. As one participant explains: *"Sometimes I get worried that my medication might stop working,"* and that for him, despite his negative experiences with side effects, *"the scariest thing is getting another symptom."*

Summary

The major theme the *Critical Role of Medication* describes the significant influence of medication on the majority of participants' experiences of recovery. Furthermore, it is evident that the participants' involvement in the FMHS influenced the value placed on the role of medication in their recoveries. Specifically, by using medication participants were able to be present to *"reality"* and attain an understanding their circumstance, which they recognized as important for reducing the likelihood they would return to a state of mind that precipitated their index offenses. Furthermore, participants endorsed plans to continue taking medication in the future for the same reason. Finally, the overarching theme of change was clearly conveyed in the way participants described the changes they experienced as a consequence of taking medication.

The Significance of Relationships

"I'm fortunate to have a good worker… he's always telling me 'You know, you're better than what you think you.' "

Every participant spoke extensively about impact of relationships on their experiences of recovery. The relationships most commonly spoken about were the ones participants had with their *psychiatrists*, with *other healthcare professional*, with their *families* or specific family members, and with their *friends and peers*. Notably, although every participant spoke explicitly about the relationships they had with persons across all four categories, their appraisal of the significance of these relationships varied, as did their feelings about whether these relationships were positively or negatively impactful on their recovery. Finally, as the bolded quote above alludes to, one common thread identified by participants in the context of having positive, supportive relationships was the experience of feeling encouraged. One participant clearly expresses this idea, stating, *"There are certain positive people in my life that tell me, 'You know, it's not too late. You can do it,'* which he further reports makes him feel that *"No matter how… much you have an illness, you know you can do anything to overcome anything."*

The Psychiatric Doctor: A Distinguished Role

The psychiatrist was identified distinctly by many of the participants as being uniquely able to support them in their recovery. Specifically, participants described psychiatrists' capacity to facilitate the use of the correct medication and to be knowledgeable about mental illnesses and treatment options. Participants also identified the need to be open in their relationships with their psychiatrists. These important contributions to the participants' experiences of recovery are comprehensively expressed in the following statement:

> *You have to be open and make sure that you don't hide anything from your psychiatric doctor, in order for them to know how to help you… by the way you express yourself and talk to them they will know if you are sick or if you are not sick, so if you don't say some things out they wouldn't know and maybe they can give you wrong medication, and then it doesn't work out for you because you are hiding a lot. But if you are open and have a good relationship with your psychiatric doctor… you will get the right help, the right medication, the*

> *right treatment, they will refer you to the right groups and all that, and then you can do well and get back to your normal lifestyle.*

Further, one participant suggests that it is because of psychiatrists knowledge base that they are uniquely able to support participants in their recovery:

> *Your mom, your friend or whoever… they're not gonna be able to help you like you doctor can 'cause they don't have the knowledge that your doctor has about mental illnesses or the insight that your doctor has about mental illnesses, so there's not much they can say to you.*

The participants also expressed other reasons why their relationships with their psychiatrists were beneficial to their experiences of recovery. For instance, one participant highlighted the important role his psychiatrist had in helping him attain insight, explaining that, *"Sometimes it'll, were to help if he were to ask me certain things that I'm scared to ask about, like certain things he sees in me, because sometimes I don't see it everything right."* Additionally, psychiatrists were able to support participants in recognizing the value of medication in their recovery, as one participant stated: *"I talked to my doctor and he tells me the medication does help you and its, the medication does get rid of symptoms."*

Psychiatrists were also credited with providing important on-going support, as is expressed in this participant's statement: *"They give me support where ever I need help, I just call them and they help me with what I need."* Furthermore, psychiatrists were seen as a vital component of future stability, as one participant stated when asked about maintaining his stability: *"I need a doctor."*

The statements made by participants about the relationships they had with their psychiatrists also allude to the power that psychiatrists have in the context of the FMHS. Whereas the previous quotes demonstrate the positive impact of the psychiatrists' power on the

participants' experiences of recovery, psychiatrists were also seen to use their power in a restrictive manner, which was perceived to have a negative influence on participants' recovery. As one participant explains, identifying the tenuousness of his relationships with psychiatrists in the FMHS, *"…doctors, they're just quick to lock up patients… ."* Another participant, revealed a similar level perception regarding the powerful influence psychiatrists on the recovery experiences of NCRMD clients, stating in reference to the ORB process, *"Every year the doctor comes in there and says [the participant] is a significant threat to society and no change and blah, blah, blah, and I wind up doing another year."*

Other Influential Professionals

In addition to identifying the significant influence of psychiatrists on their experiences of recovery, participants also identified the important influence of the relationships with other healthcare professionals. For example, participants expressed benefiting from being able to *"talk to my worker, and tell him this is what I am going through right now,"* and also to ask questions, for example*, "so how do I deal with my emotions when I feel like this, you know?"* Participants also discussed the importance of learning from the healthcare professionals they encountered over the course of their recovery. For example, one participant described, in speaking of her relationship with one of her primary nurses, *"she used to bring a lot of ideas into my life and I consumed them and they changed me, to be something different."* Still other participants reflected on the positive impact of knowing that their nurse was available when needed. As one participant explains, *"If I felt out of place, or if I felt unordinary for the day or for the moment, I can still talk to the nurse."* Importantly, as these quotes indicate, the participants' feelings of being supported in their relationships with healthcare professionals was relevant to their

experiences of recovery in inpatient settings, as well as in their current circumstances as community residents.

However, not every healthcare professional was perceived as supporting the participants' experiences of recovery. Specifically, some participants described making the decision not to seek support in the context of these more challenging relationships *"…'cause sometimes I felt uncomfortable asking the nurse."* Participants also expressed the feeling that not all healthcare professionals could be supportive of their recovery. For example, one participant reported that *"nurses, they don't care… they're like in your face kind of, you know, they, they don't give a shit about you."*

Finally, as one participant explains, relationships with healthcare professional that are not immediately supportive of recovery can improve over time. Furthermore, this participant expressed a willingness to work to improve those relationships, stating:

> *When I first met [my worker], I was like, 'who is this guy man?' And I didn't like him at all, and then I, he start, we started, you know, kicking it off, talking… he talks, we talk, sometimes we talk for almost an hour when I check-in, and uh… I have the sense that, you know, that he actually cares.*

The role of the family

Participants' experience of feeling supported by their families or members of their family varied. For one participant the support received from family members was generally described positively: *"My family, my mom especially, she's a big supporter of my life,"* and, *"My sister is there for me, although she's not here in the country, but, you know she talks to me all the time."* However, for other participants the support they received was meaningful because it was specific to a certain aspect of their recovery. As one participant described in the context of overcoming substance use, *"Pretty much my whole family, they helped me recover when it came to that."*

Similarly, another participant explained: *"My mom can let me know when I'm sick, she can see it in my eyes and stuff like that, like bags under my eye, I'm not sleeping, I'm talking about like weird stuff… ."*

Finally, only one participant identified a distinct absence of family involvement in his present life, and described the negative influence of this experience on his recovery, stating: *"That's what it's all about, recognizing that family isn't necessarily the healthiest people to be around…. that's a very painful process."*

The influence of friends and peers

The participants invariably identified having significant relationships with friends and/or peers. Notably, because of the way participants spoke about these relationships the distinction between peers and friends was not always clear. Therefore, for the purposes of this discussion, peers are those who also have experience being a client in the FMHS and friends are those persons with whom participants expressed having a close personal relationship but who were not specifically identified as also having FMHS experience. Notably, regardless of whether participants were speaking about peers or friends, these relationships were almost exclusively identified as being supportive of recovery. The reasons for this are not entirely clear, but perhaps it was due to the fact that these relationships, unlike the relationships previously discussed, are ones that participants could choose to engage in voluntarily.

Peers. Participants spoke frequently about interacting with their peers, particularly in recollection of their inpatient experiences. Participants expressed the positive influence these relationships had on their recovery experiences. For example, one participant identified *"Being around other people who are doing well with their mental health issues"* as *"a good thing,"* because she found it beneficial *"to be around them and just sharing different experiences, you*

know, about this mental health disease." This participant described a further benefit of these relationships: *"'Cause I could see others doing very well, you know, so it gave me a lot of hope."* Another participant express finding benefit in being able to learn from others, stating: *"I'd watch… my other friends that have mental illnesses too, and I'd… learn from their mistakes."* Finally, this participant spoke about peers being important people to turn to for support, stating:

> *If… I needed to ask somebody something about my symptoms, I could… just ask one on my friends, we all go through the same thing… we all have the same problem, we all have mental illnesses, so I can go to a patient… and just be like hey, um, I'm going through this right now, do you think this is real, or do you think... this is gonna happen to me… and it'll help, it'll make me feel better.*

Friends. Generally speaking participants identified having friendship as an important aspect of their recovery. As one participant identified, *"I find it very important to have a friend in the community,"* which he explained in the following statement: *"Everybody needs a friend… 'cause a friend, at the end of the day, you can talk to him about stuff you can't talk, or her, that you can't talk… to you family about."* Another participant added that not only was it important to have friendships, but that in the context of her recovery, it was also important to be open with them, stating: *"I just made new friends and I didn't hide from them, I told them I have a mental sickness"* and *"they are always giving me support."* Additionally, one participant revealed that in the context of recovering in the FMHS, even friends need to be made to feel safe: *"I have my friends, they understand my situation, they are very, very understanding and they feel safe with me."* Finally, one participant described the importance of trust and reciprocity in the friendships he has, stating: *"A friend's a friend at the end of the day, and friends look out for each other... especially… if they're trustworthy… and… you should be able to do the same for your friend."*

Summary

The major theme *Significance of Relationships* describes the participants' recovery as being hugely influenced by the relationships they had with their psychiatrists, other healthcare professionals, their families, and the friends and peers. Additionally, the relationships described by participants, particularly those with psychiatrists and other healthcare professions, reveal the influence of these relationships in the FMHS. Finally, the overarching theme of change was evident in the way participants described how relationships contributed positively or negatively to their recovery progress.

The Importance of Helping Yourself

"I did all I can to help myself too, 'cause I could see that they are helping, but if I don't try to help myself too, it's gonna be hard, so I started doing all my best to help myself…"

As the bolded quote above suggests, all the participants reported making substantial efforts to help themselves over the course of their recoveries. Universally participants saw these efforts as supporting their recovery. In describing how they have experienced and contributed to their own process of change, participants spoke about having a willingness to *accept and engage* in their recovery, highlighted the importance and beneficial influence of using *strategies to support their recoveries*, including *achieving goals* and *attending groups*, and expressed the value of *being self-aware*. Finally, every participant acknowledged that sometimes the best thing they could do to help themselves in their recoveries was to *ask for help* from someone else.

Accepting and Engaging

The participants all seemed to agree that recovery was not possible unless they began to participate in their own recovery process. However, how participants came to be engaged in their own recovery was not always clear, even to the participants themselves. As one participant's

statements indicate, she *"didn't make a decision"* to become engaged, *"it just came automatically to me, and things started flowing."* However this same participant also stated that, *"If I don't change anything I'm the one whose going to suffer the consequences,"* which suggests that she did have some sense of personal responsibility for the success of her own recovery. Participants also expressed that in order for them to be fully engaged in their own recovery, they first had to be willing to accept their circumstance. As one participant explains, *"I have really accepted myself with my mental health issues and I, I'm not ashamed of my mental health status, and that is how I managed to move on, because I have nothing to hide from."*

Strategies to Support Recovery

Participants also identified many ways in which they enacted being engaged in their recoveries. Specifically, participants identified some of the strategies they used to support their recovery efforts. For example, one participant indicated, *"I meditated a lot when I was sick,"* which he explained in the following way: *"I'd just sit in my room and just think… about like how, how I could like better myself."* Another participant expressed that *"yoga"* and *"mindfulness"* were helpful for her in the context of her recovery and another participant reported the importance of *"getting more rest."* Still another participant spoke about supporting his recovery by engaging in *"self-nurturing activit[ies],"* which he explained included things like *"listening to music," "play[ing] bridge,"* and *"fishing."* However, this participant also expressed that *"there's only so many ways you can self-nurture when you're being institutionalized,"* which implies that at least for him it was difficult to support himself in his recovery while in the FMHS. Finally, three participants identified spending time alone as being beneficial to their recoveries. As one participant stated: *"Sometimes you just wanna be by yourself."* Specifically, these participants identified benefitting from having *"privacy,"* and

feeling *"more relaxed"* and *"more happy,"* when they were alone. Interestingly, participants may have valued spending time alone because they spent much of their time recovering in close proximity to others while in the FMHS, either in an inpatient hospital setting or in shared residencies in the community.

Achieving meaningful goals. Another way in which participants reported supporting themselves in their recoveries was by working to identify and attain personally relevant and meaningful goals. As one participant explains, *"My recovery is contingent upon my goals, that I've set for myself, and meeting those goals."* The most commonly identified goals pertained to educational and/or vocational pursuits. For example, one participant stated, *"I was thinking about nursing, so I need chemistry for that, so I'm gonna start chemistry in [the near future],"* while other participants identified the importance of working to be *"a professional writer"* and *"doing an apprenticeship with plumbing."*

Participants also endorsed having goals that were more personal in nature. One participant expressed wanting to have a spouse, and two participants indicated they wanted the opportunity to have children. One participant also spoke about wanting to *"be a home owner."* However, the participants also indicated that their involvement in the FMHS lead them to feel *"a little bit skeptical,"* and at times *"just hopeless,"* about their capacity to attain their goals.

Participating in groups. Four of the five participants identified the importance of participating in groups as a way to support themselves in their recoveries. As one participant describes:

> *Cognitive behavioural therapy is a very, very good group. They teach you how to think, how to observe the world around you in a positive manner, instead of being negative they teach you to be positive, and that was my favourite group, I never wanted to miss it.*

Still another participant described the benefit attained from a group specifically aimed at improving the quality of sleep, stating: *"It's a learning group… to show you more insight about your sleep, what you can do to ah, help you sleep… methods you can do… to uh, have a better sleep."* Significantly, these comments highlights the role of learning in the context of attending groups, which suggests that the act of learning is also an important part of supporting one's own recovery.

Finally, even when participants expressed finding value in attending groups, not every group was considered useful, as one participant describes: *"The wellness group is a good group… but most of the groups they have here, it's a waste of time."* This comment highlights the importance not of attending groups per se, but attending groups that are personally relevant.

Being Self-Aware

The participants also expressed that having an awareness of themselves was an important aspect of how they supported themselves in recovery. Specifically, participants perceived that it was beneficial to have an awareness of what they were thinking and feeling, and how they were behaving, particularly in relation to their illness experience. The reasons for this varied. One participant described that having *"insight"* into his illness experience was of value to him because*"I know when I'm about to get sick."* Another participant described that being self-aware helped him solve problems:

> *I'd sit in my room and think about [whatever problems are going on at the moment]… and just think [about] any possible outcome that would happen with what's going in my head and try to figure out if it's real or not.*

Still another participant found that being self-aware helped him understand his recovery progress: *"I'm still not 100 percent recovery yet, I'm not 100 percent there, I can tell, you know… I need a little more time to be more recovery… you know, so, still, I'm still going*

through it." One further participant explained that being self-aware allowed him to recognize the importance of controlling his actions and tendency towards violence:

> *I've primarily focused, tried to focus, on not acting out in a violent nature, because I know … I can't do that because that's what I did in my index offense and I realize when you assault people you get thrown in prison and I didn't like that.*

Finally, participants identified that being self-aware meant they were, *"able to face [different challenges] and be strong and not relapse."*

Knowing When to Ask for Help

For participants the importance of helping themselves also included knowing when to turn to others and ask for help. For example, as one participant explains, *"I call my social worker at any time, I know I am free to contact him at anytime, when I'm not feeling well, when I feel that there is something wrong."* Interestingly, this comment alludes to a link between being self-aware and asking for help, an idea which is even more concretely expressed in the following statement: *"If I see in changes in me, my mood and all that, I report it to my psychiatric doctor 'cause I don't want to see myself in, in jail."* Finally, as is evidenced in this quote: *"I'm very engaged… I know when I'm about to get sick… I have a lot of insight… that's why I just decide to admit myself… ,"* there also seems to be a strong and beneficial connection between being engaged, having an awareness of one's illness experience, and knowing when to ask to help.

Participants also reported asking for help to address very practical problems. For example, one participant explained,

> *I even told my teacher that I will need some time to be one-on-one with her, because at times, maybe because of the medication I am taking, I forget, but maybe if I go one-on-one with her it will stick, into my, my mind and she's so supportive.*

Another participant, also recognizing the need to ask for help in the context of attaining educational success, stated:

> *On the campus, a mental health thing on the campus, for people mentally, with illnesses… I've been there before, so they've helped me before… if I have any questions I could go to them and they could figure it out for me.*

Another example of seeking practical support was explained by this participant, who stated about his efforts to improve his housing situation: *"So I'm asking my worker, you know, where am I gonna place, where am I gonna get a place, is a place comin' up soon?"*

Summary

The major theme, the *Importance of Helping Yourself*, describes how the participants made substantial efforts to help themselves over the course of their recovery and clearly identifies the various ways that the participants' FMHS involvement influenced the ways they choose to help themselves. Specifically, participants described the strategies they used to support their recoveries, which included achieving meaningful goals and participating in groups; further identifying how these strategies were influenced by their FMHS involvement. Similarly, participants valued their capacity to make decisions about when, for what, and to whom they would turn to ask for help when working to be self-aware. Finally, the overarching theme of change was clearly conveyed in the way participants described how they have experienced and contributed to their own change.

Navigating Challenges

"It's a struggle, but you know, I'm just fightin' through it."

The participants described facing a number of challenges in the course of their recoveries, and as the bolded quote above suggests, they described finding the will to address these challenges and carry on in their recoveries. First, participants described challenges related to the

existence of *residual symptoms* and the *experience of relapse*. Second*, managing stigma* and *addressing feelings of loss* were identified as challenges. Finally, participants described a variety of challenges that left them feeling *fearful and uncertain*.

Residual Symptoms

Some the participants reported dealing with residual or on-going symptoms of their mental illness, particularly, *"hearing voices,"* and still being *"a little delusional."* These participants expressed the importance of overcoming these symptoms. As one participant explains: *"I think getting rid of your symptoms is the most important thing in recovery."* This participant further explains, stating: *"If I could get rid of these little delusional problems I'm having, it's 5 percent of the symptoms, I think in the future I can do whatever I want."*

To address the experience of on-going symptoms the participants identified two approaches they might take. First, one participant stated: *"'Cause I still hear voices, hopefully in the future I could somehow recovery from it… like with a new meds, or like, hopefully that help me recover 'cause like I, I don't wanna hear the voices."* Interestingly, this quote highlights the critical role of medication as a primary approach to manage the participants' mental illness symptoms, but also addresses the uncertainty that medication will be effective. The second approach, identified by the participant who continues to struggle with *"a delusion that became so minor that I, I don't really show it, and I don't talk about it"*, involved this participant recognizing that *"I still have some issues that I need to talk to my doctor about."* Notably, this approach again reveals the participants' perceptions that their psychiatrists play a distinct and significant role in supporting recovery.

Experiencing Relapse

Participants spoke particularly about their experiences of relapse and identified some of the challenges they faced as a result. For example, one participant described the challenge of relapsing without being aware that he had done so, stating: *"I relapsed, I didn't know… I was telling my doctor I was symptom free for, for a long time... I didn't know I was delusional at the time."* Another participant, when speaking of his recent experience with relapse explained that the

> *…last time I got sick... I'm taking an injection and um I think… if I miss one or two medications it will not effect me, but… I just relapsed 'cause uh, you know, because I wasn't taking the capsule, the capsule was a big important method.*

This participant went on to explain that the challenge for him was that, *"It's hard to bounce back but… I keep on telling myself, you know, its, it's only for a… short time. I hope, um, to get back on my feet."* As these comments reveal, while the experience of having a relapse is not the same for everyone, it was commonly experienced as a challenge in the context of one's efforts to recover. Finally, when participants thought about a future relapse, they expressed experiencing fear and uncertainty, which is this discussed in greater detail below.

Managing Stigma

A number of the participants identified challenges dealing with stigma. One participant, for example, describes,

> *Some people they don't understand mental health. There is a stigma; they take you to be dangerous. Some people they will say 'I don't want you around my kids. Because you have a mental health issue my kids are not safe with you'.*

Another participant explains why experiencing stigma is challenging, describing *"The stigma… it scares you 'cause even if the medication does make you normal again, people are still gonna… look at you like you're a different person because you're on medication and they're not…"*

Importantly, participants' reported that the experience of stigma was harmful to their recovery because it can *"depress someone."* Another participant stated:

> *You just go home and think like, maybe I'll never have friends again, or I'll never be able to talk to that person, how much more people are gonna act like this with me in the community? So that can really scare someone.*

However, the participants also identified ways of managing the challenges of feeling stigmatized. Specifically, one participant recommends being *"around the right people, like around more positive people, people that like know that you're a human being, and treat like a human being just like they would want to be treated."*

Participants identified two further strategies for managing stigma. First, they recommend *"act[ing] as normal as possible,"* which is further explained as, *"just be[ing] you, like don't worry about anything, if you have no symptoms, and you're symptom free now, on medication, what are you worried about, just be you."* The second strategy is explained as needing to

> *…just ignore the negativity 'cause it's not gonna be everywhere, it's out there, but not every person's… gonna treat you like… you're below them because you've had a mental illness in your past or you have a mental illness… at the moment.*

Succinctly summarizing these strategies, one participant stated: *"It's a better option to find a different crowd and be you."*

Finally, two participants identified feeling, in the context of experiencing stigma, that others perceived them as unsafe to be around and as the perpetrators of harm. As one participant explained: *"You're acting like I'm gonna harm you."* These quotes suggests that the participants

in this study experienced the double stigma of being 'mad and bad' that is often referenced in the context of the forensic client experience (Bettridge & Barbaree, 2008; Quinn & Simpson, 2013).

Addressing Feelings of Loss

Although the participants in this study generally reported feeling positive about the progress they had made in their recovery, they also expressed feelings of loss; either in the context of recovery from serious mental illness, or because of their involvement in the FMHS. For example, one participant, talking about who he was prior to beginning his recovery, stated: *"I miss my unique ways… I miss the fact that people wanted to be around me 24/7 'cause I was different, and I had so many friends."* Participants also discussed things they had lost as a consequence of experiencing the side effects of medication. For example, one participant stated, in reference to activity he had previously really enjoyed, *"It's not the same, 'cause I don't have the same… flow, …so I just, I don't really even do it anymore."* Still another participant spoke about feeling as though his involvement in the FMHS had resulted in missed opportunities. As he explains, *"I was one of those people that defined your mid-thirties and mid-forties as some of the most productive years of your life… however, mine weren't, they were, without a doubt, some of the most depressing years,"* and, *"the chances of me meeting…[someone] … in the immediate future and settling down…, is you know, doesn't, doesn't, seem…"* very likely. Finally, one participant, in the context of a relapse that resulted in re-hospitalization, described feelings of loosing ground, particularly because he lost his apartment while in hospital. In his words: *"and then I got ill, and um, I wasn't to happy about losing my place."* This participant further explained that this initial feeling of loss was increased when he returned to the community, *"'cause I ended up in a rooming house… and it's hard to find housing again."*

The Presence of Fear and Uncertainty

The participants expressed feelings of fear and uncertainty in response to a variety of challenges. This section focuses on these emotional experiences.

Participants expressed feeling fear and uncertainty in relation to their mental health, and in so doing, expressed the complicated link between medication, symptoms, relapse and hospitalization. Firstly, participants expressed fear about the effectiveness of their medication. As one participant succinctly expressed: *"Sometimes I get worried that my medication might stop working."* However this fear was not expressed in isolation, but instead was linked with the fear of developing of new or returning symptoms, and the possibility of relapse. For example, one participant talked about feeling unable to control or alter the onset of symptoms, stating, *"When you become delusional it comes outta nowhere."* Speaking more specifically to the fear of unexpected symptoms, this participant explained,

> *…the scariest thing is getting another symptom, you know… you can't run from it, you know there's nothing I can, there's nothing I can say that makes it go 'Poof', and like makes it go away, right away, right then and there, and uh, it's really scary.*

Furthermore, in the context of thinking about experiencing such a relapse, one participant expressed the following fear: *"If I relapse now maybe I'll be doing something different because I wouldn't know what I am doing when I'm sick."* Linking this back to concerns about the effectiveness of medication, this participant also expressed a concern with regard to a potential relapse, *"when you come for another medication it won't work the same ways as it is working right now."* Finally, following along this line of thinking, this participant expressed a fear of being hospitalized for a prolonged period of time, stating: *"at times, people, they don't respond*

to medication; they stay right there in the hospital, for 10 years, for 15 years, because they don't recover."

There were two additional contexts in which participants expressed feelings of fear and uncertainty. The first was expressed in the context of deciding when and with whom to share that one has a serious mental illness. As one participate reports, anticipating the potential of being judged and/or treated negatively by others:

> *When I get into the work industry, I don't know if it is important for me to tell I [have a mental illness], I just want to keep that for myself and do my work as a normal person and not tell anybody that I [have a mental illness] because in a work environment at times when everybody knows your problem they won't treat you right.*

The other circumstance in which participants reported feeling fear and uncertainty related specifically to their involvement in the FMHS and the decision to use prohibited substances. For example, one participant reports, *"being threatened with being locked up",* "*because I'm smoking cannabis."* This participant describes this experience as being, *"extremely stressful,"* because the consequences of his choosing to smoke marijuana is, "*not… entirely within my control,"* and further is because of, *"not knowing where you're gonna be sleeping tonight."* The potential of being locked up as a result of using substances which is in violation of the conditions of their community discharge was also described, in the third person, by another participant:

> *…once in while they're with their friends, they wanna have… one or two beer, and you know they come in the next day and they get caught and then they, the doc's like, 'You know what? I'm gonna lock you up'.*

Finally, one participant alludes to the fear, and in this case the helplessness, that is experienced by persons in the FMHS during periods of hospitalization, stating, *"I'm in this, this place locked,*

locked down… and they wanna know everything about my life, basically, and I can't, I can't be sick, I'm in a corner, they cornered me in a corner, I can't move, you know".

Summary

The major theme of *Navigating Challenges* describes how participants experienced and addressed challenges in their recoveries. Additionally, these challenges, specifically of managing the dual stigma of being mad and bad, addressing feeling of loss, and the presence of fear and uncertainty, were clearly contextualized by the participants' involvement in the FMHS. Finally, the overarching theme of change was clearly conveyed in the way participants described addressing, and whenever possible managing or overcoming, the many challenges to their recovery.

Conclusion

This chapter contains a detailed description of the study findings. The participants' experiences and understandings of recovery as a dynamic process of change was identified as the overarching theme present in the data. The five majors themes 1) Recovering in the FMHS, 2) The Critical Role of Medication, 3) The Significance of Relationships, 4) The Importance of Helping Yourself, and 5) Navigating Challenges were discussed.

CHAPTER VI: DISCUSSION

WHAT THIS STUDY ADDS

Introduction

This discussion describes the findings from this study and considers them in the context what is already known about how people experience and understand recovery in forensic settings. The study findings are also situated within the relevant literature that addresses recovery from serious mental illness in the general mental health system. Further, a descriptive summary of the recovery experiences of community-residing individuals who have been found not criminally responsible on account of a mental disorder (NCRMD) is presented; in which the findings are considered in the context of the Spaniol and Wewiorski's (2012) phases of the process of recovery from psychiatric disability framework.

This discussion further focuses on the study's overarching theme; specifically that recovery is a process of dynamic change that is distinctly influenced by the participants' involvement in the forensic mental health system (FMHS). Consequently, each of the study themes: the influence of the FMHS on the recovery experiences of participants; the significant role medication in recovery; the importance of relationships in recovery; the substantial efforts of participants to help themselves in their recovery; and finally, the challenges in recovery, are discussed from the perspective of this overarching theme.

Recovery as a Dynamic Process of Change: The Overarching Theme

The participants in this study consistently identified their experiences of recovery as a dynamic process of personal growth and change. Specifically they described recovery as a process of developing new ways of thinking, being, and behaving as a consequence of

experiencing psychosis, committing an offense, and entering the FMHS. Recovery as a process of change is a theoretical perspective commonly described in the current literature on recovery from serious mental illness. Within this literature, recovery is conceptualized as an individualized process of growth and change that is experienced over time (Anthony, 1993; MHCC, 2012; Spaniol, Wewiorski, Gagne & Anthony, 2002), and as such, is relevant to recovery in the FMHS (Simpson & Penney, 2011).

Finally, the Spaniol and Wewiorski (2012) framework, the phases of the recovery process from psychiatric disability, also describes recovery from serious mental illness as a process of change that occurs as people develop and change over time. Specifically, the framework is characterized by four phases of change: 'overwhelmed,' 'struggling,' 'living with,' and 'living beyond.' This framework will be used to contextualize descriptive summary, which will be explicated in the final section of this chapter.

Recovering in the Forensic Mental Health System

In recounting their experiences in the FMHS, participants described the influence of being incarcerated as distinctly detrimental to any kind of mental health recovery. They identified being in jail as a negative experience, primarily because as persons with mental illnesses, they felt vulnerable and consequently, felt unsafe. They also expressed feeling that their recovery needs could not be met in a jail setting, and that they would be better served in a hospital setting.

It is noteworthy that the current literature describing what is known about how clients in forensic settings understand and experience recovery, (discussed extensively in Chapter Two), did not identify the influence of incarceration on recovery. However, negative experiences of being detained in jail are reported in the broader mental health literature, suggesting that the

participants in this study are not alone in their perceptions of incarceration as a negative experience. For example, participants in a Canadian study of mental illness in the context of homelessness also reported being incarcerated as a traumatic experience (Kirkpatrick & Byrne, 2009). Furthermore, it is known that for persons with mental health challenges, the negative impact of being incarcerated increases the likelihood of an increased illness burden, further compromising their ability to attain mental health (Mental Health Commission of Canada, 2009). Olley, Nicholls, and Brink (2009) offer some possible explanations regarding the deleterious effects of incarceration for individuals with mental health challenges. Specifically, these authors indicate that there are limited resources in jails to adequately address the needs of those with mentally health challenges, especially given the rise in the number of persons in custody. Further, the environment in jail is not therapeutically-oriented, and the distress engendered in these environments exacerbates mental health challenges and needs (Olley et al., 2009), which may explain why the participants in the current study reported their experiences of being incarcerated so negatively.

However, while Olley et al., (2009) highlight some underlying explanations concerning the negative impact of incarceration amongst individuals living with mental health challenges, these authors do not provide any insight with regard to how best to support forensic clients to overcome these traumatic experiences. It is of interest that Olsson, Strand, and Kristiansen (2014), in a study exploring how clients detained in a maximum secure forensic setting came to recovery, also found that initial periods of detention were likely to include a period of intensely negative emotions in reaction to being detained; even when the initial periods of detention were experienced in secure inpatient hospital settings, (not a jail setting).

Of further relevance, participants in both the Olsson et al. (2014) study and the current study recognized that they needed to be in hospital and felt supported in their recovery by the inpatient care teams. However, participants in both studies also identified that being hospitalized compromised their freedom and was an unfavorable experience because of the need to interact with the other patients, healthcare professionals, and the environment, which they described as being of poor quality. This dichotomy of having both positive and challenging experiences in secure inpatient forensic care settings was also endorsed by Mezey, Kavuma, Turton, Demetriou, and Wright (2010) in a qualitative descriptive study that explored forensic clients' experiences of recovery. Specifically, these authors reported that participants found that secure inpatient forensic settings supported recovery because staff and co-clients were easily accessible, but also presented challenges to recovery, specifically when staff attitudes were negative and because the environment was unpleasant.

Additionally, in a study looking at client perceptions of the accessibility of recovery in medium as compared to high secure inpatient environments (Barsky & West, 2007), the lower level of security was perceived to have increased opportunities for recovery. Lower levels of security allowed for greater access to activities to support recovery, along with an environment that was more therapeutically oriented (Barsky & West, 2007). These findings suggest that participants in the current study may have found that recovery was possible while in an inpatient hospital setting, compared to jail, since it allowed for an increased level of freedom and control, as well as increased access to a therapeutic activities and environments. Finally, although Barnao, Ward, and Casey (2015) found that inconsistencies in the provision of care were disruptive to the forensic clients rehabilitative experience, the participants in the current study,

who endorsed both positive and negative perceptions of inpatient nursing care, generally seemed to find that the care they received was beneficial to recovery.

Although participants in the current study described their present community residency as an improvement in their circumstance compared to being in jail or detained in hospital, they also identified that their freedom to act was still limited by the need to act in accordance with the authority of the ORB. The participants further described the tenuousness of this situation, specifically identifying the ease with which they could be brought back into hospital. Consequently, when the participants in this study spoke about their future recovery, the attainment of an absolute discharge and acting in accordance with the mandates of the ORB were the main foci. Specifically, these foci were the primary motivation for moving forward for some participants, while for others getting an absolute discharge and acting in accordance with the mandates of the ORB were seen as only two aspects of their on-going recovery.

Unfortunately, there is no current literature that directly addresses the role of the ORB and the necessity of attaining an absolute discharge in recovery. However, the findings from Barnao et al. (2015) may shed some light on why the attainment of an absolute discharge appears to be so important in the current study participants' experiences of recovery. As Barnao et al. describe, forensic clients found their rehabilitative progress benefitted greatly from knowing what was expected of them. Consequently, it is possible that for the participants in the current study, the conditions placed upon them by the ORB and the goal of attaining an absolute discharge in the future conveyed for them a well-delineated idea of expectations necessary for progress in recovery, an that idea that Simpson and Penney (2011) also endorse. The importance of having a clearly identified direction for recovery is further supported by the finding that

clients in forensic care settings search for, but often struggle to identify, a "way out" of the forensic system of care (Horberg, Sjogren & Dahlberg, 2012, p. 745).

In addition, the literature on forensic recovery does not address the impact of feeling vulnerable to involuntary re-hospitalization following a conditional discharge. However, Viljoen, Nicholls, Greaves, Ruiter, and Brink (2011), in a study of successful community reintegration for female forensic clients in Canada, found that those who participated in community programs outside the hospital and had insight into their substance use issues were less likely to be re-hospitalized and more likely to obtain an absolute discharge. Therefore, it may be helpful to encourage NCRMD clients who express concerns about being re-hospitalized, such as those in the current study, to participate in community-based treatment programs and to pro-actively address their substance use issues, along with providing an explanation that these actions may reduce the likelihood of being involuntarily readmitted to hospital.

Unique Challenges

The participants in this current study further identified that their involvement in the FMHS presents four distinct challenges to their experiences of recovery, namely: the constraints of the FMHS; the dehumanizing aspects of receiving treatment in the FMHS; the need to refrain from using substances; and the experience of perceiving oneself as an offender. To begin with, simply being in the FMHS was seen to negatively impact recovery, since it evoked feelings of being constrained. The perception of being constrained in and by the FMHS is well supported in the literature. For example, in a study of the impact of the 'forensic' label on forensic clients, Livingston, Rossiter, and Verdun-Jones (2011) discovered that clients identified with the feeling of being detained in the Canadian FMHS, and also the clients described their experiences as more like being in a correctional facility than a rehabilitative hospital. Furthermore, as

previously identified, Barsky and West (2007) found that clients perceived recovery progress and detention restrictions to be inversely related. This finding resonates with the perceptions of the participants in this current study; specifically, that being constrained is oppositional to experiences of recovery. However, confirming this would require further study. Lastly, to some extent, the participants' feeling of constraint is a reality, since a discharge from a secure forensic inpatient setting is always conditional on complying with certain prescribed conditions (Coffey, 2013). Furthermore, the participants in the current study perceived their experiences of being constrained within the FMHS, along with the need to demonstrate their compliance with specified release conditions, as dehumanizing and consequently, as negatively influencing their experiences of recovery. Barnao et al. (2015) made a similar observation, as the participants in their study specifically identified that being treated like a human being was important when recovering in a forensic care setting.

Another challenge identified by participants in this current was the need to absolutely abstain from substances in any situation, social or otherwise; a condition imposed by the ORB. Participants felt this condition was unnecessarily restrictive and presented challenges managing relationships because of the perceived need to explain one's abstinence, the peer pressure to use substances, and the desire to fit in or not be seen as different. To overcome these challenges participants recommended: choosing only to be around persons who abstained from substances; addressing issues of on-going substances use; and finally, to have the option of attending a community-lead substance use group when substance use was problematic, instead of being required to return to hospital. Notably, the majority of literature describing forensic clients' perspectives on recovery is focused on exploring the experiences of recovery during periods of detention, and therefore does not address the use of substances in the context of recovering in the

community while on a conditional discharge. However, as previously discussed, NCRMD clients who successfully reintegrate into the community have developed insight into their substance use (Viljoen et al., 2011).

Finally, the participants in this study felt challenged by the fact that they saw themselves as offenders; specifically, as persons who had hurt or been violent towards others. They also found recalling their index offense confusing and emotionally difficult. These findings are not surprising; as Mezey et al. (2010) identified, self-acceptance in the context of offending behaviour presents a distinct challenge for forensic clients. Furthermore, as Simpson and Penney (2011) identify, forensic clients have "extra work" in recovery, including the need to deal with the "effects of their offending" (p. 302), which includes the need to address the challenges of understanding oneself as an offender.

Summary

The findings from this study indicate that jail is experienced negatively, even traumatically, by NCRMD clients because, as persons with serious mental illness, it leaves them feeling vulnerable, unsafe, and without any option for recovery. Further, not only does this experience exacerbate their illness, it colours their recovery experience even years later. The period of hospitalization that follows incarnation was recalled positively; and for the most part, this was identified as a place where recovery begins; where individuals feel supported by the healthcare staff and the presence of peers. However, hospitalization does not come without challenges, specifically: being treated negatively by staff, the experience of the inpatient milieu, and the environment were identified as barriers to recovery. The reduction in security and increase in freedom and agency that comes with community residency was identified as supporting the recovery process. Participants were currently working on recovering and were

able to consider their future recovery. Recovery was commonly explained in the context of what was expected of them by their treatment team, required of them by the ORB, or what they understood as necessary for an absolute discharge.

The most critical challenges faced by NCRMD clients recovering in the FMHS include feeling constrained, first by their involvement in the system itself, which they found to be a depersonalizing experience, and second by the conditions of their discharge. Specifically, the substance use condition was identified as challenging, and community intervention instead of re-hospitalization was suggested as a strategy to overcome this challenge. Finally, recollections of their index offenses were emotionally difficult, as was understanding themselves as offenders.

The Critical Role of Medication

Medication was identified as a fundamental component of recovery for the participants in this study. Specifically, medication was perceived to reduce the symptoms of psychosis, which participants experienced as a return to reality and the reestablishment of normalcy. Medication was also credited with supporting recovery by sustaining better, clearer thinking, and facilitating the participants' understanding of their circumstance. Participants, even those who have struggled to do so in the past, also endorsed the intention to continue using medication to support their on-going recovery. Participants also acknowledged that without medication they may relapse, and consequently may end up either back in hospital or back in jail; both of which were perceived to be generally unfavourable and counter to their recovery progress. Finally, medication side effects were not considered a deterrent to the continued use of medication, even though for some the side effects were severe.

The extant literature also identifies the important role of medication in recovery in forensic clients experiences and understandings of recovery. Specifically, a number of authors

have found that inpatient forensic clients perceive medication as either necessary for their recovery (Mezey et al., 2010; Olsson et al., 2014) or supportive of their rehabilitative progress (Barnao et al., 2015). Specifically, Mezey et al. explained that for forensic clients, medication was viewed as important for "bringing about recovery" (p. 692), and Olsson et al. reported that medication was considered beneficial by forensic clients, because by taking it, "reality became more manageable" (p. 507). These findings are comparable to the findings in the current study; participants felt that medication resolved the symptoms of mental illness and as such, facilitated a return to reality; thus supporting the development of insight, and engagement in recovery. Further, Barnao et al. reported that participants felt it was necessary to take medication indefinitely, in order manage the symptoms of their mental illness and attain rehabilitative success. This finding compliments the findings from this current study, in which participants endorsed an understanding of the importance of taking their medication continuously to support their on-going recovery. Moreover, like the participants in this current study, the participants in the Olsson et al. study and the Mezey et al. study also described experiencing medication side effects. Participants in the Olsson et al. study indicated that the presence of side effects significantly challenged their commitment to taking medication, and further expressed that they had some difficulty in adjusting to needing to take medication. Specifically, only some participants in the current study discussed having difficulty with adjusting to taking medication and no participants identified side effects as a deterrent to taking medication.

Notably, the studies by Barnao et al. (2015), Mezey et al. (2010), and Olsson et al. (2014) did not identify a connection between medication and fear of relapse amongst study participants. The observed lack of concern regarding relapse may be because the participants in these studies were all detained in an inpatient forensic setting, where the risk and consequence of relapse may

be lower. Yet, the concerns expressed about ceasing medication leading to relapse and possible re-hospitalization by participants in the current study may be protective. This suggestion is supported by the findings from a study of female forensic clients' who were reintegrating into the community by Viljoen et al. (2011). Specifically, over the 3-year study period, participants who successfully reintegrated into the community, specifically those who did not experience hospital readmission and attained an absolute discharge, were more likely to remain on their medications than their less successful counterparts, who were either re-hospitalized for a period of longer than 7 days and/or did not attain an absolute discharge.

Finally, this focus on medication in recovery is not exclusive to the forensic client experience. As Piat, Sabetti, and Bloom (2009) found, the use of medication figures prominently in how community-residing non-forensic clients in Canada understand and experience successful recovery as well. The participants in this large multi-site study (Piat et al., 2009) reported similar reasons for using medication as the participants in the current study and the other aforementioned studies did. Specifically, participants in the Piat et al. study recognized the importance of remaining on medication and identified some fear pertaining to the risk of relapse should medication be stopped. These participants also felt medication had helped them begin to recover, and allowed them to attain a measure of stability in their illness experience (Piat et al., 2009).

Summary

The findings of this study identify that NCMRD participants reported the perception that medication plays a critical role in their recovery. Participants identified that medication reduces the symptoms of psychosis, facilitates a return to reality, and re-establishes as sense of normalcy. Medication, like hospitalization, was perceived to be where recovery begins and was recognized as necessary for recovery even in the long term. Overall, participants expressed a general sense

of commitment to its use and in particular, participants were motivated to use medication in order to minimize the possibility of relapse, re-hospitalization or reoffending. Moreover, the study findings suggest that the commitment to using medication and the desire to avoid relapse and its unpleasant consequences may be of particular importance to NCRMD clients residing in the community. However, given that non-forensic clients residing in the community have also identified the importance of medication in recovery, this commitment to the use of medication by the participants in this study may also reflect the experiences of individuals with serious mental illness. Finally, although other studies have identified the opposite (Olsson et al., 2014), in this study, medication side effects were experienced but were not reported as a deterrent to medication use.

The Significance of Relationships

Relationships were significant in the recovery of the participants in this study. Participants identified the substantial impact that psychiatrists can have on their experiences of recovery, primarily because of the uniquely powerful role psychiatrists have in implementing the participants' ORB disposition orders. Participants identified having negative feelings about the capacity of psychiatrists to initiate involuntary re-hospitalization and influence ORB proceedings. However, in general, participants reported that psychiatrists positively influenced their recovery because they were: knowledgeable about mental illness and medication; took the time to explain the benefits of medication; and supported the development of insight into their illness and circumstance. Furthermore, participants felt that having a relationship with a psychiatrist was important for attaining and maintaining stability in their recovery. Finally, participants also identified that being open with their psychiatrists about their mental illness experiences was important to the success of these relationships and their recovery.

The participants' perception of the explicit influence of psychiatrists on recovery was not an unexpected finding, as it is in keeping with much of the literature on the forensic clients' perceptions of the psychiatrists' significant role in recovery. For example, in the Mezey et al. (2010) study, the psychiatrist is identified as valuable in the participants' recovery, as someone to turn to for information about mental illness and guidance about treatment, including medication. This finding supports the experiences of participants in this study, who expressed similar sentiments about the value of their psychiatrist in their recovery. In the Barnao et al. (2015) study, psychiatrists were identified as important in forensic clients' experiences of rehabilitation because they were responsible for making decisions about the administration of rehabilitative care, and for leading the treatment team in carrying out that care. Lastly, in the Olsson et al. (2014) study, participants identified the psychiatrist as significant to recovery because they (the psychiatrists) had the power to permit or restrict access to things they (the participants) wanted. These final two points, both of which allude to the power of psychiatrist, seem to parallel the perceptions expressed by participants in this study; specifically, that psychiatrists are able to significantly influence their recovery trajectories by implementing the conditions put in place by the ORB and/or by influencing the outcomes of ORB hearings.

Participants in this study also identified other healthcare professionals as influential in the process of recovery. Specifically, in the current study, relationships with healthcare providers in which participants felt supported, could ask for help when needed, as well as being able to learn and grow, were seen as beneficial to recovery. Moreover, participants acknowledged that supportive relationships take time to develop. The finding that relationships with healthcare professionals were positively impactful to the recovery experiences of community-residing NCRMD clients was similarly identified in a number of other studies describing the recovery

experiences of inpatient forensic clients (Barnao et al., 2015; Barsky & West, 2007; Green, Batson, & Gudjonsson, 2011; Mezey et al., 2010; Olsson et al., 2014). However, the findings from these studies emphasized different aspects of supportive relationships than the participants in the current study described. For example, the Barnao et al. study highlighted that relationships in which participants felt supported in their rehabilitation were those in which the staff treated them like people, and were respectful of their emotional experience. The aspects of supportive staff relationships identified by the participants in the Mezey et al. and Olsson et al. studies were similarly described, with the addition that feeling cared for was important (Mezey et al., 2010). The study by Green et al., based on descriptive information gather from inpatient forensic clients, participants identified that they felt they were supported during recovery when relationships with staff: inspired hope; helped them to identify and work toward recovery goals; and supported them in making links in the community. Finally, the participants in the Barsky and West (2007) study described supportive relationships as ones in which staff were engaged and friendly.

Conversely, the participants in this current study identified that relationships in which they felt unsupported or uncomfortable were not considered to be of benefit to their recovery. Mezey et al. (2010) also describes aspects of relationships that forensic clients identified as particularly unsupportive for recovery, for example: when staff are "unkind, insensitive," or dispense "intolerant treatment or remarks" (p. 692). Olsson et al. (2014) adds that forensic clients report feeling unsupported when healthcare staff make false promises, are inaccessible, or fail to provide the necessary reassurances. Barnao et al. (2015) further adds that unsupportive relationships include those in which clients are made to feel like nothing more than a diagnosis

and/or a risk to public safety. Finally, the participants in the Barsky and West (2007) study explained they felt unsupported when trust was absent in these relationships.

It is also important to note that participants did not make specific reference to the discipline of these other healthcare professionals, with the exception of nursing staff. The lack of reference to specific health professions is not unusual and is in keeping with the extant literature on forensic clients' recovery experiences. Since, the participants in this study did make several specific references to the impact their relationships with nurses and nursing staff, this particular relationship will be highlighted. Specifically, participants reported feeling that nurses, when supporting recovery, provided both emotional support and opportunities for learning and personal growth. However, participants also explained that nurses were not always supportive of recovery, and instead were perceived as being uncaring and a part of the inpatient forensic care environment that must be 'dealt with'. The ambiguous nature of the relationships described by participants with nurses in the current study is consistent with the extant literature which describes ambivalent relationships between healthcare professionals and clients in forensic settings. The ambivalent nature of the relationship between participants and nurses in the current study has not been previously identified in the literature on forensic clients' experiences of recovery. However, it is of specific relevance because nurses make up the majority of the healthcare professionals providing care to NCRMD clients in the Canadian FMHS (Livingston, 2006) and therefore has implications for nursing practice that will be discussed in the next chapter.

Participants in this study also identified that relationships with family members were supportive of recovery, either generally or in relation to specific aspects of recovery, such as symptom recognition. Olsson et al. (2014) also identifies the beneficial impact that family

relationships can have on forensic clients' experiences of recovery, suggesting that these relationships (along with all the supportive professional relationships described above) are important in supporting clients to navigate periods of transition through recovery. Moreover, as a study by Tapp, Warren, Fife-Schawb, Perkinsc, and Moore (2013) emphasizes, family relationships support forensic client recovery because they demonstrate to the person that someone cares about them.

In the current study relationships with peers were seen as beneficial to recovery because relationships with others who also had mental health issues and who had succeeded were identified as engendering hope and inspiring participants to move toward a successful recovery. Specifically, participants found benefit in sharing experiences with peers, learned from the experiences of their peers, and could seek support from them when needed. Mezey et al. (2010) also speaks to the value of peer relationships, emphasizing that for inpatient forensic clients, peer relationships are particularly important in supporting recovery because they foster feelings of belonging and acceptance. Mezey et al. further points out that these relationships are of particular benefit if clients feel they are otherwise without supportive relationships, particularly without either family or supportive others outside of the forensic care setting. Although, the literature addressing the inpatient forensic client experiences of recovery emphasizes the benefit from having good relationships with peers, relationships with friends are not specifically mentioned (Barsky & West, 2007; Mezey et al., 2010). However, as the findings from the current study reveals the distinction between peers and friends is not always clear, and friendship can be present in relationships with peers or non-peers; suggesting that good quality peer relationships may be beneficial because they are, in fact, based on friendship. Finally, as participants in this study describe, friends are helpful to recovery, especially if they have knowledge of the

participants' circumstance, and if they provide support and understanding that is distinct from the support one gets from family members. Further, relationships with friends also offer the opportunity to engage in reciprocal relationships.

Summary

Relationships were identified as important to the recovery experiences of NCRMD clients. Moreover, good relationships are an important protective aspect of mental health (MHCC, 2012), so it is not surprising that they figured prominently in this study, and in the extant literature on forensic client recovery. Study participants identified psychiatrists as pivotal to their recovery, since they have knowledge about mental illness and medication, and have the power to implement the conditions of ORB dispositions and influence the ORB hearings. In open supportive relationships this power seems to be perceived positively by participants, with psychiatrists being perceived as allies in managing illness effectively. At the same time however, psychiatrists' may also be perceived with apprehension and fear because they have the power to re-hospitalize NCRMD clients; which reinforces the complex nature of this relationship. Other healthcare professionals were also seen with similar ambivalence. Participants perceived relationships to be supportive when healthcare professionals are able to support NCRMD clients to recover by providing assistance and care, as well as fostering self-acceptance. However, when participants perceived that healthcare staff were treating individuals poorly, they were perceived as untrustworthy and consequently unsupportive. Moreover, this ambiguity was specifically identified by participants in this study in their relationships with nursing staff, who were perceived as being both supportive and unsupportive of recovery. Relationships with family members were generally perceived to be supportive of recovery, primarily because they made NCRMD client feel cared about, and were perceived to inspire hope and foster feelings of

belonging and support. Relationships with peers were also perceived to be supportive of recovery because of the shared experiences within the FMHS. Friends may or may not be peers, and are considered to be supportive of recovery; they provide support that is distinct from that received from family and allow for experiences of reciprocity.

The Importance of Helping Yourself

The ability to help oneself figured prominently in this study. Participants acknowledged that becoming involved in their own recoveries was necessary for making progress, and that this required accepting themselves and their circumstance. This type of self-acceptance is an important aspect of serious mental illness recovery (Schrank & Slade, 2007), and as the participants in the current study expressed, this notion figured prominently in their understanding of recovery. Similarly, clients with experience in maximum secure forensic settings felt that their successful progression to recovery was contingent on their making a decision to embrace and take responsibility for changing the manner of their circumstance (Olsson et al., 2014). However, the findings in the Mezey et al. (2010) study suggest that while feeling better about themselves is important to forensic clients in recovery, feelings of being accepted include not just feelings of self-acceptance but also feelings of being accepted family members, the victim of the index offense and others clients may have hurt. Further, Barnao et al. (2015) identify that feeling accepted by healthcare staff is important for forensic clients in their recoveries. Therefore, given the findings from this current study, and those from the extant literature, it seems reasonable to suggest that being in positive, accepting relationships with others may be support forensic clients to develop the level of self-acceptance identified by participants as being important to their recovery progress.

The participants in this study also identified engaging in a wide range of personally meaningful activities in support of their recovery progress. Specifically strategies identified in this current study included: meditation, yoga, mindfulness, getting adequate rest, listening to music, playing card games, fishing, and spending time alone. These types activities are thought to be beneficial to the recovery of forensic clients because they support emotional coping (Barnao et al., 2015). Being busy, and engaging in a wide variety of activities, was also identified by forensic clients as beneficial to their recoveries in the studies by Barsky and West (2007), Green et al. (2011), and Olsson et al. (2014).

Participants in this study further identified strategies, such as working towards and achieving personally meaningful goals, to support their recoveries. The most commonly identified goals related to educational and career achievements, but some participants also expressed wanting to have spousal relationships and children. However, the participants in this study also identified that their ability to accomplish these goals was made more difficult because of their involvement in the FMHS. It is of interest that the identification of scholastic, vocational, spousal and/or procreative goals does not figure prominently in the extant literature on the recovery experiences of forensic clients. One explanation for this inconsistency in findings is that because the majority of the existing studies focused on understanding recovery as it is experienced in secure inpatient settings, where many of the goals identified by participants in the current study may have been unrealistic. For example, the participants in the Mezey et al. (2010) study identified vocational, educational and spousal relationships as indicators of recovery, but did not endorse having these as goals in the context of their own recovery experiences.

It is also noteworthy that the participants in this current study identified having goals that they simultaneously perceived as inaccessible, or seemingly inaccessible, because of their

involvement in the FMHS. This discrepancy may be explained by the change in circumstances experienced by participants in this current study. Specifically, as these individuals have progressed through the FMHS from hospitalization to community residency, there may have been a mismatch between their goals and their present circumstance. As Spaniol, Wewiorski, Gagne, and Anthony (2002) found, recovery is a process that involves, amongst other things, adjusting ones goals to suit ones changing circumstance. However, given that the participants in this current study expressed goals that would have been even less attainable in their past circumstances (i.e. being detained in hospital in the FMHS), this explanation seems inadequate. A better explanation may be that forensic clients identified goals for themselves that seemed unattainable or unrealistic since they were far in the future. This understanding may be important, since imagining a better future life supports coping with the challenges of their present and constrained circumstance (Olsson et al., 2014).

Participants in this study further identified that helping themselves included participating in groups, specifically ones that were relevant to their personal recovery needs. The participants in the current study specifically identified cognitive behaviour therapy groups, groups about wellness, and groups that aimed to improve sleep habits as being beneficial, because they assisted participants in finding positive ways to address challenges in their individual recoveries. Skinner, Heasley, and Stennett (2014), in a study examining the impact of motivation groups on forensic clients' experiences of recovery, also identified that forensic clients found groups to be beneficial to their recovery. Specifically, the findings from the Skinner et al. study identified that forensic clients who participated in motivational groups felt able to develop a wide range of skills that supported recovery. Further, forensic clients detained in a secure setting identified that having access to psychological therapy classes was important for their recovery (Barsky & West,

2007). Selecting the groups and therapies thought to be of personal relevance has been found to be of particular importance to the recovery of forensic clients (Barnao et al., 2015). Moreover, these clients expressed dissatisfaction when they are told which groups or therapy programs they need to attend (Barnao et al., 2015). Finally, Tapp et al. (2013), in a study of forensic clients' perspectives about what treatments are effective in high secure settings, identified that forensic clients felt that participating in either one-on-one or group psychotherapy supported their recovery, by facilitating the development of both insight and problem-solving skills. Therefore, the extant literature supports the finding from this current study that attending personally relevant groups is beneficial to the recovery of NCRMD clients.

Being self-ware was also considered important for recovery in this current study. Participants reported that having an awareness of themselves, and particularly of their illness experience, kept them grounded in reality and enabled them to better address challenges and more effectively solve problems. The current literature addressing the recovery experiences of forensic clients does not specifically identify the impact of self-awareness on recovery. However, Olsson et al. (2014) identified that the development of insight, which they suggest is the precursor to awareness, allows forensic clients to assume some responsibility for their illness experience. Additionally, in the context of serious mental illness recovery, Noiseux and Ricard (2008) also identify the value of self-awareness. These authors describe that developing self-awareness is an important element of recovery because it supports the redeveloped of a sense of self, which is often lost following the onset of psychotic symptoms. Noiseux and Ricard also describe that being self-aware leads to self-knowledge, and that this in turn supports recovery by allowing individuals to understand how they respond to their illness (address challenges) and to determine how best to move forward (solve problems).

Finally, in this current study, knowing when to ask for help was identified as an effective way that participants could support themselves in their recoveries. Participants explained that it was important to know when they needed assistance, for example when experiencing changes in mood. Further, participants felt it was valuable to reach out to supportive healthcare professionals when they had concerns. Participants also described seeking help to address practical concerns related to educational achievements and housing. Barnao et al. (2015) also identified that participants in a forensic setting recognized the importance of asking for support and resources from healthcare staff in working to achieve their rehabilitative goals, thus confirming the current study findings pertaining to the importance of seeking help from others. Finally, although much of the literature addressing the recovery experiences of forensic clients identifies that the availability of support and assistance is beneficial to recovery (Barsky & West, 2007; Green et al., 2011; Mezey et al. 2010; Olsson et al., 2014), it does not specifically identify that clients actually do find benefit from knowing when to avail themselves of that support.

Summary

The findings from this study identify that NCRMD clients support themselves in their recoveries. Participants described being engaged in their recoveries, and identified the need to accept, and take responsibility for, themselves and their circumstance. Participants also helped themselves by engaging in personally relevant activities that support their recovery. Further, participants identified and were working to achieve meaningful goals, most commonly educational or vocational pursuits that are appropriate for their circumstance as community residing NCRMD clients. Participants also described having goals that may be inaccessible in their current circumstance, however having goals of this kind may support recovery because they inspire hope for a better circumstance. Additionally, participants described findings benefit from

having participated, or currently participating, in groups; specifically when the content of the group supports them in their recoveries, either by facilitating insight or developing relevant skills. Being self-ware is another way the participants in this current study helped themselves recover. Specifically, self-awareness helped these individuals develop self-knowledge and allowed them to better respond to their illness needs and move forward in recovery. Finally, NCRMD clients that participated in this study expressed knowing that to help themselves they must know when to ask for help from others, particularly when they had concerns about their mental illness experience or needed practical assistance, for example with housing.

Navigating Challenges

Many of the challenges that the participants in this study identified that pertain specifically to their involvement in the FHMS have already been discussed. However the participants described other challenges pertaining to their experiences of recovery, and these are also contextualized by their involvement in the FMHS. First, participants in this current study identified the need to attend to the residual symptoms of psychosis. To address this challenge they identified using medication, talking with their psychiatrists, and being hopeful, which reaffirms their perception that medication and psychiatrists are important for effectively managing their mental illness and supporting their recoveries. These participants also identified relapses as challenging to their recovery. Specifically, they identified not always knowing they were relapsing and feeling that relapses resulted in a loss of recovery progress. Notably, the use, or disuse, of medication was again identified as a contributing factor to incidences of relapse.

Reviewing the extant literature, it seems that the participants in this current study appropriately identified the importance of managing residual or persistent symptoms and addressing the occurrences of actual or potential relapses. Specifically, NCRMD clients residing

in the community that experience persistent symptoms have a lower quality of life and experience impairments in many areas of life (Livingston, 2012). Furthermore, the experience of psychotic symptoms or concerns of possible decompensation are some of the reasons that NCRMD clients are re-hospitalized (Viljoen et al., 2013).

Another challenge to recovery for the participants in the current study was the experience of stigma. In the forensic population, stigma is understood to be the unfair assessment of individuals as 'dangerous,' due to the as the presence of a serious mental illness and a history of being an offender which is described as a double stigma, specifically being 'mad' and 'bad' (Bettridge & Barbaree, 2008; Mezey et al., 2010; Quinn & Simpson, 2013). Moreover, being stigmatized negatively impacts the recovery experiences of forensic clients because "stigma plays an important role in how users of mental health services are viewed and therefore treated by the public" (Fitzgerald, 2010, p. 233). Therefore, it is not surprising that participants in the current study described being made to feel as though they were unsafe to be around. Further, these participants explained that being judged for having a mental illness and for having a history of harming others left them feeling socially isolated and depressed. Finally, to overcome these experiences the participants in this current study endeavoured to: ignore the negativity, be confident in being themselves, and spend time with people who do not pass judgment.

The experience of stigma described by the participants in the current study was also identified in the experiences of the participants in the Mezey et al. (2010) study. However, the participants in the Mezey et al. study did not identify ways of managing stigma. Instead, these participants described experiences of stigma on forensic clients' capacity to accomplish the goals of recovery, specifically those related to discharge and successful community reintegration (Mezey et al., 2010). Finally, being stigmatized leaves individuals living with schizophrenia

feeling dehumanized and therefore reluctant to initiate new relationships, which may explain why experiences with stigma described by the participants in the current study resulted in feelings of loneliness and sadness (Davidson & Stayner, 1997).

Participants in the current study also reported that their experiences of recovery were tempered by feelings of loss. Most commonly, participants identified that their involvement in the FMHS had resulted in missed opportunities, either related to career pursuits or the attainment of spousal and parental roles. Other feelings of loss included, in the context of relapse and re-hospitalization, losing progress in recovery, as well as losing housing.

The feelings of loss expressed by the participants in this current study were not evidenced in the extant literature on the forensic clients' experiences of recovery. However, feelings of loss are not uncommon in the mental health recovery literature. Wisdom, Bruce, Saedi, Weis, and Green (2008) describe that mental illness is often accompanied by feelings of a loss of self, and of lost opportunities, including the opportunity to be a parent. Spaniol et al. (2002) similarly found that the experience of living with mental illness often is accompanied by the loss of meaningful roles. Further, Davidson and Stayner (1997) found that the loss of important social relationships and sense of self is experienced in the context of living with schizophrenia. The findings from these studies identify the role of loss in mental health recovery, yet these experiences have not previously been highlighted in the other studies that consider the forensic client experience of recovery. Therefore, determining the role of loss in the experience of recovery of forensic clients seems worthy of further study.

Finally, participants in the current study identified feelings of fear and uncertainty as challenging their recovery progress. Most commonly these challenging emotional experiences focused on concerns about the on-going effectiveness of medication, and the consequent

concerns of symptom relapse and losing ones grasp on reality, which could ultimately lead to re-hospitalization, and/or in the short or long-term, a re-offence and returning to jail. Participants also expressed feeling that the potential of these negative occurrences was beyond their complete control. Other issues that inspired fear and uncertainty included the fear that using substances in the community would result in being involuntarily re-hospitalization, even in the absence of mental illness symptoms, and not knowing when and with whom to share one's illness diagnosis, which relates to concerns of being stigmatized (see above).

The existing literature that considers the recovery experiences of forensic clients does not identify feelings of fear and/or uncertainty that were described by the participants in this current study. However, forensic clients have expressed feeling fearful that they may never regain any independence or control over their lives (Barnao et al., 2015), and have experienced feelings of powerlessness in relation to that absence of control (Olsson et al., 2014). Importantly, these findings seem to explain the experience of fear and uncertainty endorsed by the participants in this current study. Finally, a study by O'Sullivan, Boulter, and Black (2013) that explored the experiences of forensic clients with co-morbid substance use issues that had been involuntarily readmitted to a secure inpatient unit after having been discharged, may provide addition insights into the fear and uncertainty experienced by the participants in this current study. Specifically, participants in the O'Sullivan et al. study reported feelings of "profound" powerlessness because they did not understand the exact reasons why they had been recalled to hospital for readmission; specifically, the relationship between substance use and risk of relapse (O'Sullivan et al., 2013, p. 406). Importantly, the experience of and reasons for the involuntary readmission of the participants in the O'Sullivan et al. (2013) study seems to validate the fear and uncertainty

experienced by participants in this study; specifically, that substance use while in the community may result in involuntary hospital readmission.

Summary

The findings of this current study identify that NCRMD clients experience challenges in their recovery experiences. Specifically, participants identified the need to manage any residual psychotic symptoms, and described experiencing relapse as a challenge to and a setback in their recovery progress. Medication and engaging with a psychiatrist are identified as a way to approach these challenges. The double stigma of being dangerous and mentally ill was also experienced as a challenge to recovery by participants in this study, because it leads to feelings of isolation and despair, and makes starting new relationships feel difficult. Feelings of loss, often of meaningful roles and opportunities, were also part of the challenge of recovery for NCRMD clients identified by participants in this study. Lost progress as a consequence of relapse was also perceived as a challenge to recovery. Finally, the feelings of fear and uncertainty that were experienced by the participants in this study were perceived as hindering to recovery progress. Most prominently, participants were concerned that their medications may stop working, and that consequently they may develop new or relapsing symptoms, experience a relapse, and/or be re-hospitalized or re-offend. Participants also worried about avoiding the use of prohibited substances, and/or that using substances may lead to re-hospitalization.

Descriptive Summary

In this final section of this chapter, the Spaniol and Wewiorski (2012) framework, the phases of the process of recovery from psychiatric disability, is used to succinctly describe the experiences of recovery identified by the participants in the current study. This framework, which was discussed in detail in Chapter Three, was selected to support the development of this

descriptive summary because, as the study's theoretical framework, it describes recovery from serious mental illness as a process of change that occurs as people develop and change over time, which compliments the overarching theme that arose from the data: 'Experiencing and understanding recovery in the forensic mental health system (FMHS) as a dynamic process of change.'

Introduction

The recovery experiences of the participants in this study were initiated by the onset of psychotic symptoms, and a consequence of these experiences, the commission of an offense, which was followed by a period of incarceration and then a stay in a secure inpatient hospital setting. As these participants progressed in their recoveries, they were permitted to reside in the community, with the understanding that they would remain under legal supervision and continue to work on their recovery.

Phase One: Overwhelmed

According to Spaniol and Wewiorski's (2012) framework, the period leading up to the commission of the index offense would have occurred during the phase of being '*overwhelmed'* by illness. According to the framework, this phase of the participants' recovery would have been characterized by an initial prodromal phase, which involves the onset of symptoms and a subsequent decline in functioning. The framework further explains that this would have been followed by a breakdown, a phase of illness that often results in a loss of control of thoughts, feelings and actions, which reflects the experiences described by the participants in this study when they recalled how they felt around the time they committed their index offenses. According to Spaniol and Wewiorski, the breakdown phase is also characterized by the feeling of being overwhelmed by the experiences of symptoms and consequently fear and confusion that can lead

to feelings of despair and hopelessness. This is often the time when people are forcibly hospitalized. However, for the participants in this study, given the experiences of being incarcerated that they describe, it is likely they continued to feel overwhelmed by their illness experience even while they were in jail.

The next phase of recovery described by Spaniol and Wewiorski (2012) in the context of being overwhelmed involves a period of stabilization. In this phase people begin taking medication and are given support. For the participants in this study, this phase seems to have begun when they arrived in hospital. During this part of their experience, as the framework describes, participants were given medication and support and they began to feel an increased sense of stability within themselves and in their illness experience, which they described as a return to reality. Furthermore, the participants in this study explicitly expressed the critical role that medication played in achieving a sense of stability. According to the framework, it is also during this phase that people typically struggle to adjust to needing medication and during this time often discontinue medication and relapse, frequently more than once. These experiences were also described by the participants in this study, who reported either having these difficulties or being concerned about the potential of these difficulties.

Spaniol and Wewiorski describe this stabilization phase of recovery as period of adjustment, in which people test themselves and their illness, and in so doing learn how to live in the context of having mental illness. Further, as was expressed by participants in the current study, it is through the process of learning that insight is developed and the process of accepting oneself begins. Moreover, as the framework explains, it is at this point that people are able to begin to understand themselves and their circumstance, which the participants in this study also endorsed as being important in their recoveries. Furthermore, as Spaniol and Wewiorski

describe, this is when it becomes possible for people to begin to move forward in their recovery. Notably, according to the framework, and as the participants in the current study identified, people do not usually make a conscious decision to move forward. Instead, as the framework endorses, there is a process of emotional resolution that occurs over time, the outcome of which is a sense of self-acceptance and self-understanding, a progression that also was apparent in the experiences of participants in this study. Interestingly, according to Spaniol and Wewiorski, people in this phase of their recovery often feel very vulnerable to relapse, which may explain why the participants in this study either had relapsed, expressed a fear that they might, and/or felt uncertain about their on-going stability.

The next phase of recovery is described by Spaniol and Wewiorski (2012) as moving beyond being overwhelmed. In this phase people begin to develop a more formal explanation for understanding themselves, one that includes some aspects of their illness experience. Furthermore, this explanatory framework becomes a tool that people can use to move forward in the recovery. This explanatory framework was evident in each of the interviews conducted in this study, as each participant described their experiences of recovery in the context of their own self-understanding. However, in this study, sharing the specifics of the participants' explanatory frameworks has not been possible because it was necessary instead to maintain the participants confidentiality.

The moving beyond being overwhelmed phase of recovery is further characterized by the recognition of the need to develop coping strategies for managing oneself in the context of mental illness, which the participants in the current study accomplished by engaging in personally relevant activities and attending groups that would support them in developing the skills necessary to tackle the challenges germane to their recoveries. As Spaniol and Wewiorski

explain, people in this phase of recovery also begin to understand and accept the need for medication, even if they continue to experience some residual symptoms. Accordingly, the participants in this study endorsed having had this experience, as evidenced by the certitude with which they explained the importance of medication in their recovery success. Interestingly, as the framework describes, in this phase of recovery people continue to struggle to believe that they are capable of managing their illness, may feel they are disabled by their illness, and consequently may feel that they are controlled by, not in control of, their circumstance. This may explain why the participants in this study expressed so strongly feelings of being in a situation that was beyond their control. For these participants, the feeling of being unable to assert control of their illness was markedly exacerbated by their involvement in the FMHS, making them keenly aware of how little they were actually able to alter their circumstance. Importantly, according to the framework, as people continue to recover, this sense of being debilitated by disability and constrained by circumstance lessens. Furthermore, this may explain why the community-residing participants in this study seemed less focused on the experiences of being contained with the FMHS and more focused on the work of recovery than the findings of extant literature on the recovery experiences of inpatient forensic clients.

Phase Two: Struggling

The next phase of recovery in the Spaniol and Wewiorski (2012) framework is the '*struggling'* phase. During this phase people continue to struggle with the disability of living with serious mental illness. However, they also struggle with feelings of prejudice and discrimination as a consequence of that disability. As the participants in the current poignantly described, this is often experienced as stigma, which in the context of the double stigma of being mad and bad, presented as a distinct struggle for them. Interestingly, according to the framework,

this phase of recovery is also characterized by feelings of loneliness and hopelessness, an experience that may be exacerbated by feelings of being stigmatized (Davidson & Stayner, 1997). As the framework further describes, in this phase of recovery overcoming these negative experiences involves receiving further treatment and rehabilitative support, and specifically involves developing in one of more of the following areas: "emotional, social, vocational, physical, cognitive, and spiritual" (p. 7). For participants in this study, examples of their engagement in this phase of recovery include: accepting support from their psychiatrists and other healthcare professionals; engaging in positive, supportive relationships with family, friends and peers; managing stigma; working for educational or career goals; managing residual symptoms; and managing substance use issues. However, although not captured within the Spaniol and Wewiorski framework, it is worth noting that for the participants in this study their experiences in this phase of recovery was distinctly influenced by their involvement in the FMHS, because as forensic clients they reported always considering how their personal development and recovery progress (or lack thereof) would be interpreted by their psychiatrists and treatment teams, and ultimately, by the ORB.

Another aspect of this phase of recovery described by Spaniol and Wewiorski (2012) involves the recognition that recovery requires medication and help from others. The participants in the current study identified their engagement in this phase of recovery by endorsing the critical role of medication in their current and future recovery successes, and by expressing that helping themselves in recovery involves knowing when to ask for help from others. Moreover, the framework highlights the importance of medication in recovery and further validates the idea that the participants in this study are not alone in finding that recovery and medication are inextricably bound. Finally, according to the framework, being engaged in this phase of recovery

is further evidence that people have accepted themselves and their circumstance. Moreover, as their understanding of themselves increases it becomes incorporated into the ways in which they explain their situation and further supports them moving forward in recovery. This aspect of the Spaniol and Wewiorski framework may explain why the participants in this study choose to participate in this study: they had progressed to the point in their recovery where they felt able to share their experiences of recovery because they had accepted themselves and their circumstances and felt that they were moving forward successfully.

The next phase of recovery is described as 'moving back into life', and involves overcoming the fear and uncertainty of that has characterized the preceding phases of recovery. Specifically, the framework describes that people must develop confidence in their ability to manage their illness experiences, and the consequent circumstances of their lives. Some of the strategies identified that support people in this phase of recovery include: taking medication as prescribed; self-monitoring for a relapse in symptoms; managing residual symptoms and side-effects, and changing medications if necessary; participating in meaningful activity; engaging with personal relationships, including peer supports as well as relationships with healthcare professionals; and developing new and using existing coping skills. According to the framework, it is these activities that will inevitably lead to the confidence needed to overcome prejudice and discrimination. Moreover, until this confidence is developed, people will continue to struggle to face challenges, concerned that they will compromise the tenuous stability that has characterized their recovery thus far. This phase of recovery describes many of the experiences expressed by the participants in this study, and therefore appears to be the phase of recovery that they are in at present. Specifically, the participants expressed living with fear and uncertainty, while simultaneously making many efforts to engage in the activities that will afford them the

confidence to overcome these fears. Further, Spaniol and Wewiorski (2012) identify that in this phase of recovery people begin to develop meaningful roles and accept responsibility for themselves and their illness. Notably, these are things that the participants in this study seemed to be working towards in their current recovery, which further affirms that this is the phase that best describes where they are currently in their recovery process.

Phase Three: Living With

The next phase of recovery, the '*living with'* phase, is characterized by the presence of the confidence and skill required to successfully manage one's illness and circumstance. There many continue to be some illness-related disability, but people generally have a strong enough sense of self to feel as though they are in control of their circumstance, and not vice versa. This is clearly the phase of recovery that the participants in the current study expressed striving for. Regardless of their individual appraisal of the value of attaining an absolute discharge, the participants expressed a desire to recovery to a point where they felt a sense of control over their lives had been returned to them. Interestingly, for some this would require attaining an absolute discharge, while for others this may not be either necessary or important in order for them to feel as though their lives were their own.

Phase Four: Living Beyond

The fourth and final phase of recovery described by Spaniol and Wewiorski (2012), '*living beyond'*, occurs when the experience of mental illness has faded into the background of one's life. The illness remains present and requires attending to, but it is much less impactful on peoples' sense of themselves and does not negatively affect their daily lives. People are able to focus on their present and future without feeling either overwhelmed or dominated by the need to manage their illness, and with the stability that they have obtained no longer feeling precarious.

Interestingly, this phase of recovery seems to be the kind of recovery identified by Olsson et al. (2014) that captures what forensic clients imagine and hope for when the challenges of their present and constrained circumstance seems overwhelming.

Summary

The phases of the recovery process from psychiatric disabilities framework provides a useful way of understanding the illness and recovery experiences of the participants in this study. The first phase, 'overwhelmed,' provides insights into how these clients came to be in the FMHS, as well as how they progressed in their recoveries while in hospital. The second phase of recovery, 'struggling,' is useful for developing a better understanding of how the participants in this study manage themselves, their illness and their circumstance in the community. The third phase of recovery, 'living with,' describes the recovery the participants in this study are striving for but have not yet reached. The fourth phase, 'living beyond,' describes a recovery experience in which mental illness is no longer dominating one's life, and may represent what the participants in the current study are hoping for.

Notably, one glaring limitation of this framework is its inability to directly capture the uniqueness of the experience of recovery in the FMHS. For example, the framework does not easily accommodate the experiences of being incarcerated that the participants in this study endorsed, nor does it the readily explain the importance or nature of relationships in the recovery as described by the study participants. Therefore, it seems reasonable to suggest that a modification to this framework could more accurately describe and explain what is unique about recovering in forensic care settings. Accordingly, although the data collected in this study is insufficient for any attempt at revising this framework, I propose that this would a useful aim for future research.

Conclusion

The discussion presented in this chapter describes how NCRMD clients experience and understand recovery. The findings from this study were discussed in the context of what is currently known about forensic client recovery, as well as in the context of the literature on serious mental illness recovery, as appropriate. The phases of the process of recovery from psychiatric disabilities framework was used to provide a descriptive summary of the findings. The implications of the study findings will be discussed in the next and final chapter.

CHAPTER VII: IMPLICATIONS AND CONCLUSION

THE 'SO WHAT?' OF THE STUDY

Introduction

The findings from this study describe the recovery experiences of not criminally responsible on account of a mental disorder (NCRMD) clients who are presently residing in the community. Most significantly, the findings identify that these individuals' experiences of recovery are distinctly influenced by their involvement in the Canadian forensic mental health system (FMHS), but also follow a trajectory of personal growth and change that is very similar to those of persons with serious mental illness who are not involved in a forensic care system.

Implications for Clinical Practice and Education

Previous studies have focused on exploring the experiences of individuals who have been detained within an inpatient forensic care setting. These prior studies have identified and described the distinct influence of involuntary detainment on clients' understanding and experience of recovery (Barnao et al., 2015; Barsky & West, 2007; Green et al., 2011; Mezey et al., 2010; Olsson et al., 2014). In order to extend what is already known about recovery within forensic inpatient settings, the current study focused on describing the experience of recovery for NCRMD clients who are currently residing in the community, following discharge from forensic inpatient hospital settings. In particular, the participants in this study found that medication, supportive relationships, and helping oneself were perceived as being critically important for recovery success. Furthermore, the possibility of experiencing a relapse of symptoms and/or re-hospitalization was perceived as threatening to recovery, and within the context of recovering in the community, the experiences of stigma were seen to be of increased relevance. These findings

are significant because they identify that while the recovery experiences of community-residing forensic clients continued to be influenced by their involvement in the forensic system, there was less emphasis on the feelings of being detained within the system and an increased focus on accomplishing the work needed for further recovery while maintaining current recovery progress.

The findings of the current study suggest that clinicians working with NCRMD clients would benefit from receiving educational training that specifically: describes the recovery experiences of these clients; identifies the various stages of their recoveries; and further, that provides information about how to best support these individuals as they progress through those various stages. Specifically, the provision of this kind of focused education would assist clinicians in fulfilling the primary goal of the FMHS, which is to rehabilitate clients and facilitate their successful reintegration into the community (Bettridge & Barbaree, 2008). Moreover, recovery oriented education could meet the learning needs of clinicians working with forensic clients. As Rose, Peter, Gallop, Angus and Liaschenko (2011) found in a study exploring respect in nurse-client relationships in secure inpatient settings the Canadian FMHS: while nurses valued supporting clients in attaining their recovery goals, one of the challenges to providing effective client care was the lack of specialized training and on-going education.

Further, the findings generated from the current study indicate the significance of relationships with healthcare professionals to recovery for NCRMD clients residing in the community. Particularly, the participants identified the important role of psychiatrists in their experiences of recovery. As such, participants recognized a variety of specific underlying reasons that contributed to this influential role; namely, the power of psychiatrists within the context of the FMHS, and their expert knowledge concerning medication and mental illness. The

perception that psychiatrists have a distinct influence on the recovery experiences of clients receiving care in forensic settings was similarly identified in the extant literature. The participants in this current study further expressed feeling supported in their recovery when their psychiatrists took the time to explain to them the benefits of medication and assisted them in developing insight into their illness experience and circumstance.

Thus, clinicians working with NCRMD clients in the community, recognizing the actual or potential significance of these relationships, may wish to consider promoting recovery by encouraging the development of strong therapeutic relationships between individual clients and their psychiatrists. Nevertheless, the knowledge and skills needed to provide this kind of support are not exclusive to psychiatrists: all clinicians can promote recovery by using the knowledge and skills specific to their discipline and scope of practice to support NCRMD clients in developing an understanding of themselves, their circumstance, and the role of medication in recovery. Moreover, in the current study, participants identified the importance of their relationships with healthcare providers to their recovery, particularly in those relationships where they felt able to learn and grow.

Participants in the current study also indicated that the capacity to be open with their psychiatrists about their mental illness experience was particularly important for their recovery success. Accordingly, clinicians may be able to support the recovery of NCRMD clients by developing therapeutic relationships in which individuals feel safely able to share their illness experience. Affirming the importance of establishing meaningful therapeutic relationships with NCRMD clients, the participants in the current study expressed that their recoveries benefitted when they felt supported by and were able to seek support from their healthcare providers.

Moreover, the participants described feeling unsupported in their recoveries when they felt uncomfortable in their relationships with healthcare providers.

Finally, the findings from this study indicate that NCRMD clients are aware of, and felt negatively effected by, the power imbalance that exists between themselves and their healthcare providers, and in particular in their relationships with their psychiatrists. Therefore, clinicians working with NCRMD clients need to be aware of this power imbalance and make every effort to use this power to positively influence the recovery of individuals within their care. Specifically, clinicians can use their power in "a caring manner" to support clients in meeting their recovery needs (College of Nurses of Ontario, 2013, p. 4).

In summary, clinicians caring for NCRMD clients would benefit from receiving education that specifically enhances their understanding of how these clients experience recovery; and provides guidance about how healthcare providers can best support NCRMD clients in their recoveries. Additionally, clinicians may be able to promote recovery by supporting NCRMD clients to develop a better understanding of themselves, their mental illness experience, and their FMHS involvement. Further, study findings reinforce for clinicians the importance of establishing and maintaining meaningful, trusting therapeutic relationships with NCRMD clients recovering in the FMHS. Finally, consideration needs to be given to addressing the power inequity that exists between clinicians and clients in the FMHS; and in particular, how to use that power to support these individuals in accomplishing the work of recovery.

Implications for Nursing Practice and Education

The majority of clinicians working in the Canadian FMHS are nurses (Livingston, 2006), and as such nurses are in a position to have a significant impact on the recovery of NCRMD clients. However, the findings from the current study suggest that NCRMD clients have

ambivalent feelings about their relationships with nurses; at times describing them as caring and supportive of recovery, and at other times, identifying them as being without care and unsupportive of recovery. Therefore, it is important that nurses develop an awareness of the complexity of the therapeutic relationships they develop with NCRMD clients. Moreover, to effectively support recovery, nurses must apply their knowledge and skills to establish and maintain high quality therapeutic relationships with NCRMD clients.

However, the ability of Canadian nurses to maximally utilize their skills in the context of caring for NCRMD clients is hindered by the lack of educational opportunities provided to them in their nursing education that are specific to forensic mental health (Devnick, 2010; Pullan & Lorbergs, 2001); and consequently, many nurses are not adequately prepared to confidently assume roles in forensic care environments (Thorpe, Moorhouse & Antonello, 2009). Furthermore, the extant literature suggests that most nurses employed in forensic mental health settings learn the specifics of this specialized practice while working; specifically, from one another, and from other clinicians (Kent-Wilkinson, 2011; Scales, Mitchell & Smith, 1993). However, one of the challenges facing nurses working in secure inpatient forensic care settings in Canada is a lack of adequate in-service education and on-going training (Rose et al., 2011).

In summary, the findings from the current study indicate that supporting the recovery of NCRMD clients requires that nurses develop strong, caring relationships with these clients. Moreover, the extant literature clearly demonstrates that nurses in Canada: lack the preparatory education necessary to provide care to clients in the FMHS; must learn the required skills on the job; and yet, even in this context, continue to express feeling that they would benefit from further education. Therefore, enhancing the capacity of nurses working in the FMHS to support the recovery of NCRMD clients requires providing nurses with greater access to relevant learning

opportunities, either in undergraduate nursing programs or via on-going, institution-based, in-service education sessions. However, as the discussion below reveals, there is a limited amount of empirical and theoretical knowledge that could support the development of these types of educational programs. Consequently, I suggest that further research and theory development are imperative to improving the quality of education that could be provided to nurses and other clinicians in the FMHS; and moreover, that this is necessary if nurses are to effectively support NCRMD client recovery. Finally, in the context of the findings from the current study, research efforts that aim to develop a better understanding of the nurse-client relationship in community-based forensic care settings are of particular importance, because it is through the establishment and maintenance of high quality therapeutic relationships that nurses can effectively support NCRMD client recovery.

Implications for Future Research and Theory

The findings from this study suggest many opportunities for future research. Specifically, because the research that explores the NCRMD clients' understandings and experiences of recovery is limited to the findings from this study, and the germane international research is scant, it is important to continue to study forensic clients' experiences of recovery. For example, given the preliminary nature of this research study, it would be beneficial to conduct a much larger study exploring NCRMD clients' understandings and experiences of recovery, which could assess the truth-value and applicability of the findings from this current study. Moreover, the current study considered the perspectives of NCRMD clients residing in the community, in an urban centre in Ontario, and included both men and women in the sample. Therefore, it would useful to have a better understanding of how NCRMD clients' experiences of recovery vary according to: gender, the location of care (e.g. across provinces; urban vs. rural), and the level of

security or legal supervision within the FMHS. A larger study of this breadth would also contribute valuable knowledge that could be used to develop a theoretical framework or model that would represent the recovery experiences of forensic clients, as such a model does not presently exist. Furthermore, developing a framework or model to explain how forensic clients understand and experience recovery would be useful to support the development of educational training programs; identified above as important to enhancing the practice of clinicians working in forensic care settings.

Additionally, given the significant influence of the FMHS on the recovery experiences of NCRMD clients identified by the participants in the current study, it would be useful to further study how the forensic mental health care delivery system impacts specifically upon the experiences of recovery. For example, at present there is no literature that directly considers the role of the ORB and/or the attainment an absolute discharge on NCRMD clients' experiences of recovery. This gap in the literature is remarkable, especially given that in the current study participants identified the significant impact of these occurrences. Specifically, ORB dispositions were experienced as a prescriptive, but seemingly positive, influence on recovery, and thus need to be better understood in future research studies.

Describing the relationship between recovery and security is another area of research that could provide further insight regarding the recovery experiences of NCRMD clients. The extant literature suggests that there is an inverse relationship between recovery and security; identifying that recovery was perceived to be more accessible in medium secure settings, as compared to high secure settings, because of the reduced emphasis on security (Barsky & West, 2007). This finding, although specific to changes in security between inpatient settings, may aid in explaining why, for the community-residing participants in this current study, feelings of being

detained within the FMHS were less prominent. However, further research is required to better understand the nature of this relationship and its influence on the recovery experiences of NCRMD clients.

The findings from the current study also identify a connection between the critical role medication plays in recovery and the fear of relapse and subsequent re-hospitalization. However, the extant literature, perhaps because of the focus on inpatient recovery experiences, does not identify such a connection. Therefore, further research would allow for a better understanding of why and in which circumstances the use of medication and concerns about possible relapse are linked, as well as how this perceived link impacts experiences in NCRMD client recovery.

Additionally, given the prominent role of relationships in the recovery of forensic clients, both in this study and the extant literature, it would be useful to conduct targeted research to enhance the specificity of what is currently known about therapeutic relationships in the FMHS. Moreover, as discussed above, this was specifically identified as necessary for enhancing the quality of nurse-client relationships in the FMHS. For example, in what way do forensic clients perceive their needs changing over the course of their recoveries, and how may these changes impact their relationships with healthcare providers? This more detailed perspective of relationships would support clinicians to make the best use of the therapeutic relationship to support clients in their recoveries.

The findings from this current study also identified the importance of friendship in the recovery experiences of NCRMD clients residing in the community. This focus on friendship has not been previously identified in the literature. Therefore, it would be important to conduct a study to further explore the role of friendship in the recoveries of NCRMD clients. Moreover, because the value of peer relationships, as opposed to friendships, has been previously identified

(Barsky & West, 2007; Mezey et al., 2010; Spaniol & Wewiorski, 2012), it would be informative to determine if and in what way friendships and peer relationships are distinct.

Self-acceptance is another important aspect of serious mental illness recovery (Schrank & Slade, 2007) that also figured prominently in the findings from the current study. However, the existing literature suggests that self-acceptance is only one aspect of acceptance that impacts forensic clients' experiences of recovery, as being accepted by healthcare providers and "the outside world" is also important to forensic clients in recovery (Barnao et al., 2015; Mezey et al., 2010, p. 688). Therefore, further research into the role of self-acceptance, and acceptance more broadly, could provide more specific information about the influence of these concepts on the recovery of forensic clients, and may provide additional information that would inform clinicians about how to promote the development of self-acceptance. Moreover, the findings from this study, in combination with findings from the extant literature, suggest that in the recovery experiences of forensic clients there are conceptual links between: insight, self-awareness, accepting responsibility for ones illness and circumstance (self-acceptance), self-knowledge, and redeveloping a lost sense of self. However, the nature of the relationships between these concepts, and how together they work together to support recovery in the forensic population requires further study.

Finally, the findings from this study indicate that NCRMD clients living in the community are presented with a number of social, emotional, and/or illness-related challenges that negatively influence and/or threaten the stability of their recovery process. As the findings from this study indicate, NCRMD clients experience these challenges in ways that are distinct from the experiences of individuals who are addressing similar challenges and receiving mental health care, but not within the FMHS; further emphasizing the impact of the FMHS in recovery.

Moreover, while the extant literature confirms that these challenges are relevant in the recovery of forensic clients, there is presently no literature that considers how these clients can support themselves, or be supported, in overcoming these unique challenges. Therefore, conducting a study to identify specific challenges unique to the FMHS, as well as appropriate solutions for overcoming these challenges, would be useful in supporting improved recovery outcomes for NCRMD clients.

In summary, further research would enhance our understanding of forensic clients' experiences of recovery across many dimensions and facets of care. Conducting this research would not only enhance what is currently known about the recovery experiences of forensic clients, it would also provide useful knowledge to guide the development of a theoretical framework or model of forensic recovery, which would support recovery education programs for clinicians and would ultimately contribute to enhanced care and outcomes for clients receiving care in the Canadian FMHS.

Conclusion

The purpose of this study was to develop an increased understanding of the recovery experiences of NCRMD clients. It is evident from the findings of this preliminary study that recovery for these individuals is experienced as a dynamic process of change that is both similar to that of non-forensic clients recovering from serious mental illness, yet also distinctly influenced by their involvement in the FMHS. Furthermore, it is evident that the role of medication, relationships, and helping oneself are perceived as crucial for making progress and attaining stability in recovery, while fears of relapse, re-hospitalization and experiences with stigma inversely threaten that progress and stability. Finally, implications for clinical practice, future research and theory have been discussed.

Appendix A: Recruitment Flyer

[study institution logo]

RYERSON UNIVERSITY

An Experience of Recovery

Are you currently living in the community with a legal designation of Not-Criminally-Responsible (NCR)?

Have you previously lived in hospital on a maximum or medium secure unit?

Are you interested in talking about your recovery experiences?

If so, you may be eligible to take part in this study, which will explore **the recovery experiences of NCR clients.**

This study involves:

- **2 preliminary telephone calls: a 15 minute call to discuss participation & a 5 minute call to schedule an interview time**
- **1 in-person interview of 50-80 minutes to talk about recovery**
- **1 follow-up telephone call of 30-45 minutes to review the interview information**

This study seeks 5-10 voluntary participants, and will consider people for inclusion based on the order in which they contact the researcher.

A financial incentive will be provided.

If you have any questions about this study or are interested in participating, please contact:

Irene Boldt [contact information here]

This study is being conducted for a graduate student thesis. Ryerson REB#: 2014-308

A Story of Recovery Contact: Irene Boldt

Appendix B: Telephone Script for Initial Conversation

15 minutes

Opening: (2 minutes)

- Thank you for expressing an interest in participating in this study.
    - If the interested individual is immediately identified as known to the researcher, it will explain to this individual that their prior professional relationship means that the individual cannot participate in the study:
        - Hi X, thank you for contacting me to express you interest in participating in this study. Unfortunately, because we have worked together in the past, it will not be possible for you to be a participant in the study. The reason for this is because I decided when I designed this study that it would be inappropriate for me to engage as a researcher with people I've worked with as a nurse. That said, I'm really happy to hear that you would be willing to speak about your recovery. I hope you are doing really well.
        - Thank you for expressing your interest in this study, but as I said, it will not be possible for you to be a participant.
        - All the best to you moving forward. Take care of yourself.
        - Thanks again. Good-bye.
- Is this a good time for us to speak about the possibility of you participating in this study?
- Great. If you change you mind and want to stop speaking with me that is not a problem. Talking to me is always your choice, and you can stop anytime.
- Are you in a location that affords you some privacy?
    - If not: Would you like to call me back when you are in such a place? We can arrange time to speak together when you can be in more private location.
    - If yes: I'd like to take a little time to briefly explain the study to you, confirm that you are an eligible participant, and explain the consent process to you.
    - Is that okay for you?
    - Before we proceed, do you have any questions for me at this point?

A brief overview of the study: (3 minutes)

- Okay, let me briefly explain the study:
- My name is Irene Boldt, and I am a Ryerson University graduate student. I am conducting this study as part of my Master of Nursing degree requirements.
- The purpose of the study is interview people who have been found not criminally responsible (NCR) about their experiences of recovery, and to collect information that can be used to describe those recovery experiences.
- The goal of this study is to provide insights into the ways persons who have been found NCR experience recovery. And hopefully, those who read the results of the study will have the opportunity to enhance their current knowledge of the experiences of people who are NCR.
- I will interview five to ten participants in the study for 50-80 minutes, and all the questions will focus on the participants' recovery experiences.
- After the interview I will use the data I collected to write a summary of the data describes that participants' experiences of recovery. To ensure this summary is accurate, and does

not contain anything that the participant thinks might make him or her identifiable to others, I will talk to the participant on the telephone to review the interview transcript with him or her. This conversation, which will occur 1-2 weeks after the interview, will take 30 to 45 minutes.

- In the final stage of the study I will combine the data from all of the participants' interview transcripts and compose a summary of the interview data that describes the experiences of recovery of people who have been found NCR.
- Only this descriptive summary will be published.
- Do you have any questions about the study?
- Does participating in this study, and having the opportunity to talk about your recovery experiences, still sound interesting to you?
    - If yes: inclusion and exclusion criteria will be reviewed next.
    - If no: Thank you for taking the time to speak with me. All the best to you. Good-bye.

Confirming inclusion/exclusion criteria with potential participant: (3-4 minutes)

- Since you are still interested in participating, I think we should confirm that you would be a suitable participant.
- To do this, I need to ask you some questions. Is that okay?
    - Do you have a legal status of NCR?
    - Do you currently reside in the community?
    - Have you lived in an Ontario hospital on a Maximum or Medium secure unit?
    - Are you comfortable communicating in English?
    - Are you interested in speaking with me about your recovery experiences?
    - Are you willing to be interviewed?
    - Are you okay that, for the purposes of the study, the interview will be audio-recorded?
    - And finally, I do not remember working with you before, but I want to confirm this with you: Have we worked together as patient and nurse?
- If criteria are met: You meet all the eligibility criteria. Are you still interested in participating in this study?
    - If yes: Before we move on, do you have any questions for me at this point?
    - If not: Thank you sincerely for expressing an interest in participating, and for taking the time to speak with me. All the best to you. Good-bye.
- If criteria are not met: Unfortunately, you are not able to be a participant in this study because (provide specific reason). That said, I would like to thank you sincerely for expressing an interest in participating. Thank you for taking the time to speak with me. All the best to you. Good-bye.

An explanation of the consent process: (3-4 minutes)

- Because you are interested in participating in this study, the next step is for you to read the Consent Agreement, which I will mail or email to you if you are still interested in participating when we're done talking today
- The Consent Agreement explains everything about the study, including what is involved should you choose to participate, the risks involved with participation, the strategies in place to minimize these risks, the benefits, and the voluntary nature of participation.

- Before you decide to participate, it is important that you read the information contained in research Consent Agreement. You should take as much time as you need to decide whether or not to participate and know that your participation is voluntary. You might also want to talk about the study with a friend, a family member, a member of your treatment team, or anyone else you trust.
- You can also contact me if you have any questions or want more information about the study. My contact information is on the Consent Agreement.
- If you decide to participate, you can contact me to schedule a time for the interview. The interview will take place at [name of study institution], in a private room that I'll book for us, and we can sign the Consent Agreement together before the interview starts.

Conclusion: (3 minutes)

- I have finished explaining the consent process. Do you have any questions?
- Would you like to receive a copy of the Consent Agreement? Saying yes does not mean that you are agreeing to participate, but the Agreement will provide you with more information to support you in deciding if you want to participate.
    - If yes:
        - Would you like me to mail in to you (in a plain white envelope with no return address) or send it to you by email?
        - Please give me you email/street address. Thank you. I will destroy/delete this information, and all other personal information I've acquired about you up to this point, as soon as I've sent you the Agreement.
        - Thank you sincerely for expressing an interest in participating, and for taking the time to speak with me today. If you have any questions or want more information about the study please don't hesitate to contact me. And, if you decide to participate, please contact me to schedule a time for the interview.
        - Thank you again for taking the time to speak with me today. I will mail/email the Consent Agreement to you now.
        - Good-bye.
    - If no: Thank you sincerely for expressing an interest in participating, and for taking the time to speak with me. All the best to you. Good-bye.

Appendix C: Consent Agreement

Consent Agreement to Participate in a Research Study
AN EXPERIENCE OF RECOVERY

Name of Study: Describing the Recovery Experiences of Not-Criminally-Responsible Clients

Principal Investigator: [name of principal investigator]
[name of study institution]

Graduate Researcher: Irene Boldt, RN, Master of Nursing Student
Daphne Cockwell School of Nursing, Ryerson University

Thesis Supervisor: Elizabeth McCay, RN, PhD, Research Chair in Urban Health
Daphne Cockwell School of Nursing, Ryerson University

Introduction:
You are being invited to take part in a research study because you expressed an interest in participating. Participation in the study is voluntary, and whether you choose to participate or not, the care you receive at the [name of study institution] will remain the same. [name of principal investigator at study institution] at [name of study institution], is leading the study. Irene Boldt, a Ryerson University graduate student, is the researcher in this study and her involvement is as part of a Master of Nursing degree requirement. Dr. McCay, the Chair of Urban Health Research at Ryerson University, is supervising Irene is this process academically. Before agreeing to participate it is important that you read the information contained in this research consent agreement. It includes the details you need to know in order to decide if you wish to take part in the study. You should not sign below until you are sure you understand all the information contained in this agreement. You should take as much time as you need to make your decision, and may wish to talk about the study with a friend, a family member, a member of your treatment team, or anyone else you trust. You may also contact the researcher if you have questions, are seeking clarification, or would like additional information about the study. This study is seeking four participants receiving care from [name of study institution]. Potential participants will be considered for inclusion based on the order in which they contact the researcher.

Purpose of the Study:
The purpose of this study is to collect information that can be used to describe the recovery experiences of people who have the legal designation of not-criminally-responsible (NCR) as a result of a mental disorder.

Eligibility:
You are eligible to participate in this study if you have an NCR designation, are living in [city], and if you have lived on a maximum or medium secure unit in the past. You must be able to speak and understand English, and be willing to talk with the researcher about your experiences of recovery during an audiotaped interview.

Description of the Study and Procedures:
This study will take place in two parts.

Part One: Semi-structured Interview

- If you choose to participate in this study you will be invited to talk with the researcher about your recovery experiences. During this conversation you will be ask to talk about:
    - What recovery means to you;
    - When and how you started your recovery;
    - What you are currently doing to support your recovery, and;
    - What you expect in your future recovery.
- This one-time conversation will take place in a private room at [name of study institution].
- The conversation will take 50 – 80 minutes, it will be recorded on audiotape, and the researcher will take hand-written notes. To protect your identity, you will be asked to select a pseudonym for use during the interview.

Part Two: Reviewing your Interview Transcripts

- After the interview is over the researcher alone will listen to the audiotape, and make a written digital copy (a transcription) of everything that was said. To protect your anonymity and your privacy during this process the researcher will remove any personal details from your interview transcription. This will take 1 – 2 weeks.
- The researcher will then contact you by telephone to review the transcribed interview data with you. This conversation will take 30 – 45 minutes, and your participation is voluntary.
- The purpose of this conversation is to give you the chance to make sure your interview data is accurate and does not include any details that could be used to identify you. To accomplish this you will talk with the researcher about the contents of your transcribed interview data, and you will be able to remove, add, or change anything contained in the data.
- To further protect your anonymity and your privacy, your interview transcription will not be included in the study findings or published publicly.

Benefits of the Study:
You may not receive any benefits from participating in this study.

Risks Related to Participating in the Study and Strategies in Place to Minimize these Risks:
The most significant risk associated with participation in this study is that it is not possible to guarantee your confidentiality. Therefore, although it is unlikely, it is possible that your participation in this study might become known by a person or people not involved in the study.

There are 2 strategies being used in this study to reduce the chance that you will be identified as a participant.

1. The first strategy involves giving you the knowledge you need to protect yourself. The purpose of this is to support you in making informed decisions about whether to participate in this study, and if you choose to participate, what you share during the study and whether or not you want to share with others that you are participating.

a. All the questions asked in this study will be about your experiences of recovery, and in answering these questions you can say or not say whatever you choose. However, it is important that you know that if you tell the researcher about **a) current urges to harm yourself or someone else, b) a situation that will result in imminent harm to yourself or someone else, or c) any abuse or harm, past or present, actual or suspected, of a person under sixteen years of age,** the researcher will be legally obligated to report this information to people not involved in the study.
b. You may want to tell someone, for example a healthcare provider or your lawyer, that you participated in this study. However, before you tell anyone, you should think about what might happen if that person shares that information with anyone else. For example, if a healthcare provider includes in your health record that you participated in this study, everyone who reads your record will know you were a participant.

2. The second strategy used in this study to protect your confidentiality is the design of the study. Please refer to the Confidentiality section of this agreement, below, for a more detailed discussion of how the study design aims to protect your confidentiality.

If you are identified as a participant in this study, for example by healthcare providers, lawyers, members of the Ontario Review Board (ORB), and/or members of your peer group, it is possible that you may feel or be treated differently, or feel or be judged negatively for participating. It is also possible that if members of the media become aware of your participation, an account of your index offense and NCR finding may be shared publically. You might fear if people know you've participate in this study that this will negatively impact the contents of your disposition order, change when you might get an absolute discharge, or alter the quality of the care you receive. These should not occur; but if you think any one of them has, you can contact one of the Research Ethics Boards (REBs) that approved this study to express you concerns and attain their support. Their contact information is contained at the end of this Consent Agreement.

Other risks associated with participation in this study include any negative feelings you might have about the following:

- You may not like that this Consent Agreement and the consent process is lengthy;
- You may find it hard to decide whether to participate in a research study in which your confidentiality cannot be guaranteed;
- You might worry about that the interview will focus too much on negative experiences you've had during your recovery;
- When sharing your experiences of recovery you might remember things that make you feel upset or uncomfortable;
- When reviewing your interview transcription you might find it hard to ask the researcher to delete something that you feel is a risk to your confidentiality;
- Alternatively, you might decline to review the transcription of your interview and then worry that it contains details that could be used to identify you;
- You might worry about being identified as participant in this study even long after the study is completed.

The strategies in place to minimize the negative feelings you might have are as follows:

- The researcher will briefly explain the study and the contents of the Consent Agreement with you, and you are encouraged to ask the researcher any questions you have;
- The researcher will discuss with you the voluntary nature of participation, and has identified the risks associated with participation. It is important that you recognize that these risks should be taken seriously when deciding whether to participate, and that this decision is entirely yours;
- The researcher will discuss with you the purpose of the interview, and identify it is an opportunity to discuss any experiences, positive or negative, that are relevant to your recovery;
- The researcher will pay attention for signs of that you are upset and check in with you about how you are feeling, if you appear distressed. If at any time you want or need support from a trusted family member, friend, or healthcare provider, the researcher will assist you to connect with that supportive person;
- When reviewing your interview data with you, the researcher will ask you specifically if you have concerns about your confidentiality given the contents of the transcription, and will make any changes that you request;
- If you decline to review the transcriptions of your interview with the researcher, be assured that she will remove/has removed all personal information and/or information that might identify you as a participant and, as a second check, will have her thesis supervisor (a member of the study team) review the transcritions to ensure all this information has been removed;
- If you find yourself worrying about the possibility of being identified as participant long after the study is completed, you can contact the [name of study institution] REB and/or the Ryerson University REB to express you concerns and attain their support. Their contact information is contained at the end of this Consent Agreement.

Confidentiality:

If you choose to sign this Consent Agreement, the researcher will know your name and telephone number, and over the course of the study, for example during the interview, you may share other personal information with the researcher. This information may include specific references to your diagnosis, index offense, age, ethnicity, religion, family details, or other personal details about your life. To protect your confidentiality as a participant, none of this information, including the pseudonym you select, will be included in any published study findings or shared with anyone, except in the event that there is a legal obligation to disclose.

The research data will be accessible only to the principal investigator, the graduate researcher and her thesis supervisor, except in the following situation:

- As part of continuing review of the research, your study records may be assessed on behalf of the one of the Research Ethics Boards. A person from the research ethics team may contact you (if your contact information is available) to ask you questions about the research study and your consent to participate. In this situation, the person assessing your file or contacting you must maintain your confidentiality to the extent permitted by law.
- As part of the Research Services Quality Assurance Program, this study may be monitored and/or audited by a member of the Quality Assurance Team. Your research records and [name of study institution] records may be reviewed during which

confidentiality will be maintained as per [name of study institution] policies and the extent permitted by law.

Personal Health Information:
If you agree to participate this study, when you sign this agreement you will be asked to provide:

- Your name
- Your contact telephone number

This information is requested so that the researcher can contact you to review with you the data transcribed from your interview. As identified in the 'Confidentiality' section of this agreement, this information, along with any other personally identifying information collected from you over the course of the study, will not be shared with anyone, except in the event that there is a legal obligation to disclose.

Incentive to Participate:
If you choose to be a participant in this study you will receive a $30 cash incentive, which will be given to you at the beginning of the interview. This money is yours to keep even if you request to stop the interview before it is finished, if you decline to review the transcription of your interview with the researcher, or if you choose to conclude this conversation before it is finished.

Costs for Participation:
There are no monetary costs for you associated with participation in this study. You are being asked for a commitment of your time: 50–80 min. for the interview, and 30–45 min. to review your interview transcription.

If You Are Harmed in the Study:
Signing this consent form does not waive your legal rights nor does it relieve the principal investigator, the researcher, her thesis supervisor, or involved institutions from their legal and professional responsibilities. You will not give up any of your legal rights by signing this consent form.

Voluntary Nature of Participation and Withdrawal:

- Participation in this study is voluntary. If you decide to participate, you are free to stop your participation and withdraw your consent at any time without penalty or loss of benefits to which you are entitled.
- At any point in the study you may refuse to answer any particular question or stop participation altogether.
- You are in control over what you chose to share or not share during the study (in interview and during the interview transcription review process), and when reviewing the data transcribed from your interview with the researcher you can make any changes you want to what you have said;
- If you become upset from participating in the study you may stop at any time without giving a reason.
- If you choose to end your participation in the study before it is finished, you may request that the study investigator have all your study information withdrawn and destroyed.
- Your decision to participate or not, or to withdraw your consent, will not influence your

future relationship with the investigator, Irene Boldt, her supervisor, Elizabeth McCay, Ryerson University, [name of study institution] or the care you receive at [name of study institution].

Questions about the Study:
If you have any questions about this research study, please contact:

Principal Investigator: [Name of principal investigator at name of study institution]
[Name of study institution]
[Address of study institution]
[Telephone number of study institution]

Graduate Researcher: Irene Boldt, RN, Master of Nursing Student
Daphne Cockwell School of Nursing, Ryerson University
350 Victoria St., Toronto ON M5B 2K3
[Telephone number and email address]

Thesis Supervisor: Elizabeth McCay, RN, PhD, Research Chair in Urban Health
Daphne Cockwell School of Nursing, Ryerson University
350 Victoria St., Toronto ON M5B 2K3
416-979-5000 ex. 6331

Research Ethics Boards in this Study:
If you have questions or concerns regarding your rights as a human subject and participant in this study, you may contact [name of chair], the Chair of the [name of study institution] REB and/or the Ryerson University REB, using the contact information listed below. The members of the REBs are not part of the study team and everything you discuss with them will be kept confidential.

[Name of study institution] Research Ethics Board
Chair, [Name of chair]
[Address of of study institution]
[Telephone number of study institution]

Ryerson University Research Ethics Board
c/o Office of the Vice President, Research and Innovation
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
rebchair@ryerson.ca

If You Would Like to Participate in the Study:
If you would like to participate in this study, and have taken as much time as you need to make your decision, please contact the researcher, Irene Boldt, at [contact information], to schedule a time to for the interview. The interview will take place in a private room at [name of study

institution]. Before the interview starts, you and the researcher will sign two copies of this agreement, and you will be given one signed copy to keep for your records.

Confirmation of Consent Agreement:
My signature below indicates that I have read the information in this Agreement and have had a chance to ask any questions I had about the study. My signature also indicates that I agree to be in this study and have been told that I can change my mind and withdraw my consent to participate at any time. I have been given a copy of this agreement.

I have been told that by signing this consent agreement that I am not giving up any of my legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Person obtaining consent Date

Audio-taping

I agree to be audio-recorded for the purposes of this study. I understand how these recordings will be used, stored and destroyed.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Person obtaining consent Date

Telephone Contact to Review Interview Transcriptions

I agree to have the researcher contact me by telephone to review the transcriptions of my interview. I understand that my participation in this process is voluntary and that even though I

am signing below, I can decline to participate at the time the telephone call is received, or withdraw from participating at any point during the process of reviewing the transcriptions.

_____
Name of Participant (please print)

_____
Telephone Number(s) of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Person obtaining consent Date

Appendix D: Interview Guide

50-80 minutes

Opening: (5-10 minutes)

- Thank you for taking the time to meet with me.
- I want to confirm with you that you are comfortable talking with me today about your recovery experiences. Is this true?
- Great. Just before we sign the Consent Agreement:
- I want to remind you that your participation in this interview, in the conversation that we'll have today, is your choice, and you are in control of everything you say.
    - You do not have to tell me anything you do not want to;
    - You do not have to answer any question if you do not want to;
    - You can stop our conversation at any time, and you don't need to tell me why;
    - You can leave the room if you want to, at anytime, for any reason;
    - If you want me to exclude any or all of the information I collect during this interview all you have to do is ask me not to use it, and I will delete the information I've collected.
        - You can ask me to do that now, or when we talk later on the telephone to review the transcripts of your interview.
- Speaking of what you can choose to share or not share during the interview, you will recall that the Consent Agreement outlined what types of information I'd be obligated to report, and I'd like to remind you of them now:
    - If you tell me about 1) current urges to harm yourself or someone else, 2) a situation of imminent harm to you or someone else, or 3) abuse or harm, past or present, actual or suspected, of a person under sixteen years of age, I will have to share this information with others, and your confidentiality as a participant will be in jeopardy.
    - In the course of our conversation, as long as the information you share does not fall into one of the three categories of information outlined above, it's okay to talk anything. You can talk about past instances of wanting to hurt yourself or someone else, or about anything you've done that's against the law, as I am not under any obligation to share this information with anyone. That said, it remains a possibility that someone could use the law to gain access to this interview tape, and possibility to your identity, so keep that in mind during the course of the interview.
    - Remember, as I said before:
        - You are in control of what you share and do not share with me during this interview.
- Are you willing to sign the Agreement?
    - If yes: Great, here are two copies of the Agreement, which we will both sign. This copy, which doesn't have your identifying code on it, is for you to keep for your records, and this copy, the one with your code, and the code I'll use to today when I'm taking notes and to identify the tape cassette, is the copy I will retain.
    - If no: Well, thank you for meeting with me and for considering taking part in this study. I'm sorry that you are not going to end up being a participant, and I respect your decision.

- Before we start the interview, I'd like you to select a name for yourself, a pseudonym, that we can use when the audio recording starts. Not using your real name will help to protect your identity if someone other than me listens to the tape.
    - Also, I want to remind you that I will listen to the tape-recording of this interview, and transcribe what you say, but this transcribed data will not be published or shared publically. Nor will the pseudonym you select today. Further, I will use parts of your interview, combined with parts of the interviews from other participants, to compose a descriptive summary of the recovery experiences that I will publish, but that summary will not contain any person details that could be used to identify you. We can discuss this further when we review your individual transcripts together on the telephone in a few weeks.
    - What name have you chosen?
- I am going to start the audio recording now. Is that okay with you?
- First, before we begin the interview I would like to give you this envelope. It contains the $30 incentive to which you are entitled. Whether we need to conclude the interview before it is finished, or whether you agree to speak with me later on the phone to review your transcripts, this incentive is yours to keep. Thank you for participating in this study.
- The purpose of this interview is for us to have a conversation in which you tell me about your recovery.
- I have four main questions that will guide our conversation, one about what recovery means to you, one about your recovery in the past, one about your recovery now and one about your recovery in the future.
- I will ask each question and then listen while you tell me about your recovery. You can say whatever you want in answer to my questions. This conversation is an opportunity for you to discuss any experiences, positive or negative, that are relevant to your recovery.
- I will ask questions other questions if I want to know more about something you've said, or to prompt us if our conversation stalls.
- You don't have to answer any question you don't want to answer or don't feel comfortable answering.
- It is possible that you might feel distressed or uncomfortable during our conversation because of the things we're talking about. If that happens please let me know, and we can talk about what to do next.
- If I sense that you are distressed or uncomfortable I will ask you about how you are feeling. Is that okay?
- We can stop our conversation at any time, for any reason.
- You can ask me questions at anytime.

Body: (45-60 minutes)

- You've agreed to talk to me today about your recovery, so I thought we could start by talking about what recovery means to you. (INTRO.) (5-10 minutes)
    - So please tell me in your own words: What does recovery mean to you?
- When did recovery begin for you? (PAST) (15-20 minutes)
    - How did it happen?
    - What circumstances/events/thoughts/happenings/individuals/supports allowed recovery to happen?
    - Did you make a decision to begin to recover, or did it just happen?

- What does recovery look like in your life today? (PRESENT) (15-20 minutes)
    - How did you get here?
    - What happened to allow that? What did you overcome to get here?
    - What did you have to do? Did you change your thoughts/actions about anything in particular?
    - What help did you have? From whom?
- What does recovery in the future look like? (FUTURE) (10-15 minutes)
    - What do you need to do to get there?
    - What are some potential barriers? What do you need to watch out for?
    - What concerns do you have about getting there?
    - What/who will help you get there?

Closing: (5-10 minutes)

- Thank you for sharing your experiences of recovery with me.
- I don't have any more questions for you. Do you have any questions for me?
- I think we had a really good conversation, and you shared a lot with me. Is there anything else you want to tell me about your recovery?
- Of the things we talked about already today, is there anything you want to say more about?
- Is there anything you shared that you wish you hadn't, that you regret telling me, or that you wish you could take back?
    - Would you like me to remove that portion of our conversation from the study?
- Did anything we talked about make you feel uncomfortable or cause you distress?
    - Would you like to talk to me about how you're feeling?
    - Do you need support after we're done here today to help you feel better?
- I am going to stop the audio recording now. Is that okay?
- Thank you for taking the time to meet with me.

Appendix E: Member-Checking Guide

30-45 minutes

Opening: (5 minutes)

- Is this a good time for you to speak with me? This conversation should take between 30-45 minutes.
    - If not, we can arrange a time that would be more suitable for you.
- Are you in a location that you feel comfortable that you will not be overheard?
- Thank you for taking the time to speak with me.
- I want to remind you that your participation in this conversation is your choice:
    - You are in control of everything you say.
    - You do not have to tell me anything you do not want to;
    - You do not have to answer any question if you do not want to;
    - You can stop our conversation at any time, and you don't need to tell me why;
    - You can hang-up on me if you want to, at anytime, for any reason;
- It shouldn't be an issue during our conversation today, but to protect your confidentiality I want to remind you of the about what types of information I'll be obligated to report.
    - If you tell me about 1) current urges to harm yourself or someone else, 2) a situation of imminent harm to you or someone else, or 3) abuse or harm, past or present, actual or suspected, of a person under sixteen years of age, I will have to share this information with others.
- I have transcribed what you said during the interview.
- Would you be willing to review this information with me now?
- Thank you for being willing to do so; I value you input at this stage, as I want to ensure that the information is accurate, and that it does not contain details that you think could violate your confidentiality.
- First, I'm going to go over with you the major ideas or themes that I identified in the transcripts. Please think about whether the themes are accurate based on what we talked about, and whether or not there are aspects of it that might leave you vulnerable to being identified, especially by someone who knows the specific details of your recovery. After I'm done reading reviewing the themes with you we can discuss what things you'd like to change or remove. You can also add to the information or clarify anything if you wish.
    - If there is any information you want me to exclude all you have to do is ask me and I will not to use it; I will delete it.
- After we've discussed the immediate changes you would like to make we will go through the information more slowly, and discuss each part of it. Throughout this process you can add change or remove anything to/from the information you shared during the interview.
- Finally, I will summarize the changes you requested.
- Just like the interview, we can stop this conversation at any time, for any reason.
- Please feel free to ask me questions at anytime.
- Are you ready to proceed?

Initial review of themes: (5 minutes)

Transcript review discussion: (15-25 minutes)

- Is there anything that immediately jumps out at you that you would you to change, omit or add to this information?
    - If there is any information you want me to exclude all you have to do is ask me and I will not to use it; I will delete it.
- Does the information accurately describe your experiences of recovery as discussed in the interview?
- Is there anything in the transcript that you have concerns about in terms of leaving you vulnerable to being identified?
    - Would you like to remove or change this information to better protect your identity?
- Is there anything you would like to add?
- Is there anything you would like to omit?
- Is there anything you would like to clarify or revise in the transcribed information?
- In the information is there anything that should be highlighted or told in greater detail?
- Here is a summary of the changes you've requested thus far… (requested changes will be reviewed with participant)
- Before we wrap up our conversation let's go over the themes in the data one more time (review themes again with requested revisions).
    - Are there any final changes you would like to make?

Closing: (5 minutes)

- Thank you for taking the time to review your interview data and experiences of recovery with me.
- I don't have any more questions for you. Do you have any final questions for me?
- Do you have any concerns about the information in your interview transcripts that you'd like to share with me?
- If you have questions in the future about the study or about your participation in it, please contact me, my supervisor, or one of the two REBs that approved this study. The contact information you need to do that is on the Consent Agreement.
    - If you don't have your copy of the Consent Agreement I can give those contact numbers now.
- Thank you for participating in this study and for sharing your recovery experiences with me.
- Thank you for taking the time to speak with me today.

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