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# “Quietly Going Nuts in the Bush”: Challenges in Providing Forensic Mental Health Services in Rural British Columbia

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**Abstract.** Forensic mental health services operate in a multi-jurisdictional environment to monitor and support mentally disordered persons accused or convicted of a crime in Canada. Little is known about how these services operate in a rural context or the unique challenges they face as compared to urban settings. In-depth interviews were used to examine the perceived challenges of providing forensic services to those living in rural British Columbia. Themes that emerged suggest challenges associated with travel, resource capacity, and gaps in information sharing are some of the most difficult obstacles for service providers to overcome. Forensic psychiatric services are in demand and valued in rural areas. Suggestions for how to improve access to these services are discussed.

## Introduction

In the last decade increasing scholarly attention has focused on the prevalence of mental disorder in those processed by the criminal justice system. Since the times of deinstitutionalization growing numbers of people with mental illness are coming into contact with courts and correctional services, and this trend is expected to continue (Correctional Services of Canada, 2006; Livingston, 2008; Somers, Carter, & Russo, 2008;). Recent studies estimate that one in ten men and one in five women in federal custody have mental health problems (Correctional Services of Canada, 2006).

The increase in rates of mentally disordered offenders is concerning. Inmates with behavioural problems or mental disorders are victimized and experience trauma more often than non-mentally disordered inmates (Blitz, Wolff, Shi, 2008; Kinsler & Saxman, 2007). The presence of a mental or addictions disorder can also complicate rehabilitation efforts resulting in the “revolving door syndrome” of repeated incarcerations (Haimowitz & Applebaum, 2004). The ability of a community (or a region) to provide resources and support to reintegrate a mentally

disordered offender (MDO) will impact the health and wellbeing of that person and the community in which he/she lives (Hiday, 2006; Livingston, 2008;).

Significant discussion exists about how health and justice services can work together to address the problem of people ending up in a penal system that is not designed to treat or correct mental illness (e.g. see Somers, Ogloff, Ferguson, & Davis, 2004). The overlap of these two social systems complicates the task of assigning responsibility for the health and rehabilitation of mentally disordered individuals who commit crimes. One resource that operates in both the health and legal contexts is that of Forensic Psychiatric Services. By definition, forensic mental health services exist to support the courts. They are a health-based resource that liaises with the courts to provide “psychiatric assessment, treatment, and community case management” of mentally disordered offenders (MDOs)<sup>1</sup> in the criminal justice system (Forensic Psychiatric Services Annual Report, 2008, p.1).

Little attention has been paid thus far in the area of forensic mental health concerning the impact location has on service delivery. It simply seems to be accepted that policies designed in urban areas will be adapted and easily implemented in rural regions. And yet many additional challenges arise in supporting MDOs in northern, rural areas. In British Columbia two thirds of the province is comprised mainly of smaller communities with populations of fewer than 20,000 people (Cocco, 2009). Limited resources, long distances to travel, low population density, and

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<sup>1</sup> **Mental disorder** is defined differently in public health and legal contexts. In public health terms, mental disorders that qualify to receive treatment are the Axis I diagnoses from the DSM-IV-TR (Livingston, 2008). This includes more serious disorders such as schizophrenia, bipolar disorder, depression, etc. In legal contexts, mental disorder is defined as a “disease of the mind” (*Criminal Code*, s.2). This is a broader term that encompasses the same Axis I disorders as well as substance use disorder, developmental disorders (IQ below 70), brain injury, Foetal Alcohol Syndrome, and others (Livingston, 2008). The forensic clinic operates in a legal context, therefore the MDOs to whom they provide service have a wider range of disorders. Disorders must be considered a serious mental illness in order to qualify for treatment through the forensic services.

multicultural ways of life all influence the way mental health policies can be implemented, yet there is very little information on how these factors change the delivery of forensic mental health services. As one participant of this study, Kate<sup>2</sup>, commented, “When I was in nursing school we used to call it quietly going nuts in the bush. There is so much space up there that people can go a long time without being picked up or getting the help they need.”

This exploratory study examines how forensic mental health services are networked and delivered in a rural geographic in northern British Columbia. What challenges or barriers exist in trying to provide this service in a rural setting? How do clinicians cope with these challenges? How do other community services see forensic mental health? These questions were addressed through interviews with forensic mental health case managers, liaison workers, and other community service providers who work closely with the forensic mental health clinic. In beginning to understand the challenges specific to rural forensic care, we can begin to see ways of supporting forensic services to overcome these barriers and support the rehabilitation of offenders suffering mental illness.

## **Methodology**

### **Research Setting**

This project focuses on the delivery of forensic mental health services in northern areas of one Canadian province. The main area of interest is smaller, rural areas with populations fewer than 20,000 people. Almost all of the northern two thirds of the province falls into this category. However, the starting point for this study was a forensic psychiatric clinic (hereafter referred to as “forensics”) in a larger urban center from which all northern forensic mental health

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<sup>2</sup> Names have been changed to maintain confidentiality.

services are coordinated from. Some staff at this clinic are designated as travelling case managers who are responsible for covering the forensic mental health needs of a particular geographic region. Other staff remain in the urban centre and only provide services to those within that city. Staff include social workers, nurses, administrators, and travelling psychologists, psychiatrists and evaluators. There are many different perspectives of service delivery included in one location. In the end, interviews were conducted with five different service providers in three different geographic areas, and from three different resources: forensics, Community Corrections, and a local social service not related to forensics. Each site was at least 250 kilometres away from the others.

## **Participants**

Given the exploratory objectives of this research, a purposive sampling technique was used to gather a variety of different perspectives about the challenges in delivering mental health services in rural areas. Initially, contact was made by phone with the director of the regional clinic. She suggested one person to interview, that person in turn suggested names of others who they thought would be informative to interview. This “snowball technique” (Esterberg, 2002) was used to identify participants both at the clinic and in the surrounding communities.

I chose to include two interviews with people from outside forensic services. As Becker (1998) suggested, we often sample in an attempt to consider, “a full range of variation” (p. 71) in our phenomenon. I quickly realized that it was not possible in this project to consider the full range of rural mental health services. There were simply too many. After talking to two forensic workers it became clear that a majority of their work involved liaising with probation officers.

Community Corrections also interacts with MDOs on a regular basis and their case management duties seemed closely linked with the tasks of forensic services.

A local service provider in a smaller community was also interviewed for the project. It was suggested by a participant that she would bring unique information to the project as she had been working for a rural social service for over 15 years. Many of the challenges she faced in service delivery were similar to those faced by the forensic clinic. She also found herself indirectly working with forensic services as many of the youth she worked with had parents involved with forensic psychiatric services.

The final group of participants thus included (1) a case manager (a nurse) who traveled outside the urban area; (2) a second case manager (a social worker) who did not travel; (3) a forensic liaison worker (a nurse) remotely based in a different community; (4) a probation officer in a small town; and (5) a local government social service provider (not related to forensics) also based in a small town. Participants' years of experience in their current positions varied from 1.5 years to 35 years. Several participants had worked in other public health authority jobs before coming to their current position. Their ages ranged from the mid-twenties to mid-fifties. In general, they were quite an experienced group.

## **Interviews**

Semi-structured interview guides were constructed for each interview. General themes of interest were developed and then probing questions, specific to the participant's position, were listed under each topic. Initial themes included how forensics operates, types of clients forensics serves, relationships with other organizations, and the philosophy of how mental health services

should be delivered. However, each interview took on a life of its own. Most participants seemed genuinely interested in the interview and had individual examples and stories to share that shaped the direction of the interview. In all but one interview topics came out of natural conversation and, as suggested by Berg (2009), digressions were explored as they arose. This resulted in several unexpected discussions.

The interviews were an enjoyable experience and rapport was quickly developed in all but one of the interviews. In that interview the participant gave brief answers to each question and there was very little spontaneous conversation. I considered excluding the interview from analysis because I was concerned that it was not representative of the participant's true perspective on mental health services. However, upon reviewing the transcripts, even though the answers were brief they were consistent with themes discussed in other interviews. Also, this participant was particularly emphatic about some themes and I felt it was important to include those in the study.

Interviews ranged in length from 50 minutes to almost 2 hours with the average length being 1.5 hours. One interview was conducted over the telephone, as it was not possible to travel to the location at a time that worked. All other interviews were conducted face to face. Two of the interviews were recorded and later transcribed. In the remaining interviews extensive notes were taken. Almost everything a participant said was written down. I took time immediately after each interview to sit and record field notes about my impressions of the interview, questions to ask in future interviews, and interesting themes to consider during analysis. This process allows for the recording of rich details about the interview and promotes reflexivity in the researcher (Esterberg, 2002; Legard, Keegan & Ward, 2003).

The risk of inadvertently breaching anonymity due to the small, familiar nature of the sample was discussed with participants prior to interviews. They were given the opportunity to strike anything from the record as we were recording. Two participants did request some comments they made not be included and those were subsequently not entered into the transcripts. As the participants were in a position to best understand what could be harmful to their job or life, I offered them the opportunity to read the portions of my final paper that included them and comment on matters they believed I misunderstood or that they would like deleted. No changes were suggested. As Kate stated at the end of an interview, "Everything we have talked about here is pretty standard and not risky. I can't see any problems or sensitive areas in what I've said. You don't need to send me a copy of the paper."

## **Analysis**

Audio recordings and notes of interviews were transcribed and entered into NVivo 8 software. Initially an open, "manifest" coding method of looking for similar words or repeating events that were discussed was employed (Berg, 2009). Thirty-eight coding categories emerged. Each category was reviewed and latent meanings and common ideas within each group were considered. This produced five key repeating themes. Silverman & Marvasti (2008) warn of the tendency for coding schemes to become "powerful conceptual grid[s] from which it is difficult to escape" (p.225). In order to resist this, the data was coded again at a later date, this time using the key themes as coding categories. Data that did not fit into these groups was highlighted and analyzed again in an attempt to determine why these were outlying cases. Two themes were changed in response to this procedure.

Validity is an important concept in both quantitative and qualitative research.

Hammersley (1990) defines validity as meaning, “truth: interpreted as the extent to which an account accurately represents the social phenomena to which it refers” (p.57). In order to maintain validity in this project steps were taken to avoid “anecdotalism”, or taking lone entertaining instances to be representative of a consistent theme (Silverman & Marvasti, 2008). Quotes were considered both in the context of the interview and as a standalone representation of a theme. The frequency that themes appeared across participants was considered, but the genuine emphasis that was given to a statement was also taken into account when determining what the participant felt was important to convey.

Statements that I found particularly interesting or catchy were tagged with a separate code in order to draw attention to them. On the second round of coding these tags were considered as objectively as possible, searching the data for frequency of use or strong emphasis to determine if there was actual support for the comments/trends I found memorable. In some instances, a theme I liked could not be supported and was removed from the ultimate findings. The final product of this coding analysis is reported below.

## **Findings**

Participants discussed multiple challenges during the interviews. The three themes reported below represent the most commonly, most emphatically mentioned barriers. At times these were directly referenced, at other times they were evidenced through coding of stories the participants told or examples they gave.

## **I. Travel**

All participants spoke more than once about travelling as it related to their job. Travel was the code most often assigned during analysis (68 references, from all 5 sources). The requirement to travel, and/or work with others who travel (i.e., are responsible for more than one geographic region) is a normal way of life in northern BC and not unique to those working in forensics or probation. Provincial court services and northern psychiatric services also operate on a circuit route, serving several communities over a period of weeks or months (Ministry of Attorney General, 2009). In some more remote communities court may be held or a psychiatrist may visit as little as once every three months. Participants reported this travelling, or style of regional coverage, affected their jobs by complicating the task of arranging services for clients, creating safety issues, and hindering the coordination of meetings with other service providers.

### ***Arranging***

When clients and service providers live up to hundreds of kilometres apart a huge amount of time and effort is dedicated to arranging psychological assessments, treatments, or meetings for the client. As Sarah said, “‘How’ becomes a big question in northern areas. How do we get them services? How do we get them TO services?” Kate commented on the frustration that accompanies a failed arrangement:

I had arranged for him to take a bus and all that stuff. He had his bus ticket on Friday, but he didn't come. That can be a difficult piece, it was a lot of work to arrange for him to come. He didn't come, and I don't know what happened. We can't get in touch with him...

A particularly challenging aspect of arranging travel is navigating the smaller details. For instance, a lot of travel is by bus and is not direct. There are many stops along the way that create confusion for some clients. Often forensic clients face challenges in managing life during the best of circumstances, adding the complexity of traveling can be enough to prevent a client from attending an appointment. As Becca illustrated,

For instance, it is \$40 to take the bus, then they don't know where to get off. Then, where do they eat? What do they do once they are off? These small questions create large challenges and stress for some people, to the point where it becomes too tricky to actually complete the task of getting the assessment.

### *Safety*

Travelling for some service providers means spending a great deal of time driving alone and for others it means visiting clients' houses on their own. Both of these situations produced concerns about personal safety. Driving alone for many hours, sometimes in adverse weather conditions, creates a situation where employees need to be able to check in periodically. In some remote areas cell phones, and even satellite phones have inconsistent reception. As Kate describes,

You don't work in an office with a bunch of people, you are the only person. What are the policies when you do a home visit or even when you are driving? From here to [town name] it's very remote, right? There is no cell reception. How are you checking in and all that stuff?...It is so different with our clinic versus the Vancouver clinic. They have a lot of areas they cover but they are all within cell phone area.

Becca also spoke of the ways in which she thinks about safety when she travels to visit a client's home,

I involve the police a lot. Not as enforcement but as a safety measure in remote areas. I go to peoples' houses, often in out of town areas, and I'm the only worker

in this place...But you get a lot of information about somebody by visiting their home, and that is desirable.

The need to bring the police to a meeting with a client impacts the therapeutic relationship a case manager tries to foster but this must be balanced with the need to be safe while working. This balance is not always easy to achieve.

### *Coordinating With Other Resources*

Clients were not the only group mentioned when talking about the challenges that travelling created. Participants often spoke of having difficulty in meeting with other service providers in different towns. It is desirable to form face-to-face relationships with other resource groups, but often impossible to actually get the meeting to occur when everyone operates on a travel circuit. Sarah spoke of efforts in arranging a meeting with the probation officers in a neighbouring town,

But I have talked to their probation officers...because out of the [town name] office, they cover [multiple areas], so they themselves are travelling. So it is hard to catch them when I'm actually there.

When clients, service providers, courts, psychiatrists, and even some treatment programs are all located in different towns, coordinating comprehensive forensic services is a juggling act requiring case managers to be conscious of multiple items. They must be aware of who is where, and how and when they are going to get to the next place at the appropriate time. The hazards created through changing seasons and long driving times add to this challenge.

## **II. Resource Capacity**

When directly asked about what challenges they face in completing their job, the most common answer was, "not enough resources!" (Kate, Becca, Sarah). Both the capacity and

variety of other social services available for clients creates backlogs in referrals. However, the small capacity of northern resources are described as more of a challenge than the variety of services available. As Philip stated, “We try to match clients with the most appropriate resource, but it isn’t always available. You make do with what you have.” Problems associated with small capacity of resources included long wait times and high staff turnover rates.

### *Wait Times*

Kate and Sarah both discussed how access to basic health services is often overlooked. By nature of the definition of who forensic services helps, the majority of their clients have compromised health or an illness requiring doctor supervision. A limited number of general and family practice doctors creates difficulties for patients on medication,

Health, you take for granted. The ability to go see your family doctor if you have one. And I think you also take for granted that you don’t have a disability...I mean, I see my doctor maybe once a year, not a big deal. Some of these people see their doctors every week. You know, and then not to have that support. It would just be really hard. (Sarah)

This I couldn’t believe when I found out...We have individuals that need a biweekly injection. Well, they used to go to community health to get their injections but that no longer occurs. So they had to go to the emergency room to get their injection. They can be waiting four to six hours for a needle...nobody wants to sit in emerg to get a needle! (Kate)

The lack of doctors has larger ramifications than simply long wait times. Non-compliance with medications is often cited as a reason for psychiatric patients deteriorating to the point where they need to be returned to hospital (Olfson et al, 2000). Reaching this point creates restrictions on patients’ liberty as well as increases the risk of harm to the patient themselves, or to others.

It was emphasized that medical services were not the only resources with wait times that impacted a client’s chance at recovery. Becca stated,

Housing is another service that is heavily in demand. There are huge waitlists for the local shelters. If someone can't make it into the shelter then they live on the street or couch surf if they can. There have been a couple of deaths related to homelessness around here.

Harsher weather conditions in northern areas of Canada can amplify the dangerous effects of living on the street as compared to other areas in southern BC. Participants shared the view that maintaining a healthy, stable lifestyle that prevents relapse or recidivism is dependent on more than simply taking medication. Being able to connect clients to resources that have the capacity to provide them with supports in all aspects of their life is an essential component of any forensics job. Indeed, research also suggests patient access to supportive housing, employment and, all too often, drug and alcohol abuse programs are key services in preventing deterioration and return to hospital (Mueser, Noordsy, Drake & Fox, 2003).

### *Staff Turnover*

High rates of staff turnover prevalent in the north decrease the services a resource can provide. Turnover results in time lost to training new staff members and lost knowledge of what resources exist in neighbouring towns (and who provides those resources). As Jen and Kate mention,

It is a constant work in progress to build these relationships. Turnover is a problem. Personal connections are the only successful ones. Once these connections are formed the speed and efficiency at which a job can get done is increased. Turnover resets these connections. You have to start over again once someone leaves a service provider position (Jen).

For a while there was quite the turnover. The position had [counting] 1... 2...3. In the last 3 years they have had four people in that position. It's just getting—the turn-over, wasn't good. Now that J is in that position, he's been there for just about two years now. He's getting to know people, they are getting to know him, know that he exists. It's making it a bit easier. (Kate)

Reasons cited as to why turnover was so prevalent in rural areas included people coming from other places for a short time for the varied experiences gained through working in isolated areas, preference for a particular urban lifestyle, and (sometimes) a lack of quality relationships with supervisors. Regardless of the reason someone leaves, attrition of staff creates setbacks in the efficiency of a service. When turnover occurs multiple times a year and the service has a small staff to begin with, there is an impact on the capacity of that service to support rural clients.

### **III. Information Gaps**

As mentioned, staff turnover leads to a loss of knowledge about services operating in neighbouring communities. This is not the only challenge in communication in rural areas. Across all interviews it became clear there is significant difficulty in keeping up to date on the current state of resources in areas as far as 800 km away. There were questions raised both about the services present in each town and the need for forensic mental health services in smaller communities.

The forensic liaison worker program began over ten years ago as a satellite service of the main northern Forensic Psychiatric Services clinic. It started as a pilot program designed to inform the courts about the effect of mental disorders on an offender and to bridge the gap in information about services existing in a community to support that offender. As Becca reports, this program is helping to do just that, “[We] fill in the gaps in information between other groups. A lot of the time people know that someone needs help but they don't know how to get that help. A liaison worker fills in those gaps.”

Currently, very few communities have a full time liaison worker present. Without this direct connection to forensics it becomes more difficult to know what the state of services is in a town. Sarah described one conversation she had with a probation officer in a different town,

[I asked] is there any need for me to be coming there? That hit him too, he was like, oh I'm not sure. How are you different from community mental health? So it was just talking to him about that. I said to him, I don't even know myself, is there community mental health there?

On the local community's side, it seems there is a desire to have more access to the specialty service that forensics provides. Forensics is seen as being a specialty service that has the ability to work with clients when others cannot. Philip commented,

Forensics is useful, invaluable to have, wish we had more contact with them because they are used to dealing with the involuntary patient, those who are not always motivated for treatment or counselling. There are some [liaison workers] from forensics but they are only in certain spots...They can do more in-depth counselling and treatment with clients. Local mental health and addictions services prefer to deal with the voluntary client. They have some difficulty in accepting patients who are not as motivated to receive treatment. Sometimes we will refer someone to [MH&A] but they will return them to us, saying they cannot accept them for treatment...It is a bit of a sore spot with us that we don't have more access to forensic services. For example, they don't visit during the winter months, but [other towns] have access all year round.

Staff turnover and the difficulty in keeping abreast of the need and changes in services from afar keeps both the forensic psychiatric clinic and the local community supports guessing at how to best connect.

### **Discussion & Conclusions**

The increasing prevalence of mental disorder in prisons has prompted concern among researchers, correctional services, and community resource providers alike. Penitentiaries are not

designed to treat or support those with mental illness and yet these clients often experience a “revolving door” of repeated incarcerations (Haimowitz & Applebaum, 2004). Indeed, MDOs are considered more vulnerable to victimization and trauma than non-MDOs. Forensic Psychiatric Services is one provincial initiative designed to support MDOs and inform the court about the nature of the mental illness by providing psychiatric assessments, treatment, and community case management. Offenders come from all parts of the province, yet little research exists concerning how forensic community case management is offered in rural areas in British Columbia. The purpose of this project was to explore the obstacles existing specific to rural forensic mental health services.

It is apparent there are several challenges in providing forensic care to rural mental health clients that are not as prevalent in urban areas. The fact many services in rural areas are provided on a travelling, or circuit route, creates situations where a substantial amount of effort is dedicated to coordinating assessments, treatments, and meetings with clients and other resources. The huge geographic distances case managers and patients must travel, coupled with deadlines of court dates for pre-sentence reports increases the pressure to find creative and realistic methods of linking people with services. Case managers must juggle clients’ abilities to travel with the schedules of psychiatrists and psychological testers. Case managers and liaison workers need to consider their safety while working in isolated areas in ways that are not normally a worry in more populated regions. Relevant issues for participants included keeping in touch with others while travelling through areas without cell reception, driving in various weather conditions, and making home visits in out-of-town areas.

At the same time, the limited capacity of resources in rural areas as compared to urban hinders the ability of case managers to connect their clients with services designed to promote stability of lifestyle. Although many needed services do exist in most rural areas, long waitlists and wait times prevent clients from accessing these services and are a source of frustration for participants in this study. Issues of constant turnover and limited numbers of staff for some programs further decrease the ability of services to accept clients, particularly if behavioural problems exist. This turnover, combined with staff being responsible for serving multiple communities, is also associated with difficulties in determining the need for forensic services and how to best connect with other agencies working with a similar clientele.

Participants' perceptions of important challenges in delivering forensic services have several implications and point to directions for future research. Increasing advances in technology ameliorate some of the barriers created by the need to travel. Participants were supportive of video conferencing such as Telehealth to conduct psychological assessments in time to meet court dates. The overall opinion is that Telehealth is a sound method of improving the services forensics provides.<sup>3</sup> The body of research into the use and efficacy of videoconferencing in health fields is growing and, in general, supports the participants' views (e.g. see Miller, Clark, Veltkamp, Burtan, & Swope, 2008; Ohinmaa, Roine, Hailey, Kuusimaki, & Winblad, 2008; Sevean, Dampier, Spadoni, Strickland, Pilatzke, 2009). Further research into the best provision of Telehealth services to more small communities would be beneficial.

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<sup>3</sup> This support was voiced by Becca, Kate, and Sarah. It was given with the assumption that appropriate safeguards and alternatives were in place should a client not qualify (i.e. was "too sick" [Kate]) or choose to have an in-person evaluation.

This project revealed a great deal of wonder among service providers about the need for forensic services in given areas. This is a valid query considering the low population density in northern BC. With a total population of less than 400,000 people living in the northern two thirds of the province (Cocco, 2009) it is easy to speculate on the cost benefit ratio of employing such a specialized service. In other words, is it worth having case managers and liaison workers in such small areas? Participants both from forensics and from local agencies answered this question with an emphatic yes. The limited capacity of other resources creates a strain forensics can help relieve. Forensics has the knowledge and the time to spend with difficult clients who may otherwise dominate a local service provider's time. Hence, forensics is able to quickly respond to a client who begins deteriorating. Future research should work to identify ways in which communications between centralized services (such as forensics) and the regions they serve can be improved. Learning how to best connect with those working in satellite offices will increase the efficiency of all involved.

### **Strengths & Limitations**

This was an exploratory study designed to examine *what* challenges exist in providing forensic rural services. It did not go beyond this first step to assess *why* these exist or *how* to best reduce the difficulties faced by rural staff. A broad scope of questions was used in interviews to canvass service providers for their opinions and perspectives on the main issues facing northern areas. Growing up in northern BC provided me with background information that allowed for more natural conversation with participants. Mentioning my hometown often prompted a relaxing in participants. They would begin to use place names more freely and we were able to have an easy rapport during the interviews.

This study included a variety of perspectives on forensic psychiatric services from both within and outside the forensic realm. This was beneficial in providing information about how forensics fits into the culture of service provision in rural areas. It highlighted the challenges existing across fields versus those specific to forensics. However, only views of service providers were included. Hearing the other side of the story, as experienced by MDOs themselves, would offer valuable information regarding what services are needed, what are effective, and what is frustrating when trying to recover.

An important limit to this project was that perspectives of Aboriginal culture were not included. In the end almost all participants were Caucasian. It is well known that Aboriginal people in Canada are over-represented in the criminal justice system (Correctional Services of Canada, 2009). As such, there are likely some who will interact with forensic mental health services. Limited access to culturally specific treatment programs or case management may serve as substantial barriers to recovery for this group in ways that are unique. Future research needs to examine specific forensic mental health needs and services for Aboriginal clients.

Forensic psychiatric services provide an important service to offenders with mental disorder and to the courts these offenders come into contact with. Supplying this specialized support in rural areas presents several challenges. Unique conditions and ways of life in rural areas create unique barriers to overcome. It is hoped that by identifying important barriers, suggesting future directions of research, and drawing attention to the dearth of existing literature on rural forensic mental health research this study acts as a starting point for future projects. When the consequences of impaired service delivery are as serious as delayed access to

medication or psychological assessment for a pre-sentence report they deserve both political and research attention.

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