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'Forensic' labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness ☆

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ABSTRACT

Increasingly, specialized 'forensic' mental health services are being developed to address the criminogenic and clinical needs of people with mental illness who are involved in the criminal justice system. Theoretically, the construction of such specialized services can produce simultaneous positive benefits and negative consequences. This mixed methods study examined and compared the level of self-stigma that was experienced by people who receive compulsory community-based treatment services in the forensic ($n=52$) and civil ($n=39$) mental health systems of British Columbia, Canada. The quantitative findings indicate that 'forensic' labelling was not associated with elevated levels of self-stigma. Quantitative level of self-stigma was significantly associated with psychiatric symptom severity, history of incarceration, and history of homelessness. The qualitative findings suggest that access to high-quality, well-resourced forensic mental health services may, for some service users, come at the risk of increased exposure to social and structural stigma. Together, these findings reveal some of the strengths and weaknesses that are associated with organizing forensic mental health services using a specialized service delivery model.

1. Introduction

Subjective experiences are shaped by macro-level social and structural factors. The manner in which society chooses to deal with mental illness – reflected in and enshrined by mental health policy and service delivery models – has both direct and indirect effects on those who live with mental illness. The structural factors that influence the subjective experience of self-stigma for people with mental illness have been the subject of little empirical attention, even though it has been acknowledged that such factors are important for the creation and perpetuation of stigma: "The policies and institutional practices we create to address social problems are critical for stigma — they can induce it or they can minimize or even block it" (Link et al., 2008, p. 409). The present study evaluates the degree to which delivering services through a specialized forensic mental health system contributes to experiences of self-stigma among 'forensic' service users.

1.1. Self-stigma

Self-stigma has been defined as a subjective process, embedded within a socio-cultural context, characterized by negative feelings and adverse outcomes that result from an individual's experiences, perceptions, or anticipation of negative social reaction on the basis of their mental illness (Weiss et al., 2006; Livingston and Boyd, 2010). A large body of research has documented the ways in which self-stigma affects the lives of people with mental illness. Studies have found that self-stigma is associated with low self-esteem (Link et al., 2001, 2008; Ritsher et al., 2003; Lysaker et al., 2007b, 2008c; Yanos et al., 2008), poor quality of life (Bjorkman and Svensson, 2005; Rüsch et al., 2006; Lysaker et al., 2007a), reduced self-efficacy (Corrigan et al., 2006; Fung et al., 2007; Watson et al., 2007), and elevated psychiatric symptom severity (Link et al., 2002; Kahng and Mowbray, 2005; Rusch et al., 2008; Rüsch et al., 2009). Research has also found that self-stigma is related to poor treatment adherence (Tsang et al., 2006, 2009; Fung et al., 2008; Adewuya et al., 2009; Fung and Tsang, 2010). While these studies offer important insights into the devastating effects of self-stigma for people with mental illness, they do not expose the structures and processes that are responsible for producing and legitimizing differences in power and social status.

Several contemporary stigma theorists (Link and Phelan, 2001; Parker and Aggleton, 2003; Scambler, 2006; Yang et al., 2007) have highlighted the need to move beyond the tradition of studying stigma at an individual-level. Accordingly, a small number of studies have attempted to consider structural-level factors by examining the extent

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to which self-stigma is influenced by features of the healthcare system, which itself may be viewed as an expression of a particular society's dominant cultural values and beliefs. Several Belgian studies have examined the organizational features that are related to stigma experiences for people with mental illness (Verhaeghe and Bracke, 2007, 2008; Verhaeghe et al., 2007, 2008). For example, one study found that the service-level characteristics of mental health rehabilitation centres (e.g., size, composition of client population, kind of supplied activities) had a weak association with self-stigma (Verhaeghe and Bracke, 2007). Another study revealed that self-stigma among people with mental illness was not significantly associated with the method by which they received psychiatric services (i.e., voluntary versus involuntary) (Link et al., 2008). Other 'structural' studies have resulted in mixed findings about whether receiving mental health care in different settings (e.g., psychiatric versus general hospitals) is associated with stigma experiences (Angermeyer et al., 1987; Chee et al., 2005; Verhaeghe et al., 2007). This body of research offers an early glimpse into the degree to which self-stigma is associated with structural factors that relate to the design and organization of health systems. Additional research is needed to deepen our understanding about the amount of influence that various policies and social institutions have on subjective experiences of self-stigma.

1.2. Forensic labelling

The forensic mental health system contains both criminal justice and mental health elements and is, therefore, often characterized as a hybrid of these two systems. A 'forensic' label is assigned to a person with mental illness after they have allegedly committed an illegal act and have been court-ordered to receive forensic mental health services. While the label is intended to serve an administrative function by communicating that the person is being treated by forensic services (Buchannan, 2002), it may symbolically imply that the person to whom the 'forensic' label is affixed is inherently different (i.e., more dangerous, prone to criminality) from others. Moreover, the creation of a 'forensic' mental health service user has the potential to trigger additional exclusionary processes that deepen the marginalization of this social group.

The pernicious effect of 'forensic' labelling has been alluded to in a number of publications (Whittle and Scally, 1998; Skipworth and Humberstone, 2002; Arboleda-Florez, 2003), and has been identified as a substantial barrier to successful community reintegration: "An individual who acquires the 'forensic' label is severely compromised in his/her ability to access opportunities (e.g., employment, housing) normally available to civilly committed clients and the general population" (Ontario, 2002, p. 25). Indeed, qualitative studies with offender populations in correctional systems have confirmed that the 'dual stigma' of living with mental illness is perceived as a major challenge for community re-entry (Roskes et al., 1999; Hartwell, 2004). To date, only one study has been published on the topic of self-stigma for people who receive forensic mental health services (Margetic et al., 2008). The study, which involved 62 men who were receiving services in the Croatian forensic psychiatric system, detected a few variables that were correlated with stigma experiences (e.g., more severe psychiatric symptoms, younger age, and non-violent offence). While the study offers preliminary findings about the stigma experiences of people who receive forensic psychiatric services, it did have some methodological limitations, including a non-comparative design and a weak measure of stigma that only consisted of three items. The present study addressed these limitations by using a standardized measure of self-stigma and by comparing the experiences of forensic and non-forensic mental health services users.

Forensic mental healthcare in British Columbia (BC), Canada has evolved into a highly-specialized system with inpatient and outpatient services that largely operate in parallel with the civil mental health system. Our overall objective was to examine how service users of a specialized 'forensic' system experience self-stigma. It was hypothesized that a relatively high level of self-stigma would be found among persons with mental illness who are assigned a 'forensic' label.

2. Methods

2.1. Participants

A non-probabilistic sampling method was used to recruit participants. At the time of recruitment, each participant was receiving compulsory community treatment services within either the civil or forensic mental health systems of BC, Canada. Inclusion criteria were: (i) certified under the BC civil *Mental Health Act* (civil group) or adjudicated 'Not Criminally Responsible on Account of Mental Disorder' (NCRMD) under the *Criminal Code of Canada* (forensic group); (ii) receiving compulsory treatment in the community for at least 30 days; (iii) 18 to 65 years of age; and (iv) diagnosed with either schizophrenia, other psychotic disorder, or bipolar disorder. Psychiatric diagnosis was not independently confirmed; rather, it was ascertained by reviewing each participant's medical file to identify the diagnosis that had been formulated by their treating psychiatrist.

Baseline interviews were completed with 91 individuals (52 forensic, 39 civil). An overview of the participants' sociodemographic and clinical characteristics is provided in Table 1. In comparison to the civil group, participants in the forensic group were more likely to be male, be living in a supported/transitional setting, and have had an overnight stay in jail or prison. As well, participants in the forensic group had significantly ($P<0.01$) fewer unmet service needs (CANFOR). Regarding psychiatric symptom severity (BASIS-24 total), there were no significant differences between the average scores of the forensic ($M=0.73$, $SD=0.46$) and civil ($M=0.82$, $SD=0.47$) groups ($F=0.78$, $df=1,88$, $P>0.05$). On average, forensic participants had been involved in the forensic mental health system for 5.5 years ($SD=5.8$, median $=4.0$) prior to the study.

2.2. Design and procedure

The research protocol was approved by the Simon Fraser University Research Ethics Board and written research consent was obtained from each participant. A cohort design with a quantitatively driven mixed methods approach that included a simultaneous qualitative supplemental component (QUAN + qual) was used (Morse and Niehaus, 2009).

The primary mechanism for collecting data was self-report, in-person, structured interviews with the participants. Standardized, quantitative measures were administered to the participants. Unlike a rigidly prescribed structured interview, the mixed method approach that was adopted provided a degree of flexibility to the interviewers by allowing them to probe participants' responses in order to uncover deeper meaning in relation to their experiences of stigma. The quantitative measures were also supplemented with open-ended questions that were inserted into the structured interview guide. Interviews were not audio recorded; however, the interviewer ensured that the participants' narratives were accurately captured by the detailed field notes. The qualitative data presented here focuses on the forensic participants' responses to a question that asked about their experiences of stigma in relation to their 'forensic' status. Each participant's clinical case manager was also interviewed in order to assess the participant's current service needs.

2.3. Measures

2.3.1. Psychiatric symptom severity

Psychiatric symptom severity was measured using the Behavior and Symptom Identification Scale-24 (BASIS-24) (Eisen et al., 2004). The BASIS-24 is a self-report measure for assessing the symptom severity and functional difficulties of people with mental illness. The measure consists of 24 items and assesses the following six domains: depression/functioning, interpersonal relationships, psychotic symptoms, alcohol/drug use, emotional lability, and self-harm. Overall, the BASIS-24 demonstrated good internal consistency ($\alpha=0.83$).

2.3.2. Quality of life

Quality of life was measured using the Wisconsin Quality of Life Index (WQL) (Becker et al., 1993). The WQL is a self-report measure of quality of life for persons with severe mental illness. It consists of approximately 100 items that address the following eight domains: life satisfaction, occupational activities, well-being, physical health, relationships, finances, daily living, and psychiatric symptoms. The WQL total score contains 45 items that demonstrated good internal consistency ($\alpha=0.87$).

2.3.3. Service needs

Service needs were measured using the forensic version of the Camberwell Assessment of Need (CANFOR) (Thomas et al., 2003). The CANFOR evaluates service needs across 25 domains and queries whether community services and supports have sufficiently met the needs of the service user. The CANFOR has demonstrated high levels of inter-rater reliability and moderate to high levels of test-retest reliability (Thomas et al., 2008).

2.3.4. Self-stigma

Self-stigma was measured with the Internalized Stigma of Mental Illness (ISMI) scale (Ritsher et al., 2003). The ISMI is a self-report questionnaire that is designed to measure the internalized, subjective experiences of stigma for people with mental illness. The ISMI consists of 29 items and contains five subscales: alienation, stereotype endorsement, discrimination