RESEARCH BASIS

Guidelines for conducting forensic patient-oriented research

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Patient-oriented research can be a powerful way to support trauma-informed, recovery-oriented care in forensic mental health settings.

These guidelines examine five key dimensions of forensic patient-oriented research (POR) along with core principles that are key to success. They are designed to provide a practical foundation for forensic POR based on evidence and acknowledged best practices.

Applying the guidelines will create the conditions for research projects that are equitable, safe, respectful and help build long-lasting relationships of trust in forensic settings.

Guidelines for Conducting Forensic Patient-Oriented Research

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Overview of the guidelines

Patient-oriented research (POR) is the practice of involving people in research that affects their lives. In POR, patients may be research participants, partners or advisors. They have a say in what research gets done and how it happens.

Key to POR is recognizing the importance of patients' leadership, perspectives, priorities, and experiences for driving action or change. It puts priority on people living in a specific setting, though it also values the input of others associated with that setting such as staff and administrators. POR can help challenge stigma, break down structures that marginalize people, and pave the way for trauma-informed, recovery-oriented care (Waypoint Research Institute, 2024).

Forensic POR is patient-oriented research carried out in secure forensic mental health settings — facilities that care for patients whose mental illnesses have led to involvement with the criminal justice system (Waypoint Research Institute, 2024).

POR can be uniquely challenging in forensic mental health environments, which have multiple levels of security and are home to people with different mental health needs and cognitive abilities. At the same time, there are few context-specific tools and resources on how to undertake it. These guidelines were developed to advance the practice of forensic POR.

Purpose and scope

These guidelines provide practical direction for planning and conducting forensic POR projects in secure forensic mental health settings. Co-developed by a team of patient advisors, frontline forensic staff, researchers, and Patient/Client and Family Council (PCFC) staff, the guidelines are grounded in lived and living experience, best practices, and lessons learned at the Waypoint Centre for Mental Health Care.

The guidelines focus on five dimensions of forensic POR and cover all phases of a research project from initial planning to implementation and completion:

1. Resourcing, orientation and training
2. Compensation, consent and confidentiality
3. Relationships, shared understanding and support
4. Levels of engagement
5. Evaluation and sustainability

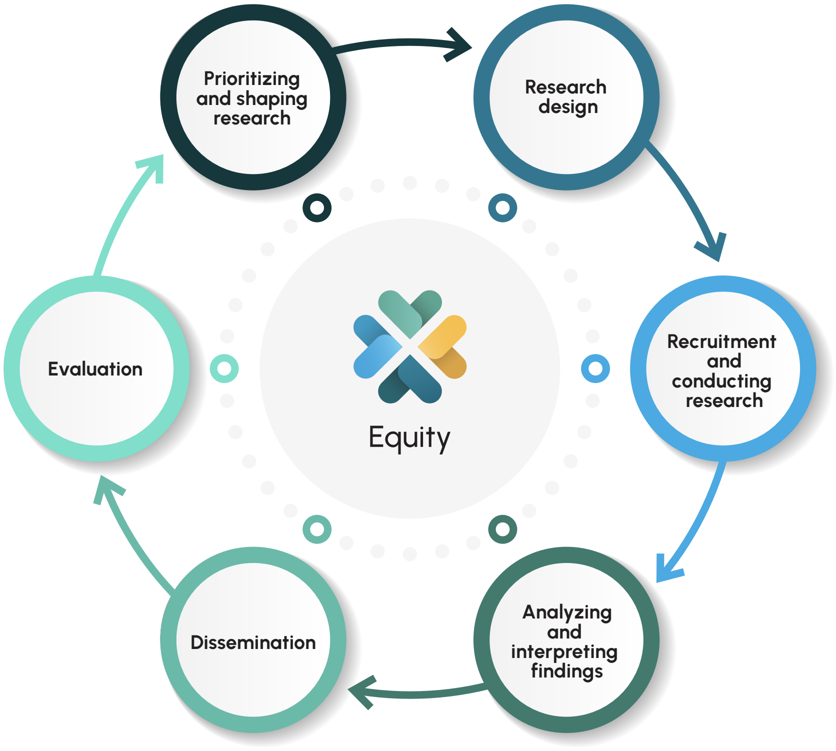
As you plan and conduct a research project using the guidelines, consider where each dimension fits within a typical research cycle (Figure A). For example, relationship building and shared understanding are important throughout the entire lifecycle of a project, while orientation and training will likely occur earlier in the cycle. Considerations around compensation and asking patients to consent to being a research partner will typically arise during the shaping research or research design phase.

The guidelines are not intended to be used in a sequential order aligned with traditional research cycles. Nevertheless, it is important to understand the guidance in this report as you design, plan, conduct, share findings, and evaluate your project.

Finally, because we view equity as a foundational principle that influences all stages, we have placed it at the center of the cycle so that it is considered and evaluated throughout a research project.

The guidelines and tools will be updated regularly to reflect new research findings and ongoing learnings from implementation.

We have developed a practical **handbook** to complement these guidelines and the supporting research. It provides actionable advice for anyone looking to design, conduct, or participate in patient-oriented research within forensic mental health settings.



Adapted lifecycle for forensic patient-oriented research (Figure A)

Who are the guidelines for?

The guidelines are intended for a wide range of audiences:

- Researchers planning or conducting forensic POR
- Hospital staff including clinical, allied, security, and other frontline staff as well as PCFC staff supporting or engaging in forensic POR
- Patients serving as research partners or advisors on forensic POR projects
- Hospital administrators including executives, directors, and managers seeking to support and embed forensic POR into institutional policy and practice
- Educators and trainers building POR skills in forensic mental health care settings
- Research ethics committees reviewing forensic POR protocols (Faulkner, 2004)

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Centring equity

Embedding equity in POR is foundational. Patients have historically faced profound systemic exclusion and compounded vulnerabilities and harms in their lives, so assessing and integrating equity at every stage of the research process is essential.

Drawing on the **Ontario SPOR SUPPORT Unit (OSSU) Equity Framework**, research teams are encouraged to begin by asking: Whose knowledge counts? Whose needs are prioritized? Who is at the table, who may be missing, and why?

To put equity into practice:

1. **Apply an equity lens early, often and consistently**

   Equity assessments should begin at project conception and continue through design, data collection, analysis, knowledge translation, and evaluation. Consider how social and structural determinants such as criminalization, racism, colonialism, gender, disability, and poverty may shape both the research process and the experiences of people involved.

2. **Use the domains of the OSSU Equity Framework to:**

   - Build inclusive and diverse teams
   - Build equity-oriented partnerships
   - Centre equity in POR methods
   - Centre equity in capacity building and training
   - Centre equity in knowledge translation and impact

3. **Be reflexive and transparent**

   Incorporate regular equity check-ins throughout the project lifecycle. Note how decisions are made, who is at the table, and how power and privilege are being navigated. Use the OSSU Equity Framework to support this process.

4. **Recognize and redress harms**

   Many forensic service users carry histories of systemic and institutional harm. Conducting equity assessments includes creating safe conditions for engagement and being accountable when harm occurs. This means building trust and valuing the time, knowledge, and vulnerability of those involved.

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Underlying principles and values

The following principles and values underpin all aspects of forensic POR and guide effective and respectful engagement with patients as research partners and advisors. These are not steps to follow, but rather foundational working methods that support all dimensions of forensic patient-oriented research. When these values are practiced, forensic POR has the potential to not only engage patients but also to create spaces for patients to feel genuinely involved (Waypoint Research Institute, 2024).

Key commitments and practices

Protect and uphold individual dignity as the very essence and bedrock of forensic POR. Recognize each patient's inherent human rights and ensure they are never defined by their histories but instead honoured as whole individuals.

Cultivate mutual respect by striving to work in authentic, equal partnerships and ensuring patients' voices are heard, understood, and taken seriously. This should be done free from bias, judgement, and discrimination (BC Mental Health and Service Use Services, 2024a; Dell et al., 2023; Evans et al., 2025; Faulkner & Morris, 2003; Kip et al., 2019; Waypoint Research Institute, 2024).

Ensure inclusive and equitable engagement by creating tailored opportunities that value all perspectives (Aboaja, Forsyth et al., 2021; Cook, 2012; Faulkner & Morris, 2003; Faulkner, 2004; Faulkner, 2006; Inglis & Swain, 2012; Jones, 2017; Livingston et al., 2013; Shaw, 2023; Waypoint Research Institute, 2024) and involve diverse patients, including Indigenous people (Chatterjee et al., 2023), Black people and people of colour, 2SLGBTQ+ individuals, persons with disabilities, and those living with intersectional identities. It is important for all engagement to be authentic, ensuring people have real opportunities to contribute and aren't just 'token' participants.

Build an interdisciplinary research team of patients, hospital staff, PCFC staff, and researchers, as forensic POR is a collective endeavour (Deljavan et al., 2025; Waypoint Research Institute, 2024).

Build long-term, trusting relationships with patients and staff (Aboaja, Atewogboye et al., 2021; Aboaja, Forsyth et al., 2021; Cook & Inglis, 2008; Deljavan et al., 2025; Dell et al., 2023; Evans et al., 2025; Faulkner & Morris, 2003; Faulkner, 2006; Waypoint Research Institute, 2024). Work actively toward creating an environment where everyone feels as physically and emotionally safe as possible (Evans et al., 2025; Waypoint Research Institute, 2024) and touch base routinely to confirm patients still want (and feel able) to stay engaged.

Maintain transparency by communicating honestly and clearly and being upfront about goals, expectations, processes, and how patients' views will be incorporated into the research being done (BC Mental Health and Substance Use Services, 2024b; Evans et al., 2025; Faulkner & Morris, 2003; Faulkner, 2004; Vollm et al., 2017; Waypoint Research Institute, 2024).

Address patients' potential fears by eliminating the possibility of repercussions as a result of their involvement in research. Make it explicit that what patients share when engaged in research will not be used against them or have a negative impact on their Review Board status, levels of activity in hospital, or treatment (Evans et al., 2025; Waypoint Research Institute, 2024) except in cases where there is a legitimate risk of harm to themselves or others. Be mindful that not all patients will take such reassurances at face value. Some may remain skeptical.

Be accountable to the patient community by conducting high-quality research that matters to patients, avoids reinforcing stereotypes or stigma, is explicit about its assumptions (Faulkner, 2004), and ensures findings are first shared with those involved. Patients involved in research should be first to benefit (Evans et al., 2025). It should be clarified up front how any benefits will happen for patients.

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Dimension 1: Resourcing, orientation and training

1

Resourcing

Resourcing in forensic POR means ensuring financial, training, and structural supports are in place to enable safe and authentic patient engagement throughout the lifecycle of a project. Resource considerations often start during the grant application stages of a project and continue throughout the project lifecycle and beyond.

Guidelines

FUNDING

- Allocate adequate funding (Cook, 2012; Faulkner & Morris, 2003; Faulkner, 2006; Vollm et al., 2017)—10% or more of the total project budget—for patient engagement (Faulkner and Morris, 2003). This should ideally cover:
  - Compensation and remuneration (BC Mental Health and Service Use Services, 2024c; Faulkner, 2004; MacInnes et al., 2011). The first goal should be for compensation to be financial. In cases where that is not possible, other forms of compensation should be identified and offered.
  - Activities that build and strengthen connections between patients, the public, and other organizations, such as social or informal gatherings (Cook, 2012; Faulkner, 2004) and knowledge exchange events.
  - Staff time to lead, support, and mentor (Cook, 2012; Faulkner, 2004; Livingston et al., 2013b).
  - Roles for supervision, coordination, and back-ups (i.e., recruiting more patients than initially planned) to cover absences or drop-offs (Faulkner, 2004).
  - Physical resources such as meeting space and communication technology (Faulkner, 2004).
  - Training and skill development opportunities (Faulkner, 2004).
  - Diverse dissemination formats (e.g., plain language summaries, oral presentations) (Faulkner, 2004).

TIME PLANNING

- Plan for extra time at every stage of the project (Cook and Inglis, 2008; Cook, 2012; Faulkner, 2006; Livingston et al., 2013b; MacInnes et al., 2011; Vollm et al., 2017) to:
  - Support patients in understanding the research project (Cook and Inglis, 2008).
  - Build trust and mutual respect with patients and staff (Faulkner, 2006; Lewis Morton et al., 2017) through informal conversations ("just talking") (Cook, 2012; Deljavan et al., 2025).
  - Recruit patients and maintain consistent engagement (Faulkner, 2006).
  - Offer practical help so people can attend meetings and carry out their research responsibilities (Cook, 2012). For example, provide printed materials in advance or offer support with reading and writing if needed.

- Share information in a variety of formats and for various comprehension levels and maintain communication during study gaps or delays (Cook, 2012).
- Navigate institutional processes (e.g., Research Ethics Boards, patient employment contracts or agreements) (Cook, 2012).
- Plan research activities around patient routines and treatment schedules (Cook, 2012, MacInnes et al., 2011).
- Plan for unexpected disruptions such as last-minute cancelled activities (Cook, 2012; Cook & Inglis, 2008; Deljavan et al., 2025), incidents on the units, limited meeting space (MacInnes et al., 2011) or fluctuating mental health needs.
- Gather feedback from collaborators on current processes and plans — and adjust as needed.

Orientation and training

Everyone in secure forensic settings should have a basic understanding of research and forensic POR (Evans et al., 2025). More specific training and capacity building are needed for those engaged in forensic POR, including patient partners and advisors, researchers, and staff.

Guidelines

BUILDING RESEARCH KNOWLEDGE

- Begin by gauging baseline knowledge of patients about research generally (Deljavan et al., 2025), their readiness to research, and what motivates them to want to learn about research — whether driven by intrinsic or extrinsic factors.
- Establish an expert group of patients and staff to meet regularly and help raise awareness of forensic POR. Patients with experience can support the onboarding of new participants.
- Ensure patients understand the study's focus and objectives, including its aims, scope, and potential impacts, so they can make an informed decision about engaging and feel prepared to contribute meaningfully. Provide opportunities for patients to co-define study aims, scope and impacts at the outset.
- Focus on building understanding rather than simply delivering information (Cook & Inglis, 2008) and offer additional resources and optional exercises to reinforce learning (Aboaja, Atewogboye et al., 2021).
- Teach foundational health and mental health concepts and illustrate their relevance to the study.
- Plan for capacity building (Banongo et al., 2006). Equip research partners and advisors with foundational research knowledge and applied skills, including an appreciation of the research cycle (Aboaja, Atewogboye et al., 2021), research design and methodologies (Livingston et al.,

2013; MacInnes et al., 2011; Waypoint Research Institute, 2024), common research terminology (Faulkner, 2006), and research ethics (Faulkner, 2004; Livingston et al., 2013) including confidentiality and consent.

- Introduce core concepts of forensic POR (Waypoint Research Institute, 2024) and the role of patient engagement in research (Aboaja, Forsyth et al., 2021).
- Offer training that is specific to patients' roles in the project (Livingston et al., 2013; MacInnes et al., 2011). This may include developing practical skills such as participant recruitment, qualitative interviewing, data analysis (Faulkner, 2006; Livingston et al., 2013), and digital skills like creating tables and graphs (Aboaja, Atewogboye et al., 2021).
- Be transparent about any conceptual and theoretical frameworks from the beginning so that patients and staff can adjudge the theoretical concepts as valid and reliable for interpreting their experiences and determine if they want to engage in this research (Faulkner, 2004).

SKILL DEVELOPMENT

- Strengthen communication skills, such as storytelling, public speaking, presenting findings (BC Mental Health and Substance Use Services, 2024a), and drawing on one's own lived or living experience (Waypoint Research Institute, 2024).
- Support the development of self-advocacy (Faulkner and Morris, 2003), confidence, critical thinking (Cook and Inglis, 2008; Waypoint Research Institute, 2024), and peer support skills such as active listening and group facilitation (Shaw, 2023).
- Include training on reflexivity and bias awareness (Lewis Morton et al., 2017; Vollm et al., 2017), encouraging patients to reflect on their assumptions to the extent they are able to do so.
- Clarify standards of respect and boundaries, outlining appropriate interactions, confidentiality expectations, and professional conduct when working alongside other patients and hospital staff.
- Provide training in communication and conflict resolution to cultivate respectful team dynamics and ensure patient partners feel recognized and valued.
- Include training that builds skills in fielding audience questions during presentations and responding to external reviewers' comments during the peer-review process.

STRUCTURING AND ORGANIZING TRAINING

- Deliver training to patients that is flexible and adaptable, meeting different needs, strengths, and experience levels (Faulkner, 2004; Vollm et al., 2017):
    - Schedule training to align with milestones in the research process: 1) pre-research orientation sessions to establish foundational knowledge; 2) phase-specific training delivered before each research stage; and 3) parallel sessions that run alongside the project to minimize gaps between learning and application and ensure patients acquire relevant knowledge and skills when most needed (Cook & Inglis, 2012; Faulkner, 2004; Vollm et al., 2017). Patients report a strong preference for this type of "on-the-journey" learning that is integrated throughout the research process.

- Offer multiple training workshops over time, allowing patients to revisit and build upon earlier concepts (Rutherford et al., 2025). This involves a recursive approach whereby learners engage in in-depth discussions about previously covered content to improve comprehension and retention (Cook & Inglis, 2012).
- Incorporate both team-based, one-on-one and e-learning formats, tailoring delivery to each patient's preferences, abilities and levels of activity.
- Adapt training to suit patients' access to resources. For example, if a unit restricts access to technology, ensure training is modified accordingly to use printed or in-person delivery methods.
- Use a variety of teaching strategies to accommodate different learning styles, including interactive approaches (e.g., enquiry-based, kinaesthetic, and differentiated instruction), traditional didactic lectures, and informal or on-the-job learning (Aboaja, Atewogboye et al., 2021; Faulkner & Morris, 2003; Livingston et al., 2013).
- Use plain language throughout the training (Cook & Inglis, 2012; Waypoint Research Institute, 2024) and incorporate varied presentation formats, visual aids, shared-meaning tools (e.g., illustrated dictionaries), and short video scenarios that surface issues of concern rather than supplying answers (Cook & Inglis, 2008; Faulkner, 2006).
- Build understanding through informal conversations (Waypoint Research Institute, 2024), group discussions (taking on a recursive approach where other patient partners or advisors can help simplify learnings to each other), role playing (e.g., mock interviews), case vignettes, and other small group activities, such as presenting research-related ideas to each other (Cook & Inglis, 2008; Cook & Inglis, 2012; Livingston et al., 2013).
- Recognize that some learners may need more support than others. Modify training materials as needed and provide individualized assistance to ensure equitable access to training content.
- Invite patient participants to reflect on their key takeaways and offer suggestions for enhancing content, adjusting workload, and refining the format—such as adding practical examples, reducing pre-session tasks, or shortening session length.
- Be aware that some patients may have to discontinue their participation in research and have open, upfront conversations about that possibility early in the process (Faulkner, 2004).
- Reinforce achievements by providing patients with a printed certificate or other acknowledgement when they complete any training.

TAKING A RELATIONAL APPROACH

- Prepare researchers and staff for relational and trauma-informed engagement:
  - Prepare for the realities of the forensic environment, including considerations related to risk, safety (Faulkner, 2004; Vollm et al., 2017), and structural barriers to engagement (Evans et al., 2025). While it is important to acknowledge these factors, avoid overemphasizing potential risks, which can reinforce stigma and undermine the development of authentic partnerships.

- Ensure staff have an adequate understanding of the value of patient engagement in research (Aboaja, Forsyth et al., 2021) as well as the value of formal and informal peer support schemes and approaches (Shaw, 2025).
- Teach foundational health and mental health concepts.
- Address stigma and discrimination and challenge assumptions about patients' abilities to be engaged in research (Evans et al., 2025; Rutherford et al., 2024).
- Apply insights from epistemic injustice literature — the systematic undervaluing of certain voices — to help researchers recognize and amplify the knowledge and perspectives of patients, particularly by equipping them with the skills to interpret diverse communication styles, including those shaped by intellectual disabilities or personality disorders (Evans et al., 2025).
- Provide training in trauma-informed approaches (BC Mental Health and Substance Use Services, 2024a; Evans et al., 2025; Waypoint Research Institute, 2024), de-escalation practices (Evans et al., 2025; Faulkner, 2004; Vollm et al., 2017), relational security (Evans et al., 2025), and using non-stigmatizing language (Mental Health Commission of Canada, 2025).
- Equip researchers to navigate tensions between engagement practices and staff safety concerns (Evans et al., 2025; Vollm et al., 2017).
- Offer guidance on how to build relationships and communicate relationally (Evans et al., 2025; Waypoint Research Institute, 2024). Promote learning from patient/client and family councils, especially in communication, active listening, and the subtleties of trust building (Deljavan et al., 2025).

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Dimension 2: Confidentiality, consent, and compensation

2

Confidentiality

Confidentiality in forensic POR has two aspects, both of which must be clearly explained and maintained throughout the research process:

Patients *engaged as research partners and advisors* must be free to speak openly without fear of consequences, and their engagement in research should not negatively affect their legal status, levels of activity in hospital, or care.

Patient *research participants* must have their personal data handled in accordance with ethical and legal standards.

Guidelines

ESTABLISHING AND EXPLAINING CONFIDENTIALITY

- Explain confidentiality policies verbally and in writing, and work with patients to define any situations where confidentiality may be limited (Faulkner, 2004). For example, in peer support (Shaw, 2023), confidentiality is only ever breached if there is clear, imminent risk of harm to self or others. Also, be explicit about the nature of relationships between research partners and research participants. Some may already know one another within the forensic community and these relationships could extend beyond the end of the research project (Faulkner, 2004).
- Ensure confidentiality agreements are grounded in shared understanding, especially in projects involving multiple interest holders (Vollm et al., 2017) or involving sensitive topics (MacInnes et al., 2011).
- Explain in writing how patients' perspectives and views will be used (Vollm et al., 2017; Waypoint Research Institute, 2024). Reinforce that the perspectives patients share with the research team will not be reported to the Forensic Review Board, be documented in their clinical chart, or affect their level or care (Evans et al., 2025; Waypoint Research Institute, 2024). That said, on a case-by-case basis some patients may want to have their involvement known to the Review Board if they think it will have a positive impact; in those cases, consider offering to make their participation known.
- Address common fears, such as the concern that notetaking is a way of gathering "evidence" against individuals. Explain why you take notes, how those notes are secured, and who will see them. Advise the clinical liaison officer team to omit any reference to POR engagement from hospital reports unless a patient explicitly requested otherwise.
- Offer patients the option to use pseudonyms, remove identifying features, and ensure patient comfort with anonymity before dissemination (Banongo et al., 2006; Inglis & Swain, 2012; Cook & Inglis, 2008). Clearly explain that even anonymized data (especially personal narratives) can sometimes be identifiable (Banongo et al., 2006). This also applies to authorship, where patients have the choice to publish under their real names or pseudonyms depending on their comfort and preferences.

- Refrain from discussing prior clinical interactions or past incidents during team meetings and focus on research activities instead (Vollm et al., 2019). At the same time, be prepared for what people may want to share through the research process. Some experiences may be highly traumatic.
- Anticipate any legal or subpoena concerns by consulting legal counsel and the research ethics board early on.

Consent

Consent in forensic POR also has two aspects that must be explained clearly and maintained throughout the research process:

1. Consent to *engage as a research partner or advisor.*
2. Consent to be a *research participant.*

Guidelines

ESTABLISHING CONSENT

- Presume capacity to consent by treating all patients as capable of engagement. Focus on enabling understanding (Aboaja, Atewogboye et al., 2021; Cook & Inglis, 2008) while recognizing that some patients may distrust research — viewing it as part of "the system" — or may have difficulty balancing research with their daily lives. In those cases, enlist a neutral facilitator to help assess the individual's continued involvement. Since capacity can fluctuate (e.g., people can have "good days" and "bad days") gauge readiness with a simple check-in like, "How are you doing today?"
- Ensure capacity to consent by establishing a shared understanding early and conducting regular check-ins that account for changes in health status, treatment schedules, length of stay, and interpersonal needs (Cook & Inglis, 2008). Don't rely solely on staff opinions about who should participate in research, though remain open to advice (Banongo et al., 2006), especially from seasoned staff who have good rapport with patients.
- Maintain clear boundaries between research and clinical care (Banongo et al., 2006; Vollm et al., 2017) and clearly communicate to patients that choosing to be on a research team, or deciding not to at any stage, will have no effect on their treatment or care (Cook and Inglis, 2008). Also let patients know that researchers do not have access to patient charting systems.
- Offer consent as a choice, respecting each person's preferred level of engagement (Aboaja, Atewogboye et al., 2021; BC Mental Health and Substance Use Services, 2024a; Faulkner, 2006; Jones, 2017).
- Treat consent as an ongoing and active process and not a single, passive event (Banongo et al., 2006; Cook & Inglis, 2008; Jones, 2017; Vollm et al., 2017).

COMMUNICATING AND SUPPORTING CONSENT

- Provide all consent information in plain language, avoiding jargon while at the same time preserving the original message (Cook & Inglis, 2008). For example, use terms such as "agree" or "disagree" rather than "consent" (Cook & Inglis, 2008; Faulkner, 2006; Vollm et al., 2017). Adapt consent materials across multiple formats (written, verbal, visual, multimedia) tailored to different literacy levels, learning styles, and mental health challenges (Cook & Inglis, 2008; Cook & Inglis, 2012; Inglis & Swain, 2012; Jones, 2017; Lewis Morton et al., 2017; Vollm et al., 2017).
- Have face-to-face consent conversations (Vollm et al., 2017), use personal dialogue and visible notetaking (Jones, 2017), and proactively invite questions from patients rather than waiting for them (Cook & Inglis, 2008). Minimize reliance on digital tools (Vollm et al., 2017).
- Offer support during the consent process — from caregivers, staff, or peers, based on the patient's preference — to foster a better understanding of the purpose and process of research (Cook & Inglis, 2008; Cook & Inglis, 2012).
- Involve experienced patient partners in recruitment and consent discussions so that prospective partners can see firsthand that the research project is worthwhile and aims to engage them meaningfully (Rutherford et al., 2024).
- Clearly communicate that consent is never tied to levels of activity, treatment, or legal status and that everyone has the right to decline or withdraw consent at any time without consequences (Cook & Inglis, 2012; Inglis & Swain, 2012). Proactively address consent-related pressures and fears by building in safeguards (Cook & Inglis, 2008; Cook & Inglis, 2012; Faulkner, 2006;). Co-develop a follow-up plan for absences so that patients who step away temporarily can rejoin a project on their own terms (e.g., "If you miss a meeting, we'll check in next week to see if you'd like to rejoin…").

Compensation

In forensic POR, compensation refers both to financial and non-financial recognition of patient partners' time, expertise, and contributions. It is meant to be flexible, responsive, and a way of reducing barriers to engagement (BC Mental Health and Substance Use Services, 2024c) while reflecting a broader commitment to equity, respect, and reciprocity.

Guidelines

ESTABLISHING APROACHES TO COMPENSATION

- Determine compensation details at the outset, establishing agreements around how much will be offered, what tasks are included, and how and when compensation will be delivered (BC Mental Health and Service Use Services, 2024b; BC Mental Health Substance Use Services, 2024c; Vollm et al., 2017).

- Communicate with patients about pay limits and benefit implications by explaining any hospital policy caps on compensation and how payments could affect disability or income support benefits (Banongo et al., 2006; Faulkner, 2004). If a patient's total annual compensation exceeds $500, explore alternatives to help mitigate benefit impacts.

OFFERING AND MANAGING COMPENSATION

- Offer flexible forms of recognition. Provide monetary compensation to all patient partners and advisors, while respecting their choice to decline or request alternative forms of recognition (BC Mental Health and Substance Use Services, 2024a; BC Mental Health and Substance Use Services, 2024c; Faulkner and Morris, 2003; Waypoint Research Institute, 2024). Alternatives may include opportunities for learning, co-authorships, peer connection, fun and social activities, future employment potential, a sense of purpose (Faulkner & Morris, 2003; Faulkner, 2004; Faulkner, 2006), or a certificate of engagement.
- Ensure compensation is fair and equitable. Avoid large differences in pay for patients doing similar work (BC Mental Health and Substance Use Services, 2024c), and compensate for all relevant time, including preparation (e.g., training, practicing for presentations), meetings, and follow-ups, if agreed upon in advance (BC Mental Health and Substance Use Services, 2024b; BC Mental Health and Substance Use Services, 2024c). It is recommended to provide full compensation for meetings attended, even if a patient arrives late or cannot complete tasks (Banongo et al., 2006). Be sure to share information about the compensation amount and frequency of payments from the very beginning of your work together.
- Work with finance departments to ensure timely payment (BC Mental Health and Substance Use Services, 2024c; MacInnes et al., 2011) — ideally within two weeks (BC Mental Health and Substance Use Services, 2024c; Faulkner, 2006). Slow payments can cause frustration or lead to disengagement (Faulkner, 2006; Vollm et al., 2017). Deposit money into patients' PIN accounts. Do not compensate patients in cash (Banongo et al., 2006). Offer alternative payment options for those without bank accounts or necessary documentation (Faulkner, 2006).

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Dimension 3: Relationships, shared understanding, and support

3

Relationships

In forensic POR, strong relationships are foundational to every aspect of the research process and should be built before research begins (Waypoint Research Institute, 2024).

Guidelines

ESTABLISHING CONTACT AND BUILDING TRUST

- From day one, introduce yourself by name and be transparent about your role and presence on the unit. Remember that not all patients will want to engage and respect their boundaries (Deljavan et al., 2025).
- Dedicate time and patience to building rapport, especially in secure settings where trust is limited (Deljavan et al., 2025; Faulkner and Morris, 2003; MacInnes et al., 2011; Vollm et al., 2017).
- Foster trust through consistent, ongoing interactions, spending informal, unstructured time on the units and across the hospital (Evans et al., 2025; MacInnes et al., 2011; Waypoint Research Institute, 2024). Attend unit community meetings, be present in shared hospital spaces (e.g., Vocational Services, Central Rec), and show up at events like family picnics, holiday parties, etc. (Deljavan et al., 2025).
- Practice active listening and seek common ground with patients (e.g., through interests such as music, sports, hobbies). Consider leveraging existing relationships if an internal POR team has already developed them.
- Tailor relationship building to patient preferences — offer 1:1 sessions (Banongo et al., 2006; Cook and Inglis, 2008;) or small focus groups to promote a sense of working together (Jones, 2017).
- Consider whether group- or individual-based engagement is better suited for the goals and structure of the project (Banongo et al., 2006).
- Introduce research discussions gradually once comfort and trust are established. Signs of readiness may include patient curiosity, questions about research, or interest in getting involved. Remain attentive to these cues and allow patients to set the pace of engagement (Deljavan et al., 2025).
- Acknowledge that different patients may have different levels of comfort with various research activities. For example, some may enjoy interviewing other patients while others may not; though those who don't may rather assist in designing interview questions or working on the backend of the project (Faulkner, 2004).

WORKING WITH STAFF AND OTHERS

- Acknowledge variability in professional support across disciplines and build engagement strategies accordingly (Vollm et al., 2017).
- Engage staff early as allies — build positive relationships and leverage their rapport with patients to facilitate introductions, coordinate engagement activities, and arrange security escorts when needed (Aboaja, Atewogboye et al., 2021; Cook and Inglis, 2008; Deljavan et al., 2025; Evans et al., 2025; Faulkner and Morris, 2003; Faulkner, 2004; Lewis Morton et al., 2017; Vollm et al., 2017).
- Keep research meetings with staff separate from those with patients. Reassure patients that what they share in research meetings will not be passed on to staff to help address any fears they may have about repercussions (*see 2.1: Confidentiality*).
- Throughout the research process, check in with patients to see if there's a staff or peer support worker in the hospital they feel comfortable with, and ask if they'd like that person involved in any way. Patients may be more open when accompanied by someone they trust. If so, communicate with that staff member about the patient's preference and clarify how they can support the process. This not only acknowledges the staff's positive relationship with the patient but can also encourage their ongoing involvement in the research journey.
- When possible and with patient consent, build relationships with patients' family members, close friends, or caregivers, and draw on them as additional supports (Cook and Inglis, 2008). Note that some patients have few or no external contacts, and that some people who have relationships with patients may not always act in their best interests. Always apply confidentiality considerations to interactions with members of the patient's extended circle.
- Create a welcoming environment that supports comfort, focus, and relationship building. This may include offering food and refreshments (Faulkner, 2006), dog-therapy visits (Waypoint Research Institute, 2024), or simply holding meetings in quiet, low-distraction spaces (Aboaja, Atewogboye et al., 2021). Encourage creativity in how welcoming spaces are designed to suit each setting. When possible, offer patients a choice of approved meeting locations. Designate clear research spaces and work with the forensic security office and clinical teams to allow patients from different units to attend the same sessions.
- Use skilled facilitators (e.g., peer researchers) to help guide group dynamics — clarifying misunderstandings, managing dominant voices, promoting open dialogue and safe disclosure of sensitive information, and keeping meetings centered on patient priorities (Jones, 2017; Livingston et al., 2013; McKeown et al., 2022).
- Cultivate enthusiastic staff champions to sustain momentum (Evans et al., 2025). Consider hiring a dedicated project manager or someone with previous experience in secure services to help coordinate the project, support recruitment efforts, and maintain ongoing engagement (Kip et al., 2019; Vollm et al., 2017).

ADDRESSING POWER DYNAMICS

- Recognize and continuously reflect on the balance of power in forensic settings and address issues related to unintended coercion and safeguarding (Aboaja, Atewogboye et al., 2021; Faulkner and Morris, 2003; Livingston et al., 2013; Waypoint Research Institute, 2024; Vollm et al., 2017).
- Avoid having clinical team members serve as patient engagement facilitators to reduce the risk of unintentional coercion, discomfort, or deterring patients from sharing their voices authentically (Aboaja, Atewogboye et al., 2021; Shaw, 2023; Vollm et al., 2017). That said, in some cases, patients may feel more comfortable when supported by a familiar staff member (*see "Work with staff and other supports" above*).
- Establish fair methods for equal engagement in the research process from the outset. This includes creating space for debate and consensus-building (Lewis-Morton et al., 2017), setting up clear processes to manage inevitable disagreements (MacInnes et al., 2011), and democratic decision-making such as majority rule or sub-committees when needed (Dell et al., 2023; Faulkner, 2006; MacInnes et al., 2011).
- Consider the impact of shared or differing identities between researchers and patients (Faulkner, 2004; Faulkner and Morris, 2003; Rutherford et al., 2024), and how role transitions (e.g., from patient-to-patient researcher) can affect the respect and consideration given to an individual's views (Vollm et al., 2017).
- Use neutral terms to refer to patients involved in research (e.g., "project advisor"), so their experience could be listed on their resume without explicitly referencing their use of mental health services (Vollm et al., 2017).
- Consider removing titles in some contexts to avoid reinforcing hierarchies (e.g., PhD, psychiatrist, expert) (Dell et al., 2023), while acknowledging the importance of expertise. Use titles when they add necessary clarity, credibility, or are required, as dropping them indiscriminately can unintentionally devalue credentials.
- Where possible and appropriate, and following a well-defined approach, have patient partners conduct interviews — while taking steps to avoid sampling and response bias (Livingston et al., 2013; Vollm et al., 2017).
- Invite patients to co-produce and co-author a paper. This can unearth different ways of interpreting data and reduce power inequities in dissemination (Lewis Morton et al., 2017). Involving patients in co-authorship renders findings more credible and accessible (Banongo et al., 2006). Prepare patient partners for the peer-review process and support them by addressing external reviewers' comments (MacInnes et al., 2011).

Shared understanding

Shared understanding in forensic POR is about establishing a common grasp of research goals, processes, roles, and boundaries — achieved through accessible and tailored communication — so that all patient partners engage in research with clarity and confidence.

Guidelines

ESTABLISHING AND MAINTAINING SHARED UNDERSTANDING

- Convene a session at the outset of the engagement to:
    - Present an overview of the project requirements (Faulkner, 2004; Mental Health Commission of Canada, 2025)
    - Co-create a "shared goals agreement" or terms of reference document that clearly explains engagement is voluntary and patients can pause or withdraw at any time without consequence
    - Review background documents (e.g., list of committee members, strategic plans, past agendas/minutes) (BC Mental Health and Substance Use Services, 2024a; BC Mental Health and Service Use Services, 2024b)
    - Define roles, deliverables, and expectations (Kip et al., 2019; MacInnes et al., 2011; Mental Health Commission of Canada, 2025)
- Be transparent about who is on the research committee, including other patient partners and advisors, hospital staff, researchers, PCFC staff, and other interest holders. Explain outline how each member contributes.
- Provide the same orientation for every new patient who joins the research team (BC Mental Health and Substance Use Services, 2024a; Vollm et al., 2017).
- Record team meeting minutes so that those absent due to health or a change in levels of activity can review them (Dell et al., 2023).
- Use an integrated knowledge translation (IKT) approach to explore patients' understanding of the research process, and their experiences with past research, identify gaps in their knowledge, and begin addressing these gaps through knowledge products and strategies (Deljavan et al., 2025).
- Prioritize clear and accessible communication throughout the research process by:
    - Using plain language and creative, tailored strategies (Cook and Inglis, 2008; Faulkner and Morris, 2003; Faulkner, 2006; MacInnes et al., 2011; Vollm et al., 2017) — such as pictures, tape-recording, widgets software, video, posters, and stickers (Faulkner and Morris, 2003; McKeown et al., 2022). At the same time, be mindful of hospital safety and security protocols.
    - Creating a glossary of common terms and acronyms used (BC Mental Health and Substance Use Services, 2024a).
    - Consulting with speech and language specialists (Jones, 2017) as needed to adapt communication approaches for individuals who may experience difficulties with language, comprehension, or expression.

Support

Support in forensic POR is the proactive provision of emotional, practical, and safety measures to anticipate and address patients' needs and sustain their wellbeing throughout their engagement in the research process.

Guidelines

STRUCTURING SUPPORT

- Co-develop individualized support plans with patients at the outset to identify needs, preferences (BC Mental Health and Substance Use Services, 2024a), and confidence-building strategies (Vollm et al., 2017). Offer access to neutral support personnel (e.g., a staff liaison) when/as appropriate (BC Mental Health and Substance Use Services, 2024a; Vollm et al., 2017).
- Support patient partners in navigating the emotional complexity of their roles — listening to others' stories, reflecting on their own experiences, and serving as bridges between the research team and the patient community.
- Incorporate safety and crisis plans for times of distress, absence, or role overlap (e.g., when a patient is a *research participant* and a *patient partner*) (Aboaja, Atewogboye et al., 2021; Dell et al., 2023; Faulkner, 2004; Vollm et al., 2017). Plans should also account for potential safety risks during engagement, including how to respond if a patient makes threats towards themselves or others. Establish clear protocols in advance for de-escalation, staff involvement, and follow-up, ensuring that all team members know how to respond while upholding trauma-informed practices.
- Build in debriefing time after emotionally intense discussions or incidents (Waypoint Research Institute, 2024) to support emotional processing and reduce consultation fatigue (Aboaja, Atewogboye et al., 2021; Cook and Inglis, 2008; Vollm et al., 2017). End sessions early if needed and check in regularly throughout. Communicate any risks of harm to self or others to the unit care team but try to de-escalate first and involve staff only when necessary so patients don't feel you're "reporting back" on them.
- Anticipate and address tensions that may arise from staff or patient attitudes about patient engagement in research, and from the potential workload burdens on patients (Vollm et al., 2017).
- Hold regular check-ins, either one on one or in groups, to discuss progress, needs, or concerns (Banongo et al., 2006; Kip et al., 2019; MacInnes et al., 2011). Include the principal investigator whenever possible (Vollm et al., 2017) and schedule these check-ins at set intervals or as needed (BC Mental Health and Substance Use Services, 2024a; MacInnes et al., 2011; Vollm et al., 2017), to whatever extent patients are comfortable — without pestering (Waypoint Research Institute, 2024). Offer scheduled phone calls as an alternative to in-person or virtual meetings to reduce barriers and make engagement less taxing for patients.
- Discuss and co-develop peer mentoring arrangements with patient partners — whether formal or informal, buddy systems, or mutual support groups — and provide ongoing opportunities for patients to give and receive peer support (Banongo et al., 2006; Cook and Inglis, 2008; Livingston et al., 2013; Shaw, 2023).
- Allow researchers to work in pairs for mutual support (Vollm et al., 2017).

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Dimension 4: Levels of engagement

4

Levels of engagement

Levels of engagement in forensic POR refer to the different ways patients may be engaged in a research project, depending on their preferences, circumstances, and needs. In secure settings, engagement may vary across patients and fluctuate over time, so fostering engagement requires creating inclusive opportunities for all patients to contribute.

Guidelines

SETTING AN APPROACH TO ENGAGEMENT

- Use frameworks to identify and plan the level of patient engagement that best fits the project's context and goals (Dell et al., 2023) and to clearly communicate the specific levels engagement being requested (Mental Health Commission of Canada, 2025). As part of this, be clear about what is expected from both researchers and patient partners. Anticipate fluctuation — patients may step away partway through or join mid-project. Provide these opportunities and plan accordingly.
- To whatever extent is possible, involve everyone, including patients, in designing the project plan from the beginning. Doing so helps facilitate trust, ownership, and alignment with patient needs (Dell et al., 2023; Faulkner, 2004; Faulkner, 2006; Faulkner and Morris, 2003).
- Ensure inclusion of patients who are in seclusion or unable to attend groups by sharing group insights one-on-one, inviting their input, and integrating their contributions into team discussions (Jones, 2017).

BUILDING IN PATIENT PRIORITIES

- Use engagement activities to help identify patient-informed research priorities. Strategies may include:
  - Presenting current research topics and examples of patient-identified priorities to stimulate discussion and generate ideas (Faulkner and Morris, 2003).
  - Asking straightforward, personally relevant questions such as "What concerns you now?" or "What do you find helpful?" to foster meaningful dialogue (Faulkner, 2006).
  - Ensuring that proposed research topics reflect patients' personal and current concerns (Faulkner, 2006). It's important to let patients know ahead of time to be prepared to work on a research topic that might not feel so relevant to them individually. This is to create realistic expectations.
  - Seeking funding for a dedicated project where patient partners consult with peers across high, medium, and low secure settings (Faulkner and Morris, 2003).

DISSEMINATING AND IMPLEMENTING FINDINGS

- Identify feasible dissemination strategies with staff (Faulkner, 2006).
- Consider organizing presentations within secure settings and using patient-developed materials (e.g., PowerPoint presentations, creative works) as discussion points in forums (Jones, 2017).
- Invite patients to participate in or co-lead dissemination of research findings to internal or external healthcare providers, depending on their level of engagement. Many academic conferences now offer virtual options, allowing patient partners and advisors to present via Zoom without leaving the secure setting. Consult your hospital's policies to ensure patient privacy is protected accordingly.
- Explore online dissemination options, such as creating a dedicated webpage for forensic POR.
- Disseminate research findings through a variety of creative methods (Dell et al., 2023) to engage diverse audiences, including:
    - Lay summaries (Rutherford et al., 2025)
    - "Easy read" versions
    - Theatre presentations and other arts-based methods (Dell et al., 2023)
    - Papers in professional practice journals (rather than research journals)
    - Articles written for journals and magazines (or sources of grey literature) that reach service users (Cook, 2012)
    - In-house seminars (Banongo et al., 2006)
    - Poster presentations at conferences (Rutherford et al., 2024)
- Consider including patient participants in implementing research findings or working alongside professionals and policymakers on prevention strategies to resolve issues raised by the research.

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Dimension 5: Evaluation and sustainability

5

Evaluation

Beyond measuring outcomes, evaluation in forensic POR is also about learning from the experience, giving patients and staff a chance to reflect, share feedback, and assess if the research remained aligned with patient priorities.

As forensic POR intends to be relational — considering who speaks, who is heard and how decisions are shared — then measurement should also be relational. This involves evaluating factors such as trust, psychological safety, power-sharing, recognition and sustainability.

A considered approach to evaluation also supports closure at the end of a project and informs future planning.

Guidelines

DEBRIEFING AND GATHERING FEEDBACK

- Implement proper debriefing practices and processes for identifying lessons learned (Waypoint Research Institute, 2024).
- Evaluate not only the engagement process and experience but also the impact: how engagement shifts practices, decisions, or outcomes more broadly.
- Invite feedback from patient partners both at the end of the project and also at key touchpoints throughout. Give space for reflection and concerns, as well as for input on priorities, progress, and findings (Cook and Inglis, 2008; Faulkner, 2006). Balance this with care, as overly frequent check-ins can feel performative or dehumanizing.
  - Explore feedback dimensions such as accessibility, degree of engagement, whether patients would recommend the experience to others, the coherence and effectiveness of the process, if it could be attended with minimal opportunity cost, etc. (Aboaja, Atewogboye et al., 2021).
  - Use surveys (RedCap or paper) to explore patients' experiences related to autonomy, self-esteem, knowledge growth, self-perception, etc.
  - Use creative and informal approaches to gain reflections. Consider storytelling or guided open-ended questions (Cook and Inglis, 2008).
- Offer staff the same opportunity as patients to reflect and gather insights on what they learned, how their relationships with patients evolved, and how they used their role to engage patients (Cook and Inglis, 2008).
- Plan for closure for everyone. Acknowledge and address the difficulties associated with ending projects, such as the termination of research roles, the dissolution of close relationships (Banongo et al., 2006; Faulkner and Morris, 2003; Faulkner, 2006), maintaining the interest of patients (Faulkner, 2006), managing expectations, and justifying the project's conclusion (Banongo et al., 2006).

Sustainability

Sustainability in forensic POR focuses on extending its impact, ensuring continuity over time, and maintaining momentum beyond individual projects.

Guidelines

BUILDING ON MOMENTUM

- Leverage the expert group of patients and staff established at the outset of the project to promote future engagement in POR in secure settings, "spread the word", and publicize examples of relevant research (Faulkner and Morris, 2003; Vollm et al., 2017). Patients can contribute testimonials, digital stories, or posters for the units.
- Consult with knowledge translation experts and patient partners to integrate knowledge into practice (Dell et al., 2023).
- Create pathways to support continued engagement after patients leave the hospital or forensic system so their voices can continue to shape research (Banongo et al., 2006). Consider forming a 'POR alumni' group.
- Work with decision-makers responsible for hospital policies/procedures to ensure integration of findings into practice.

THINKING LONG-TERM

- Reset research priorities at regular intervals (e.g., every five years) to ensure ongoing alignment with evolving patient and service needs (Aboaja, Forsyth et al., 2021).
- Advocate for long-term investment. Forensic POR requires time, resources, and institutional commitment, yet funders and academic systems often undervalue it (Cook, 2012; Faulkner, 2006). Plan for sustainability by budgeting sufficient time and resources to support long-term engagement (Aboaja, Atewogboye et al., 2021; Faulkner and Morris, 2003).

Glossary

Engagement

A person's ability to contribute actively, meaningfully and collaboratively to the research process.

Epistemic injustice

Injustice and unfairness related to what someone knows or the knowledge they can access. When a person's knowledge is not considered valid or is excluded by a group or system, they are experiencing epistemic injustice.

Equity

Making sure all people are treated fairly, included, respected for what they know and benefit from similar outcomes.

Forensic Review Board

A body that reviews the status of people in forensic mental health care and makes decisions about where they should be placed.

Honoraria

Small payments or other forms of compensation that are given to acknowledge a person's effort or contribution.

Integrated knowledge translation (IKT)

A way of doing research that has researchers partner with the people who will use the research to make sure it is relevant and has a positive impact.

Knowledge translation

Sharing research findings with people who can use them, and supporting the process of making them usable.

Meeting minutes

Written notes from meetings that remind people of what was discussed and any agreements reached or actions to be taken.

Participatory research

Research that involves the people affected by an issue in studying it to drive action or change.

Patient participant

A patient who takes part in a research project.

Patient partner

A patient who takes part in a research project as a co-researcher or advisor.

Patient-oriented research (POR)

Patient-oriented research ranges from information-sharing about research to consultation, collaboration and true partnership in research by researchers and patients together. In forensic mental health settings, POR is known as 'forensic POR'. The Canadian Institutes of Health Research have proposed changing their term for this type of research to "people-centered and partnership-oriented research".

Patient/client family council

A council that partners with mental health and addictions services providers to improve people's experience of care. The Patient and Client Family Council (PCFC) at Waypoint is a non-profit organization with staff and volunteers who have personal experience with the mental health and addictions systems.

Peer researcher

Somone with personal experience of an issue who contributes to research on that issue.

Peer support

Support provided by people with lived and living experience to each other.

Plain language

A way of writing and speaking that is simple, clear, non-technical and meant to be understood by the broadest possible audience.

Relational security

Safety and security practices based on staff knowledge of a patient and their environment.

Research participant

Someone who takes part in a research project.

Trauma-informed approaches

Approaches to care and working with others that recognize the impacts trauma and other forms of suffering or inequity may have had in their lives, and that shape how they act.

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