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TABLE OF CONTENTS

Editorial

Vicarious trauma and occupational hazard for forensic mental health professionals 1
John Bradford, Gary Chaimowitz

Original Article

Examining the use of the recovery model with individuals found not criminally responsible on account of mental disorder: Revealing tensions between risk management strategies and recovery 3
Michael Gulayets, Ashlyn Sawyer

Psychiatric admissions: The first law in Saudi Arabia 23
Abdullah H Alqahtani

Case Report

Kratom-induced Psychosis: Case report and literature investigation 29
Sebastien S Prat, Syed Ali Rizvi, Gary A Chaimowitz

Letter to the Editor

Offering group mental health programs in a maximum security correctional facility: Observations, outcomes and recommendations 35
Amar Ghelani

International Journal of Risk and Recovery
EST. 2017

Editorial

Vicarious trauma and occupational hazard for forensic mental health professionals

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Vicarious trauma or vicarious traumatization is the effects on a health-care worker that results from the empathic engagement or therapeutic relationship with clients or patients and their reports of traumatic experiences. The term was coined in response to the experience of psychotherapists working with trauma survivors and is widely attributed to McCann and Pearlman 1990 [1]. They developed a constructivist self-development theory discussing therapist reactions to clients' traumatic material. They described that vicarious trauma can be understood as related to the graphic and painful material trauma clients portray to the therapists as well as the therapists unique cognitive schemas or beliefs and assumptions about self and others [1]. This theory has developed, has subsequently been described as compassion fatigue and has been subject to a considerable amount of research since this early description [2-18]. It has also focused on various professionals, including mental health professionals, and their vulnerability from working with a variety of clients or patients [4-6,8-10,12-14,19]. In this context, forensic mental health professionals are not specifically mentioned, although it is quite clear that the nature of the work that they do would make them vulnerable to vicarious trauma and "compassion fatigue."

The authors argue that forensic mental health professionals and other professionals who work in the criminal justice system are distinctly at risk for exposure to highly traumatizing material as part of forensic psychiatric and mental health evaluations. This material includes explicit post-mortem pictures, videos of the crime or crime scene and, in rare circumstances, sexual homicide perpetrators' records of their acts.

With technological advances and social media, the ability to record in vivid detail and to share this material has significantly increased the potential for vicarious trauma. What was once the occasional grainy black-and-white pictures became the colour photographs before becoming the multitude of digital pictures and videos covering every angle and every aspect often multiple times. Digital resolution of image capture and display improved. Ease of transmission and storage means more people can view and share. Curiosity and teaching contributed to a wider sharing of this material, well before reports of increasing vicarious trauma sequelae began to emerge. Experts in the forensic psychiatry field have often viewed reading about and viewing crime scenes as an interesting and expected part of their work. However, the insidious creep of more images and more details allowed progression of the effects of vicarious trauma or vicarious traumatization to go unreported for so long.

Particularly traumatizing has been the digital capture of crimes against children, especially sexual crimes including child pornography. The less frequent auditory or visual depiction of crimes in progress, where the terror of the victim is captured in full sensory mode, can be hard to erase from memory. Even now, the mere cellphone recording by members of the public witness to crimes and death and played out on TV screens can be disturbing.

It is in this new world that we find ourselves. Owing to the bravery of experts speaking out about their experiences with the mental health consequences of dealing with reading about these crimes, hearing from victims and seeing recorded material, we in forensic psychiatry should firstly acknowledge that vicarious trauma is an occupational hazard in the forensic psychiatry domain. We can and should develop guidelines for the management of forensic psychiatry material. We should also put in place accessible supports for those experiencing vicarious trauma.

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Original Article

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Examining the use of the recovery model with individuals found not criminally responsible on account of mental disorder: Revealing tensions between risk management strategies and recovery

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In providing the care and control of individuals found not criminally responsible on account of mental disorder (NCRMD), forensic psychiatry attempts to balance the protection of society with the treatment of mental illness. A new approach in mental health care is the recovery model, which centres on the understanding that there should be a recovery in, not a recovery from serious mental illness. In clinical practice, this means that treatment decisions should be made in collaboration with patients and include their personal circumstances, such as criminality and aspirations. Concepts that intersect with these goals are elements like choice, hope, personal responsibility and empowerment. This paper examines the implementation of the recovery model in forensic mental health settings and provides an in-depth exploration and evaluation of the model as it is practised at a forensic psychiatric outpatient clinic with individuals found NCRMD. Ten participants, including both individuals found NCRMD and psychiatric professionals, took part in semi-structured interviews. Qualitative data analysis of the interview transcripts identified the following six themes: choice, recovery, hope, responsibility, agency, and risk. This paper examines the experiences, perceptions, and challenges of implementing the recovery model in a forensic psychiatric setting and compares its strategies to the predominant risk-based forensic practices. The analysis suggests that it is difficult to implement the recovery model in a forensic setting without compromising either the recovery model or the risk management approach.

Key words: *NCRMD, not criminally responsible on account of mental disorder, recovery model, risk management, outpatient setting, qualitative, forensic mental health*

Introduction

Individuals found not criminally responsible on account of mental disorder (NCRMD) experience a wide variety of forms of regulation as approaches to their care and control shift in response to legislative action, psychiatric techniques, and changes in risk perception. This study provides an examination of the use of the recovery model in the psychiatric care of individuals found NCRMD who have been discharged to a forensic psychiatric outpatient clinic. This paper first offers a brief historical review of the forms of regulation faced by the criminally insane leading up to contemporary practices, such as risk assessment and management strategies and the recovery model approach. Thereafter, it provides the results of a study where individuals found NCRMD and psychiatric professionals were interviewed about their views on the implementation of the recovery model. This paper concludes with a discussion of the results and the implications for individuals found NCRMD and psychiatric staff, as well as the larger psycho-legal system responsible for regulating these individuals.

Shifts in the Regulation of Criminal Insanity in Canada

For more than a century and a half, Canada has followed the M'Naghten Rules in determining criminal insanity. While the rules governing the mental disorder defence have not changed significantly, the forms of regulation faced by those found criminally insane have altered radically. Before the mid-19th century, criminal insanity acquittals were held in common jails with other prisoners and were typically treated no differently than the guilty. In the mid-19th century, one specially constructed asylum located within the walls of the Kingston Penitentiary was provided for the criminally insane in Canada. However, there was little to distinguish the conditions or treatment of inmates in this facility from the penitentiary itself. Ironically, individuals who were relieved of criminal responsibility because of insanity suffered the same or often worse fate than those found guilty of their crimes. The primary reason to employ the defence was as a means of evading the noose [1]. At the end of the 19th century in Canada, a person found criminally insane was " to be kept in strict custody in such place and in such manner as to the court seems fit, until the pleasure of the lieutenant-governor is known" [2]. In practical terms, an insanity acquittal provided for the automatic detention "in strict custody" of the defendant in an asylum until the lieutenant-governor of the province saw fit that the person is released. This disposition was automatic and there was no formal process or procedure in law that would allow this person to be discharged. In reality, these individuals were held indefinitely in this strict custody [3].

In the late 19th and early 20th century, the federal government negotiated agreements with the provincial governments for the care and control of the criminally insane to be directed within provincially operated asylums. This marked the beginning of more specialized care, placed in the hands of psychiatrists rather than the custodial care previously endured by inmates. During this period, such specialized care took the form of a "moral treatment," which attempted to resocialize the person found insane. Throughout the first three-quarters of the 20th century, as psychiatry developed and refined its practices, the criminally insane experienced a wide variety of treatments from techniques such as hydrotherapy, lobotomies, and shock therapy, to the use of more modern treatments such as psychopharmaceuticals [4,5].

The deinstitutionalization movement, beginning in the late 1960s, provided the impetus for a shift in regulation and treatment modalities. In 1969, the Canadian government passed a statute that permits (but does not require) the lieutenant-governor to appoint a board to review cases of those held in custody and advise the lieutenant-overnor [6]. The review board's mandate was to review each case shortly after a finding of not guilty by reason of insanity and on an annual basis thereafter for the purpose of providing recommendations to the lieutenant-governor; however, there was no provision that the recommendations should or must be followed by the lieutenant-governor [3]. The formation of panels, whose task was to advise the lieutenant-governor, was a significant development in the governance of criminal insanity, as well as in the rights of those detained under insanity laws. Yet, there was still no provision in law for the release of these individuals, except at the lieutenant-governor's pleasure.

This predicament was altered in 1972 when the Canadian government added a statute that officially allowed the discharge of a person acquitted of insanity [7,8]. For the first time in Canadian insanity laws, this statute made it clear that the lieutenant-governor may discharge from custody a person found not guilty for reasons of insanity if "it would be in the best interest of the accused and not contrary to the interest of the public." The lieutenant-governor could make this discharge either absolute or subject to conditions.

The formation of review boards raised the accountability of the psychiatric system, and the inclusion of discharge provisions increased the procedural options available to the lieutenant-governor. While these developments enhanced the procedural safeguards in the detention of the criminally insane, the review boards were strictly advisory, and the lieutenant-governor was still

given a wide amount of discretion over the place, manner, and duration of committal of a person found not guilty for reasons of insanity. Within this system, the courts had no jurisdiction on habeas corpus to review, challenge, or reverse the exercise of this discretion.

The early 1990s saw a radical shift in the regulation of criminal insanity. In the Swain verdict, the Supreme Court determined that the automatic detention of an individual acquitted of insanity deprives them of the right to liberty and that such deprivation does not accord with the principles of fundamental justice. As a result, the Canadian federal government was required to rewrite the legal provisions regarding the insanity defence and in February 1992 *Bill C-30* was subsequently passed [9].

Bill C-30 made several significant changes to the regulation of criminal insanity. Along with changes in terminology (e.g., “criminally insane” becomes “not criminally responsible on account of mental disorder”; “disease of the mind” becomes “mental disorder”) the new provisions introduced several other changes, such as making an appeal of the disposition rendered possible (s.672.72) [10]. Perhaps the most significant change was to the nature of the disposition of individuals found NCRMD. After a verdict of NCRMD is rendered, the case comes under the jurisdiction of a provincial or territorial review board that is responsible for granting a disposition concerning the individual. With the passage of *Bill C-30*, the review board of each province or territory was elevated from a strictly advisory role to the sole adjudicator of the disposition of individuals found NCRMD. The *Canadian Criminal Code* (s.672.54) provides that one of the following dispositions be made following a ruling of NCRMD:

- if, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, the accused is discharged absolutely; or
- the accused may be discharged subject to such conditions as the court or Review Board considers appropriate; or
- the accused may be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate [10].

The *Canadian Criminal Code* instructs that a disposition takes into consideration the need to protect the public from dangerous individuals, the mental conditions of the accused, the reintegration of the accused into society, and the other needs of the accused. Under the law, indefinite detention without regular review is no longer possible, automatic detention is no longer a certainty, and the supervision of the criminally insane in the community becomes not only a possibility but, for the majority of patients, the preferred situation. This transformation from “strict custody” to a disposition that balances the needs of the accused with the protection of society clearly demonstrates a changing attitude toward the rights of offenders with mental disorders. This attitude also indicates and necessitates changing modes regulation of criminal insanity.

Contemporary Forms of Regulation of Individuals Found NCRMD

By the end of the 20th century, the notion of risk predominated theoretical, and practical approaches in sociology, criminology and psychiatric practice [11-14]. Case law reinforced that the primary task of the review board system was to engage in risk assessment and management activities. For example, in the 1999 case of *Winko v. British Columbia* (Forensic Psychiatric Institute), the Supreme Court of Canada ruled that the review board engages in a “risk management exercise” that provides a disposition that is “least onerous and restrictive” for the accused [15]. Discharge must be issued in cases where there is not sufficient evidence to establish a significant threat to the safety of the public. Similarly, in 2003, the Supreme Court of Canada (*R. v. Owen*) added that although the review board is required, like the court, to make findings of fact, its most important and difficult task is to make predictions regarding future risk of harm [16]. More recently, the Canadian government amended the Criminal Code, allowing courts to designate some individuals found

NCRMD as high-risk accused (HRA) [17]. Under these provisions, individuals found NCRMD following a serious violent event (e.g., homicide, aggravated assault) are designated HRA based on the likelihood of future violence or the extreme nature of the offence that led to the verdict. Individuals designated HRA are detained in hospital, can have their disposition reviews extended from annually to every three years, and cannot be conditionally or absolutely discharged unless a Superior Court lifts the designation [18-20]. With these new provisions, the emphasis is still clearly on risk assessment and management; however, the focus shifts from least onerous and restrictive dispositions to a risk management focus that prioritizes public safety.

Within the context of the care and control of individuals found NCRMD, psychiatric treatment teams and review boards increasingly use actuarial and structured clinical risk assessment tools to identify dynamic and static risk factors associated with re-offending and relapse [21]. The primary objective of this approach is to assess the risks posed by the individual and to implement strategies that manage them through psychiatric techniques, as well as dispositions and conditions imposed by the review board [22-24]. In the attempt to balance individual rights and freedoms with public safety, risk assessment and management formed as methods of understanding the relation between diverse predictors (e.g., substance use, psychiatric symptoms, negative attitudes) and violence as a means to guide mental health practitioners and review board decisions, as well as policy, legislation, rights, and liberties [25].

Despite the widespread use of risk assessments and research suggesting their clinical benefit, some issues have been identified with their use. For example, the risk-based approach to psychiatric care has been criticized as lacking clinical transparency and not involving the individual in their own care, which suppresses patient ambition and recovery. In addition, concepts measured by assessments, such as risk and responsiveness, are imprecisely defined, which undermines the objective claims of these measures [26].

The Recovery Model

Within this context of risk assessment and management, there has recently been growing interest and utilization of a new recovery model in psychiatric practice. The model aims to empower the patient to play an integral part in their own care and recovery. Where previous models emphasized expert power and control over diagnosis and treatment of mental illness, the recovery model focuses on hope, wellness, choice, cultural and individual differences, self-empowerment, and the alleviation of stigma [27-29]. From this perspective, recovery is understood as a process or continuum, subjectively defined and directed by the person experiencing mental health issues instead of by an expert. In other words, recovery is not a singular outcome; it can mean different things to different people within different settings [30]. In terms of treatment, clinical decisions are considered best made in collaboration with patients and should include their personal circumstances, such as criminality, family relations, socioeconomic standing, culture, and aspirations [31]. Clinicians must understand that they are in a partnership with their patient who is not compelled to accept their directives. It is implied that patients are given a level of empowerment in the form of choices about their personal treatment and recovery, followed by negotiation and agreement [31]. The negotiation and agreement phase is particularly important as recovery advocates share the belief that mental illness exists and it can impair rational processes. However, alongside this is the philosophy that people suffering from mental illness are full moral and political agents and should not be defined based on their diagnosis or collection of symptoms [32]. The recovery movement doesn't ignore the importance of psychiatry and diagnostics but emphasizes that psychiatric decisions should also include consumers of psychiatry and allow for agency and social participation [32]. This can be important when considering issues within psychiatry like treatment resistance because it is most often regarded as a frustrating clinical phenomenon that demoralizes doctor and patients, leading to pejorative responses [31]. Within forensic

psychiatry, outcomes of risk assessments in review boards are sometimes directly linked to these same issues, making it challenging for consumers and staff alike to become and stay motivated.

This new definition of recovery suggests that a focus on hope and empowerment will facilitate reductions in recidivism and allow for healthy integration back into society. The recovery model relies on a hope that people, through personal recovery, will be inclined to reduce risk factors, increase treatment compliance, and foster well-being because of their ability to cultivate hope in themselves rather than relying on an institutional process. Thus, the recovery model allows for a relationship of trust to grow through collaborative mechanisms. In other words, instead of generating power-over the individual, the recovery model's conceptualization of empowerment includes generating power-to, power-with, and power-from-within the individual.

Recovery Model in Forensic Practice

The virtue of client empowerment is promoted within mental health care but can be challenging when put into forensic practice. Making matters more complex is the reality that the recovery model is a relatively new psychiatric model and is arguably more complicated to implement in forensic mental health settings, especially with individuals found NCRMD [28,33]. Studies that have examined the implementation of the recovery model in a forensic setting are also limited and have mixed results.

Shepherd et al. provided a meta-analysis of studies that examined the recovery process in forensic settings, finding three themes salient in the literature: safety and security, hope and social networks, and identity [34]. Safety and security were described to be provided either relationally with a caregiver or through one's physical environment. Both of these elements have the capability to become toxic if perceived as more restrictive than supportive. The concept of hope was also seen in relation to a forensic client's desire for supportive relationships, individual expression, and personal autonomy. A tension exists within forensic mental health care between these desires and the necessity of risk management. Shepard et al. found that identity work served as a final theme in literature and contained three principles: making sense of past experiences, understanding the role of mental disorder, and constructing a sense of self [34]. Examples used by participants included recalling personal traumas, developing an understanding of offending behaviour and mental illness through supportive treatment, and identifying past and future social roles within the community. Other studies examining patient-centred approaches to recovery in forensic care have similarly found positive relationships, collaboration, hope, identity, meaning in life, self-acceptance, and self-management as being central concepts to the process [35-39].

What is intertwined among these concepts are the crucial differences between general and forensic mental health settings, particularly the constraints forensic clients have because of their criminal label. Additionally, personal recovery within forensic settings has been found to be subsumed at times by an exaggerated emphasis on judicial measure, where the construction of personal development often paralleled judicial progress rather than through client definition [34, 40,41]. In other words, the concept of choice is provided on the basis of limited opportunity as opposed to autonomous choice. An example of this was found in Livingston et al's evaluative study on the effectiveness of patient engagement interventions in a forensic hospital [42]. That research found that the recovery model had little effect on internalized stigma and service engagement, despite an overall improvement in client experience within the forensic system.

In part, obstacles faced by the recovery model in forensic environments have been directly attributed to issues related to judicial status, client self-image, compliancy, and insight [40]. Issues of this nature can prove to be especially difficult to change in forensic clients. Correspondingly, forensic clients suffering from serious mental illness may only experience improvement in symptoms and functional impairment over a long

period of time and to a limited extent [43]. As such, viewing recovery as synonymous with an absence of mental illness may be unattainable in some cases and detrimental to one's personal development in others.

Another difficulty in implementing the recovery model in a forensic setting is that many social and political forces influence the way clients are seen and managed [44]. By utilizing an individualistic approach, client decision-making may be greeted with anxiety by clinicians and lead to inconsistencies in treatment [26]. Professional resistance to the recovery model includes feeling that empowerment in treatment is already common practice, that the recovery model adds to workloads, does not align with organizational priorities or service needs, represents a fad, requires expensive services, exposes liability, can be used with only a small portion of clients, and is difficult to define [27,42,45]. Furthermore, there is a lot of skepticism over whether individuals found NCRMD would be able to make and abide patient-directed treatment styles, and whether review board members, psychiatric staff and broader society would accept less risk-based approaches in

their care and control. Because medical models and other contemporary treatment models appear to provide a sense of control and certainty, consumer-centred models have been perceived as a threat to the security and safety of clients and the public [27].

Despite these challenges, the implementation of the recovery model within forensic practice has been recognized to be successful in improving perceptions around treatment. The recovery model provides the opportunity to foster a sense of hope and empowerment within clients who may feel disenfranchised by the involuntary processes placed upon them [42]. Likewise, it has been suggested that recovery-based care can provide clients with an otherwise unlikely opportunity to develop a self-identity, escape social exclusion, and lend peer support to others in similar circumstances [26,42]. Rather than fearing that recovery-oriented care may disrupt treatment and increase risk, some authors have suggested that this approach can be helpful in clarifying a client's risk, as well as strengthen client-clinician partnerships in working on protective factors [28,46]. An example of this was established in Bouman et al., where forensic outpatients who had satisfaction with health, life fulfillment, and meaning in life were found to have decreased levels of recidivism [47]. There is also evidence to support that the recovery model in forensic psychiatry can significantly increase treatment engagement [48].

Regardless of the opinion, approach, or implementation of the recovery model, its core philosophy juxtaposes historical and contemporary models of forensic treatment and requires that the delivery of care experienced by offenders with mental disorders be reconsidered. Noticeable among the literature is the difficulty and complexity of dual recovery, both from mental illness and criminality, especially within the confines of the review board system. An exploration of the use of the recovery model within forensic psychiatry will provide a better understanding of this approach in the regulation of individuals found NCRMD.

Methods

Research Setting and Participants

This project strives to gain insight into the experiences, perceptions, and opinions of individuals found NCRMD and psychiatric professionals about the introduction of the recovery model in a forensic setting. Data were collected through semi-structured interviews conducted at Forensic Assessment and Community Services (FACS), the forensic psychiatric outpatient clinic of Alberta Hospital Edmonton (a service of Alberta Health Services). FACS is the primary outpatient clinic that provides the care and follow-up for individuals found NCRMD when they are discharged to the community by the Alberta Review Board. Participants included individuals found NCRMD who received outpatient treatment under the recovery model, and psychiatric staff from FACS (e.g., nurses, social workers, occupational therapists) who were primarily responsible for delivering the recovery model in this setting.

Neither author is employed at the clinic or was involved in the clinical care of the individuals found NCRMD. This project was reviewed by the MacEwan University Research Ethics Board, which deemed it to be quality improvement research, and was also approved by Alberta Health Services.

Purposeful sampling was used to recruit participants; however, all interviewees for this research project voluntarily participated. Since not all patients at FACS were being treated with the recovery model at the time of this research, a staff member approached NCRMD clients being treated with the recovery model and psychiatric staff with knowledge of the recovery model and asked them if they were willing to participate in an interview.

Data Collection

In total, five individuals found NCRMD and five psychiatric professionals volunteered to participate in the research project. All participants were given the chance to read over, ask questions and sign the consent form before the interview took place. Individuals were informed that participation in the research interview was voluntary, information shared would remain confidential and that all participants had the right to decline or withdraw from participating at any time, without penalty. Individuals found NCRMD were also informed that participation was not a legal requirement, nor part of their treatment, and that interview data would not be shared with staff or review board members. Likewise, psychiatric professionals were informed that this research project was not an evaluation of staff members, but an examination of the application of the recovery model in this setting.

All interviews took place in a private office at FACS and lasted 30 to 60 minutes. Specific information on individual characteristics such as index offence, diagnosis, or psychiatric and criminological history was not asked nor included. Interviews with individuals found NCRMD focused primarily on their perception of treatment and their understanding of the recovery model's basic tenets. Questions guiding these interviews included topics such as power, empowerment, hope, choice, and personal responsibility. Interviews with psychiatric professionals focused on their experiences, perceptions, and opinions on treatment models being used with the NCRMD population, their knowledge of the recovery model, and to what degree they believed it could be implemented within a forensic mental health setting. Staff interviews also included questions on specific recovery model core values such as hope, choice, empowerment, and personal responsibility. All interviews were audio-recorded to facilitate data transcription.

Data Analysis

Data collected through all interviews were analyzed using thematic analysis, a form of pattern recognition [49,50]. Data analysis began with the transcription of recorded interviews and the removal of any potentially identifying information. Pseudonyms are used to maintain anonymity. After transcriptions of the interviews were completed, memos, reflections, trends, and initial themes were noted to maintain rigour.

In the second phase of coding, the interview documents were uploaded to NVivo, a data analysis software that allows data codes to be collected and organized. In this phase, each interview was reviewed for codes and larger themes that provide insight into how the recovery model works within a forensic psychiatric setting.

In the final phase, codes were grouped into six main themes: giving choice, recovery as a journey, facilitating and maintaining hope, client responsibility and accountability, balancing agency, and (re)considering risk. Both first-order and second-order themes are presented in Table 1.

Results

Giving Choice

Many of the questions looming over the recovery model's introduction into a forensic psychiatric setting reflect the boundaries of client-driven choice that can be made while under the gaze of both legal and psychiatric supervision. If, by

Table 1 - Qualitative Themes About the Use of the Recovery Model as Perceived by Clients and Service Providers

Subtheme	Illustrative quotes
	Giving Choice
Freedom	Choice allows them to get that autonomy, to be able to decide how their wellness path is going to look. (Staff)
Independence	Just hearing those kind of things where they kind of say, “Hey, it was me. I did this. This is my life. I have to control what and how I progress” (Staff)
	That they are taking the right steps and they want to change. In theory we should be able to trust them a little bit more with the direction they’re going. (Staff)
No New Practice	But it’s kind of a model, kind of an attitude that I’ve had the whole time. So, I don’t think there’s a dramatic switch in it. It’s not like a light switch went off and we’ve gone from this approach to the recovery model and the relationship is changed. (Staff)
	Recovery as Journey
Fresh Start	Some client’s reaction is kind of eye-opening, like “What do you mean I get to decide what I want to do?” because they had years of “This is the program you need to attend.” (Staff)
Journey	The clients don’t see themselves as just a number, they see themselves as an individual with choice, on a journey, trying to fulfill their lives. (Staff)
Realized Insight	I just did a recovery plan and it’s about goal setting. Part of it was about goal setting, and instead of making my goals too far to reach, I’ve broke them down and I’m working on them slowly. A little bit at a time, like more realistic things. (Client)
	I have a lot of insight of where I went and where I wanted to be, where I am now. (Client)
Recovery as Ongoing	My recovery with my mental illness—I’ll have to deal with for a long time. I don’t think there is an end to it. (Client)
Recovery as Weaving	Acceptance is the key I feel. I accept “Okay this is what’s wrong with me” and what do they say, “Play the tape all the way through” when you’re not doing so well. (Client)
	It’s just constantly helping them see that there will be challenges with their mental illness and if you know, if they become unwell, it’s not a failure on their part. It’s just part of that recovery system. (Staff)
	Facilitating and Maintaining Hope
Client Empowerment	It makes me feel good. It makes me feel like I’m more independent and I can, you know, take care of my own stuff. But they’re always there if I need help. (Client)
	I have more say. My recovery plan in the hospital, I didn’t have much say, but at FACS they let me say “what do you want?” and stuff like that. (Client)
Facilitate Engagement	So, giving them that opportunity to say “Hey, what if we tried this?” and not just saying, “That’s not part of our model” (Staff)
Hope	Empowerment in the recovery model is empowering the client to believe they have hope for change and empowering them to want to be part of that hope for change, not just moving along the system because they are told to. (Staff)
Intrinsic Motivation	It’s up to me if I’m going to comply with my disposition order. (Client)
	Some of the people who work here know what I’m capable of doing and they’ve asked me a few times like “What are you doing? You’re not …you’re easy going. You’re not fighting the system. You’ve changed. You’re working all the time” and I just want this warrant to be over with. (Client)
Recovery as Possible	Recovery means getting back to the place where you, when the person has a mental illness, but the medication brings the person back to the same spot. (Client)
	It’s just, it’s kind of like life. Life goes on, things happen in life and you move, you continue with your life. That’s recovery. (Staff)
Staff Satisfaction	Hopefully in practice if the client is working towards goals, they’ve identified and reduced risk. So, it should be a win-win situation. (Staff)

Table 1 continued

Subtheme	Illustrative quotes
	Client Responsibility and Accountability
Acceptance	At first it was a little bit hard, but when you're a client, you end up realizing that you don't have full freedom, but you do have the resources there to get close to it. (Client)
Consequences	I just think, man like it was way worse [in hospital] than now and it chills me out and you know resets my mind. Just to remember that I'm out, I'm in the community, I'm doing well, and I'm not in there anymore suffering. (Client)
	Nobody else made that choice; they have to take that responsibility and hopefully see how it affected them and what may be some consequences from that occurrence. (Staff)
	Client Responsibility and Accountability, continued
Governing Self	I'm going down the straight and narrow, and you know, I'm doing well. So, it doesn't really bother me, the fact that they do have control because I'm doing everything I'm supposed to be doing anyways. (Client)
Personal Responsibility	It doesn't matter the responsibility that I have, I'm going to follow the Review Board's conditions. (Client)
Therapy Roadblocks	Some clients need to be nudged along. Some may take advantage of it. The fact that they can choose may create the attitude where "I don't feel like doing anything" for the next 2 months, 6 months, 2 years. Then they're delaying recovery. (Staff)
	Balancing Agency
'Guided' Choice	They still can choose but giving them the choices that are going to make them more successful and bring them more independence in the community. (Staff)
'Wearing Two Hats'	We want to be able to collaborate with them, but we also are answering to the community and to reducing risk. (Staff)
External Motivation	I think in the past in a forensic setting, change was mandated; external forces are causing an individual to make the healthy or the correct choice that society expects them to make. I feel like as soon as that external force is no longer available, which is the warrant for the NCR, that change disappears 'cause it wasn't an actual internal change. (Staff)
Recovery as Risk Management	Recovery means abstinence from drugs and maintaining good mental health, … as well as small things like hygiene, keeping my room clean, and being active. (Client)
Resistance	Before, we used to say "You have to keep a job if you want to keep using the privilege of going into the city," whereas now we might say "If you don't have a job, what else are you going to in the city with your time?." They might say nothing and we're stuck. (Staff)
Staff Control and Agency	As much as I have power and I have consequences that I can implement on an individual, the ones that have a lot of power are the ones that have figured out that despite all that, as a treatment team, we still can't control them. (Staff)
Unfettered Choice	I'd love to just say, for them to just say "Okay you don't have to come back again" but, you know, I don't know what my reaction would be. (Client)
	Some clinicians will interpret [the recovery model] and say its client-centered, client driven, but then it's taken to the nth degree, where we just have no structure, no guidance, no real focus. (Staff)
	(re)Considering Risk
Lack of Insight	We can still work with them and work on their strengths and stuff but that's where that medical model has to take place, because we have to maintain their mental stability. (Staff)
Legal Barrier	There's a higher power, the Board of Review, not even us, determining how they're going to prog-ress. (Staff)
Minimized Choice	To me, [the recovery model is] a balance of no choice to somewhere in the middle 'cause there has to be some kind of boundaries and perimeters around it. If you think about people in general, you and I have choices in everything we do, but we have to make those choices within the confines of system as much as we like our freedom to make choice of anything. (Staff)

Table 1 continued

Subtheme	Illustrative quotes
	Client Responsibility and Accountability
Risk	It really seems like if there's any one negative thing, even if it's completely out of your control, they will take that and punish you for it. (Client)
	I'm not saying I'm a proponent of drug use, but [client] is not really a harm right now [using cannabis]. He's not causing any harm, his mental health has actually improved, but I strongly believe that the Board would not accept that life choice and would expect him to quit and stop using before they would ever consider giving him any more freedoms or liberties. (Staff)

definition, a person deemed NCRMD is found such on the basis that they were incapable of making choices between right and wrong at the time of their offence, to what extent should they be able to make or guide choices in their treatment? Likewise, to what extent can client-directed choices be fully made in treatment when, under legal disposition, community safety and minimizing risk must take precedence?

In both NCRMD client and psychiatric staff interviews, choice as part of the recovery model was conceptualized to be much more complex than just patient-driven decision-making. Instead, it appeared to be imagined on varying levels, where patients are consulted and given choices about what they feel would most likely lead them to recovery instead of being prescribed predetermined treatment plans. However, this approach required staff to take on a less restrictive, "more conscious" approach to "take a step back" and allow the client to sit in the driver's seat of their lives.

> *So, it really is client-driven and allowing them to kind of evolve, I guess you could say in their journey… if you want to call it that. But really, them being the driver and we're just the supporting passengers kind of thing. (Staff)*

The opportunity to be given choices over treatment not only asserted the client as the driver but also made them feel that being provided the option of choice reflected the trust staff had in them to make good decisions and better support themselves and other clients within the NCRMD system. One staff member highlighted this, mentioning how having the opportunity to make choices about their treatment was a way for clients to escape the rigidity of previous treatment approaches. At the same time, sstaff also noted that they now had increased freedom in decision-making. As well, the recovery model provided an increased ability to practise outside strict treatment guidelines and gain meaningful feedback through collaboration between professionals and recovery clients.

> *I really like the direction that our team is going, in that it is nice to be able to… have… a clinical director that's in support of this and allowing us to kind of branch out and look at things outside the way it's been looked at for the last however many years. (Staff)*

As much as staff felt that adopting the recovery model's fundamentals into their organization was no new practice and allowed both client and clinician to work outside of strict guidelines, all participants mentioned how sharply this model contrasted larger institutional practices that had either been used previously or remained prominent in inpatient mental health settings and the criminal justice system. Clients' experiences with the restricting nature of inpatient confinement lead to a greater appreciation of the opportunity they now have to possess any sort of voice or agency, let alone choice in treatment. For example, a client said: "So, a lot of it just is being grateful for what I have now compared to what I had before."

Clinicians validated the viewpoints of the clients, pointing out that the concept of choice is usually stifled once a mental label and criminal label meet. Because of the long duration within the

forensic system, choice had become irrelevant for many clients. One staff member described past health-care system practice as "a very old archaic way of thinking," in that withholding client choice over decisions about their lives, demanding people to do what the system told them to do, and expecting people to live a better life afterward, was in no way intrinsically motivating. Clinicians discussed how clients were surprised that after losing a great deal of independence, agency, hope, and empowerment, that a model based on these ideals would ever be offered to them.

> *Choices sparked a lot of interest in a lot of our clients because a lot of times choice had been taken away from them through the judicial system or hospitalization, where choice is no longer a factor. (Staff)*

> *Not knowing that they had choice previously. Some client's reaction is kind of eye-opening, like "What do you mean I get to decide what I want to do?" because they had years of "This is the program you need to attend." (Staff)*

Nevertheless, all participants acknowledged that the legal barriers imposed upon NCRMD individuals provide a significant impediment for clients receiving more freedom of choice in areas both within and outside of the recovery model. In this case, the agency of choice was contingently juxtaposed to legal disposition. The level to which one can make choices regarding care is less about one's capacity to make good decisions and more about whether these proposed choices fall within court-mandated orders. For clients, it was pointed out that attending the forensic outpatient clinic and participating in meetings or being exposed to the recovery model itself is not of one's own course of action but simply available options that the system has to govern them.

> *Uhm, just the fact that I have to come. Like it's not of my own volition, it's expected of me and if I don't, well then I get into trouble. It's not enjoyable. Not having full autonomy over your own life is pretty shitty. (Client)*

Psychiatric staff acknowledged that the legal constraints work against the recovery model principles that they are trying to instill, making it hard to inculcate them effectively. Both clinicians and individuals found NCRMD experienced an uphill battle of maintaining hope, facilitating empowerment, and acting with agency under the umbrella of legal conditions imposed by the review board. However, psychiatric staff also mentioned that because of the legal guidelines that must be met by individuals found NCRMD, minimized choice, at times, is necessary to ensure that these standards are met and that safety of the individual and the community takes precedence over the agency that the individual experiences in their treatment.

> *I mean with our guys, there's some points where we need to kind of take control of their treatment just because of that legal disposition. (Staff)*

> *We kind of push them into doing some kind of structured daily activity, and then when they quit doing that, or want to quit doing that, we say no. (Staff)*

Recovery as Journey

The process of self-motivation and actualization is not dissimilar from the journey of recovery nor the NCRMD legal process. One client mentioned that recovery was an ongoing process that required a person to consistently work on themselves, but also said that the review board system was similarly lengthy and ongoing, where, "everything is so slow, so cautious."

The process of recovery and risk reduction became one and the same. A central theme that emerged when clients were asked what recovery meant to them was that recovery was the maintenance of good mental health or a clear mind. The other component to recovery for clients was reducing risk factors. This included abstinence from drugs and alcohol, continuing with psychiatric and medical treatments, having good hygiene, being prosocial, and taking things

day by day in a "normal kind of a manner, like a normal citizen."

Although no client specifically mentioned the recovery model as being particularly beneficial to their recovery, they did mention that perhaps the recovery model could benefit those who have a harder time being able to set goals. They also mentioned that the recovery model was more helpful for staff than themselves as it reminded staff of their goals and directed their work with them:

> *It was presented to me to do a care plan and then a follow-up and it's kind of helped me with my recovery 'cause that way they know where my thoughts are and it's on paper, so they don't just forget about it if they read it or something. (Client)*

Staff differentiated rehabilitation from recovery, stating that rehabilitation was something that aligned more closely with a restorative justice process, where risk factors were worked upon to bring about real change. Recovery, on the other hand, was more about empowering the client to make their own choices, set their own goals, and the meaningfulness attached to the process of doing so. However, recovery was also seen as something that fulfills the outcomes of reduced risk to self and the community, and that part of the recovery process may involve a reduction in agency if risk is increased.

> *So sometimes part of that recovery might mean that they might have to go back to the hospital to stabilize or restabilize themselves and to prevent anything that could be harmful to the community or themselves. (Staff)*

In this respect, the concept of recovery both built and dismantled therapeutic alliances. Recovery was a stepping stone that worked toward building a healthy future and stable relationships with the community, serving somewhat in parallel to risk reductive practices.

Both the concept of recovery and the recovery model itself were recognized as not being able to surpass or reconcile previous psychiatric experiences, stigma, and current legal restraints.

> *Sometimes it's tough with mental health though, to break down those barriers, the stigma, and getting them to trust that you're willing to help, because for a lot of them, I would think that their experiences with mental health hasn't been great. (Staff)*

Staff mentioned that recovery, for both clients and themselves, involved a process of unlearning past forensic psychiatry ideals and practices. The ability for clients to make their own choices in treatment required time, motivation, and the facilitation of empowerment.

> *But I also think that it's more work for staff… because you have to spend the time with the client. Like I said before, you have to motivate them or spend the time to figure out what they need 'cause sometimes they don't know…. they've been in the system for so long that they've never had a choice. (Staff)*

Facilitating and Maintaining Hope

Staff mentioned that part of facilitating empowerment in clients is about being less judgemental and open to real, honest conversations with clients without punishing them for it. One staff member stated that they felt the recovery model had helped provide a comfortable space that could facilitate truth and betterment. Increasing hope in clients was in part related to the amount of hope staff had in their client advocacy as well as in the recovery model. Another element of this was also believing that the recovery model would create more hope in review board members that clients have the ability to succeed and that clients would feel more hope from the board's encouragement.

In terms of what facilitated hope in clinicians, the progression of the client, the achievement of their goals, and overall joy or meaning in the client's life were listed most frequently. Also, much like the process of recovery, hope in a client involved the understanding that there may be periods of

no change or setbacks and that ultimately hope needed to be based on whether the client was content with where they are.

> *That we see a client progressing from year to year to year to eventually get off the warrant. Or the ones that may still need the warrant for a longer period of time, they are happy, they are content where they are in their lives, and they've reached maybe what they consider their plateau. We may think they have a ways to go yet, but they are happy where they are at. That they actually have some joy in life. (Staff)*

That being said, hope for clients was not completely separated from reducing risk. Hope also correlated to clients achieving absolute discharge, which meant that the clinicians succeeded in their efforts. Conversely, when a client was unable to get off the warrant, both hope in the client and in the staff member's level of job satisfaction was felt as disempowering. Some staff stated that they would like to see more clients get off the warrant when they have abided requirements mandated by the review board. Similarly, they discussed the difficulty in trying to empower clients who saw the review board as an obstacle in their lives. One clinician mentioned that although their job is that of care and control, when a client is struggling in treatment, both the client and clinician experience a loss in hope.

> *I think when someone is struggling and the treatment team isn't able to intervene, I think we feel like we have less hope in them and I think they feel like they have less hope for themselves as well. (Staff)*

Another staff member stated that the amount of hope they feel throughout a client's recovery is ultimately unrelated to the duty that they have to fulfill. "Do I have more hope or less hope? My job is the same. Obviously, we want all of our clients to succeed. Some won't get there."

One individual found NCRMD talked about feeling hopeless and the effects it had both on their personal and legal recovery. The individual lost their conditional discharge and was readmitted to the hospital after going into a manic state. When asked about hope in treatment, the client responded.

> *No, that's a really fair question 'cause what would have affected that negative decision I made I was referring to earlier…. Like if you feel hopeless about your situation or things are getting to you because say, progress has been halted or even there's been steps backwards and you feel like you'll never get out of the situation, you might just stop caring and for a brief moment may make some stupid mistake. (Client)*

Without a feeling of hope and empowerment in their lives and in their treatment, client progress was halted. During difficult times, through the social support of the treatment team, clients mentioned that they were reminded that poor decisions were not necessarily characteristic of the individual but rather based on feeling a sense of hopelessness. Clinicians stated that conversations about situations that halted recovery were not about blaming the client for what they did but having them take personal responsibility and discover the reasons why it happened in the first place.

Client Responsibility and Accountability

Personal responsibility in a forensic setting was understood both by staff and client as:

> *… understanding and being able to take responsibility for a person's mental wellness, such that they can maintain the ability to be safe in the community and understand what they're doing with regards to social norms and if not that at least the legal system. (Staff)*

As much as staff felt that the recovery model is a step in the right direction, there was still a consideration as to how the model's emphasis on accountability could fit into a forensic framework.

> *I think it's a model that's sort of recognized as beneficial…. It's definitely the*

model that we should be using primarily, but I think it's difficult to interpret how accountability and responsibility for the patient fits into it. (Staff)

Part of this had to do with staff criticism that the recovery model can be interpreted or applied without clients being fully responsible for their actions. This would, in turn, remove the natural consequences associated with decision-making that we face in our day-to-day lives. As such, the client would be shielded from consequence and the potential for public risk could become apparent when they are no longer guided by outpatient staff members.

Conversely, it was suggested that outside of the recovery model, other contemporary models also shield clients from being held personally responsible.

So, lots of times our clients end up being shielded from those original, natural consequences because they have so many supports around them. So, we end up sort of having to make those, uhm, consequences more, more black and white for them. (Staff)

This was seen as making it more difficult for a client who is under the recovery model to fully understand personal responsibility in decision-making. One clinician mentioned that it's easier for clients to be dependent on staff to make choices for them than it is to make choices for oneself and be responsible for the outcomes of these choices.

I think it, in ways, wears heavier on the client because it's sometimes hard to figure out, especially if you have a mental illness or are kind of lost, right. Especially if you've made a lot of choices, being at the centre and having to direct your own path is sometimes harder than having someone tell you "This what you have to do. This is how you're going to make it better. I have the answer for you." (Staff)

Another staff member had a differing perspective, mentioning that when risk management and the recovery model are done in conjunction, risk would decrease, hope and agency would increase, and the recovery process would be shorter. It was also stated throughout interviews with psychiatric professionals that if a client was taking the recovery model seriously and risk factors were being managed, trust in clients and in the recovery model would increase. As one clinician pointed out, even if clients partake in risk-reducing activities to gain more agency, outcomes will still be of benefit because they have been personally responsible for their choices, they made those choices for themselves, and they aligned with factors that benefit mental health.

The complexity of what choice means for a client encouraged clinicians to interpret choice as being more guided than free. Complete free choice was seen negatively and understood as not only allowing the client to be able to choose whatever they wanted but also having the option to choose nothing at all. By allowing a client to make the choice not to participate in bettering themselves through treatment, staff believed this undermined the personal responsibility that links choice and consequence, and also undermined the efforts made by clinicians to facilitate client success.

Some may take advantage of it… some may have the attitude where "I don't feel like doing anything" for the next 2 months, 6 months, 2 years. When they're delaying recovery. (Staff)

In terms of clinician responsibility, none of the staff felt that the recovery model had in any way changed the level of personal responsibility or liability they had in client decisions and actions. For clients, it was mentioned that their legal obligations made them personally responsible regardless of what model is being used. Some mentioned that this was because free choice in a forensic psychiatric setting disregarded individual circumstances that a patient may be faced with.

All clients interviewed felt that what the recovery model was trying to implement, such as goal planning, self-monitoring, and collaborating with

staff, was something they had personal responsibility doing regardless of what model was being used. Many also felt that the amount of responsibility and choice they experienced was the most someone in their legal situation could have.

Balancing Agency

The emphasis on client agency under the recovery model is not just providing clients with more choice, but helping clients understand the choices that are available to them and facilitating a sense of empowerment through that understanding. A critique of previous treatment models was that the motivation for a client to comply with treatment and court-mandated orders was achieved through external force. However, this motivation had no lasting effect on the client once they were discharged. The recovery process, in the opinions of psychiatric professionals, allows for more internal change and better treatment compliance.

> *Teasing out that concept of choice for them and with them is really what it's about, at least in my understanding what they can choose, and lots of times with the legal system, we're restricted in what choices they can make, but I think having them make those choices, understanding that they're making those choices and how those are affecting them. (Staff)*

This concept was also reiterated by clients, as one stated, "It's up to me if I'm going to comply with my disposition order." Most clients also felt that the amount of agency they had currently experienced was sufficient to them and that they were satisfied with the amount of choice they had, or even if they had more choice, they would be in a very similar position as they are right now.

The issue with facilitating agency while minimizing risk also arose in the interviews with staff. They noted that the more agency a client has in making decisions, the more limited they may be in other ways due to the legal disposition both the individual and staff have to abide by. In other words, increased client agency can be complicated by risk factors.

> *It's easy to talk of sharing power when you're talking about "Do you want to go to school?" or "Do you want to get a job?" It's different to talk about sharing power when you're like "I know you want to come off your medication, but that means that we have to put you into a secure hospital setting to do that because we're pretty convinced it's going to be dangerous to you and to other people. (Staff)*

In this regard, balancing client agency grew to include balancing both the ideals of the recovery model with the practice of risk management. However, it appears the recovery model cannot be practised as a separate system apart from risk management, but rather as an auxiliary component of risk management.

> *We want to be able to let them take ownership of their lives and make those decisions so that in the end, or if there is any chance or warnings that there is going to be risk, we need to manage it and then (the decision) kind of becomes a treatment team decision. (Staff)*

The issue of balancing care and control with recovery and risk also confused the stability of the therapeutic alliance necessary for the practice of the recovery model. Practitioner-patient relationships was less dependent on how well fit both parties were with one another, but whether staff were perceiving the client as at risk versus in recovery. Through this, clients felt inclined to govern themselves in ways that would make them appear capable of managing themselves without intervention or concern for the risk they may pose.

> *They're nice people and you can talk to them, but like I said, they're friendly, not your friends. So, you still have to watch not what you say, but how you say it. 'Cause they look at it, from my understanding, they look at things from a risk factor. What's the possible risk that I could be doing and if I just say it wrong, then I could be penalized by it. (Client)*

> *It really seems like if there's any one negative thing, even if it's completely out*

> *of your control, they will take that and punish you for it. (Client)*

Psychiatric staff acknowledged that working with individuals found NCRMD usually involved a long-term, close working relationship that can seem intrusive at times. Ideally, staff-client relationships should consist of equal power relations, but in practice within the forensic system, there is an undeniably large power differential that cannot be avoided due to the legal conditions imposed on the individual and enforced by the professional. Staff acknowledged that situations where clients exert personal agency can be potentially a double-edged sword because greater independence can also increase the amount of risk or concern staff have for the client's mental stability. These concerns directly impacted whether a client's agency in decision-making would be allowed or minimized.

(Re)Considering Risk

In relation to the process of minimizing choices available to the client, psychiatric staff acknowledged that sometimes restrictions were imposed on clients that may not have been necessary to ensure safety.

> *Like there are times that we might be a little more conservative, a little bit more restrictive than what might be ideal, but I think that also comes from also kind of erring on the side of caution. (Staff)*

Cautiousness stems from the clinician's duty to manage the client's risk to themselves and the community. The emphasis on risk management often prevented staff from engaging in activities with the client that were not directly risk related.

> *Maybe I'd like to spend more time with somebody or help them get more engaged with something, but it doesn't really benefit them risk-wise, and in that respect, I'm not supposed to spend my time doing that. (Staff)*

Recovery model principles did not always align with risk management tasks and at times seemed to challenge the concept of risk. Staff reported that some client activities that appeared to be risky previous to the recovery model may have been seen as such because they did not align with what a "normal" lifestyle looks like. An example of this that was brought up by two staff members who described an issue with one client who breached his disposition every day by smoking marijuana, but who otherwise posed minimal risk to himself and others.

> *So, always looking at it from a risk perspective and saying, "Okay well, yes he got a positive screen, but he's not ill, we don't feel he's posing a risk now," so what do we do about that? Do we breach him and put him in the hospital where he really doesn't need an admission? (Staff)*

> *I'm not saying I'm a proponent of drug use, but he's not really a harm right now. He's not causing any harm, his mental health has actually improved, but I strongly believe that the board would not accept that life choice and would expect him to quit and stop using before they would ever consider giving him any more freedoms or liberties. (Staff)*

The responses from both staff members challenge typical notions of risk and also suggest that minimizing choice and uncritically imposing risk management strategies can actually be counterproductive. Staff also discussed this dilemma when daily routines were considered, questioning when lifestyle choices become risk factors.

> *Before we used to be like "If you don't keep your apartment reasonable, we have to move you back to hospital" but now we don't do that. We say "Well, how come you're not able to do it? What can we do to help you?" Maybe it's just okay that it doesn't get done. Maybe that's better, right? I don't know. (Staff)*

Clinicians described the rigidity of the review board in defining acceptable lifestyle choices that had to be met to be considered the lowest possible risk and at consideration for conditional or absolute discharge. A staff member stressed

that along with opening up the definition of what risk is, for the recovery model to work in a forensic setting the review board would also have to be open to interpreting what is and isn't an acceptable life choice in relation to this new definition of risk.

> *So, part of it is having them accept the model and accept individual's different life choices. So, I'm not saying about a choice that harms others, but having choices that may not necessarily be someone on the board's choice in life but being able to accept that it's someone else's choice in life. (Staff)*

> *It's a very westernized Canadian lifestyle that they expect people to live, whereas we have, if you look at our patients, all types of people with different genders and different sexualities, and stuff like that and that I think is really hard for the board to understand. So, then the individual is expected to live this very prescribed lifestyle… and so it has pushed some very marginalized and very vulnerable individuals into a system that really doesn't work for them. (Staff)*

If such issues are not reconciled, staff questioned how the recovery model and its basic principles would be able to be sustained. Ultimately, the recovery model would have to adjust to current practices and ideals of the review board, or the review board would have to adjust to the recovery model and new notions of what the concept of both risk and recovery mean.

Discussion

Since the establishment of the M'Naghten Rules more than 150 years ago, individuals found criminally insane have experienced a wide variety of approaches in their care and control. A contemporary approach used in psychiatry is the recovery model. The six themes highlighted within the results of this study—choice, recovery, hope, responsibility, agency, and risk—demonstrate that the simplicity of the recovery model is complicated by the complexity of the forensic system. The questions around the use of the recovery model in a forensic setting are less about whether it can be applied and more about how its application interacts with these themes and the dominant risk management approach. Several issues become apparent when the recovery model is implemented in a forensic psychiatric outpatient setting.

First, the legal dispositions imposed on individuals found NCRMD continue to restrict autonomy when the recovery model is used within a forensic setting. No matter the amount of choice and agency clients and clinicians believe they have, both acknowledge that these concepts are bound by legal dispositions and risk management practices, which take precedence. Although choice and opportunities for agency are provided to clients, these choices are constrained by the expectation that clients can and will make decisions that align with the expectations of their care providers and the review board. Moreover, if a client withheld the demonstration of autonomy or responsibility, the progress of their recovery was questioned and they were likely to experience increased monitoring, independent of client preference or whether they felt ready or had the capability to make decisions for themselves.

Second, at a fundamental level, definitions of recovery differ between the recovery model and the risk management model. The recovery model allows clients to self-define recovery, which means that recovery will mean something different for every individual. On the other hand, the risk management model defines recovery using much narrower, more standardized clinical indicators (e.g., remission, compliance, insight) or absence of recidivism. With such potentially different objectives, what is considered recovery in one approach might be insignificant or irrelevant in the other.

A final implication of the use of recovery model techniques is that they can be adapted into risk management techniques. Clients mentioned how the model seemed to serve as a tool for the treatment team to check up on them and know what they were thinking or doing. In this respect, the recovery model can be perceived as another

risk assessment tool—a mechanism to assess and govern clients while also holding them responsible for their individual choices.

Conclusions

This research highlights the challenges faced by individuals who simultaneously experience mental health and criminal labels. Both clients and staff acknowledge how the amount of choice a client could have was less about their ability to make choices and more about whether these choices were considered high or low risk, and whether they align with court-mandated orders. Although the recovery model aims to individualize the treatment process, the question remains, how much and in what areas can individualization in treatment occur? For clients, even the decision to participate in the recovery model was not of one's own course of action but an available procedure that the forensic system has in governing the individual. In this setting, it appeared that clients who were already in a good position in their recovery were selected to participate in the recovery model and collaborate on their treatment decisions. What was required of clients to participate in the recovery model was a demonstration of compliance and the ability to govern themselves, reduce risk factors, and make choices that would facilitate success in the system. In other words, to be selected to participate in the recovery model, one had to demonstrate that they were already successfully engaging in recovery model practices.

The findings of this project are similar to previous studies that examine the use of the recovery model in forensic psychiatric settings. The recovery model becomes limited in its application when risk management techniques take precedence [27,34,40-42]. While the recovery model succeeds in increasing choice, hope, and responsibility in the client, it appears that it cannot be implemented without compromising some major elements of the model. The tensions between the introduction of the recovery model and existing risk management practices prove to be complicated and suggest that the application of the recovery model cannot be fully implemented without modification to some of the basic tenets of the model. Amalgamating the two models raises the question: has the recovery model been implemented into a forensic setting, or has forensic psychiatry simply utilized components of the model that are beneficial for risk management strategies? The recovery model, in its purest form, appears incompatible with the culture of current forensic psychiatry. This disparity highlights the complicated balance that forensic psychiatry attempts to strike between care and control, risk and recovery.

Conflict of Interest: none

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Ethical Approval:

This study was reviewed and approved as quality improvement research by the MacEwan University Research Ethics Board. The study was also endorsed by Alberta Health Services Research Office.

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ORIGINAL ARTICLE

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Psychiatric admissions: The first law in Saudi Arabia

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The Mental Health Care Law in Saudi Arabia was passed in 2014. This paper focuses on the articles of the law that are related to psychiatric admissions both voluntary and involuntary. The mental health-care law is similar to the laws in western countries. However, these articles and subsections are curtailed to the limited health systems and to the local culture. As the mental health-care system and culture evolves, the mental health-care law will be modified in the future.

Key words: Mental health, law, Saudi Arabia, legislation

Introduction

For centuries, physicians practised medicine without a law guiding their practice. They took an oath relevant to their region or religion, and they were expected to be knowledgeable and wise. The first known laws regulating the work of physicians are almost 4000 years old: the Hammurabi's law [1]. Fifteen hundred years later, Aristotle and Hippocrates modified many of the ways physicians interacted with their patients, students, and teachers [2,3]. This was followed by a period when those healing and treating lost the scientific perspective brought by earlier scholars and became magical and surrounded by superstition. In Medieval Europe, supernatural powers were thought to cause illness and the aim was to salvage the soul rather than treat the body [4]. Islam's teachings, through the Quran and Hadeeth (sayings of the prophet Muhammad) and the translations from Greece and other cultures, shaped medicine in the Islamic era [5].

The first asylum for the sick was called "bimaristan" and was the earliest form of hospitals. The hospital policy was that

> *the hospital shall keep all patients, men and women, until they are completely recovered. All costs are to be borne by the hospital whether the people come from afar or near, whether they are residents or foreigners, strong or weak, low or high, rich or poor, employed or unemployed, blind or signed, physically or mentally ill, learned or illiterate. There are no conditions of consideration and payment; none is objected to or even indirectly hinted at for non-payment. The entire service is through the magnificence of God, the generous one.*

In addition to treating patients, large hospitals had medical schools and libraries attached to them [6].

A Mental Health Care Law was passed in Saudi Arabia in 2014 [7]. It aims to regulate and promote mental health-care services. It also protects the rights and dignity of psychiatric patients, their families, and community. Lastly, it develops a mechanism for dealing with and treating psychiatric patients in a mental health treatment facility.

Before 2014, psychiatric facilities self-regulated and followed the general health law [8,9]. Modern mental health care is only a few decades old, so the need for a mental health-care law is relatively recent. The first psychiatric hospital in Saudi Arabia was built in 1952 in Taif near the

holy city of Mecca [10]. By the 1980s, there were only two main psychiatric hospitals. Decentralization of psychiatric services led to the establishment of 21 regional psychiatric hospitals. By 2014, these hospitals were also supported by psychiatric clinics in more than 125 general and private hospitals [10].

In general, many of the articles in the Saudi Mental Health Care Law are similar in principle to the cultural norms in Saudi Arabia. The culture in Saudi Arabia is deeply rooted in Islamic teachings. At the same time, the law is similar to those of western countries. Stating that the Saudi mental health care is rooted in Islam and similar to western laws may seem contradictory, but core western values like democracy, freedom and justice are also found in Islam.

When mentioning admission in psychiatry, an involuntary process and restriction of freedom comes to mind for many. An involuntary admission is a legal procedure when a mentally ill individual is admitted against their will. The history of involuntary admission dates back to the early history of mental illness. Social stigma lead some societies to confine mentally ill patients to their home and their relatives used to hide them. The other extreme involved patients with mental illness being left to wander in the streets, vulnerable, dangerous to others or all three, depending on the nature of their mental disorder and associated behaviour. Today, involuntary admission mainly occurs when the individual with mental illness is considered dangerous to themselves or others, in theory, resulting in a decrease in the rate of mental health-related suicide and crime.

The involuntary admission debate is vast [11-14]. Regulating mental health admission is necessary to avoid the tragedies associated with confining relatively healthy people for extended periods of time or freeing an ill person resulting in suicide or crime [15]. In this article, the author addresses the main concepts of psychiatric care according to the new law in Saudi Arabia, specifically an analysis of voluntary, emergency and involuntary admissions.

Voluntary Admission

The principles of the voluntary admission are specified in Article 10. It states that an

> *admission to a mental health treatment facility shall be voluntary upon written consent of a psychiatric patient if capable of giving consent, or his guardian. A patient may leave if he so wishes unless involuntary admission applies to him.*

Article 10 solves a long-time problem in Saudi Arabian psychiatric facilities. It was a common defensive practice to only discharge a patient if a relative came to collect them. This put a strain on already limited psychiatric beds. The number of beds is 1.25 per 10,000 population, compared with 8.7 and 3.3 in Europe and the Americas, respectively [16]. The news media has noted that there were 356 patients in the main psychiatric hospital that should have been discharged, but nobody came to collect them [17].

The problem becomes more complicated when the psychiatric patient is female. This is due to the common practice that a woman is always accompanied by her legal guardian (father, brother, son or husband) when conducting official business, including admission, discharge, and consent for any medical procedure. This is not based on any law. The basic law of Saudi Arabia, Article 31, says that the state takes care of health issues and provides health care for every citizen without differentiating between males and females in any subsections [18]. If a patient was admitted voluntarily, they can be discharged against medical advice unless the conditions of an involuntary admission are present.

Emergency Admission

The legal requirements of an emergency admission are considered in Articles 11 and 12 of the Mental Health Care Law. Article 11 provides the background of the emergency admission. It states that

> *a physician working in emergency departments in all hospitals shall have the authority to provisionally admit a*

psychiatric patient under emergency admission for observation and treatment purposes if the involuntary admission conditions set forth in Article 13 of this law, excluding paragraph 3 of said Article, apply to said patient.

Article 13 is the first article of the Mental Health Care Law that refers to involuntary admission. Any physician covering the emergency room can admit "a psychiatric patient" against their will for up to 72 hours. The conditions for emergency admission are similar to involuntary admission, without the need for two psychiatrists' evaluation and signature. The first condition is the clear evidence of severe mental disorder that represents an actual or potential threat to self or others at the time of examination. The second condition is that the admission is necessary for the recovery, improvement or control of the deterioration of the mental condition.

As soon as the patient is admitted, they will be evaluated by two psychiatrists and the emergency admission will either be converted to an involuntary admission or revoked. If the emergency admission is conducted in a non-psychiatric facility, then the emergency physician should inform management about the emergency admission. Arrangements should be made to transfer the patient to a psychiatric facility in the same city if a bed is available or any nearby mental health facility.

Article 12 of the law allows other health-care professionals to decide whether to keep someone in hospital during the initial phase of their evaluation. It specified that:

In the absence of a specialized psychiatrist or any other physician to assess the condition of a psychiatric patient, a psychologist, social worker, counsellor or psychiatric nurse may involuntarily detain said psychiatric patient in the hospital on a temporary basis.

In this article of the law, a psychologist, social worker, counsellor or psychiatric nurse may involuntarily detain a psychiatric patient for 8 hours. The wording of the law is "detention" not "admission" because these health professionals do not have the privilege of admitting.

The author is not aware of any other mental health legislation that permits a social worker, counsellor, psychiatric nurse or psychologist to detain patients.

The most likely reason for including other health professionals in this article of the law is the great shortage of psychiatrists. In 2016, there were 718 qualified psychiatrists serving 32 million Saudis, compared with 2200 psychiatrists serving 34 million Canadians.

Another possible reason for including other health professionals is that the need to detain individuals sometimes arise outside of the hospital, and the first responders are social workers or nurses, not physicians. In cases where there is an immediate danger to the patient or others, it may be more effective to train more people in mental health first aid. All health-care professionals in Saudi Arabia are required to attend emergency training when renewing their licences (such as taking a cardio-pulmonary resuscitation course).The person making a temporary involuntary detention decision will inform the physician on duty and the administration of the mental health treatment facility of the condition of the psychiatric patient. The temporary involuntary detention period expires after 8 hours or when a physician's evaluation of the patient.

The exclusion of the third section of Article 13 is because many emergency departments are not covered by psychiatrists. Therefore, to prevent actual or potential harm to self or others, it is the duty of the emergency department physicians to assess and decide if an emergency admission is necessary. Ideally, a psychiatrist will examine the patient within a relatively short time and make a proper evaluation before either continuing the involuntary admission or revoking the emergency admission. In unfortunate situations, when psychiatrist is not available, it is not clear whether the duration of the emergency admission can be extended by the emergency physician or the team following the patient. Usually, management is involved as early as possible to

arrange to transfer the patient to a mental health facility or to have the patient assessed by the psychiatrist.

Involuntary Admission

Articles 13, 14, 16 and 24 of the Mental Health Care Law dictate the legal conditions of a psychiatric involuntary admission. The conditions for involuntary admission are the same as an emergency admission with the addition of the evaluation of two psychiatrists justifying the need for the admission. The legal process is similar to many mental health acts in other countries; however, in the Saudi law, no attempt is made to differentiate whether the individual has insight or not. Safety of the psychiatric patient and others takes precedence over their right to consent to the admission. Also, the interpretation of the actual and potential threat is left to the judgment of the attending health-care professional in the case of an emergency admission or the psychiatrists in the case of involuntary admissions.

These legal requirements involve other services because the detention can occur outside the mental health facility. The transfer of involuntarily admitted patients to a mental health facility is of the responsibility of the following government sectors:

- Red Crescent (RC)
- Ministry of Interior
- police department.

When the RC is called to transfer the patient, the patient should be accompanied by a family member. If the patient resists transfer or threatens the RC with a weapon, police are called. RC personnel phone the receiving mental health facility for any queries about the transfer and ensure that the patient is settled before arriving at by the facility.

The Ministry of Interior will be involved if the patient is carrying a weapon. Once under control, the patient should be kept in the same area where they were initially assessed, and the RC becomes responsible for transferring the patient to the mental health facility.

If the patient has already committed a crime, they are taken to the police station.

The RC trains its personnel about psychiatric disorders, addiction and how to effectively respond to aggressive psychiatric patients. The Ministry of Health directs this training.

The Ministry of Health is responsible for receiving patients from the RC or the police. Indeed, it is the ministry's responsibility to ensure the RC and the police have access to the addresses and phone numbers of the mental health institution to facilitate direct contact with the on-call psychiatrists. In addition, the ministry provides private security services inside the mental health facilities.

The initial duration of the involuntary admission is similar to emergency admission (72 hours). This can be extended to 30 days, then 90 days and 180 days, if needed. Each time an involuntary admission is extended, the psychiatrists immediately notify the administration of the mental health-care facility. Once the justifications for the involuntary admission cease to exist, the admission should be terminated even if the stipulated period of admission has not expired. For each extension, two psychiatrists provide a report justifying the extension of the involuntary admission. The condition of the admission and the justification for its continuation are reviewed regularly.

If the patient is still unstable after 180 days, the local supervisory board for mental health-care reviews the case and makes the decision to continue with the involuntary admission. The patient, their guardian or legal representative have the right to request the discontinuation of the involuntary admission by the mental health facility. A response is given within 7 days. If the mental health facility rejects the patient's request and they wish to appeal, they can apply to the local supervisory board for a review of the decision. A response is given within 21 days. In addition, when an involuntarily admitted patient poses an actual or potential threat to someone, the guardian or legal representative as well as the police are informed. The same process applies when a

patient escapes, with the addition of the administration of the mental health treatment facility coordinating with law enforcement agencies to recommit the patient.

To ensure that psychiatric patients' rights are respected, the mental health treatment facility is required to review all the conditions and procedures of involuntary admissions. The local supervisory board for mental health care is notified of the names of involuntarily admitted inpatients within 48 business hours from the time of admission. The mental health treatment facility is required to maintain a record of the patient's name, age, nationality, distinctive features, identification number, date of issuance, admission and discharge dates, name of the person who brought them in, if any, and all other necessary information. The mental health treatment facility should allow the members of the general and local supervisory boards for mental health care, representatives thereof, and committees set up thereby, to perform their supervisory functions provided for in this law in all departments of the treatment facilities. Articles 3 to 8 cover the law regulating the general and local supervisory boards for mental health care. Both boards are not yet well-established.

Conclusion

This first mental health law in Saudi Arabia has been a major step in the improvement of the care of psychiatric patients. It has helped organized the processes that regulate their admissions. Saudi Arabia is making progress in creating these laws and implementing them. The Mental Health Care Law is now similar in many ways to those applied in western countries. Many of the articles and subsections are interpreted in the context of the available health system. As Saudis see an improvement in the mental health system and an increase in the number of psychiatric facilities and psychiatrists, the mental health law will continue to evolve.

A legal framework is necessary to regulate the rights and duties of individuals living in a community. The Mental Health Care Law in Saudi Arabia is present to ensure that professionals act responsibly with individuals who may be vulnerable due to their mental disorder.

Conflict of interest: None

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Case Report

Kratom-induced psychosis: Case report and literature investigation

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Substance use disorder is a major concern for public health. Legal substances are often misused to get high. Beside the risk of developing subsequent mental health and physical conditions, one of major risk is related to behavioural changes leading to criminal behaviour. Some of these substances need regulation to ensure public as well as individual safety. This article is a case report describing Mitragyna speciosa (Kratom) induced psychosis in a patient suffering from schizophrenia. We hope this article can bring attention to regulating bodies about the risks associated with readily available "legal" drugs like Kratom.

Key words: Psychosis, schizophrenia, Kratom, Mitragyna speciosa, drug-induced, legal highs

Introduction

For the last decade we have seen an increase in the amount and variety of substances that have infiltrated the drug market. They are being abused for their neuroactive properties. Most of these substances are legal, and readily available. They pose a significant risk to consumers due to the lack of scientific studies and quality control of the products [1]. These substances can be natural products with psychoactive effects, chemically altered products, or misuse of an existing drug (i.e., gravol) [2]. They are qualified as "legal high" or "herbal high" when these substances are not prohibited by the country where they are used. The most commonly used and widely published are caffeine pills, synthetic cannabinoid, and cathinones found in bath salts [3].

Mitragyna speciosa is one of these new substances. It is found on the market under the name Kratom and can be found associated with other substances under the names Ketum, Krypton, K2, depending on the other substance(s) present. This product comes from the leaves of a tree primarily from Malaysia and Thailand and is known for its opioid-like symptoms [4].

Mitragyna speciosa, among the other legal high substances, is of a major concern in mental health and notably in forensic psychiatry world. Its use is not prohibited in many countries, yet it can pose a major impact on a patient's mental stability and risk of violence. Our paper presents a case of a patient enrolled in a forensic psychiatry program who developed psychosis after abusing Mitragyna speciosa.

Case report

We present the case of a 28-year-old man who was diagnosed with schizophrenia. He was free from any psychotic symptoms for several years and treated with long-acting risperidone and oral olanzapine. One week after his discharge from the inpatient program, the police were contacted due to his bizarre behaviour and suspicious activities. He was brought back to the hospital. He was dismissive and irritable with paranoid thinking. His presentation was similar to his previous admissions where he presented with unstable psychotic symptoms. As a result, we increased his olanzapine to 15 mg daily.

He was kept in the hospital due to his unstable mental status and risk of violence. His symptoms evolved in three phases over a three-week period. As described above, he initially presented with a thought disorder phase, being dismissive, and non-compliant. The second phase consisted of a clear paranoid phase where he was more talkative, but oppositional, paranoid, and more extraverted. The third phase consisted of a hypomanic phase where he was being jovial, giving away his money to copatients. He had no racing thoughts or pressured speech. During his previous admissions he never had any kind of mood-related symptoms. After three weeks he returned back to baseline as a symptom free, high functioning individual.

This individual acknowledged the use of Kratom, which helped us identify it on the urine sample taken at the time of admission. His urine drug screen was also positive for Lorazepam, olanzapine and Risperidone (his current medications) and Mitragyna speciosa. He explained that he purchased Kratom off the internet because it was advertised as an anxiety relieving substance, and he had been denied an increased dosage of Lorazepam. He further articulated that he believed that Kratom would be a desirable product as it has some energizing effects.

The patient also appeared to be quite knowledgeable about Kratom, as he provided explanation as to the different types of the Kratom teas, identified by their colour (red, green, white and black) and their respective effects. He said he purchased all four types to feel more energized in the morning and get some help with sleep at night. The amount of product he used remained unknown to us.

After this incident, substance use disorder became one of the main targets of the patient's rehabilitation program. He became mindful that his brain is sensitive to any psychoactive substances, and he should remain away from it. In the past, he presented some minor but obvious changes of his mental status, which resulted from using caffeine pills.

Discussion

This case report is the first to report the impact of Kraton on an individual suffering from a severe mental illness. As detailed below, the relationship between this substance and psychiatric symptoms is not clear in literature. This case highlights that Mitragyna speciosa is a misused substance with significant neurocognitive effects and is a readily available source for a "legal" high.

Characteristics of Mitragyna speciosa

Mitragyna speciosa originates from Malaysia, Thailand and Indonesia. Due to its opioid-like effect it is used either to become intoxicated, to treat opiate addiction due to its ability to manage withdrawal symptoms, or both. The literature also describes its use by local people in South Asia for increasing energy and performance (such as driving bike taxis) [5].

The effects of Mitragyna speciosa are varied by the type and age of the plant and its veins. According to websites advocating for the use of this tea, each of the four veins have a distinct effect:

1. red vein is known for its calming influence that can help users unwind and release tension;
2. white vein is more energizing and contributes to a positive mood;
3. green vein is used as a mild energy booster that can perk the user up without putting them on edge; and
4. yellow vein is made from young leaves and has slightly higher energizing effects [6,7].

Mitragyna speciosa became popular on the internet and its "beneficial" effects spread quickly. The reason for its rapid and efficient market increase is likely due to its unregulated retail. Furthermore, it is presented as an herbal and natural product [8]. Mitragyna speciosa was banned in many countries, including Malaysia and Thailand. There continues to be no regulation in the European Union, and it is highly dependent on each individual country. It is under surveillance in the United States, after being banned for a short time. An organized protest on September 13, 2016, seemed to have played a role in the reintegration of Mitragyna speciosa as a legal substance [5,9].

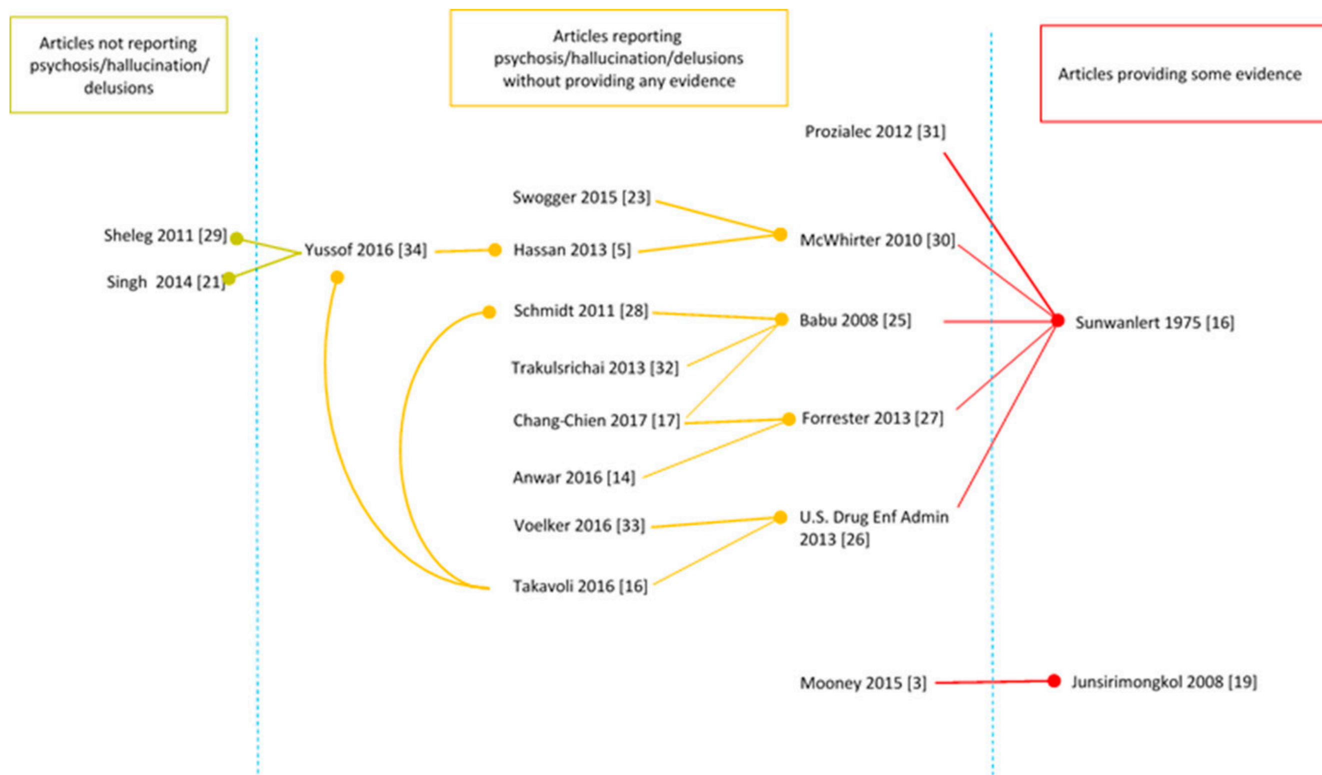

Figure 1: Articles claiming about Kratom-induced Psychosis and their sources – x ●—— y means "x cited by y"

Clinical manifestations under Mitragyna speciosa

Although many argue the potential medical uses of Mitragyna speciosa, there is a lack of data illustrating its potential pharmacological effects or its side effects [8,10]. Some articles have attributed fatalities to its use. However, in some of these cases, Mitragyna speciosa did not appear to be the only substance consumed [11,12]. One recent paper argued that it is not an opioid-like product [13]. Rather it may have antipsychotic effects due to its binding affinity to dopamine D2 receptors [11]. The data published is a result of clinical trials on animals and observational studies on humans. If Kratom was simply an opioid-like substance, it would not have energizing effects. There is definite need for more research on this substance.

One of our goals in this case report was to understand the relation between Kratom and psychosis. Many articles list the potential of developing psychosis as a possible side effect of Kratom. However, when we performed a systematic literature review using key words Kratom and psychosis or hallucination in PubMed, PsychNET, and Web of Science databases, only six articles were found [11,14–18]. This is in contrast to the several articles found when using Google Scholar. Due to this discrepancy we looked more closely at several articles from Google Scholar that claimed a relation between psychosis and Mitragyna speciosa. Many of these articles simply repeated what was stated in another article (see Figure 1). It is concerning that authors continue to repeat the same information without any clear validity. Moreover, to report Kratom-induced psychosis, some authors cited articles that never reported this possible side effect.

This thorough literature investigation leads us to believe that only one article was published exposing the risk of Mitragyna speciosa and psychotic episode [16]. Through this literature review we found that there is only a single article published in 1975 that highlights the potential risk of psychosis when using Mitragyna speciosa. This article described five instances of psychosis in 30 Kratom users. The case descriptors were quite succinct. No information about past psychiatric history of the patients (except for two out of five

who had previous diagnosis of a psychotic disorder) was provided. Furthermore, no information was provided on how the patients were diagnosed; therefore, it is possible the diagnosis was solely based on clinical opinion. An abstract from 2008 is accessible online commenting on hallucination and delusions among individuals who used Kratom [19]. Despite multiple attempts to contact the author of this abstract, we have not been able to access the full content of the article. Therefore, it seems that since 1975, there is no clear and reliable evidence about Mitragyna speciosa induced psychotic disorder. This may suggest that Kratom, on its own, does not induce any psychotic event; however, it may enhance a psychotic episode when the individual presents with some mental vulnerabilities.

Despite the low level of evidence to link Mitragyna speciosa and psychosis, the clinical observation of our case is highly suggestive that his worsening symptoms are due to the consumption of this substance. Based on the information gathered during our literature review, we felt the need to hypothesize why our patient developed these symptoms to understand why this substance has induced relapsing of his symptoms. Although opiates are not particularly known to induce a psychotic episode, some articles suggest that psychosis can result from opiate withdrawal [20]. Therefore, the opioid-like effect of Mitragyna speciosa may be the reason why our patient became psychotic. However, a recent study suggested that the substance can have antipsychotic properties [13]. Therefore, by binding D2 receptors [11] Mitragyna speciosa may inhibit the therapeutic potential of antipsychotic medication. Nonetheless, it seems that being predisposed to psychosis due to underlying schizophrenia is the reason our patient developed psychotic symptoms while using Kratom. However, there is a lack of evidence that conveys that Mitragyna speciosa causes psychosis.

The risk of legal high

Moreover, this case also raises our concerns about the potentiality of a legal high, particularly by individuals who are predisposed to behavioural changes. The risk of legal high exists at several levels. The concerns are primarily because these legal substances are considered as natural substance and are difficult to ban. Therefore, studies need to be conducted to prove the effects of the substance. This is even more difficult when the substance is identified as beneficial by a group of users such as for Kratom [1,5,21]. In addition to this, these substances come into the market as unknown substances, which cannot fall under any local regulation [1]. As a result, the European Union has not been able to make any clear recommendation on how to deal with this issue, and each country has developed its own legislation regarding Kratom [22].

The other difficulty encountered with legal high is related to the internet. The internet has been pivotal in helping spread the knowledge on the substance and where to get supplied. Some websites specialize in these substances [1,23]. They often provide information about the benefits and potential side effects. However, to our knowledge, they do not provide any information regarding the composition of the product and the potential interaction with other active substance (such as medication). Indeed, often no formal study, such as analytical chemistry, is performed. Some authors identified that the propaganda offered by the internet has two effects on the individuals:

1. it helps the young users to get introduced to legal high and
2. it offers a platform for older users to try new substances [1].

Another issue identified with legal high is related to the composition and the use of the product. A study performed in the United Kingdom analyzed the components in legal high bought on several occasions during a 6-month period [24]. It showed that although the components remained the same, the concentration variated over time. As it is often identified in addiction program, users experience side effects, sometimes leading to death, when they go to a new supplier for the same drug, as the concentration may be different, and therefore their tolerance lower. There is then a real issue related to the lack of knowledge. In addition, it was also identified for

Kratom, that the concentration used in Western countries was much higher than those available in Malaysia or Thailand, which may explain why negative outcome occur more frequently in Western countries [21].

Conclusion

Legal high in general and Kratom in particular present several issues that affects the health of people who use it. In our opinion, there is low evidence at this stage to say that Kratom has a potential to enhance psychotic episode on its own. However, it can affect those individuals who have a predisposition to psychosis. We are unsure as to how it will be regulated in Canada and the United States. What is clear however is that if these countries plan to keep this substance legal, there is a definite need for further research to highlight that the benefits outweigh the potential harm.

Conflict of Interest: none

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Letter to the Editor

Offering group mental health programs in a maximum-security correctional facility: Observations, outcomes, and recommendations

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Dear Editor,

Individuals with serious mental illness (SMI) are overrepresented in Canadian correctional facilities and make up an estimated 15% to 20% of the prison population [1]. To address the needs of this population, the Ontario Ministry of Community Safety and Correctional Services and the Ministry of Health and Long-Term Care partnered in 2015 with the Centre for Addiction and Mental Health (CAMH) to establish the Forensic Early Intervention Service (FEIS). The FEIS is a multidisciplinary psychiatric team that offers triage, assessment, and rehabilitative services for clients within a men's maximum-security detention facility in Toronto, Ontario, Canada. As part of the partnership, the FEIS has worked alongside correctional officers and health-care staff since 2016 to provide group programs for clients with mental health and addiction challenges. These programs have evolved to occur weekly in a high- security supportive care unit.

The FEIS team intentionally offers services on units where clients with the most persistent SMI are housed. Access to psychiatric support in Ontario prisons is limited due to heavy demands on resources, high turnover of inmates, and other structural factors [2]. In addition, clients may be reluctant to accept care and treatment in custody for a variety of reasons [3]. These factors present unique challenges when formulating and delivering mental health services in custody.

Therapeutic Approaches and Process

Group programs facilitated by the FEIS are designed to address the immediate mental health needs of participants. Materials are psychoeducational in nature, about one hour in length, and emphasize practical skill development. The subject matter focuses on stress management, goal setting, release planning, understanding psychosis, relapse prevention, anger regulation, medication, and other related areas. The FEIS uses therapeutic approaches that have demonstrated effectiveness in prison settings, including motivational interviewing (MI) and dialectical behaviour therapy (DBT), and integrate them into programming to address ambivalence regarding change and reduce impulsiveness [4,5].

Coordination with and input from correctional officers (COs) are essential, as they are tasked with ensuring the safety and security of all clients and staff on units. COs retain the most updated information regarding client behaviour, sleep, social tensions, and risk factors. As a result, they can most effectively identify clients suitable to be offered the opportunity to attend the program. Details regarding the physical location of the group and other security protocols are reviewed regularly with security staff to maintain the safety of all involved.

Three to eight participants typically attend each group, depending on client interest and staff consultation. Participants change from week to week as clients are released from custody or transferred to other units, though a core group of two to three usually attend regularly.

Limits to confidentiality, attendance, and information regarding health record processes are reviewed at the onset of each session. Group rules are discussed at this time and participants are given an opportunity to provide thoughts on appropriate guidelines. At the end of each session, voluntary feedback forms are distributed to gain participant perspectives regarding services offered.

Observations, Challenges, and Opportunities

From the FEIS's experience, facilitating programs in high-security settings poses a variety of challenges. Due to limited space, this program takes place outside client cells in the open area of the supportive care unit. Issues of security and staffing are often in flux and incidents in other areas of the facility (i.e., institutional searches or physical altercations) can affect the availability of staff to monitor the program. Inmates not attending the program can cause disruption by yelling or banging on cell doors. Tension among clients may be elevated and increased levels of CO monitoring are sporadically needed to reduce the risk of conflict. Client agitation can occasionally escalate to threats of violence between group members or frustration toward the facilitator, which may require CO support.

In addition to managing tensions, complex group processes require close attention. Participant sharing or side conversations often deviate from the material and may require guidance toward the rehabilitative subject matter. Grievances related to the legal system, medication distribution, and other issues unrelated to programming may require validation or redirection, depending on the relevance of the concern. Inappropriate laughter or disorganized thought processes need to be selectively addressed or ignored. Clients who find they are unable to tolerate the social environment may require space to leave the group as needed.

The FEIS has observed that motivation for change among clients attending rehabilitative programs in custody occurs on a continuum. Participants may be pre-contemplative regarding recovery and demonstrate limited insight toward the impact of their substance use. Some may attend out of a mistaken belief that engaging with services can provide an opportunity for early release. Clients who have been isolated for periods of time may be seeking opportunities to socialize. Despite the range of motivations, staff believe all participants can benefit from engaging in a pro-social group activity. This is especially true when evidence-based information is presented, a safe space for peer support is provided, and discussions create opportunities to consider alternative methods for coping.

Participants contemplating recovery demonstrate remarkable potential to engage with the material and supportive environment. Motivational interviewing techniques are highly effective with this population in identifying barriers to change. Discussions among participants can reveal the benefits and costs of changing problematic substance use patterns, as well as the costs and benefits of no change. Others in the preparation, action, or maintenance stages of change generally demonstrate good insight and motivation. These clients are most likely to learn from the material, share life experiences, develop new coping skills, and support others who may be struggling. Through engaging in prison-based mental health programs, clients can use incarceration as a turning point and opportunity to cultivate a vision for a healthier future.

Discussion

Between November 2018 and May 2019, 22 groups sessions had been offered on a supportive care unit, with about 140 clients attending and 42 submitting feedback forms. Program evaluation focused on basic questioning to assess feedback regarding client learning, whether they felt they could apply what was learned, and whether the skills discussed might help them live well in the community. Opportunities to share comments related to what was liked and disliked about the program were also provided. Table 1 presents results from the feedback forms.

When asked about what participants liked, respondents indicated: coping skills, peer support, realistic goal setting, and developing skills to help with stress, how to relax. When asked what they

Table 1 – Feedback form results

Statement	Agree	Somewhat agree	Somewhat disagree	Disagree
I learned something new from the group	88.0%	12.0%	0%	0%
I feel like I might be able to use what I learned in my everyday life	78.5%	21.5%	0%	0%
What I learned in this group might help me live and stay in the community	80.0%	20.0%	0%	0%

did not like, some participants expressed frustration regarding prison processes, others who spoke out of turn, and some material being difficult to comprehend. As outcomes and feedback continue to be evaluated, programming can be adapted to meet the changing needs of clients attending these psychoeducational programs. Responses may be disproportionately positive due to selection bias, as those who may not have been satisfied with services might not have submitted feedback forms. Furthermore, the final sample may not be fully representative of the targeted population due to group attrition. Ongoing evaluation of FEIS groups and broader programming will include efforts to obtain feedback from individuals who disengage from our services. Future research may be able to establish a correlation between positive group experiences and reduced recidivism, likely mediated through improved relapse prevention planning, medication compliance, and amenability to community support.

Recommendations

For clinicians interested in providing mental health programs in correctional facilities, we recommend fostering open communication and collaborative partnerships with COs and healthcare staff.

Having correctional staff set the time and location of groups is important, as they may have schedules for meals, medication distribution, and other activities.

Protocols for ethical decision-making must be established for addressing participant healthcare or safety concerns should they arise during groups [6].

Consistency around processes can reinforce staff and client expectations.

Flexibility is required when groups are rescheduled due to institutional issues and persistence is sometimes needed to keep programs operational. The FEIS encourages patience and empathy when supporting this population, as we may not be aware of the multiple stressors clients are coping with.

A calm, non-confrontational, and validating approach is recommended when de-escalating agitated clients, and clear boundaries should be set at the onset of sessions.

Keeping language simple and information practical is useful for maintaining group focus, as literacy levels and language barriers may affect engagement.

Finally, explicit commitments to creating a mutually respectful environment can set the foundation for productive group programs.

Conflict of Interest: none

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