NURSING STRATEGIES FOR WORKING WITH PATIENTS PERCEIVED TO BE CHALLENGING AND DIFFICULT: A DISCOURSE ANALYSIS

A Thesis Submitted to the
College of Graduate and Postdoctoral Studies
In Partial Fulfillment of the Requirements
For the Degree of Master in Nursing
In the College of Nursing
University of Saskatchewan
Saskatoon

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ABSTRACT

The forensic mental health nursing milieu presents unique challenges for nursing practice. Nurses contend with dual and conflicting roles of caring and custody. The provision of care is complicated by a mandate to ensure patients adhere to institutional rules and expectations, especially in high security settings. In these settings nurses work with patients they perceive to be challenging – a patient group identified as causing significant negative effects on nurses. Yet strategies for working with this group of patients remains relatively unstudied. The present study explored the strategies nurses employed when working with patients they perceived to be challenging in the high security forensic mental health setting. One-to-one, semi-structured interviews were conducted with seven nurses working in this setting. A discourse analysis methodology was utilized to explore challenging behaviours, nursing strategies, the construction of patient subjectivities by nurses, and power dynamics within the system. Participants identified two distinct groups of patients perceived to be challenging – patients with psychotic disorders and patients with antisocial personality disorder– both of which were deemed to be treatment resistant. Strategies for working with patients focused primarily on risk management and the prevention of disruptive or violent patient behaviours as opposed to therapeutic interventions and recovery. Participants identified the highly restrictive setting and limitations on patient freedoms as significant barriers to working with patients in a therapeutic manner. An analysis of nursing practice unit power dynamics, in particular Foucault's disciplinary power apparatus, provided a framework for conceptualizing the role of nurses and patients in this setting. Implications for nursing practice and future research are explored.

Keywords: Forensic mental health, forensic nursing, nursing, treatment resistant patients, challenging patients, discourse analysis, power, Foucault, antisocial personality disorder, schizophrenia, psychotic disorders

ACKNOWLEDGEMENTS

The research project outlined in this thesis would not have been possible without the guidance, contributions, and feedback from a number of people.

I would first like to thank my spouse, Victoria. She has been a constant source of support and encouragement throughout my entire Master of Nursing program, and long ago accepted that I will be in school for the majority of my adult like.

I would next like to thank my supervisor, Cindy Peternelj-Taylor. Cindy has been endlessly kind and patient with me throughout my program. Cindy was willing to not only take me on as a student, but to co-develop a special readings course in forensic mental health nursing, allowing me to further explore this topic about which I am so passionate. I was also privileged enough to work with Cindy in the planning for the Custody and Caring conference, putting me in touch with experts in the field from across the planet.

I would like to thank Gerri Lasiuk and Mark Olver, the members of my thesis committee. Their guidance and feedback helped me to focus my studies and make this project more realistic and successful.

Next, I would like to thank the nurses and staff at the forensic hospital at which I recruited participants and at which I started my nursing career. You all taught me so much about the world of forensic nursing, how to be kind and patient in some unimaginably challenging situations. An enormous thank you to those who participated in this study and spoke so openly and honestly about your experiences. The richness of your contributions allowed me to write this study.

Finally, I would like to thank my colleagues at MacEwan University, in particular Holly Symonds-Brown and Margaret Milner. Your ongoing support, guidance, and suggestions

allowed me to balance full time work and full time study and helped keep me focused on this work.

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ABBREVIATIONS USED

ASPD: Antisocial Personality Disorder

NCR: Not Criminally Responsible

NCRMD: Not Criminally Responsible on Account of a Mental Disorder

Chapter 1 Introduction

Nurses practicing in forensic mental health settings encounter unique practice challenges, where they are forced to balance the duty to provide care with the rules and restrictions of a secure facility or correctional setting. This dual role – acting as both an agent of care and an agent of control – is central to the challenge of nursing in this milieu (Holmes, 2002; Peternelj-Taylor, 1999). Forensic mental health nursing occurs in a number of diverse settings, including secure forensic units in mental health facilities and/or general hospitals, secure forensic mental health hospitals, specialized mental health facilities in correctional institutions, and community support services. Patients in these settings often present with highly complex, treatment resistant diagnoses, including psychotic disorders (Charette et al., 2015; Haag et al., 2016; Zarkovic Palijan et al., 2009), where co-morbidities of personality disorders and/or substance use disorders mix with histories of criminal behaviour and possible violence (Bowers et al., 2011; Howard et al., 2013).

In Canada, when individuals have committed a crime, but it is determined that they suffer from a mental illness that made them incapable of understanding the nature and consequences of that crime, they may be declared Not Criminally Responsible on Account of a Mental Disorder (NCRMD; Criminal Code, R.S., 1985, c. C-46, s. 16) instead of being found guilty of the criminal act they committed. These individuals are then held in a secure forensic hospital for treatment and fall under the jurisdiction of a provincial Review Board, as opposed to detention in a conventional correctional facility (Latimer & Lawrence, 2006). In addition, if it is determined that an individual suffering from a mental illness is incapable of understanding the court process or communicating with a lawyer, they may be designated as “unfit to stand trial” (Criminal Code, R.S., 1985, c. C-46, S. 16) and will be held at a secure forensic hospital for treatment until

they are determined to be "fit" for trial. Furthermore, in federal, provincial and territorial penitentiaries, inmates who suffer from mental illness (but have not met the criteria for "unfit" or NCRMD) may require care in specialized mental health units (Holmes, 2002; Perron & Holmes, 2011). Increases in the numbers of mentally ill prisoners are being reported in Canada, a result of de-institutionalization and poor community supports, as well as the prison setting itself contributing the mental health challenges for incarcerated persons (Chaimowitz, 2012; Jacob, 2012; Nijdam-Jones et al., 2017). These secure forensic hospitals and mental health units in correctional facilities are the primary milieus of practice for forensic mental health nurses in Canada. The goal of these settings is the "social rehabilitation of inmates" (Holmes, 2005, p. 4) – to treat the individual's mental illness while minimizing the risk they pose to themselves and others (Crocker et al., 2013). Eventual transition outside of the secure setting and into community settings is a primary goal of nursing care (McKenna et al., 2014; McKeown et al., 2016).

Meeting these goals can be challenging, and nurses are tasked with the provision of care aimed at achieving these goals. While nurses find success in facilitating the progress of many patients through the forensic mental health system, some patients are resistant to the provision of care, may be uncooperative, and may exhibit acts of aggression or violence (Aiyegbusi & Kelly, 2015; Dickens et al., 2013; McKeown et al., 2016; Tomlinson, 2015). The majority of patients in these settings suffer from psychotic disorders (Charette et al., 2015; Haag et al., 2016), with frequent co-morbidities of personality and/or substance use disorders (Howard et al., 2013; Zarkovic Palijan et al., 2009). Treatment of these individuals can prove complex and challenging (Howard et al., 2013). The difficulties of working with patients, especially those who are resistant to care, is a significant source of stress for forensic mental health nurses (Aiyegbusi &

Kelly, 2015; Bowers et al., 2011; Jacob, 2012; Newman et al., 2020). Power dynamics between patients and nurses in a highly restrictive setting further complicate nursing capacities to form therapeutic relationships, and may contribute to patient resistance to care (Holmes, 2005; Holmes & Federman, 2006). Effective and therapeutic strategies for the provision of care with patients perceived to be challenging by nursing staff remains elusive (McKeown et al., 2016).

Chapter 2 Purpose and Objectives

The purpose of this research was to explore the clinical issues faced by nurses in high security forensic mental health settings when working with patients they perceive to be challenging, and to examine the strategies employed by nurses to work with these individuals. An understanding of the various ways in which these patients are perceived to be uncooperative or difficult will illustrate the scope of challenging behaviours encountered by nurses, and will highlight the dual role of custody and care nurses adopt in this setting. The objectives of this study were to: (1) Describe the behaviours and actions that patients use that nurses find most challenging; (2) Identify strategies utilized by nurses, both successful and unsuccessful, to work with patients they perceive to be challenging; and (3) situate these nurse-patient interactions within the greater context of power dynamics in the high security forensic mental health setting.

Chapter 3 Relevance to Nursing

The forensic mental health milieu is a unique practice setting for nurses, wherein they must balance a dual mandate to provide patient care while also enforcing the rules and expectations of the institution. This dual role of custody and care can negatively impact a nurse's ability to form therapeutic and trusting relationships with patients, and the restrictions of the setting may push nurses towards more punitive and custodial approaches to care. Patients who are uncooperative, aggressive, or violent may not comprise the majority of the population (McKeown et al., 2016), but their actions have significant negative impacts on nursing staff (Aiyegbusi & Kelly, 2015). The physical and emotional risk of harm to nurses is so common in all practice settings that is seen by many as simply part of the job (Bowers et al., 2011). Despite a shift in recent years towards a recovery-oriented approach to patient care in forensic settings, patients perceived to be uncooperative and difficult continue to negatively affect nursing staff. Effective strategies for their care that avoid punitive measures remain elusive. McKeown et al. (2016) called for further study of this patient population, including strategies to effectively work with them. The examination of strategies employed by nurses, with both positive and negative outcomes, may assist in understanding effective nursing approaches and prevent future negative outcomes. Situating patient behaviours and nursing strategies within the framework of power relations may illustrate the role that power dynamics play within the therapeutic nurse-client relationship for patients that nurses perceive as challenging.

Chapter 4 Literature Review

4.1 Custody and Caring

In the forensic mental health setting, a dual mandate of providing public safety from those who have committed crimes and the provision of mental health services for the mentally ill intersect in a paradox of custody and caring (Peternelj-Taylor, 1999). When caring for an involuntary population, concerns about public safety, the safety of fellow staff and patients, and adherence to institutional rules and expectations clash with the nurses' duty to provide care that is "inclusive, collaborative, and egalitarian" (Livingston et al., 2012, p. 346). Nurses work to facilitate patient progress, encourage hope, address stigma, and create meaning in patient lives (Drennan & Alred, 2012b). In contrast to this mandate, nurses may also take on a secondary role as a peace officer or correctional guard, where they are required to enforce the strict rules of the forensic system (Holmes, 2002). Nurses bear responsibility for the surveillance of patient activities, the reporting of rule violations to necessary authorities, and the discipline and punishment of patients who fail to follow the rules (Chandley et al., 2014; Holmes, 2005; Perron & Holmes, 2011). Schafer and Peternelj-Taylor (2003) described nurses, in the process of reporting on patient progress to the greater treatment team, as having "the power to deny the patient freedom" (p. 607). The necessity for nurses to enforce the rules of the institution and carry out the discipline of patients who do not follow these rules places forensic mental health nurses outside the typical scope of nursing practice (Jacob, 2012).

An integral component of forensic mental health nursing practice is the concept of risk, including both risk assessment and risk management. Barker (2012) defined risk within this context as "individuals (or groups of individuals) acting in a harmful way towards others. This might mean in a violent way, but may also include bullying, manipulation for personal gain,

intimidation, or other ‘challenging’ behaviours” (p. 25). The assessment of an individual’s risk of acting in harmful ways is viewed as an important skill for nurses in these settings. Risk assessment may be achieved through nurses’ judgement and knowledge of their patients, but may also use more formal risk assessment instruments such as the Brøset Violence Checklist and the Dynamic Appraisal of Situational Aggression (Maguire et al., 2018). Risk management encapsulates the wide range of nursing interventions utilized to both treat and minimize harmful behaviours in day-to-day interactions with patients (Barker, 2012), such as de-escalation, the limiting of privileges, or the use of restraints. Patient histories of risk behaviours, including violence in these settings can prioritize a risk management focus, at the expense of patient freedom and autonomy.

The foundation of nursing practice in all settings is the nurse-patient relationship, though challenges exist in their formation in forensic mental health settings. An understanding of patient histories, including the crimes committed, can create a disconnect between nurses and patients (Jacob et al., 2009). Inversely, previous negative experiences with health care or correctional workers can limit a patient’s willingness to engage with nurses (Ferrito et al., 2012). Establishing a therapeutic relationship based on trust and respect facilitates the provision of nursing care, even within the highly restrictive forensic setting (Rose et al., 2011). McKeown et al. (2016) noted the importance of “warm, effective, consistent relationships” (p. 239) in facilitating a patient’s journey to recovery, mirroring similar findings by Livingston et al. (2012). In developing these relationships, Schafer and Peternelj-Taylor (2003) described the importance of considering the patient’s experiences, while Rask and Brunt (2007) recommended “dipping” (p. 171); attempting to understand a patient’s behaviours by dipping into their thoughts. Crucial in this milieu, in the context of the nurse-patient relationship, is the creation and maintenance of boundaries to ensure

safe and ethical practice for both nurses and patients (Peternelj-Taylor & Yonge, 2003; Schafer & Peternelj-Taylor, 2003). Despite the challenges that exist within this paradox of custody and caring endemic to nurses in the forensic mental health setting, the development of therapeutic relationships is both possible and beneficial to patient outcomes.

4.2 Recovery

Beginning in the 1960s and 1970s, mental health services began to shift their perspective on the delivery of care, away from biomedical and rehabilitation-focused modes of care to a recovery-oriented perspective, rooted in a patient-centered focus (Drennan & Alred, 2012b; Pouncey & Lukens, 2010; Simpson & Penney, 2011). Rehabilitation aimed to meet the needs of mental health patients, where "the focus of the service has the provider consulting and collaborating with the patient but led by the service. Recovery suggests a shift to the patient leading the process as far as they can and drawing on service provider resources to do so" (Drennan & Alred, 2012a, p. ix). Though a myriad of working definitions and conceptualizations of recovery exist, the patient-centered focus aims for the best life possible for individual patients experiencing mental illness. Davidson et al. (2006) state that recovery aims to "enable people with psychiatric disabilities to lead safe, dignified, and full lives in the community" (p. 641). Jacobson and Greenley (2001) differentiate between the internal and external conditions of recovery; internal conditions, for the individual on the recovery journey, include hope, healing, empowerment, and connection, whereas external conditions consist of human rights, a culture of healing, and recovery-oriented services. In its guidelines for recovery-oriented practice, the Mental Health Commission of Canada (MHCC; 2015) highlights recovery as a highly personal process, emphasizing autonomy and self-determination, and building on existing individual strengths. Under these guidelines mental health practitioners are encouraged to build "mutually

respectful and collaborative partnerships" (p. 36) and to prioritize the needs of the individual patient. This shift towards recovery has also signaled a shift in the nature of the nurse-patient relationship – one built upon collaboration and respect, moving away from more paternalistic and coercive approaches to care (Pouncey & Lukens, 2010).

4.2.1 Recovery in Forensic Mental Health

In recent years, there has been an international movement to extend recovery beyond conventional mental health care and into forensic settings (MHCC, 2015; Drennan & Alred, 2012b; McKenna et al., 2014). In an environment where admission is involuntary – and often long-term – and access to privileges and freedoms is often contingent on cooperation with treatment modalities, the implementation of recovery poses challenges unique to the forensic milieu (Young, 2011). Legal obligations to maintain patients in custody and the importance of risk management can impact the degree of freedom and autonomy available to patients in forensic settings (Drennen & Alred, 2012b; McKeown et al., 2016; Turton et al., 2011). A goal of recovery is the greater inclusion of individuals suffering from mental illness, though, paradoxically, the purpose of a forensic facility is to specifically exclude individuals from greater society (Dorkins & Adshead, 2011). Moving beyond the stigma of mental illness is central to recovery, but patients in forensic mental health facilities also carry the additional stigma of their criminal status. Recovery from "being seen as both 'mad' and 'bad'" (Mezey et al., 2010, p. 691) is unique to the forensic milieu; with many patients finding this offender identity a greater obstacle to recovery (Drennan & Alred, 2012b). Furthermore, entrenched workplace cultures, insufficient training, and lack of leadership can pose challenges to the implementation of recovery-oriented practice in forensic settings (McKenna et al., 2014). The restricted nature of forensic facilities, the legal obligation to maintain public safety, the dual stigma that patients

face, and issues such as staff resistance all make the transition to a recovery-orientation in forensic mental health settings a unique challenge.

Despite these challenges, recovery has been successfully implemented in a number of forensic mental health settings by recognizing the specific challenges of the milieu and the patient populations, and utilizing therapeutic nurse-patient relationships to improve outcomes (Chandley et al., 2014; Drennan & Alred, 2012b; Ferrito et al, 2012; Livingston et al., 2012; McKenna et al., 2014; McKeown et al., 2016; Simpson & Penney, 2011; Turton et al., 2011). The existence of a therapeutic milieu and increased patient engagement is linked to improved perceptions of recovery (Livingston et al., 2012). McKenna et al. (2014) outlined a number of strategies to implement recovery in the forensic setting, including creating a vision of "a life worth living" (p. 65), promoting hope through the establishment of short-term goals, providing as much choice and autonomy to patients as is realistic in the secure setting, providing meaningful engagement, and focusing on the strengths of the individual patients. Regarding the management of risk inherent in the forensic milieu, Barker (2012) advocates for the inclusion of patients in their assessments of risk – a collaborative approach that builds examination of risk into the recovery process itself. Furthermore, McKenna et al. (2014) suggested that staff take "calculated risks" (p. 68) to manage patient risk, using their relationships with, and knowledge of patients to make decisions most likely to meet the patient's goals for recovery. Barker (2012) further proposed a re-thinking of risk management through a process of positive risk-taking. Positive relationships, built on trust and an investment in a patient's recovery, are crucial to meeting these goals (McKeown et al., 2016). Recovery presents as a more egalitarian opportunity for nursing practice in forensic settings, moving beyond previous strategies based on control and consequences (Chandley et al., 2014).

4.2.2 Barriers to Recovery

Though the implementation of recovery has had positive impacts on the lives of many patients in the forensic mental health milieu, it cannot be viewed as a panacea in this highly complex field of nursing practice (Chandley et al., 2014). Taking responsibility for one's mental health and one's criminal past is a critical element of recovery in this milieu (McKeown et al., 2016). However, many patients are unwilling to do so, and deny, minimize, or justify their offenses (Drennan & Alred, 2012b). Patients may be suspicious of nursing staff and their motivations (Schafer & Peternelj-Taylor, 2003), while those with histories of abuse and trauma may have difficulty trusting others (Ferrito et al., 2012), with subsequent negative impacts on their willingness or ability to engage in the recovery process. Particular psychiatric diagnoses and co-morbidities common amongst forensic mental health patients have been identified as being treatment resistant, including psychotic disorders (often characterized by a lack of insight) (Pijnenborg et al., 2013), personality disorders, substance use disorders, and psychopathy (Howard et al., 2013; Zarkovic Palijan et al., 2009). In a setting that prioritizes risk management, patients deemed unsafe or unsuitable may be excluded from therapeutic activities such as group sessions or occupational therapy (Bowers et al., 2011). Even in settings where a recovery orientation exists, some patients continue to pose challenges to nursing staff in a variety of ways, from a refusal to engage with treatment to episodes of violence and aggression. Strategies to work with the "determined recalcitrant" (McKeown et al., 2016, p. 240) that lie outside of custodial, coercive measures remain elusive.

4.3 Use of Restraints

Forensic mental health patients who engage in threatening, aggressive or violent behaviours are frequently subjected to the use of restraints. Despite policies and protocols

emphasizing the use of restraint as a last resort, and a growing emphasis on patient autonomy and human rights, the use of restraints is widespread in forensic mental health settings (Gildberg et al., 2015; Holmes et al., 2015; Hui et al., 2013; Jacob et al., 2019). Hui et al. (2013) described four categories of restraints used in forensic settings. Physical restraints, which entail patients held by one or more staff members; their movements restricted. Mechanical restraints involving the use of restrictive devices, such as belts and shackles. Seclusion or environmental restraint, which involves the locking of a patient in a dedicated room. The use of tranquilizing or sedating medications is the final form of restraint, and is also referred to as chemical restraint. The language used to describe types of restraint varies and conflicting views on the use of restraints in the forensic mental health setting exist. Hui et al. (2013) concluded that "those who authorize appear to view the therapeutic benefits of coercive measures while those who are expected to employ coercive interventions appear to view such practices with fear, anxiety, anger, and even resentment" (p. 65). Nursing staff decisions on the use of restraints relate to risk management and perceived threats amongst patients (Jacob et al., 2019), with nurses ascribing positive outcomes on a patient's mental health following the use of restraints (Holmes et al., 2015).

A diversity of patient perspectives on the use of restraints in forensic mental health settings exists in the literature, however patients primarily view their use as more punitive than do nurses (Hui et al., 2013). In their study of the use of seclusion in forensic mental health, Holmes et al. (2015) concluded that patients found the experience to be challenging and describe feelings of abandonment and a loss of dignity. The use of restraints can lead to a disintegration of a therapeutic nurse-patient relationship, especially if the patient views their use as punitive (Jacob et al., 2019). However, therapeutic interactions between patients and nurses during the restraint experience itself is linked to better outcomes after the event has ended (Holmes et al.,

2015). The use of restraints in the forensic mental health setting further complicates a nurse's ability to develop and maintain therapeutic relationships with patients.

4.4 Patient Resistance

Significant efforts have been dedicated to the research of patient violence and aggression in the forensic mental health milieu, the causes and management of these episodes, and their impact on nursing staff (Aiyegbusi & Kelly, 2015; Bader et al., 2014; Berring et al., 2015; Bowers et al., 2011; Dickens et al., 2013; Nicholls et al., 2009). In a review of the international literature on inpatient violence and aggression, Bowers et al. (2011) concluded that forensic mental health patients engage in the highest rates of aggression amongst all inpatient mental health populations. Tomlinson (2015) defined aggression as "any form of intended verbal or physical behaviour directed toward another living being or the self that… causes (or could reasonably cause) unwanted psychological or physical harm to the target of this behaviour" (p. 24). Responsibility for this aggression and violence, according to nurses, lies with the patients themselves (Berring et al., 2015): nurses manage these episodes, and aim to use de-escalation strategies to prevent further acts of aggression and violence (Dickens et al., 2013). Acts of aggression and violence are common enough that most nurses see them as part of the job (Bowers et al., 2011).

Beyond these acts of violence and aggression, there are other means in which engagement in therapeutic nurse-patient relationships and the recovery process face challenges. In a setting where nurses are responsible for the enforcement of institutional rules, the role of authority figure can negatively impact nurses' ability to develop trusting, therapeutic relationships (Holmes, 2005; Jacob, 2012). Some patients "may regard nurses as captors" (Holmes et al., 2015, p. 209). This may compound with patient histories of trauma and abuse

(Ferrito et al., 2012), including patients with personality disorders (Aiyegbusi & Kelly, 2015), to create circumstances in which therapeutic relationships with nurses are not possible (Holmes, 2005). A patient's mental health status may make the formation of any form of therapeutic relationship impossible (Holmes et al., 2015). As well, having knowledge of a patient's criminal past may invoke feelings of fear and abjection and nurses may distance themselves from patients, at the expense of the therapeutic relationship (Jacob et al., 2009). In environments defined by the tension of binary oppositions, the "positive feelings experienced in transference can by contrasted with the negative emotions that forensic patients may evoke in counter-transference (Mason, 2002, p. 518). Splitting is a common patient behaviour for nurses to identify and manage, especially amongst individuals diagnosed with personality disorders (Bowan & Mason, 2012). According to Green (2018), splitting occurs in a treatment team when groups of staff develop strongly opposing feelings towards a patient, leading to discord amongst the team. Responsibility for this splitting is placed upon the patient and is often associated with personality disorder diagnoses. Finally, and most simply, patients may refuse to speak to or engage with nursing staff who attempt to engage them in therapy (Holmes, 2002). The process of recovery is hindered in these cases, with some patients refusing engagement or cooperation for extended periods, even years (McKeown, 2016).

4.5 Impacts of Challenging Behaviours

The impact on nurses of these challenging encounters with patients is significant. Acts of patient aggression and violence leave nurses "feeling threatened and belittled" (Aiyegbusi & Kelly, 2015, p. 284), often with long-lasting emotional consequences. In a literature review of patient violence and aggression, Bowers et al. (2011) described a wide range of impacts on nurses: physical injuries, negative views towards patients, workplace fear, a decrease in job

satisfaction, anxiety, increased stress, post-traumatic stress disorder, fatigue, substance use, an impact on personal relationships outside of work, and resignation from employment. Newman et al. (2020) described emotional exhaustion, cynicism, and burnout associated with nursing practice in the forensic mental health setting. Holmes (2005) noted the "cultural shock" (p. 9) experienced by nurses entering the forensic mental health setting can alter their previously held beliefs about therapy and care and influence them to participate in institutional culture of coercion and discipline. Jacob (2012) explored the cognitive dissonance that occurs in settings where nurses are faced with the dual responsibility of fulfilling both correctional and healthcare mandates and found that their cognitive dissonance could be minimized by reorganizing their conceptualization of their roles. Specifically, two strategies were employed by nurses: 1) to view disciplinary or punitive interventions as being therapeutic; and 2) to shift perceptions of patients as deviant. Similarly, Perron & Holmes (2011) found that nurses viewed uncooperative or non-compliant patients as deviant, while Berring et al. (2015), in examining acts of patient aggression and violence, also found that nurses constructed patients as deviant, "who do not know what is best for them" (p. 303). The impacts of uncooperative, non-compliant, aggressive or violent patients on nurses is profound. Not only do nurses suffer a wide range of physical and emotional consequences, but the nature of forensic mental health institutions fundamentally alters their perceptions of their roles, and their patients. In essence, there exists the potential for therapy and caring to give way to custody and control.

4.6 Nursing Strategies

When working with patients perceived to be challenging or difficult, what strategies do nurses employ? If a recovery approach is not possible, are strategies rooted in therapy and caring still possible? Or do nurses rely on more punitive, custodial approaches? Herein lies the focus of

this study. Perron and Holmes (2011) noted that "a lack of collaboration is usually managed with medication and/or a time-out" (pp. 199-200). Though the use of seclusion can be beneficial for patients during times of crisis (Dickens et al., 2013), there is danger of its overuse, and the risk of patients viewing it as a form of punishment (Holmes et al., 2015). Patients in seclusion or those deemed high risk are frequently excluded from unit activities or group sessions (Bowers et al., 2011), despite the fact that meaningful engagement and occupation are identified as key to wellness and recovery (McKeown et al., 2016). The limiting of patient freedoms is a common trigger for aggression and violence (Bowers et al., 2011), which may perpetuate restrictive measures for challenging or difficult patients. Patients viewed as uncooperative or recalcitrant by nursing staff have been identified as a priority for further investigation (McKeown et al., 2016), especially given the significant impacts they can have on the wellness and practice of forensic mental health nurses. In terms of nursing strategies, if full engagement in recovery is not possible, do options that fall within the realm of therapy and caring still exist, or do nurses simply resort to disciplinary and custodial approaches?

4.7 Total Institutions and Power

Theoretical and philosophical conceptions of nursing practice in the forensic mental health milieu frequently explored in the literature focus primarily on the highly restrictive nature of the setting and the power dynamics that exist therein. Sociologist Erving Goffman (1961) conceptualized places where the lives of inhabitants are highly regimented and structured, while being separated from the outside world, as total institutions. Boarding schools, army barracks, prisons, psychiatric hospitals, and concentration camps are offered as examples of the total institution; forensic mental health facilities represent a combination of both prisons and psychiatric hospitals. The process of entering the institution, according to Goffman (1961) is one

of mortification. Upon admission, a shift occurs in the identity of the patient – the person that existed on the outside is transformed, signalling significant and "progressive changes that occur in the beliefs that he has concerning himself" (p. 4). This process consists of "a series of abasements, degradations, humiliations, and profanations of self" (p. 14). The admission process to a forensic mental health facility is described as traumatic and distressing by patients (Askola et al., 2016). The maximum-security participants in a study by Horberg et al. (2012) described themselves as "'not-living,' in so far as they describe that they are not themselves anymore" (p. 747). Yet this shift in identity and perception of self is not exclusive to the patients. Holmes and Federman (2006) identified a similar process occurring with nurses in forensic settings where the realities and culture of these institutions are unlike those experienced by nurses in other settings. As such, transformation of identity occurs in nurses, too. This conceptualization of the total institution underlies the profound impact a forensic admission has on patients (and nurses), and underscores the antagonism and asymmetries in power dynamics that exist between nurses and patients.

In a total institution like the forensic mental health milieu, where patients are subject to extensive restrictions on freedom and autonomy, and where nurses possess the ability (and responsibility) to ensure patients adhere to rules and expectations, power dynamics between these two actors are ripe with complexity. The most frequently used framework for considering power dynamics comes from the work of Michel Foucault, particularly *Discipline and Punish: The Birth of the Prison* (1995). Foucault (1926-1984), a French critical theorist, wrote a wide range of historical analyses of social conditions, including madness, knowledge, sexuality, and discourse (Mills, 2003). He also wrote extensively on different forms of power as they relate to punishment, and the shift in dominance of these forms over time. Foucault considered sovereign

power – that of the king – to be a concentrated, absolute power that is exercised by an individual. Coercion is a technique of the sovereign power. Disciplinary power began to replace sovereign power with the rise of the Industrial Revolution and the need to manage large numbers of people over long periods of time. Disciplinary power is a more subtle and anonymous form of power: it spreads through all elements of life (Foucault, 2006). Modeled on the concept of the ideal prison as proposed by Jeremy Bentham (1748-1832) – the panopticon – is a circular structure with a central watchtower. The inmates occupy individual cells in exterior walls of the prison and are constantly visible from this central station. The prisoners cannot see who occupies this central viewpoint – it is anonymous (Bentham, 1995). Foucault expanded this model of constant surveillance beyond the prison to become representative of modern power dynamics. From surveillance of individuals came knowledge – this knowledge is power. Those who fail to conform to rules and expectations are subject to disciplinary consequences. Foucault (2006) considered individuals who continuously failed to adhere to norms and expectations, who required increasingly intensive forms of discipline, the "anomie" (p. 54). Certainly, the patients in forensic mental health settings, particularly patients perceived to be challenging and uncooperative, fit within this definition. A third form of Foucauldian power – pastoral power (Foucault, 1994) – has been explored in the context of the forensic mental health milieu (Holmes, 2002). Under pastoral power, the pastor (or guide) "knows its subjects in detail" (Holmes, 2002, p. 86) and acts as an agent of care for its subjects. The techniques of this form of power are the confession and therapy. In developing a relationship with their subjects, the pastor – or in this setting, the nurse – creates a sense of trust and respect. This relationship can then be used to guide subjects towards preferred outcomes and allow for a more nuanced control of

subjects. These forms of power and their respective techniques provide a framework from which to conceptualize and critique the role of the nurse in forensic mental health settings.

In many ways the high security forensic mental health unit resembles Foucault's (1995) disciplinary power apparatus. This is most apparent with patients who will not or cannot adhere to the goals and expectations of the institution. Patients are subject to constant surveillance, and their behaviours monitored against institutional rules and expectations. While most patients aim to improve their mental health and ability to function within the institution and in the community, those who fail to follow these rules and expectations are subject to disciplinary actions, with nurses being frequent agents of punishment. Yet the techniques of power utilized by nurses extends beyond these disciplinary forms. Holmes (2002, 2005) situated the forensic mental health setting within this Foucauldian conceptualization of power and noted that nurses deploy techniques from all three forms of power (sovereign, disciplinary, and pastoral) in the control of patients. Patients who fail to adhere to institutional expectations may have nurses call on security or corrections officers to ensure their compliance. This coercion is a form of sovereign power. In their ongoing surveillance, nurses ensure that patients only occupy permitted spaces on the unit, participate in required activities, and levy punishments for patients who fail to comply, such as a restriction of privileges. Disciplinary power relies on this technique of surveillance to operate. Under pastoral power, the pastor or guide must possess intimate knowledge of their subjects, who are expected to confess and reveal their transgressions. Here nurses exercise pastoral power in the act of therapy, specifically in the expectation that patients take responsibility for both their mental health and criminal acts - a key element of recovery (Drennan & Alred, 2012b). Nurses then guide patients in the therapeutic process of rehabilitation and recovery. Patients who fail to engage in this process, however, may languish in the forensic

setting indefinitely, may be subjected to more coercive or punitive measures, leading to the concern of 'imposed recovery' (Young, 2011). Where recovery becomes the official mandate of the correctional or secure setting, patients who refuse to engage in this process may have it imposed upon them, regardless. Nurses themselves are not immune to these forms and techniques of power (Holmes, 2002, 2005; Holmes & Federman, 2006). Foucault (1995), in describing the carceral environment, notes that staff in prisons are also subject to surveillance, wherein supervisors may monitor and judge their actions; they too cannot escape the disciplinary apparatus. Holmes (2002, 2005) explores nurses as 'objects of power' in these settings, where the rules and expectations of the institution apply to them, as well. The impact of these techniques of power on both patients and nurses cannot be ignored, as patients may come to view nurses as agents of authority, as captors complicit in their ongoing detention.

4.8 Discourse

Discourse plays a central role in the exercise of power in the forensic mental health milieu. Mills (2001) describes discourse as "groupings of utterances or sentences, statements which are enacted within a social context, which are determined by that social context and which contribute to the way that social context continues its existence" (p. 11). This definition of discourse is grounded in the work of Foucault. Cheek (2004) reminds us that Foucault's notion of power is productive, not necessarily repressive, and that power "enables certain knowledge to be produced and 'known'" (p. 1143). This power allows certain discourses in health care to be privileged while others are marginalized. Indeed, these discourses are interwoven into existing power structures. In analyzing the written records of patient aggression in a forensic mental health setting, Berring et al. (2015) noted that "discourses in healthcare records shape and maintain certain representations of patients, by allowing what is included and what is excluded"

(p. 298). These written records construct aggressive patients as deviant and dangerous, placing blame for the aggression solely at the hands of the patients. The construction of patients as deviant or dangerous correlates with the discussion on power dynamics in the forensic setting. Viewing the setting within the framework of disciplinary power, the deviant individual is one who fails to adhere to the expected rules or norms, and is subsequently subjected to disciplinary action. These discourses "shape nursing practice" (Perron & Holmes, 2011, p. 200), and legitimize the use of punitive and custodial approaches to nursing care.

Chapter 5 Theoretical Framework

The theoretical framework of this research is grounded in conceptions of power elucidated by Foucault (1995, 2006). As previously stated, the forensic mental health setting is situated in complex and problematic power relations (Holmes, 2002, 2005) that impact the construction of patient identities (Berring et al., 2015, Perron & Holmes, 2011) and can shift nursing practice away from therapeutic and recover-based ideals toward more punitive and custodial approaches (Jacob, 2012). Therapeutic approaches to nursing care of patients perceived to be challenging and difficult were explored within this framework of power relations. Integral to a Foucauldian conception of power dynamics is the role of discourse (Mills, 2001). Relations of power shape which discourses are privileged and which are marginalized, what is said and what is not said. Discourse analysis, according to Mercer (2013), "permits interrogation of ideological assumptions and power equities… a strategy suited to researching disciplinary apparatus of high-secure psychiatry" (p. 29). A discourse analysis methodology, rooted in the work of Fairclough (2003), was utilized to analyze nurses' perspectives of working with patients they perceived to be challenging and difficult, and allow these perspectives to be situated within the power dynamics of the forensic setting or secure environment as conceptualized by Holmes (2002, 2005).

5.1 Discourse Analysis Methodology

The present study examined the following questions: (1) What are the strategies used by nurses when working with challenging and difficult patients in a high security forensic mental health setting?; (2) What specific actions and behaviours do patients exhibit that nurses find challenging?' and (3) How do the actions of patients and the strategies of nurses fit within the greater context of power dynamics in the high security forensic mental health setting?

The study consisted of two phases. Phase one was data collection, in the form of semi-structured interviews with nurses from the high security forensic mental health setting. Phase two consisted of transcription of these interviews, with a subsequent discourse analysis of the data provided and a consideration of outcomes.

In the present study, the use of a discourse analysis methodology not only allowed for an exploration of the behaviours of challenging patients and the strategies used by nurses through semi-structured interviews, it also placed these discourses in the context of power relations in the forensic mental health setting. Responses to semi-structured interviews provided concrete examples of patient behaviours and nursing strategies, while subsequent discourse analysis placed these phenomena in the context of Foucauldian power dynamics. Discourse analysis does not prescribe a specific approach, but instead "uses 'conventional' data collection techniques to generate texts able to be analysed discursively from a particular understanding of discourse analysis and driven by a certain theoretical frame" (Cheek, 2004, pp. 1145-1146). Discourse analysis assumes that language is not neutral or value free (Cheek, 2004) and looks to explore that which "extends beyond the boundaries of the sentence" (Mills, 2001, p. 132). Fairclough (2003) noted that discourse analysis allows one to examine the social effects of a text. The particular context in which discourse exists – specifically nurses discussing their roles in a high security forensic mental health setting – impacts not only what is said, but what is not said. What is left unsaid often reveals what is assumed, and can reveal the rules of the institutions in which the statements were made (Cheek, 2004; Fairclough, 2003). Discourse analysis allows for an examination of "variability in accounts and performative aspects of language as social practice" (Mercer, 2013, p. 29). Not only do discourses "represent and reflect a certain version of reality, they also play a part in the very construction and maintenance of that reality itself" (Cheek, 2004,

p. 1144). Power and discourse go hand-in-hand. They shape the way we view the world and the relations therein (Fairclough & Wodak, 1997), and further shape the way nurses practice (Perron & Holmes, 2011). An analysis of discourse allows us to move from the 'micro' of a text to the 'macro' of power (Fairclough, 2003); taking the texts of nurses' descriptions of the patients they perceive to be challenging and placing them within the greater context of power relations found in the forensic setting.

A discourse analysis methodology focuses more on the use of language – its function – than on those using the language (McCloskey, 2008). Sample size in this methodology is not prescribed; the goal is to collect sufficient data to understand the role discourses play in a specific context. Wodak and Meyer (2001) suggest that researchers sample until a diversity of perspectives has been achieved. Interviews are aimed at understanding a discourse, "how it functions and what it accomplishes" (McCloskey, 2008, p. 32). Initial questions should give opportunity for the participant to openly discuss the subject, and to ask for specific examples. If inconsistencies arise in the participant's accounts, these should be clarified by the interviewer (McCloskey, 2008). The transcription and coding of discourse analysis interviews can be a lengthy and complex process. Beyond the simple transcription of interview texts, elements such as corrections, pauses, and hesitations should also be noted (Potter & Wetherell, 1987). In coding, all data should be considered for references to the research question, as well as anything unanticipated (McCloskey, 2008). Subsequent analysis of text should look for key words or themes, at how subjects are constructed, at how language is used to represent reality (Crowe, 2005). The function of words – here, words like cooperative, uncooperative, compliant, therapeutic – should be noted, as well as any assumptions made by participants (Fairclough,

2003). The aim of analysis "is to understand the social processes generated by the text, including the social conditions and context in which these processes occur" (McCloskey, 2008, p. 35).

Chapter 6 Analytical Framework

6.1 Study Context/Setting

Participants were recruited for the present study from two high security units in a forensic mental health hospital in Western Canada. The forensic building is part of a larger mental health hospital campus and consists of several units with differing mandates and security levels, including two high security units. One unit is designated for the treatment of high acuity patients, while the other is designated for court-ordered mental health assessments. However, an intermixing of patients exists between these two units. Patient activities are highly regulated and supervised on these units. Patients cannot leave the units without supervision and are searched upon return to the unit. Nurses work out of secure, locked nursing stations that provide visibility to all areas of the units. Patients are assigned to individual rooms with single beds and no other furniture. All doors to patient rooms lock automatically and can only be opened by staff using a chip card or building keys. Patients have access to common space on the unit during the day, including televisions and sofas, table tennis, and supervised billiards, with the exception of those being held in environmental restraints, also referred to as seclusion. Both units have two dedicated seclusion rooms with toilet and sink facilities. Security staff are present in the building, but are not dedicated to these high security units. All staff wear duress alarms that, when activated, engage a building-wide alert. Patients have supervised access to a recreation area and secure outdoor courtyard at scheduled times.

The two high security units are staffed primarily by nurses and psychiatric aides. Nurses carry a designation of either Registered Nurse (RN) or Registered Psychiatric Nurse (RPN), and are responsible for the care of patients. Both RNs and RPNs possess identical scopes of practice on these units. There are approximately thirty full time and regular part time nurses (RN and

RPN) working across these units. Patient care consists of therapeutic interventions such as individual and group sessions, recreation activities, and occupational therapy, as well as medication administration, documentation, creation of patient care plans, regular checks of all patients, also known as rounds, and enforcement of unit and institutional rules. Psychiatric aides assist with the supervision of patients during meals, recreation, and courtyard activities, as well as activities or appointments outside of the building. Psychiatric aides also assist with rounds, and provide constant observations for high risk patients when required. In addition, both units have dedicated psychiatrists, psychologists, social workers, and occupational and recreational therapists. However, ongoing care and supervision of patients is conducted primarily by the nurses and psychiatric aides.

6.2 Participants

Seven participants were recruited for the present study from the two high security forensic mental health units. Participants were eligible for participation if they worked either full time or part time on one of the forensic mental health units at the time of recruitment, or had worked on one of these units in a full or part-time capacity in the past six months. Nurses working in a casual capacity on these units, graduate nurses, and psychiatric aides were excluded from participation. Both male and female nurses participated in interviews. Ages ranged from early 20s to late 50s. Participants' years of nursing experience ranged from two years to over twenty years.

6.3 Recruitment

Recruitment of participants was achieved through a combination of poster advertisement (Appendix A) and snowball sampling. Recruitment posters were placed in the nursing stations

and medication rooms of both units. With permission from unit managers, I spoke directly to nurses on both units during shift change the same day recruitment posters were posted on March 5, 2020. Three participants were recruited through these efforts. Two of these participants facilitated the recruitment of the remaining four participants. I was contacted by email or via a dedicated research cell phone by interested participants to arrange interviews and to provide informed consent forms. All individuals who expressed interest in participation agreed to participate and took part in subsequent interviews.

6.4 Ethical Considerations

Ethical approval from both the University of Saskatchewan Behavioural Research Ethics Board, and the Health Research Ethics Board of Alberta was obtained prior to recruitment and data collection. All participants were assigned randomly numbered pseudonyms. Due to the small pool of potential available participants, demographic information was not collected to ensure confidentiality. These pseudonyms were also used to label all audio and transcript files. All interviews were audiotaped using a digital recorder and transcribed verbatim. Some quotes were modified to exclude the names or identifying characteristics of any participants or patients in a manner that maintained the essence of the content while ensuring confidentiality was maintained. Similarly, some quotes were modified to disguise the name or location of the hospital and to which provincial Review Board patients were assigned.

It was recognized that, through the course of the interviews, participants may have discussed or remembered potentially traumatic experiences from the study setting. Participants were briefed prior to the commencement of interviews, and information regarding their workplace counselling services was provided. All participants were given the opportunity to review their transcripts once completed, however none of the participants chose to do so.

I worked as a Registered Nurse on one of these units in a part-time capacity for approximately three years, but had not worked on the unit for over two years at the time of recruitment. Some of the participants were individuals I had worked with, however all participants who met these circumstances were aware of the voluntary nature of participation. Prior to the commencement of the formal interviews, all participants were reminded of my dedication to confidentiality, and to present information in their interviews that did not assume I was familiar with the setting or individual patients. To guard against my own biases and perspectives gained during my time working in this setting, I ensured that I followed the guided, open-ended questions, and allowed the participants to lead discussions

6.5 Informed Consent

Informed consent was obtained from all participants. The informed consent form (Appendix B) was provided to all participants via email prior to their interviews. Participants returned signed consent forms via email prior to their interviews.

6.6 Design

To explore participants' perspectives on and strategies for working with patients they perceived to be challenging in the maximum security forensic mental health hospital setting, semi-structured interviews were conducted. A series of open-ended questions were utilized to guide interviews (Appendix C). Participants were asked to describe the setting in which they worked and the patients with whom they worked. Moreover, they were asked to describe the patients they perceived to be difficult or challenging to work with and the behaviours these particular patients engaged in that they found challenging. Participants were asked to describe strategies they have utilized or witnessed that led to both positive and negative outcomes with

these identified patients. Finally, participants were asked how they felt towards patients perceived to be challenging, and their perspective on what they believed caused these behaviours. The initial study design allowed for either in person or telephone interviews to be conducted. However, recruitment began in March, 2020 during the onset of the COVID-19 pandemic in Canada. As per direction from the health authority's Research Ethics Board, only telephone interviews were conducted to avoid in-person participation and minimize risk.

6.7 Procedure and data collection

Single telephone interviews with seven participants were conducted over a three-week time span (March 22 – April 9, 2020). Interviews were arranged at times deemed convenient for participants. Prior to interviews all participants were provided with a copy of the informed consent form via email, which all participants either signed and returned via email, or reviewed and provided verbal consent prior to starting their interview. Informed consent was reviewed on the telephone prior to the initiation of formal interviews. Interviews ranged from ten to forty-five minutes in length. The open-ended, guiding questions shaped the overall direction of the interviews, though there was opportunity throughout to explore specific areas in greater detail, and for participants to provide examples and expand into areas they felt relevant. As mentioned previously, I had worked on one of the sample units in the past, and some of the participants who volunteered were individuals I had worked with. The description of the study objectives in the informed consent form and the open-ended nature of interview questions ensured these participants were free to explore topics as they deemed relevant. It is my opinion that this pre-existing work relationship resulted in these participants being more candid and open about their experiences than those with whom I had no pre-existing relationship. All interviews were audio recorded and securely stored on password protected computer. All participants were given the

opportunity to review and revise their interviews once transcription was completed, however none of the participants expressed interest in this option.

After completion of the seventh interview, no further potential participants contacted me expressing interest in participation. Participants who were active in recruitment did not locate any additional interested nurses who fit the inclusion criteria. Discourse analysis methodology does not prescribe a specific sample size, but instead aims to collect sufficient data to explore a diversity of perspectives (Wodak & Meyer, 2001). Upon review of the existing interviews, it was determined that a broad diversity of perspectives was obtained, and that no additional recruitment was necessary. Participants were randomly assigned numbered pseudonyms to maintain confidentiality, especially relevant given the small pool of nurses that met the inclusion criteria and due to the snowballing method of recruitment.

All interviews were transcribed verbatim, including all pauses, corrections, and hesitations, the inclusion of which is necessary in a discourse analysis methodology (Potter & Wetherell, 1987). All interviews were reviewed multiple times to ensure accurate transcription. All transcripts were read and considered multiple times – the process of immersing oneself in the data. Extensive notes were written in the margins of the printed transcripts over the course of multiple readings, including oft-repeated terms or phrases, common topics, and specific language used when constructing patient subjectivities. These notes were then organized into more structured notes and topics that addressed the research questions, including how the patients were constructed by the nurses, and how language was used to represent reality (Crowe, 2005). Not only did the interview subjects provide concrete descriptions of the setting in which they worked, the behaviours of patients they perceived to be challenging, and the strategies employed to work with these patients, using a discourse analysis methodology provided insight into "the social

processes generated by the text, including the social conditions and context in which these processes occur" (McCloskey, 2008, p. 35).

Chapter 7 Findings

Participants offered a variety of perspectives on their practice, the patients with whom they worked, and the strategies they employed when working with them. Two distinct groups of patients perceived to be challenging emerged in the interviews – patients with psychotic disorders and patients diagnosed with antisocial personality disorder. Participants primarily described patients with psychotic disorders as being treatment resistant, however it became clear that both groups of patients could be described as treatment resistant. Both groups of patients perceived by participates to be challenging are subsequently defined as treatment resistant here. Differing challenging behaviours and actions were identified with these two groups of patients. The construction of these two groups of patients by participants also differed, as did the subsequent strategies utilized for working with the two patient groups. Some contrasting approaches to patient care emerged in the interviews. Despite the differences in the two patient groups, participants consistently identified the highly restrictive nature of the high security forensic mental health setting as a point of tension and frustration for both patients and nurses.

A diversity of perspectives and experiences were expressed by participants. Many offered candid, honest, and at times stark views of their workplace and their patients. Quotations presented here illustrate the nurses' experiences and perspectives, including the challenges they faced in the high security forensic mental health setting. Specific language was used by participants to describe their patients and experiences. Subsequent analysis of these accounts incorporated much of this language, but also incorporated my own interpretation and understanding of these accounts. Thorne (2020) noted that in qualitative research, the researcher comes to understand the phenomena being explored in a manner that may not appear in any specific quotation.

7.1 Setting

The setting in which participants practice is a forensic mental health hospital in Western Canada. The two units of practice from which participants were recruited are the designated maximum-security units in the hospital. Though the two units have differing designated purposes – one is intended for forensic assessment and the other for intensive care treatment of high acuity patients – participants noted that there was much overlap of purpose between the two.

> It's a forensic remand assessment and treatment unit (participant 4).
>
> The highest security unit in the forensics building, our purpose, well one of them, is to have court ordered assessments – court ordered patients who need assessment for NCR, or fitness for trial. We also have some NCR patients who are currently being housed on our unit (participant 5).

While the purported focus of each unit may be different, participants described the two units as being very similar with regard to the level of security and types of patients under forensic purview.

7.2 Patients

Nurses working on these two units interacted with a diversity of patients with regard to both legal status and mental health diagnoses. Patients on these units may include those found NCR, those undergoing court-ordered assessments, and those transferred from conventional remand and correctional facilities for intensive mental health treatment under provincial mental health legislation. For example, participant 2 stated:

> Typically we work with people who… require mental health treatment and currently have either certificates or they're there for an assessment… or they're there for NCR treatment.

While participant 3 referred to the patients in the following way:

> I would say actually a large amount of the population on this unit is about, maybe, seventy-five percent people who are currently going through…court matters. So they're either… being sentenced or they're going through trials, things like that, and then I would say the other percentage would be our NCR population, so a lot of the really ill, treatment resistant patients.

Patients on the units who were deemed NCR by the court are assigned to the hospital indefinitely for treatment, whereas those undergoing treatment under mental health legislation or assessment are transferred from remand or correctional settings temporarily. The length of patient stay on the unit is highly variable, and is often dependent on the patient's legal status. Those undergoing court-ordered assessments or treatment under mental health legislation have shorter stays on the units as noted by participants 6 and 7.

> They're brought to us, we do an assessment – not fit to stand trial – so we typically certify them, start a treatment, and then medicate them and then the psychiatrist typically asks them questions about the court proceedings. Once they get their basic rights we ship them back to remand… so they get their sentencing done (participant 7).
>
> They stay with us a short period of time, maybe thirty days, sometimes longer, however long it takes to make the assessment (participant 6).

Unlike the relatively short stays of these assessment or treatment patients, those on the units with a status of NCR may have much longer stays on the high security units as illustrated by participant 3 who stated:

> Treatment resistant patients actually remain on our unit for a very long time due to their acuity and things like that… We do have one patient who has been on this unit since I believe about 2001.

The extensive time spent on the units or in the hospital was a common theme when describing NCR patients.

> They will be around for a long time, those boys (participant 5).

Patients undergoing assessments typically experienced shorter stays than those found NCR, with the latter potentially remaining in hospital for many years.

Participants described a number of mental health diagnoses common amongst the patients admitted to the two maximum security units. The most frequently identified diagnoses amongst participants were psychotic disorders, personality disorders, and substance use disorders. Participant 6 stated:

> Historically we've seen a lot of individuals who are floridly psychotic, who have schizophrenia, or schizoaffective, or bipolar one – they're either manic when they come to us, or they have auditory hallucinations when they're schizophrenic, but more and more we see a lot of drug induced psychosis… We've seen a lot of geriatric individuals come through, potentially with more dementia type of illness…than before, and the main thing we're getting a lot right now is antisocial personality disorders and all the other types of personality disorders you can think of (participant 6).

Amongst the NCR patient population on the units, participants primarily identified schizophrenia and antisocial personality disorder as the most common diagnoses.

> Mostly schizophrenia… [and] typically the antisocial traits, the antisocials (participant 7).

A range of diagnoses existed amongst the patients admitted to the units, though psychotic disorders and personality disorders, most notably antisocial personality disorder, were identified as most common.

7.3 Challenging patients

Despite the wide diversity of patients and their legal status that the participants worked with in the maximum security forensic mental health setting, they consistently identified long-term NCR patients as being the most challenging to work with. Within this patient group, participants identified two subsets of patients to be the most challenging: patients with psychotic disorders and patients with antisocial personality disorder. Though the patients with psychotic disorders were frequently described as being treatment resistant, it emerged that both groups of patients identified as challenging met the description of treatment resistance. What they found challenging regarding patient behaviours and potential treatment risks differed between the two groups, as did the construction of these patients, and the strategies employed to work with them.

7.3.1 Patients with Psychotic Disorders

Patients living with, what participants described as treatment-resistant psychotic disorders, were frequently identified as being challenging. This group of patients typically had long-term stays on the units and were considered unsafe for treatment in any other settings, as illustrated by participant 3.

> When they're quite ill and they're not responding to any of the treatment that we've tried, a lot of the time the most difficult thing we deal with is kind of managing them. How can we work with them, because our perception of something for them may be something completely different, right? So finding that balance and how can we provide them with

the most amount of support that we can while also maintaining the safety of everybody on the unit.

Participant 7 noted that:

> Treatment resistant patients…like, they have been there for the longest ever, and we give them every single medication that is available, and they're not responding.

Patients with psychotic disorders were described by their lack of response to conventional treatments, including many psychiatric medications. Patients diagnosed with psychotic disorders were often described as being challenging to work with due to their unpredictable and aggressive behaviours. One participant described it as:

> You know, people who just sporadically, spontaneously without any provocation be hitting someone (participant 4).

Another participant stated:

> We've had individuals who have become quite aggressive and, this is more the organic mental illness mixed in a little bit with dementia, perhaps, which has become very challenging because there's no way for us to figure – they don't escalate – you know, it's very random, there's no, there's no rhyme or reason (participant 6).

Another participant noted that a lack of understanding of directions or requests can lead to aggression:

> His understanding of something that we want him to do – he doesn't necessarily get why, or he'll kind of not really understand it… he's highly aggressive (participant 3).

One participant described feelings of fear towards one patient when first starting to work with them:

> I was afraid of him when I first met him. I was quite afraid of him (participant 5).

The challenging aspects of patients diagnosed with psychotic disorders related to their unpredictability, potential for violent behaviours, and a sense of fear they elicited.

A number of participants described patients with psychotic disorders as the most challenging to work with in the high security forensic mental health setting. They described patients as remaining on the units for long periods of time and their highly unpredictable and potentially violent behaviours were related to their untreatable mental illness and their inability to understand nurses' directions or interventions. Given these risks, and given that these two units are the highest security units in the facility, there is no other setting or unit in which these patients can be placed, making for the multi-year long stays described by the participants.

7.3.2 Patients Diagnosed with Antisocial Personality Disorder

The second group of patients consistently identified by participants as challenging were those described as having a diagnosis of antisocial personality disorder (ASPD), or at least described as enacting antisocial traits or characteristics. There were a number of behaviours and characteristics found in this group of patients that participants perceived to be challenging in the high security forensic mental health setting.

Whether patients with ASPD could be trusted to be honest and truthful was identified as a challenge by some of the nurses.

> These patients normally do not always tell the full truth, and I find that very difficult (participant 1).

> Some of these guys, right? And you know with the drug seeking, their antisocial personality, deceitful, lying behaviours (participant 4).

A sense of entitlement and an unwillingness to follow rules was also identified as being challenging, as participant 7 stated:

> The typical social norms doesn't make any sense to them. So they just come and, you know, do things, whatever the things that they want to do, and if you try to cue them for what is acceptable they just don't like it and then they are, you know, they escalate from there. And sometimes reasoning with them doesn't work – they're absolutely entitled – it seems like the world is, you know, is revolving around them. So it's sometimes very difficult to just, you know, let them, you know, explain you're not the only person here, you need to – when you're on this unit, you know you need to take some things into consideration: you can't do this, you can't do that. But they just can't understand it. They just feel like, you know, they are entitled and they should have every single right.

Another participant identified some of these patients in terms of their psychopathy:

> Usually those patients tend to have some kind of psychopathy going on (participant 5).

Lying, deceit, a refusal to follow unit and institutional rules, and entitlement were all behaviours described as challenging with this group of patients, with one participant describing patients in terms of psychopathy.

Personal attacks directed at nurses by patients described as antisocial were a challenge identified by nurses on both units. One nurse stated:

> Maybe they're targeting you, and then it's becoming very personal for them…the biggest challenge is not taking some of the direct personal attacks personally (participant 2).

Another participant described treatment from some patients as abusive:

> A lot of the time it can be very difficult, very frustrating when you're either being verbally abused, physically abused, things like that (participant 3).

These personal attacks were described as sometimes racially motivated, as participant 2 noted:

> Coming at you for your skin tone (participant 2).

Or a nurse's age or gender could be a factor in a patient's behaviour, according to participant 4:

> The problem is worse is when they're taking an order from say a younger girl, like a female nurse (participant 4).

One nurse described concerns about patients obtaining and then disclosing personal information about them, describing:

> What you said to someone else and they overheard it and now they're, you know, repeating your personal information, sharing it with other patients (participant 2).

The nurses on these units described personal attacks, including verbal and physical abuse, as well as inappropriate disclosure of personal information, experienced as challenging behaviours from patients with antisocial personality disorder.

This abusive behaviour perpetrated by patients described as antisocial had a negative impact on the workplace culture. One participant lamented:

> Working with difficult patients sometimes has a negative effect on the work culture itself, and the way people work together in the nursing station as a result of the – sometimes the difficulties that they have working with the patients outside of the nursing station (participant 2).

Staff splitting was identified as an issue that arose when working with these patients, as stated by participant 6:

> Some of the issues we come across would be staff splitting.

The abuse leveled towards nurses by some patients had the potential to create discord amongst the nurses on the unit, and could lead to staff splitting.

Commonly associated with the patient group described as antisocial by the nurses interviewed were concerns about substance use and addictions. According to one nurse:

> One of the main things is we have, like, a lot of contraband on the unit, and so they're not giving the full truth about where they've gotten it (participant 1).

Another participant stated:

> [With] addictions, it's kind of difficult and challenging because either they're going through withdrawals, or they're drug seeking (participant 4).

Patients in the forensic mental health setting with a NCR legal status must abide by the provisions and privileges granted by the provincial Review Board in their dispositions. Participant 6 noted the challenges these create in regard to substance use:

> They have dispositions, which is basically legal paperwork that says what they can and can't do, and that includes no…drugs or no alcohol or anything.

Failure to adhere to the conditions of these dispositions can limit a patient's progress and future levels of privileges granted by the Review Board. And this use of substances was also a concern if they were shared with patients on the units there for court-ordered assessments.

> When both of them, you know, co-mingle in the same unit, both types of patients will indulge in substances, right? And so that's…another one that, you know, prevents them from moving forward (participant 6).

Substance use was identified as a challenging issue with patients with ASPD. It violated both unit rules and the parameters of a patient's Review Board disposition, and could hinder a patient's progress.

The use of substances and other behaviours that violated the hospital rules or a patient's privileges within their disposition could result in a patient being moved from a lower acuity unit within the hospital to one of the high security units. This movement between units was viewed as

a source of frustration amongst the nurses working on the high security units. As discussed by participant 6:

> We get a lot of individuals as well that have undergone that system and are now…not criminally responsible, and they're going through rehab [a low security unit], but have become acutely ill for one reason or another, and we don't have the resources in a step-down unit to maintain or to keep them safe, so we [they] bring them to us.

Nurses discussed the frustration of working with these patients towards successful transfer back to a rehabilitation unit, only to have them return a short time later to the high security setting, as participant 6 further articulated:

> It's frustrating for them to be shuttled back and forth in the system. So, the most challenging patients that we have are the ones that have a tendency to move to the less acute units, and then right away move back up to the most acute units, and usually it's the result of some sort of altercation, manipulation, anything. It often times involves drugs…not necessarily physical abuse… So personally it's quite frustrating to have all this work done and sending them down, and then right away they shoot themselves in the foot and they're brought back up to us, because within a week they're dealing drugs, within a week they're doing drugs (participant 6).

This transfer back to a high security unit was viewed as a step back in a patient's progress, and could lead to a sense of frustration for the patients as well. According to participant 2:

> The general feeling on this unit, it's an acute unit, it's people who have left rehab and now they've deteriorated so now they're on this unit, so they're just – it's generally not a good place to be, mentally. It's basically – you've taken a step back. If you're on this unit you've taken a step back for whatever reason, and so I think that's what kind of leading

> up to the anger, and they just kind of take it out on staff in different ways based on their own history.

A combination of frustration amongst both nurses and patients in a perceived lack of patient progress was attributed to burnout amongst the nurses.

> So, with these particular individuals, you know, professionally I feel like there's a lot of roadblocks for them to get rehabilitated. And that's what's causing them to become more and more frustrated, which in turn has posed a lot of barriers to us providing care, and has caused a lot of nursing burnout… you see the same individual move back and forth, back and forth, year after year after year with the same story. And you don't see any progress (participant 6).

Participant 6 further described any progress with these patients as temporary:

> With these individuals that we continually see moving back and forth, you're stuck in the same level of therapeutic communication, right? It's the same level of support that you're providing, there is no further insight that they gain. If they do gain insight that's gone when they use substances and their judgement still remains poor, and that's exhausting to provide that same level of support for naught.

Participants expressed a desire to see patients progress from high to low acuity settings and not return to the high acuity units. They attributed the patient's return to the high security unit to that patient's inability to meet the expectations of the low acuity units. Participants described the most challenging patients as those who continually cycle between units, often due to substance use, and attributed a sense of frustration and burnout in this patient group.

Associated with this movement of patients between the rehabilitation and high security units is a change in the privileges available to patients. Many of the privileges available to

patients in the low security rehabilitation setting are not permitted on the high security units, such as going outside to smoke cigarettes. Issues related to the availability and administration of privileges were identified as a source of conflict with patients and between unit staff.

> Things as simple as giving patients privileges, for example, one of the issues we have on a day to day basis is we have NCRs come upstairs – individuals who are undergoing rehab – they're sent upstairs because they were acutely ill, and that might be on account of substance use or something like that, but now there's barriers to sending them back down because a lot of the care teams have taken it upon themselves to actually refuse to take certain individuals back and so these individuals might be stable in staying upstairs with us, but they have no privileges… something that they're used to, and so we're kind of arguing as staff – can they have privileges? This poses a threat to safety with these individuals bringing in, say, drugs to the remanded patients who are undergoing assessment, and simple things like do we allow our patients to go outside for a smoke break, which they've always had? (participant 6).

Nurses expressed concern that substance use could not only affect the mental health of patients with ASPD, but could also affect the mental health of the patients around them, leading to potential safety issues. Patients have care plans outlining their privileges on the unit, but many desire to have the privileges to which they were accustomed on a lower acuity unit. This was identified as a source of conflict by multiple participants:

> They think it's too harsh [the care plan], they're not getting enough privileges, things like that, so that can be one of the negative outcomes is where, maybe, as I've heard from other patients, it's, "You guys are forcing me to do this, but I don't want to do it." I would say that would be one of the tougher things, because these guys are under, usually,

> the provincial Review Board or they're under very strict, strict privileges, things like that, so sometimes that can develop the negative rapport between the staff and the patients here (participant 3).
>
> You gotta explain, man, you know you came here, you know downstairs it's a rehab facility, it's a rehab unit, it's lots of privileges. Here it's, like, maximum security. The privileges are, you know, very minimal, you know? Let's see what we can do for you, I can't let you go out to smoke, but here are the things I can tell you (participant 7).

The restrictions the high security setting pose on patient privileges can lead to conflict between patients and nurses. The determination of what privileges a patient should have can also lead to conflict between nurses, as articulated by participant 6.

> One of the things we've tried to do we've had quite of an issue with is some patients come up and some of us want to allow them to have these smoke breaks because they get walks as privileges. And some don't want to allow them to have them, and both have very valid reasons as to why, but the implementation of a care plan that prevents them from having it – that becomes a huge problem.

Another nurse identified physicians granting privileges that are not allowed on the high security unit as a source of conflict:

> Where the conflict does arise is usually – "the doctor said I was allowed" – there's confrontations between nurses and patients where we try and get everyone on the same page, but I think our patients get really frustrated (participant 5).

Patient expectations of the level of privileges they desire are restricted by the rules and expectations of the high security setting. In particular, the loss of privileges by patients described as challenging due to their antisocial tendencies can create conflict. Furthermore, differences in

opinions amongst unit staff around what level of privileges should be granted to patients can cause disagreement and conflict between those staff members.

Patients described by participants as being challenging due to their antisocial tendencies or behaviours posed a number of issues for nurses working in the high security forensic mental health setting. Participants described patients as untrustworthy and manipulative. They also described them as entitled and unwilling to follow directions or unit rules. Nurses described being subjected to verbal and physical abuse, to racist and sexist attacks, and having personal and private information disclosed by patients. Patients were described by their long-term stays in the forensic hospital setting and by frequent movement between high security and rehabilitation settings. Nurses described working with patients toward meeting the requirements for transfer to a less acute unit, only to have them quickly returned to their unit due to substance use or an inability to meet the expectations of the rehabilitation setting. Conflict would arise over the privileges granted to patients in the high security units, especially when privileges were more restrictive than what the patients enjoyed on the rehabilitation units. Nurses also described disagreements amongst themselves and other disciplines over what level of privileges were appropriate for patients. The continuous movement of patients between units and the perceived lack of progress made was identified as a source of ongoing frustration and even burnout amongst nurses.

7.4 Nursing Strategies

Participants were asked to explain and describe the strategies they utilized when working with patients they perceived to be challenging. The participants were asked to describe strategies that led to both positive and negative outcomes with this patient group. While some nurses discussed strategies – both positive and negative – utilized for patients with psychotic disorders,

most of the discussions focused on the patient group described as antisocial. Strategies for working with the group of patients with psychotic disorders focused primarily on risk management and patient quality of life. Strategies for working with patients with ASPD were more varied, and not all participants agreed on which strategies were most effective. The management of patient behaviours, acknowledging the restrictions of the units, and a focus on meeting the requirements for transfer to a low acuity unit were the most agreed upon strategies. There was no consensus on any specific model or theory of care for working with this patient population identified by the group of participants.

7.4.1 Strategies: Patients with Psychotic Disorders

When asked to describe strategies for working with patients with psychotic disorders that resulted in positive outcomes, participants described the importance of comprehensive care plans that found a balance between patient freedoms and risk management. As articulated by participant 3.

> Because of his aggression, we've actually had a very comprehensive care plan for him, a lot of assessments are done by the nurses who are taking care of him that day… safety is a big one for us as well, so we formulated something with security for him to be able to take him outside for exercise or make programs for him… in a safe manner, but that often really, solely depends on the patient, right?

Given safety concerns, this group may spend considerable time in seclusion, also referred to as environmental restraints due to their unpredictable and aggressive behaviours. In such cases, patients may be allowed out of environmental restraint when nurses determine it is safe for the patient to do so, but are still maintained in mechanical restraints. Participant 6 expressed frustration with this role:

> Imagine a belt going around your waist, and then it's got these little sort of cuffs that – they're not steel cuffs or anything like that – they're very, you know we're very careful in how we apply them and how much pressure they're put on and they're checked regularly… and so these individuals are allowed out on constant obs [observation], so they're being monitored constantly with staff at stand-by on the unit to socialize with other patients, to watch television, and so on, and that's improved their quality of life.

These restraints are viewed as necessary to maintain safety on the unit, as described by participant 5:

> The hardest one for me to work with… spends all of his time in seclusion. He's quite violent when he comes out to spend time on the unit. He has to be in wrist shackles because he's assaulted so many people. Many, many people.

Despite the stated risks of bringing these patients out of environmental restraints, nurses viewed it necessary to provide some level of quality of life.

> To give them some freedom instead of maintaining them in seclusion all the time, we've been trying out different measures of providing them a level of freedom in terms of quality of life (participant 6).

The opportunity of going outside of the secure building while in these mechanical restraints is an option for this group of patients. As noted by participant 3.

> He's able to go outside, he's able to socialize with other patients who are out there and for exercise, and just for, you know, the betterment of whatever we can give him. Like the most that we can within the circumstances of everything, right?

Participants described the extensive use of restraints with patients with psychotic disorders. A reduction in the use of and/or a reduction in the harshness of restraints used was described as a

strategy to provide some level of quality of life when seeking a balance between patient freedoms and risk management.

When asked to describe strategies for working with this group of patients that resulted in negative outcomes, participants noted concerns around not including patients in developing care plans and not recognizing the impact of the patient's mental illness on their ability to understand a nurse's approach to their care. Participant 3 stated:

> A lot of the times, sometimes these care plans the patient doesn't necessarily want to partake in or want anything to do with – they either think it's too harsh, they're not getting enough privileges, things like that so… one of the negative outcomes is where… it's, "You guys are forcing me to do this, but I don't want to do it."

Patients desire a level of freedom and privileges that are deemed unsafe by the staff or are not permitted by the patient's Review Board disposition. Patients may not understand these restrictions because of their mental illness. If nurses do not consider this, it can lead to challenges, as noted by participant 6.

> If your approach is too abrupt, right, there's some individuals that are more cognitively aware than others, and others have less of the ability to regulate their own emotions… individuals who are mentally ill and have some sort of brain injury, maybe they're lower functioning, they're quicker to anger. It's more difficult for them to understand complicated things, or for you to present everything in the context of the situation, so you're doing something as much as moving towards them abruptly and in a superior or confrontational manner with a raised tone of voice… is enough of a trigger that they can become quite aggressive quite quickly.

Participants noted the importance of working with these patients, with an understanding of deficits related to their diagnoses to achieve positive results, as illustrated by participant 3.

> Ultimately you have to work with the patient. I find a lot of the times something what happens is we make these care plans without really telling them and expect them to have, to just follow it point blank.

Finding appropriate ways to deny patient requests in a non-abrupt manner was identified as important.

> The patient reacts to being told no right away, right? Sometimes they need to be let down easy, sometimes you need to be able to tell them that while, you know, it's right now because of the situation perhaps that's saying, unfortunately, I can't provide that kind of thing, right? (participant 6).

Taking time to communicate the rationale for denying a patient's request was viewed as more favourable than a simple and abrupt denial.

When working with patients with psychotic disorders, nurses described the importance of developing comprehensive care plans that provide a balance between allowing patient freedoms while managing the risk of violence. Finding appropriate times to bring patients out of environmental restraints to spend time on the units or to go outside were viewed as ways to provide some level of quality of life. Working with patients to develop these care plans was viewed as vital to the success of the plan, though it was acknowledged that this does not always occur. Nurses described these patients as suffering from cognitive deficits related to their mental illness that could prevent them from understanding the restrictions placed upon them. When these deficits were not adequately considered, nurses described the potential for the patients to become frustrated and even violent. Taking time to explain the rationale for the patient's care

and ensuring it was understood was viewed as vital to avoiding negative outcomes with this group of patients.

7.4.2 Strategies: Patients with Antisocial Personality Disorder

The nurses interviewed spent considerably more time exploring the strategies employed – both positive and negative – with patients described as antisocial. These strategies differed from those utilized with patients with psychotic disorders. Nurses considered patients with ASPD to have greater control of their behaviours, allowing greater opportunity to develop therapeutic relationships, which could be harnessed to work towards more positive outcomes. An ability to compromise and be flexible in the enforcement of unit rules was viewed as an important strategy to achieve positive outcomes. Nurses also identified the importance of not taking personally the abuse that these patients directed towards them; maintaining professional boundaries and accepting that these patients will make mistakes.

Taking the time to build trusting, therapeutic relationships with patients considered to be challenging due to their antisocial tendencies was consistently identified as central to positive outcomes. One participant stated:

> We have one patient who has antisocial personality disorder and I'm very open with her and honest and I've built, like, a therapeutic rapport with her and she has a tendency to kind of divulge information towards me when she's ready to (participant 1).

Spending time with the patients was viewed as important to this process, according to participant 5:

> I like to be out with the patients as much as possible. It helps me with my assessments and such, and getting to know them better.

If a patient is escalating in their behaviours, a pre-existing positive relationship was identified as helpful, as described by participant 1:

> If a patient is escalating and you have built that therapeutic rapport with them, sometimes, with that therapeutic rapport you're able to deescalate the situation without having to get security involved, having to get multiple other staff involved, you're able to have just like a one-on-one conversation, deescalate the situation so it doesn't escalate to something further, and potentially violent.

In contrast to an authoritarian approach, this building of a therapeutic relationship with patients could lead to more positive outcomes, as noted by participant 2.

> Just building some rapport with them, rather than just being an authority all the time. That way when you did need them – their cooperation – they approach you. You can approach them and they might actually listen to you, to reason with them a little bit more, rather than being – enforcing all the rules strictly all the time.

Nurses noted that when a therapeutic relationship existed with a patient, they had greater potential to deescalate in difficult situations. This willingness to build relationships with patients was viewed as contrary to a strict, authoritarian approach to providing care.

A willingness to avoid strict enforcement of unit rules was viewed as a common strategy for achieving positive outcomes with patients with ASPD. One participant noted:

> Depending on the staff, you know, there's some who are rigid or by the book… they're strict. For me, what works for me is I can compromise. I'm not going to come down with a heavy – I'm not going to throw down the rules – I can compromise (participant 4).

By showing a willingness to compromise, nurses hope that patients will reciprocate.

> I can give some leeway, but I expect some cooperation back – in return – and I find usually that works for me (participant 4).

One nurse described making exceptions to rules around the administration of nicotine replacement therapy:

> Like a nicotine inhaler, you know, "Ok you've been a good guy" you know, and they'll ask for like three sprays or four sprays instead of the normal two sprays, and then, you know, you kind of like – you've been settled and yeah I can compromise… and you're just kind of like, building a bond, building a kind of therapeutic relationship… saying, hey, you know I'm easy to work with, I'm easy to get along with and expect the same from you (participant 4).

Not rigidly enforcing all unit rules with patients with ASPD was described by nurses to build more positive relationships with patients, and provided opportunity for greater cooperation.

When nurses were not willing or able to be flexible in the enforcement of unit rules, nurses described the importance of acknowledging restrictions with patients, including identifying the consequences to both patient and nurse if the rules were not followed. In doing so, nurses aimed to develop a sense of empathy with the patients. Participant 7, thoughtfully shared the following:

> At times, you know, I just feel like I am on their side instead of, you know, even though the request doesn't make sense I'll just – what I do is I kind of make them, kind of feel like me. I say you know what you're asking this, you are requesting this, man, I can't do this because I'm a healthcare professional. I can't meet this request. But if you put yourself in my shoes, man, right now you know I don't have any problem with you doing this, but if you're me, and if I go, you know, do something that I'm not supposed to be doing I'll be losing my job and all that. And they're understanding that. I just, you know, tell them if you were me how would you feel right now… I can empathize with you man,

> I know it's difficult right now where you are, you don't want to be here, man. You know, I feel you, but you gotta understand that there's nothing I can do at this point.

By acknowledging that both patients and nurses are restricted by the rules of the institution, and by acknowledging the consequences of not following those rules, nurses aimed to build a sense of empathy with patients, which was described as leading to positive outcomes.

Recognizing that unit rules and access to privileges can change between different acuity-level units in the facility, nurses noted the importance of maintaining a level of stability and routine for this group of patients they viewed as challenging. One participant noted:

> When you're dealing with individuals who are antisocial… they need a lot more stability than that, and a lot more routine regularity (participant 6).

Participant 6 further described how keeping consistent care plans when patients do move between units was identified as important.

> They're trying to implement a, like, an all-unit inclusive care plan between all of the doctors and all of the units with these particular individuals, so it, like, provides a level of routine and regularity when they get sent to the more acute units because of whatever reasons, you know, but it has steps for them to take for them to get back to the lower units, because every time they move from one unit to another, everything changes for them.

When patients are moved from a rehabilitation unit to one of the high security units, the loss of privileges can be a source of conflict. Outlining a clear set of rules and expectations for patients to follow that allow them to return to the rehabilitation units was identified as important.

An inconsistency of care and enforcement of unit rules was identified by some participants as leading to negative outcomes with antisocial patients. While some nurses

identified selective enforcement of unit rules as an opportunity to build relationships with patients, other nurses viewed this as a source of conflict.

> I think the inconsistency is probably the number one problem on the unit. Because what one nurse will do tonight, another will… "oh, you're not allowed to do that." So that's just a matter of us – we need to tighten our team up (participant 5).

This selective enforcement of rules was identified as an opportunity for patients to push boundaries. According to participant 4:

> It can backfire, where, in that they can take advantage of that, uh, therapeutic relationship I'm trying to establish by, you know, overstepping their boundaries, maybe expecting more in return, and then when you do say no, it can backfire… and potentially lead to, you know, disastrous outcomes.

A split in nursing perspectives on the enforcement of rules was evident. One participant attributed this split to generational differences between nurses:

> We have a lot of nurses who are quite wise, because they've been there for thirty plus years. And a lot of new, up and coming nurses, and both have been taught different schools of nursing and different approaches to nursing and now there's almost – it's almost as if there's a staff split without the patient even being involved (participant 6).

Ongoing interactions with challenging patients was attributed to a negative work culture.

> Working with these difficult patients sometimes has a negative effect on the work culture itself. Sometimes the difficulties that they have working with the patients outside of the nursing station, and I think that's also something that… is kind of unavoidable, but is a problem as well (participant 2).

While some nurses noted the importance of consistent care between all nurses when working with patients with ASPD, others noted that strategic and selective enforcement of rules provided opportunity to build relationships. Differences in these approaches were attributed by one nurse to a generational gap in nursing approaches.

Despite differences in perspectives on the consistency of rule enforcement, a consensus existed amongst participants on the importance of avoiding strict or punitive approaches with patients with ASPD. Finding ways to deny patient requests in a respectful manner was viewed as preferable to abrupt and strict rule enforcement.

> Being strict and being… you know, antagonistic to something… If you just say, "Ok I want this, I want to go on grounds and smoke right now." And, "come on, you can't do that, you know you lost all your privileges, go to your room, man." And then you know if you do that they escalate and then the next thing you know you take them down and then, you know, called security and you have to put them in seclusion… I feel like that never works (participant 7).

Nurses acknowledged that the actions of staff can cause a patient to escalate, leading to the use of restraints. Participant 1 stated:

> Some staff member who have a very abrupt approach with these, with some patients, which has led to de-escalation not taking that time to have that one-on-one conversation, talking to them out front with lots of people around, which led to an escalation in behaviour, and ultimately to environmental restraints.

Furthermore, a patient's care plan itself could be considered as being too punitive, leading to patient challenges.

> I've seen it done where perhaps the care plan becomes way too restrictive and punitive as well, you know, like, you can't – if you do this, then you get punished, if you do this, then these privileges get taken off for an extreme amount of time, and it gets to the point where they feel suffocated and they react (participant 6).

Taking on a highly restrictive and punitive approach to patient care with patients with ASPD was viewed as a negative approach, with the potential to lead to patient escalation and the use of restraints.

While much emphasis was placed on the actions and behaviours of patients with ASPD presenting challenges to the provision of care, some nurses acknowledged that the actions or approaches of nurses themselves could create challenges. The abrupt and punitive approaches described above were noted to cause an escalation of challenging behaviours amongst the antisocial patients.

> It's a combination of, you know, the patients themselves, their behaviour, their upbringing, their personality… and their illness. And… the environment they're in, including how they're treated by the staff (participant 4).

When asked to describe approaches that led to negative outcomes with antisocial patients, participant 5 stated:

> A lot of it is (sighs) who the staff are, how they are; what's the vibe on the unit, that kind of thing.

While participant 4 observed:

> I've seen where some of our clients are, you know, loosely use the word mistreated, quote unquote, right? And then they can turn on you, right? (participant 4).

Nurses acknowledged that they themselves could be responsible for initiating challenging behaviours amongst patients with ASPD.

In times where nurses were exposed to abusive and challenging behaviours from patients diagnosed with ASPD, participants underlined the importance of maintaining professionalism and not taking the attacks personally. Furthermore, recognizing the cause of a patient's abusive behaviours helped to provide context and understanding. For participant 2:

> The biggest challenge is not taking some of the direct personal attacks personally… challenging you possibly every day, it's hard not to take that home. But you've always got to remember that you're there to do a job and, you know, just try your best not to take it personal.

While participant 3 explained abusive behaviour in the following way.

> It can be very difficult, very frustrating when you're either being verbally abused, physically abused, things like that. But, ultimately, personally for me I've always been able to dissociate it, dissociate from it quite well, and never had any serious negative impacts on my work or what I do because ultimately I am here for them.

A recognition of the patient's circumstances and the restrictions placed on them helped to frame some of these challenging behaviours.

> I understand everyone has a bad day, I understand everyone has the right to be angry and frustrated, I understand that, you know, sometimes they need to voice out that frustration. I mean, I don't agree with how they voice out or carry out or act out their aggression and frustration if it's, you know, inappropriately. But I understand they also – you know they're locked up, they need to vent, and the got other issues going on (participant 4).

Rotating challenging patients between nurses was identified as a management strategy by participant 5.

> We all have our favourites, we all have our not-favourites. We just switch it around to keep workloads even.

Recognizing that attacks and abuse should not be taken personally, that nurses are there to help their patients in a professional manner, and that challenging behaviours can be linked to the restrictive context in which patients find themselves can facilitate this process. Rotating the assignment of challenging patients was identified as a strategy to decrease the burden on nurses.

Participants spent significantly more time discussing the strategies utilized when working with patients diagnosed with ASPD than they did patients with psychotic disorders. Not all participants agreed on the most effective approaches. Participants emphasized the importance of building positive, therapeutic relationships with patients and noted that these relationships can be utilized to prevent patient misbehaviours or to more successfully deescalate challenging situations when they do arise. Taking a calm and measured approach to patient concerns and to rule enforcement was linked to positive outcomes. As opposed to abrupt and strict denial of patient requests, taking time to explain the rationale for a request denial was viewed as important. Building a sense of empathy and explaining that non-enforcement of rules could also lead to negative consequences for nurses was identified as being important. Some participants argued that selective enforcement of rules could help build better relationships with patients, and minimize the potential for misbehaviour. Others disagreed, and insisted that consistency of rule enforcement minimized the potential for conflict to occur between nurses and patients. It was also noted that the actions of nurses could initiate patient misbehaviours: patients were not always responsible for the creation of conflict.

7.5 Recovery

When asked to describe a specific model or theory of care that guided their practice, the majority of participants did not identify any specific models or theories. One participant identified patient-centered care as their guiding model. Recovery was mentioned by participants as a model they were supposed to be following, however they described the units and the patients as too acute for recovery to be realistic.

> We have these initiatives like recovery-oriented care… which pose a lot of issues with, you know, a lot of roadblocks and barriers for us to provide these types of care. And so more and more we're leaning towards care in terms of how the patient sees care, and that's a great initiative if you're – for a lot of us that's great if you're in a medical unit but when you're dealing with individuals who are antisocial… they need a lot more stability than that (participant 6).

The acuity of a patient's mental illness was further considered a barrier to recovery.

> You've got to remember these are acutely ill and mentally ill patients, right? So how much do you really want to give them the ability to manage their care when they're acutely ill and also, just, that oppositional sort of defiance being a result of just consistently moving back and forth with no real progress to speak of (participant 6).

Linking the movement of patients back and forth between low and high security units to a patient's failure to follow institutional rules and expectations, nurses wondered how realistic it was to put more control into the hands of patients.

> They say we are supposed to be using recovery – recovery care model… but there is limitations to recovery care model when it comes to forensic – in the context of forensics. So, recovery care model is definitely about instilling hope, you know, the goals and their

> hopes and dreams to be defined by the patient… so it works for some, but it doesn't work for all (participant 7).

The goal of transitioning patients out of the hospital setting and into the community was viewed as unrealistic for some patients.

> These individuals lack enough insight and judgement to truly comprehend what it is that needs to be done for them to move through and rehabilitate themselves back into the community. So instead they move forwards because they're able to in the short term manage their behaviours and control their emotions, but in the long term they're unable to do so (participant 6).

Setting realistic and achievable goals for patients to transition into lower security or community settings was also viewed as an obstacle.

> For NCR patients, they can have, you know, they get their privileges, the board is giving them lots of privileges, including city, unsupervised city so they can work. But their limitation is – you have a criminal record. Let's say you're an NCR for murdering five people and you want to be a police officer. That – I don't think that's ever going to work, because it's not realistic, there's limitations (participant 7).

Participants did not identify a common model or theory guiding their own practice. Recovery was noted as a model that they were *supposed* to follow, however participants perceived the goals of recovery to be unrealistic for many patients found in the high security setting.

7.6 Construction of patients

The construction of patients perceived to be challenging by nurses working in a high security forensic mental health setting was also split between the two main patient groups identified above. Patients with a diagnosis of a psychotic disorder, primarily those with a

diagnosis of schizophrenia, were constructed as having little control over their actions, as being victims of their mental illness. These patients were viewed in a sympathetic manner by the nurses interviewed. In contrast, patients described as antisocial were constructed as having greater control over their actions than the patients with a psychotic disorder. This patient group was described as entitled and untrustworthy and of having self-serving motives for their behaviours. Though not viewed in the same sympathetic manner as the patients with psychotic disorders, nurses did acknowledge that difficult lives, struggles with addictions, and difficult histories contributed to the challenging behaviours of this patient group. Common to both groups of patients, however, was a sense of resignation, a sense that little could be done to help.

7.6.1 Construction of Patients with Psychotic Disorders

As explored, patients described as challenging due to their psychotic disorder were constructed as unpredictable and not in control of their behaviours. Though not all patients with psychotic disorders were identified as challenging, those defined as treatment resistant were identified as most challenging. Despite all efforts, interventions, and medications, there is no improvement in their mental health. Participant 7 described it this way.

> Treatment resistant patients… have been there for the longest ever, and we give them every single medication that is available and they're not responding… They're still going after people and beating them up.

While participant 6 described it I this way:

> They don't escalate, you know? It's very random. There's no – there's no rhyme or reason.

One nurse described this resistance to treatment as impacting a patient's perception:

> How can we work with them, because our perception of something for them may be something completely different, right? (participant 3).

This difference in perception was linked to an inability of these patients to understand the care and directions given by nurses.

> It's their mental illness that makes them not comply with the rules and, you know, they won't take a shower, they will drink from the toilet, you know, things like that. It makes it challenging, but the mental illness part of it – it's not the behaviour (participant 7).

This loss of control attributed to mental illness could lead to acts of aggression that the patient later regrets.

> At times they don't remember what they were doing, so when you tell them, you know, this is what you were doing, they feel sorry (participant 7).

Nurses constructed patients as falling victim to their treatment resistant psychotic disorder, and spoke of them in sympathetic terms:

> One of our older gentlemen – he is also treatment resistant schizophrenic – can be very aggressive in some moments, but in other moments he can be absolutely great (participant 3).

One nurse described a sense of sadness around the use of restraints:

> I find that hard. It makes me sad to see him, you know, to have the shackles on. He seems more used to it. I'm not used to it (participant 5).

Patients with a diagnosis of a psychotic disorder and who were described as treatment resistant were constructed as unpredictable, as victims of their mental illness, and requiring various forms of restraints to ensure safety on the units. These patients were often described as enjoyable to work with but also had the potential to be incredibly violent. Nurses described feelings of sympathy and sadness around the restrictive measures and strategies required to work with them. One nurse described a sense of resignation:

There's nothing that you can do for that kind of patient (participant 7).

Patients who were constructed primarily in relation to their mental illness, were in a sense, not responsible for their behaviours, due to their illness. Nurses described these patients with a degree of sympathy and sadness, noting there was little to be done to improve their situations.

7.6.2 Construction of Patients with Antisocial Personality Disorder

In contrast to the patients presenting with psychotic disorders, nurses constructed the antisocial group of patients in terms of their ability to control their actions and behaviours. Patients described as antisocial were constructed as untrustworthy, of having underlying motives, and as unwilling to work with nurses, despite the nurses' best efforts to work with them. Participant 6 describe this group in the following way:

> They have a little bit more control over their emotions and they're a bit more cognitively aware.

While participant 7 described this group in the following way:

> Being antisocial does not mean there's medications for it. You know, with a mental illness you can change it, but it's just a behaviour that they have, and I think of behaviour – there's no medication for behaviour that you can change… Not all the antisocials are really receptive to teaching, they just think the entire world is wrong and they're the only one that's right. So it's very, very, very challenging to teach them, because they're never gonna be receptive to teaching and it's a behaviour to think that everybody else is wrong.

This construction of patients with ASPD as unwilling to take responsibility was illustrated by a suggestion that they are looking at others to blame for their long stays in the hospital, as noted by participant 2:

> Their animosity towards the staff are basically the same because they're all stuck there for so many years, and they need someone to blame.

Patients were constructed as having more agency and control over their behaviours, but, at the same time, unwilling to work with nurses towards an eventual transition into the community. This left one participant wondering if patients actually wanted to leave the setting:

> If you're there long enough, you develop this attitude that you…wonder: do these patients want to move out into the system? … perhaps these individuals don't want to rehabilitate and move into the community (participant 6).

With these long stays in hospital, these patients were described as being especially aware of institutional boundaries.

> We have some individuals who have been there for the last twenty plus years, and they have been in that setting for so long that they understand where the boundaries and limitations lie, and so they push and abuse the system to best benefit themselves (participant 6).

In contrast to the patients with psychotic disorders, participants constructed the group of patients perceived to be challenging due to their antisocial tendencies as having control over their behaviours and actions. However, their antisocial tendencies prevented them from taking responsibility for their actions and working towards a transition into the community. Instead, patients are described as institutionalized, as unwilling to leave the setting while blaming others for remaining in the hospital setting.

Despite this construction of antisocial patients as manipulative and unwilling to take responsibility for their actions, nurses acknowledged factors in patients' lives that contributed to these behaviours. Nurses identified histories of trauma and struggles with addictions as contributing to these challenging behaviours. Participant 3 recalled that:

> A lot of them come from very difficult upbringings. A lot of very sad stories, that if you tell people they don't necessarily even believe that that can happen to a person… We have a lot of patients here who were either homeless, you know, or drug dealers, prostitutes, etcetera… What's happened to them in the past as children or as adults, even.

Participant 4's response was much more direct.

> A lot of these guys are – it's engrained in their friggin' behaviour from birth… you know with the drug seeking, their antisocial personality, deceitful, lying behaviours. Maybe, you know, maybe they grew up with having to fight for every scrap, foods, you know and claw their way up to the top, you know? It's a dog-eat-dog world out there.

Ongoing struggles with substance use and addictions contributed to a patient's long term stay in the hospital.

> I do understand why these individuals use substances, or abuse substances, rather … Especially with the addictions piece being added on, and so they move back and forth, up and down, up and down (participant 6).

The reality of a long term stay in hospital with many perceived setbacks combined with the highly restrictive nature of the setting was attributed to a sense of loss of control.

> Sometimes they lie and become aggressive, or demeaning to others because they don't have that control in their lives (participant 1).

Participant 4, stated:

> You know they're locked up, they need to vent, and they got other issues going on aside from their court issues and maybe addictions issues, and so I don't carry a grudge.

This recognition of patient histories and ongoing struggles within the hospital allowed nurses to humanize these patients.

> Our clients are human, too, so, and no one's perfect. We all have our faults. So you can't expect these guys to be a model patient and be, you know, a model patient every day… there's so many variables (participant 4).

Despite this ability to humanize these patients, nurses were not optimistic about the prospects of successful rehabilitation:

> There's no medication for them. They are, just, you know, they're antisocials and psychopaths so there's nothing you can do for them (participant 7).

Patients with ASPD were constructed as coming from difficult lives, including histories of trauma and substance use. These histories influenced their antisocial behaviours while in the hospital, as well as their ability to cope with the restrictions placed upon them.

7.7 Power dynamics

Though I did not specifically ask participants to explore issues of power dynamics in the high security forensic mental health setting, topics related to power did emerge in interviews. Participants primarily addressed the highly restrictive nature of the setting, with subsequent impacts on both patients and nurses. Restrictions placed on patients were attributed to acts of frustration, aggression, and a sense of loss of control. Similarly, nurses linked restrictions on their own practice as a source of frustration and potential conflict with management. Restrictions placed on both patients and nurses led to one participant warning that nurses may mirror the attitudes and behaviours of their challenging patients.

7.7.1 Patient restrictions

Nurses identified the highly restrictive nature of the high security forensic mental health setting, as well as provincial Review Board dispositions on patient privileges as having a negative impact on patient behaviours. In the high security setting, patients may not have access

to many of the privileges granted on the low security rehabilitation units, such as going outside to smoke cigarettes. Participants attributed feelings of loss of control, suffocation, and frustration amongst patients due to these restrictions; in combination with lengthy hospital admissions, nurses tied these feelings to negative patient outcomes and challenging behaviours. The use of chemical restraints was tied to challenging patient behaviours:

> We've had to give some patients injections against their will, for their own safety or for staff safety (participant 3).

In addition to these restrictions coming from institutional rules or outside agencies, patient care plans, created by nurses in conjunction with other disciplines, also placed significant restrictions on patients.

> Care plans are made by the nurses, formulated with the doctors or the behaviour specialists… but a lot of the times sometimes these care plans the patient doesn't necessarily want to partake in or want anything to do with. They either think it's too harsh, they're not getting enough privileges, things like that (participant 3).

Not only are patients subject to institutional rules and Review Board dispositions, they may face restrictions based on care plans formulated by nurses.

7.7.2 Nurse restrictions

In addition to restrictions placed on patients in the high security forensic mental health setting, nurses described restrictions placed on their own practice. These included perceived dissonance between nurses and management, a lack of clear guidance from management, challenges from patients, and a desire to implement alternative practices not permitted in the institution. Participants described having to follow policies dictated by higher levels.

> There's a lot of dissonance between upper management and, or the health authority as a whole, as their policies and their protocols, and the ability for us to have nursing care the way we have always done nursing care (participant 6).

These policies were described as having a negative effect on a nurse's ability to work with challenging patients. For example, noting the challenges related to patient substance use, one nurse described a desire to implement harm reduction approaches:

> I'm frustrated not just with the patients, but I'm frustrated with the system, because the system right now, you know, we're part of corrections, but we're also part of the health authority, and we're only part of corrections when it seems to benefit us, but it never seems to benefit us when it comes to substance use, which is one of the biggest problems that we have right now, and they haven't looked into implementing harm reduction approaches (participant 6).

Harm reduction was identified as a strategy to work with patient substance use, but was noted as not possible under institutional rules. These restrictions on nursing practice were described as immovable:

> Often times because, well what we know are their barriers, we can't move them. Those obstacles and been set forth by higher powers, so to speak (participant 6).

Strategic breaking of rules was described as a method to develop more positive relationships with patients perceived to be challenging, such as providing more than the permitted nicotine replacement medications, or bringing food in for patients:

> I've also seen where, you know, you treat these guys, you know say for example sometimes I'll bring chips for all the patients, and you know food's a powerful, powerful persuasive tool. And these guys are like your best friends (participant 4).

Other nurses, however, emphasized the importance of consistency between nurses, noting this manipulation of rules could lead to negative outcomes. Differential adherence to unit rules created tension not only between nurses and management, but between nurses and patients, and between nurses themselves. A sense of frustration with a lack of progress with challenging patients, related to institutional restrictions, led one participant to describe the danger of mirroring challenging patient attitudes:

> You're starting to teeter on the boundary of… you have to now be careful that you're not mirroring the patient, right? You know what I mean, like their emotions – you're not mirroring them, you're not taking on biases that – you have to remain professionally neutral. And that becomes more and more difficult the longer these individuals spend time with you in this setting (participant 6).

Nurses' frustration was compared to patient frustration, and the danger of replicating patient attitudes towards the institution. The restrictions placed on patients and the restrictions placed on nurses were both identified as sources of frustration and conflict. And despite a recognition that alternative approaches could benefit both patients and nurses, it was perceived that such alternatives could not be implemented.

Chapter 8 Discussion

Nurses working in the high security forensic mental health setting work with a variety of patients, with diverse legal statuses, diagnoses, and treatment options. While the nurses interviewed for this research described many mandates for patient care in the forensic hospital setting, the patients considered most challenging were those under the NCR status. Two groups of challenging patients were identified by participants: (1) Those described as suffering from treatment resistant psychotic disorders, primarily schizophrenia, and (2) Those described as diagnosed with antisocial personality disorder, often identified simply as antisocial. Both groups of patients were characterized by their NCR status, lengthy time spent in the hospital, and an inability to be successfully transitioned into the community. Though participants did refer to patients described as having psychotic disorders as treatment resistant, it was clear that both groups of challenging patients identified could be described as treatment resistant. Though nurses constructed the two groups of patients in very different ways and offered different strategies to achieve positive outcomes when working with these patients. A common theme in participants' attitude toward both groups of patients was a sense of resignation that nothing could be done, that treatment had failed. Strategies for nursing care focused not on eventual transition to a community setting, but on the management of these patients' challenging behaviours and the minimization of risk.

8.1 Not Criminally Responsible

In Canada, individuals found NCR for crimes committed are primarily relegated to the care of forensic hospitals, as opposed to provincial or federal correctional facilities (Latimer & Lawrence, 2006). Authority of care and permitted freedoms falls to provincial or territorial Review Boards (Crocker et al., 2015a). These Review Boards are mandated to impose the least

restrictive measures possible on individuals, while maintaining the safety of the public. Individuals found NCR remain in hospital until the Review Board deems them safe and capable of transition to a community setting. An absolute discharge may be granted by the Review Board, wherein the individual "would no longer be under the jurisdiction of a Review Board and would return to the community free of legal conditions" (Haag et al., 2016). In a longitudinal survey of the NCR population in Alberta, Canada from 1941 to 2015, Haag et al. (2016) found this population spent an average of 5.7 years under Review Board jurisdiction before absolute discharge. However, some individuals spent several decades under Review Board jurisdiction. Transition to the community is not guaranteed, and individuals may remain in secure forensic hospital settings indefinitely if the Review Board considers this necessary (Latimer & Lawrence, 2006). In a related study of the NCR population in Alberta, Richer et al. (2018) found the recidivism rate for NCR individuals was 19.7%, though only 56.3% of recidivism occurred after an absolute discharge. The majority of individuals found NCR spend less than a decade under Review Board jurisdiction, and few reoffend after discharge.

Review Boards provide dispositions to individuals, generally on an annual basis, outlining the level of privileges available. Treatment teams must work within the restrictions and privileges granted by Review Boards when providing patient care (Latimer & Lawrence, 2006). Within the forensic hospital setting, different units may exist based on level of security. In this study, patients considered to be acutely mentally ill or unsuitable for any other setting were placed on two high security units. Though these units had multiple mandates for patient care, the goal for NCR patients was primarily the treatment of their illness and eventual transition to lower security units – here described as rehabilitation units. On the rehabilitation units, patient care goals were aimed at transition to a community setting, less restrictive Review Board dispositions,

and an eventual absolute discharge. Patients considered too acutely mentally ill, or those who failed to adhere to the rules and expectations of the rehabilitation units could be sent back to the high security units examined in this study.

The most common mental health diagnoses of individuals found NCR in Canada are psychotic disorders (Crocker et al., 2015b; Haag et al., 2016), though a small proportion of this population are diagnosed with Antisocial Personality Disorder (ASPD). This diagnosis may be separate from or may co-occur with another disorder. In the present study, the two groups of patients described as challenging by nurses were those described as suffering from psychotic disorders and those described as antisocial. In particular, these two groups of patients were associated with very lengthy admissions to the hospital setting, some spanning multiple decades. Patients identified as most challenging were exceptional cases, with sometimes decades-long confinement under Review Board jurisdiction and viewed as unlikely or unable to receive an absolute discharge. Patients with psychotic disorders were viewed as unresponsive to medications and other interventions, and too unpredictable and acutely mentally ill to be transitioned to the rehabilitation units. Patients with ASPD, however, were described as frequently transitioning between the high security and rehabilitation units. In essence both groups could be described as treatment resistant. Nurses described moving from rehabilitation to high security units in negative terms, as a step-back in a patient's progress. Common reasons for this transition were an inability to follow rehabilitation unit rules, and substance use. The limitations and restrictions placed on NCR patients – a combination of both institutional rules and Review Board dispositions – were identified as a significant source of tension and frustration, and as responsible for many of the behaviours nurses found challenging.

8.2 Patients with Psychotic Disorders

The challenging behaviours described by nurses exhibited by treatment resistant patients with psychotic disorders centered primarily on their unpredictability and acts of aggression. Despite attempts to treat and manage these patients' illness with medications and other treatments, such as recreation activities and group activities, unpredictable acts of aggression and violence were ever-present. Through their descriptions of patients with treatment resistant psychotic disorders, nurses constructed their subjectivities. These discourses – these descriptions – are productive "because they make possible the creation of social categories and social practices" (Perron & Holmes, 2011, p. 193). Through the process of these interviews, it became clear that participants had created the social category of treatment resistant patient with a psychotic disorder. Subsequent strategies for working with these patients are produced, in part, through these discourses. Perron and Holmes (2011), in their examination of patient subjectivities in a Canadian psychiatric care penitentiary, also found nurses created various categories of patient subjectivities, including the patient as risk. The ever-present potential for patient instability structured a nurse's practice. Jacob and Holmes (2011), in a similar study, noted that "patients are defined by the potential (risk) violence they embody" (p. 75). Strategies for working with risky, unpredictable patients focused on the minimization of risk.

Huband et al. (2018), in their review of long-stay forensic mental health patients, noted that many patients potentially require potential life-long institutional care. These long-stay patients often carry a diagnosis of schizophrenia, with treatments focused on risk management and safety. Due to the acuity of their illness, they are unsuitable for placement on low security units or community settings. Hodel and West (2003) described mentally ill offenders diagnosed with treatment resistant schizophrenia as being cognitively impaired. For these patients, encountering complex situations often resulted in their feeling overwhelmed and responding with

anger or violence. In the forensic mental health setting, nurses constructed patients as accountable for their behaviours, with this accountability "conceptualized as the product of rational thought" (Jacob, 2012, p. 182). Nurses in the present study constructed patients diagnosed with psychotic disorders as unpredictable, unable to process or understand their environments, and by their potential for violence. Challenging behaviours were related to this unpredictability and a potential for violence, based on the patients' history of violence. Contrary to Jacob's (2012) findings, nurses in the present study did not attribute rationality to patients with psychotic disorders These patients were constructed as victims of their illness and thus not accountable for their behaviours. An abrupt approach to patient interactions that failed to consider this lack of rationality often resulted in negative outcomes, including patient aggression. To maintain the safety of unit staff and other patients, this necessitated extensive, long-term use of environmental restraints, and the use of mechanical restraints when these patients came out to interact with other patients or to leave the unit. Determination of when patients were suitable for time out of seclusion was based on the outcomes of risk assessment tools; patients did not decide, and neither, in a sense, did nurses. The parameters of risk assessment and risk management determined when these events occurred. In a discourse analysis methodology, that which is unsaid can be as, or more, significant as that which is said (Cheek, 2004; Fairclough, 2003). Nurses in the present study did not explore the potential for patients with psychotic disorders to transition to rehabilitation units or community settings, underlying the assumption that these patients would never be suitable for these settings, with the conclusion that this group of patients would continue to be treated in the high security setting indefinitely. Treatment focused on risk management, with efforts to provide some semblance of quality of life.

In forensic mental health inpatient settings, traditional treatment methods that aim to successfully transition patients into community settings have failed to meet the unique needs of long-stay, treatment resistant patients (Huband et al., 2018). Patient autonomy and quality of life suffer as a result. Völlm et al. (2016) attributed this failure to meet patient needs as systemic, the result of institutional inflexibility. Nonetheless, a focus on patient quality of life becomes a priority. Finding opportunities for meaningful patient occupation, despite the highly restrictive setting, was attributed to more positive patient outcomes (McKeown et al., 2016). Nurses in the present study identified the need to address quality of life within the restrictions of the institution for patients with psychotic disorders. Strategies focused primarily on releasing patients from environmental restraints, mediated through the use of mechanical restraints. This provided patients with the opportunity for social interaction, watching television, and going onto hospital grounds – the provision of meaningful occupation. Nurses viewed these strategies as an attempt at providing some semblance of quality of life to patients. Strategies were mediated through individualized patient care plans, though nurses acknowledged that these were highly restrictive and often failed to meet patient's desires. A mandate for safety and risk management overruled patient objections. In an attempt to find a balance between risk management and patient quality of life, risk management was prioritized.

Previous studies conclude that nurses working in high security forensic mental health settings desire to see patients move on to lower security settings and eventually transition to the community (McKenna et al., 2014; Völmm et al., 2016). Nurses in the present study expressed similar desires, though they did not describe this desire in relation patients with psychotic disorders. Instead, nurses expressed a sense of resignation regarding the future of these patients and an acknowledgment that nothing could be done. However, nurses spoke of patients with

sympathy, feeling sad for the restrictive measures and the frequent use of restraints. They maintained an intention to do whatever possible to meet patient needs. Nurses had not given up on these patients. These findings correlate with the findings of Völmm et al. (2016), who found forensic staff worked to avoid a warehousing mentality, where patients were given up on, and instead continued to provide therapeutic interventions, regardless of their effectiveness. Despite their negative feelings towards the significant use of restraints, nurses in the present study expressed a desire to maintain whatever quality of life was possible even when they believed that these treatment resistant patients with psychotic disorders had no prospects for transition to less acute settings. The nurses remained committed to providing the best care they felt was possible despite a recognition that it would not contribute to long-term progress.

The topic of recovery was not addressed by any of the present study's participants with regards to patients with psychotic disorders, even though recovery was identified as the mandated model of care on the units. Within a discourse analysis methodology, this omission is relevant. This omission suggests that participants believe recovery is not applicable or realistic within this patient population. An emphasis on risk management, here, outweighs the tenets of recovery. Tomlin et al. (2018) noted the ever-present emphasis on risk management in forensic mental health settings comes at the expense of therapeutic interventions. Staff reluctance to relinquish a risk-management approach in forensic mental health settings has been noted elsewhere (Barker, 2012; Livingston et al., 2012; McKenna et al., 2014; McKeown et al., 2014; McKeown at al., 2016), as such an approach is viewed as an invitation for patient misbehaviours and unsafe unit conditions. Implementation of recovery in high security forensic mental health settings focuses on the democratization of decision making among nurses and patients (McKeown et al., 2016), wherein patients have considerably more say in their care and

treatment. In the present study, however, nurses constructed patients with psychotic disorders as incapable of making decisions on their care that fit within safety expectations. A risk management focus outweighed the potential to implement recovery.

8.3 Patients with Antisocial Personality Disorder

Contrary to patients with psychotic disorders, patients with ASPD were constructed as rational subjects, capable of accountability and taking responsibility for their behaviours. Nonetheless, participant constructions of this group of patients also described them as treatment resistant. Challenging behaviours attributed to patients with ASPD related to their unwillingness to follow institutional rules and expectations, unsanctioned substance use, manipulation, and a tendency to push boundaries. Strategies described as achieving positive outcomes focused on taking time to build positive relationships and discussing with patients the rationale for nursing decisions, especially around the denial of patient requests or enforcement of unit rules. Acknowledging the restrictions of unit rules and expectations facilitated this process, with some nurses suggesting flexibility in rule enforcement as a means of building more positive relationships. This strategy was not agreed upon by all nurses, however, with some emphasizing the importance of consistency in rule enforcement to avoid the pushing of boundaries by patients. A significant challenge identified by participants was the cyclical rotation of patients with ASPD between high security and rehabilitation units. An inability to follow rehabilitation unit rules resulted in patient transfer back to high security. Nurses in the high security units focused their efforts on assisting patients to meet the requirements for transfer back to rehabilitation. Recovery was considered as unrealistic for these patients in the high security setting. Similar to the patients with psychotic disorders described as treatment resistant, nurses

were sceptical that patients with antisocial personality disorder could successfully transition out of the hospital and into the community.

The construction of antisocial patient subjectivities differed from those of the psychotic disordered group of patients. As with this group, the construction of antisocial patient subjectivities is productive, and informs the nursing practices utilized with these patients. Patients with ASPD were constructed as entitled and capable of pushing boundaries to their own benefit. Patients were constructed as accountable, rational subjects capable of making decisions and understanding consequences. However, nurses constructed this patient group as looking to blame others for the negative consequences of their actions. Participants acknowledged that many patients came from histories of trauma and abuse and that these histories influenced and shaped their subjectivities. In suggesting that this patient group was distrustful of authority, nursing strategies focused on acknowledging that unit and institutional rules were beyond a nurse's control, or could be selectively enforced in an effort to build relationships. However, with selective enforcement of rules, nurses worried that patients could exploit these charitable ways, or could lead to expectations that all nurses would do the same. Long stays in hospital and frequent rotation between high security and rehabilitation units led nurses to describe patients as institutionalized, leaving them to wonder if the patients had any desire to progress into a community setting. The construction of patients as rational, but unwilling to follow unit and institutional rules led nurses to question underlying motives, and their willingness or ability to change. Here, too, nurses questioned whether anything could be done with this patient group. Patients with ASPD, too, were treatment resistant.

Multiple studies of forensic mental health settings have identified personality disordered patients as an especially challenging group of patients. Nurses in a study by Jacob (2012)

associated personality disordered patients with conniving and manipulative behaviours. Construction of subjectivities focused on language of deviance, not on clinical or medical representations. To avoid being manipulated, nurses in this study described avoiding interactions with these personality disordered patients as much as possible. Aiyegbusi and Kelly (2015) noted the significant emotional labour associated with the verbal and physical abuse, accusations, and manipulations of personality disordered patients. A survey by Mason et al. (2010) found that nurses considered personality disordered patients as difficult to treat, and who required a greater focus on management than clinical treatment. Vincze et al. (2015) expressed concern that challenging patients occupy a large proportion of a nurse's time, at the expense of therapeutic opportunities for less disruptive patients. Personality disordered patients in forensic mental health settings are consistently associated with challenging and manipulative behaviours that require management, as opposed to therapy.

Nursing strategies for working with antisocial patients in the present study also focused on the management and prevention of challenging behaviours. The highly restrictive setting, including unit and institutional rules and expectations, contributed to tension in the nurse-patient relationship. Nurses described a responsibility to enforce rules and expectations, to deny unpermitted patient requests, and the potential for conflict associated with these interactions. The manner in which nurses approached these responsibilities was associated with their outcomes. Negative outcomes were characterized by an escalation in patient misbehaviours, including targeted verbal assaults and disclosure of personal information, and a deterioration in the nurse-patient relationship. A consensus existed amongst nurses that a strict or punitive nursing response to these situations resulted in negative outcomes. Positive outcomes were characterized by de-escalation and the absence of patient misbehaviours. A more compassionate and patient

approach was associated with these positive outcomes. Nurses described taking the time to explain their rationale and an appeal to the inflexibility of unit and institutional rules as effective strategies here, allowing nurses to maintain their relationships with their patients. Maguire et al. (2014) characterized these two contrasting approaches when setting limits in the forensic mental health setting as authoritative and authoritarian. Patients in the study "expected that limits would be set on their antisocial behaviour" (p. 156), but the manner in which limits were set influenced the outcome. An authoritative approach to limit setting was described as fair and respectful, where nurses took the time to listen to patient concerns, and led to positive outcomes. An authoritarian approach was described as aggressive and intimidating, where nurses did not take the time to consider a patient's concerns, and was associated with negative outcomes, including patient aggression.

Similar strategies have been identified as effective in correctional settings. Dynamic security describes a practice to both maintain safety and develop respectful relationships between staff and incarcerated persons. With this practice, "prisoners are less likely to be disruptive if they regard officers as fair, reasonable and trustworthy" (Leggett & Hirons, 2007, p. 234). Related to dynamic security are core correctional practices, a model aimed to "increase the therapeutic potential of rehabilitation programs for offenders" (Dowden & Andrews, 2004, p. 204). Under these practices, staff aim to be fair and transparent in the enforcement of rules. They also model prosocial behaviours and attitudes, and engage in "open, warm, and enthusiastic communication" (p. 205). Both dynamic security and core correctional practices recognize the benefit of avoiding punitive and dominating approaches in favour of positive relationships and the fair enforcement of institutional rules. These models mirror the authoritative approach to limit setting described by Maguire et al. (2014). Nurses in the present study endorsed an

authoritative approach to setting limits and enforcing unit and institutional rules, and associated an authoritarian approach with negative outcomes.

Enforcement of unit and institutional rules emerged as a point of contention amongst participants in the present study. Challenging behaviours amongst the antisocial group of patients was consistently linked to tension and conflict around maintenance of these rules or the disciplinary actions expected when rules were broken. According to Jacob (2012), the constant enforcement of rules turns nurses into authority figures. When patients misbehave, it is nurses who intervene. These disciplinary interventions are aimed at the management of deviant behaviours, not the therapeutic treatment of the patient. Tomlin et al. (2018) noted an overemphasis on security and discipline has a negative effect on therapeutic opportunities. Some participants in the present study endorsed the value of flexibility in rule enforcement with antisocial patients. An ability to compromise was noted as an effective strategy to prevent an escalation in patient misbehaviours. The decision on when and how this selective rule enforcement occurred lied entirely with the nurse, and it was recognized that not all nurses were willing to do so. Holmes (2005) found nurses in a Canadian forensic psychiatric penitentiary setting also exercised this flexibility and that "[s]ome team members may choose to alleviate an inmate's sanction in order to preserve a 'caring' relationship. As such, the possibility of overlooking a minor offense guarantees, in some cases, a therapeutic bond between nurses and inmates" (p. 5-6). Enactment of this flexibility was based on a nurse's judgement. Some nurses in the present study also chose to disobey unit and institutional rules to which they were subjected, such as bringing snacks for patients as a means of building relationships. McKenna et al. (2014) described this flexibility in rule enforcement as taking "calculated risks" (p. 68). An understanding of the individual patient was described as central to these calculated risks, which

were acknowledged as a radical strategy within secure settings. Some nurses in the present study endorsed selective rule enforcement as a positive strategy for working with antisocial patients, leading to a decrease in patient misbehaviour and opportunity to build stronger nurse-patient relationships.

Not all nurses in the present study, however, agreed on the efficacy or appropriateness of this selective rule enforcement strategy. An inconsistency in care was noted by some to create greater challenges with the antisocial patient group. Patients were described as constantly pushing boundaries to their own advantage, and if one nurse chose not to enforce a specific rule, patients were noted to expect similar leniency from other nurses. If not granted, this could lead to an escalation of patient misbehaviours, and potential splitting of staff members. Green (2018) described splitting as occurring when groups of staff develop strongly divergent views towards particular patients, especially those with a diagnosis of a personality disorder. While Green contended that responsibility for splitting is usually placed on the patients, in the current study responsibility for splitting was placed on nurses. In particular, generational differences in nursing practice philosophies were attributed to differing approaches to rule enforcement. Instead of this selective rule enforcement or calculated risks (McKenna et al. 2014), some nurses advocated for strict consistency in rule enforcement. In effect, this meant strict enforcement of all unit and institutional rules. Though consensus existed amongst nurses that an authoritarian – here described as strict and abrupt - approach to denying patient requests or setting limits led to an escalation of patient behaviours and negative outcomes, disagreement existed as to how consistently rules should be enforced.

For patients to progress through decreasing levels of security in the forensic mental health setting, with eventual transition to a community setting, meeting institutional and Review

Board expectations is necessary. Those who fail to meet these expectations find themselves languishing long-term in high security units or are found unsuitable for transition to community settings. Nurses working in these settings view this progress through the system as a positive treatment outcome, as indicative of successful nursing practice, and as indicative of a job well done (McKenna et al., 2014; Volman et al., 2016). Nurses in the present study expressed a sense of frustration with patients described as antisocial and their inability to meet these outcomes in a sustained fashion. Patient progress to rehabilitation units was viewed as temporary; transfer back to the high security setting was viewed as inevitable. In the high security forensic mental health setting, McKeown et al. (2016) noted that "cooperation with the system is a prerequisite for progress towards eventual discharge" (p. 240). These authors go on to conclude that "cooperation in this context is inevitably bound up with limited choice and may very well be effectively compelled upon service users" (p. 240). Nurses working in this context become skeptical of a patient's sincerity and cooperation with treatment. Patients who continuously failed to cooperate with treatment and remain in the high security settings for years were described as "determined recalcitrants" (p. 240). In the present study, the most challenging antisocial patients described by nurses align with this description. However, nurses fully acknowledged that their role in the high security setting was to assist patients in meeting the expectations for transfer to a rehabilitation setting. This process was rooted within a framework of compliance, not on therapeutic interventions. Structured care plans existed with specific expectations for patients to meet to be eligible for this transfer. These highly disciplinary approaches were aimed at the management of patient misbehaviour, not on treatment, correlating with the findings of Jacob (2012). Participants in the study by Jacob (2012) re-organized these disciplinary interventions within a therapeutic framework as a means of reconciling the cognitive

dissonance that exists when nurses are expected to meet the dual mandates of custody and caring. In the present study, however, participants recognized these disciplinary approaches as lacking in therapeutic value. Exploring restrictions with patients was viewed as a positive strategy to address patient misbehaviours. The goal was to simply transition patients off the unit, allowing other units to take on the challenge of managing these patients. Unit and institutional rules were to be followed – to varying degrees, depending on the individual nurse – but were recognized as restrictive and punitive.

An expectation for patients to strictly adhere to institutional rules to see any opportunity to progress beyond the inpatient setting and into the community is linked to feelings of loss of control and resignation amongst patients. Vincze et al. (2015) attributed patient suffering to the unmovable restrictions placed on patients in the forensic mental health setting. Patients have no choice but to adapt to these restrictions or act out, leading to further restrictions. Nurses have no choice but to enforce these restrictions, including the use of coercive measures. The solution is for nurses to teach patients to adhere to the rules – an approach endorsed by participants in the present study. Tomlin et al. (2018) described a patient's navigation of the system, following institutional expectations as a means of transitioning to the community. A failure to do so results in an indefinite length of stay in the institution – a point of tension for patients. Forensic mental health patients in the study by Askola et al. (2016) felt they did not belong in the hospital to begin with. The very placement in the forensic setting is viewed as punishment, without therapeutic value (Mollerhoj & Stolan, 2018). Patients described a feeling of being stuck in the system and described a constant desire to escape the care (Horberg et al., 2012). Patients compare their placement in hospital to a life sentence (Askola et al., 2016); a failure to develop

any sense of hope for transition to community settings leads to patient institutionalization (Tomlin et al., 2018).

Nurses in the present study constructed antisocial patients as institutionalized and wondered if these patients had any desire to leave. Patients in the study by Horberg et al. (2012) described the tension between fighting for a sense of dignity and giving up and giving in to institutional expectations, which often resulted in a sense of resignation. This sense of loss of control was attributed to these feelings of an inability to leave the setting. Once patients adapt to the situation and give in to the rules, they begin to see progress (Askola et al., 2016; Horberg et al., 2012; McKeown et al., 2016). Patients have a degree of choice, but only a choice of compliance leads to progress within the system. Holmes and Murray (2011) stated, "[a]ny autonomy the forensic psychiatry patient does experience is a false autonomy, as it is clear that his submission to institutional order is total" (p. 299). Participants in the current study endorsed this perspective – the only means for antisocial patients to progress out of the high security setting was to adhere to unit rules and expectations. Care plans focused on the management of forbidden behaviours, such as substance use, facilitated this process. The most challenging of patients were either unwilling or unable to adhere to these expectations, and were destined, from the perspective of participants, to remain indefinitely.

The implementation of a recovery orientation in forensic mental health settings has been attributed to positive patient outcomes (Drennan & Alred, 2012b; Livingston et al., 2012), including in the high security setting (McKenna et al., 2014; McKeown et al., 2016). The promotion of choice, within the confines of the setting, is viewed as critical (McKenna et al., 2014). Participants in the current study described an institutional expectation to utilize recovery in their patient care, but viewed recovery as not applicable and unrealistic with the antisocial

group of patients. Nurses described their goals for patient care here as meeting the expectations for transfer to a rehabilitation unit. The activities or goals that patients desired were not permitted under the restrictions of the high security unit. McKeown et al. (2014) emphasized the importance of involving patients perceived to be challenging in their care, including the allowance of flexibility, to minimize tension and conflict. Gillard et al. (2015) concluded that developing skills to exercise control over their lives was an effective strategy for recovery in patients with personality disorders. In the current study, participants viewed these perspectives as unrealistic. Patient care was aimed at transition to rehabilitation units, where the work of recovery was more realistic in a less restrictive setting.

The transition towards recovery in the forensic mental health setting, especially high security environments, presents unique challenges. Drennan and Alred (2012b) traced the history of treatment perspectives in forensic mental health from rehabilitation to recovery, noting that recovery shifts focus towards the patient. While recovery has seen widespread implementation in conventional mental health settings, the authors describe its implementation in forensic settings as a "profound challenge" (p. 12). While this transition is possible, McKenna et al. (2014) noted a decade-long transition was necessary on the particular unit examined. In the present study, the language of recovery was conspicuously absent from interviews with participants – a significant outcome in a discourse analysis methodology. Some participants acknowledged that recovery was the purported model of practice in the institution, but it was quickly dismissed as unrealistic, especially with patients perceived to be challenging. Of note, the low security units in the facility were referred to as rehabilitation units, not as recovery units. While not the focus of the present study, it was apparent that recovery had not been embraced as beneficial or even realistic by participants.

Patient backgrounds, including histories of trauma, were viewed as responsible for many of the behaviours viewed as challenging in the antisocial group of patients. Participants described patients by their deep mistrust of hospital staff, as inherently antagonistic towards any perceived authorities. Patients in the study by Askola et al. (2016) described nurses as "villains" (p. 7). They described an antagonistic relationship with a forensic institution that emphasized control and bureaucracy. Horberg et al. (2012) found that patients defined the forensic setting by its lack of care, by its focus on punishment. Aiyegbusi and Kelly (2015) related forensic mental health patient histories of trauma to highly challenging behaviours in personality disordered patients, and suggested an acknowledgement of these histories as a means of understanding and contextualizing challenging behaviours. Nurses in the current study did relate challenging behaviours in antisocial patients to their histories. They also suggested that these behaviours made the implementation of recovery in the high security setting unrealistic.

8.4 Power dynamics and the total institution

Forensic mental health institutions have been widely explored in regards to their power dynamics and in relation to Goffman's (1961) concept of the total institution (Holmes, 2002; Holmes, 2005; Holmes & Federman, 2006; Jacob, 2012). Described as a setting where the lives of inhabitants are both highly regimented and separated from the outside world, the high security forensic mental health units described by participants in the present study resembles the total institution. Patients in this setting are placed under significant restrictions, are expected to adhere to strict unit rules, and may only leave the units under highly controlled circumstances. Through these restrictive measures, a mortification process occurs, wherein the patient is no longer who they were on the outside; they take on a new identity within the institution. Patient compliance within this total institution is the responsibility of nurses. When asked to describe the most

challenging patients encountered in their high security forensic mental health units, participants described two groups of patients: those with psychotic disorders and those who they described as antisocial. The nurses' construction of these two groups of patients informed the treatment strategies utilized in their practice. The constructed patient subjectivities, when examined through discourse analysis, "allows for the examination of the relationship between language, knowledge, subjectivity, power and social practices" (Perron & Holmes, 2011). Language is not neutral (Cheek, 2004), and the power dynamics that exist between nurses, patients, and the institution in the high security forensic mental health setting can be analysed through the nurse's discourse.

An examination of power relations in forensic mental health settings utilizing the work of Michel Foucault (1995) provides a framework for understanding the dynamics that exist between nurses and patients, and between nurses and the institution. Holmes (2005) and Holmes and Federman (2006) explored these dynamics within three of Foucault's forms of power: sovereign, disciplinary, and pastoral. Within each form of power exists various techniques for power to be exercised. Sovereign power – that of the king – is absolute, and is in the forensic setting is exercised as coercion. According to Holmes (2005), nurses in forensic mental health settings also act as peace officers, and bear the responsibility of ensuring patients follow institutional rules. When patients fail to follow these rules, nurses can enforce the rules, or call for other agents to ensure compliance. In the current study, nurses were responsible for enforcing unit and institutional rules, but also had the ability to call on hospital security to assist when necessary. Disruptive or violent patients could be placed in seclusion or given chemical restraints. Nurses acknowledged that their enforcement of rules could result in coercive acts. This coercion was most evident in the group of patients with psychotic disorders, where patients were viewed as

incapable of controlling their behaviours and required significant restraints to maintain unit safety. Disciplinary power, related to the concept of the panopticon, focuses on the techniques of surveillance and normalizing judgements (Foucault, 2006). Holmes (2005) related disciplinary power to a nurse's continuous surveillance of patients, and commitment to ensuring a patient's strict adherence to their care plan. Foucault (2006) stated, "there is a continuous pressure of this disciplinary power, which is not brought to bear on an offense or damage but on potential behavior" (p. 51). Participants in the present study spoke extensively on the importance of preventing patient misbehaviours, or deescalating patient behaviours before they become unmanageable. Finally, Holmes (2005) identified pastoral power as a form of power utilized in the forensic mental health setting. This power is exercised through the technique of therapy. Patients are expected to take responsibility for their mental health and their actions, with nurses facilitating this process through therapeutic practices. The goal of therapy is the self-management of unpermitted behaviours by patients. Nurses in the present study identified the value of building therapeutic relationships with patients, noting a reliance on these relationships to facilitate patient de-escalation. While all three forms of Foucauldian power explored by Holmes (2005) were evident in the present study, most relevant here is disciplinary power, especially as it relates to the antisocial group of patients.

Foucault (2006) described disciplinary power by the totality of its expanse, stating "it is a total hold, or, at any rate, tends to be an exhaustive capture of the individual's body, actions, time, and behaviour" (p. 46). He traced the origins of disciplinary power from late seventeenth century military service, wherein soldiers became full-time professionals. Confinement in barracks, physical training, and unitary marching were part of this discipline. The objects of disciplinary power are under constant supervision and surveillance, to the point where discipline

becomes habitual. Disciplinary power extended to schools and the workshops of the industrial revolution. The focus of discipline preceded the unpermitted act and brought its gaze to potential behaviours. This is the panoptic character of disciplinary power. An individual's success within the disciplinary system was determined by their class or rank. In the present study, patients in the high security units are rigidly confined to the setting. Their actions from day to day are highly regulated by unit schedules and their individual care plans. Especially when working with the antisocial group of patients, nurses described their intention on the prevention of patient escalation or misbehaviour. Patients who adhered to this disciplinary structure progressed through the system, on to rehabilitation units and eventually community settings – these were not the patients nurses described as challenging. The challenging patients failed to adhere to the disciplinary structure and required punishment, including the use of restraints, loss of privileges, and extended stays on the high security units.

Within the disciplinary system, Foucault (2006) described those who failed to fit within the rules and expectations as "something like a residue" (p. 53). He went on to state:

> Disciplinary systems…which classify, hierarchize, supervise, and so on, come up against those who cannot be classified, those who escape supervision, those who cannot enter the system of distribution, in short, the residual, the irreducible, the unclassifiable, the inassimilable (p. 53).

These individuals expose the margins of disciplinary power. In an effort to capture and normalize these anomalies into the disciplinary structure, supplementary disciplinary systems are created, work that can be never-ending. The patient group described as most challenging due to their antisocial tendencies in the current study match this description. A failure to adhere to cultural norms – committing crimes, suffering from mental illness – places them in forensic

mental health system of capture. This system aims to normalize. However, within this system, they continue to evade this normalizing process. They fail to adhere to unit and institutional rules, they fail to meet the requirements for progress through the system. As such, additional supplementary systems are created in an effort to normalize, here in the form of care plans. These care plans lay out specific means and expectations for patients to be re-captured within the disciplinary system. Patients who choose to continuously disobey these expectations – these 'determined recalcitrants' (McKeown et al., 2016) – are left to languish long-term in the high security units, or continuously cycle between the high security and rehabilitation units.

The construction of patient subjectivities is woven into the disciplinary power structure that exists in the forensic mental health setting. The challenging or difficult patient exists within the context of a disciplinary power apparatus that isolates and problematizes those who fail to adhere to expectations or rules. Foucault (2006) related this notion to the school system, "[t]he individual who cannot be reached by school discipline can only exist in relation to this discipline; someone who does not learn to read and write can only appear as a problem, as a limit, when the school adopts the disciplinary schema" (p. 53). However, within the all-encompassing, totalizing disciplinary power apparatus, the only solutions that exist lie within the logic of this apparatus. Patients are expected to achieve autonomy, to take full responsibility for their actions or their illness; their adherence to the system should be habitual. For the group of patients with psychotic disorders in the present study, this autonomy will never be achieved. They are constructed as not responsible for their actions, as victims of their illness. The high security unit is the proverbial end of the line – there is nowhere else the patient can go. For the antisocial group of patients, constructed as rational and responsible for their actions, the logic of the disciplinary system expects this autonomy to be achieved; when they fail, new systems are

created. New care plans are created, hospital-wide plans are attempted – continued efforts are made to make these patients fit within the system. But this expectation of autonomy is a false autonomy, according to Holmes & Murray (2011). These authors concluded that behaviour modification programs – in the present study a component of a patient's care plan – give the illusion of choice and autonomy for the forensic mental health patient. Acceptable choices and autonomy must exist within institutional expectations. Nurses in the present study concluded there was little hope of progress for both groups of challenging patients. Both groups of patients expose the margins of the disciplinary power apparatus, though they can only be conceived of through the logic of this system.

To Foucault (1995), power is not possessed or held: it flows, it is capillary. Those who fill supervisory roles are themselves supervised. Foucault (2006) noted, "[e]ven the person in charge of a disciplinary system is caught up within a broader system in which he is supervised in turn, and at the heart of which he is himself subject to discipline" (p. 55). Nurses do not possess a monopoly on the techniques of disciplinary power. Holmes (2005) described nurses as both subjects and objects of power. As subjects of power, they exercise the techniques of power, such as coercion and surveillance, over their patients, and are capable of enacting punishments for misbehaviour. As objects of power, nurses themselves are subjected to techniques of power, such as surveillance and discipline from hospital management. The disciplinary power apparatus of the institution envelops all within its boundaries. Nurses in the present study consistently spoke of the need to enforce unit and hospital rules. Yet they acknowledged that these restrictions and their enforcement led to patient frustration and potential violence. They admitted that the rules they were expected to enforce were especially strict and punitive, but they had to enforce them, regardless. Vincze et al. (2015) concluded that the restrictions of the forensic mental health

setting caused a suffering in patients that could not be removed. Nurses have no choice but to uphold these power structures. In the present study, nurses described actively exploring these restrictions with patients, noting that, like patients, if nurses did not follow the rules, they, too, would be subjected to disciplinary actions. A sense of empathy was built between patients and nurses around the reality that both existed within a disciplinary system. One nurse even warned that nurses could mirror the frustrations with the system exhibited by the patients. Both nurses and patients are captured within this apparatus, within these capillary webs of disciplinary power. The frustrations experienced by both are similar. That nurses described a sense of empathy with the patient's experience illustrates this stark reality.

Within this disciplinary power apparatus of the forensic mental health setting, any instance of failure to adhere to expectations is an act of resistance. Both patients and nurses are capable of these acts of resistance. The most obvious patient act of resistance is the refusal to adhere to institutional rules. With the antisocial group of patients especially, nurses stated patients knew the rules, but chose not to follow them. But these acts of resistance can be more subtle. Surveillance is a central technique of disciplinary power (Foucault, 1995; 2006), and is utilized by nurses in the forensic mental health setting (Holmes, 2005). But nurses do not possess a monopoly on the use of this technique. Nurses in the present study described patients surveilling nurses, listening to their conversations for personal information which they would then disclose without the nurse's consent. Holmes (2005) described patient silence as an act of resistance; by refusing to engage with nurses, these patients resisted the nurse's use of pastoral power. Naturally, nurses described their responsibility to enforce consequences for these patient acts of resistance.

Nurses, too, are also capable of these acts of resistance. Most frequently addressed in the present study was the selective enforcement of rules. In recognizing the highly restrictive nature of the setting, some nurses described leniency in rule enforcement as a strategy to both avoid patient misbehaviours and to build relationships. Here nurses chose when and where to enforce specific rules. McKenna et al. (2014) described this strategy as taking calculated risks, whereas Barker (2012) identified the strategy of positive risk-taking. Holmes (2005) also found that nurses did not always enforce rules as a means of developing patient relationships. Nurses in the present study described leniency in punishment when patients did break the rules. One nurse stated that patients cannot be expected to constantly act as model patients and endorsed forgoing punishments in some situations. In an all-encompassing disciplinary power apparatus, enforcement is continuous. Nurses resisted here, at times, though the decision as to when and where this selective enforcement occurred lied entirely with the nurse. Unanimous agreement on this strategy of resistance did not exist, however. Other nurses endorsed the maintenance of a strict disciplinary system, stated that inconsistency created greater problems. Not all patients in this setting followed the rules, and neither did all of the nurses.

These acts of resistance amongst nurses were described as selective and strategic. It was acknowledged that the power dynamics of the system were too strong and all-encompassing for any significant changes to the disciplinary structure to occur. This was acknowledged as a source of frustration by some nurses. Strategies for patient care that existed outside of the accepted practices of the institution were identified as having potential to improve patient outcomes. A harm-reduction approach to ongoing patient substance use was identified as an example. Such an approach, however, exists outside the logic of the forensic disciplinary power apparatus. Nurses desired the implementation of strategies that existed outside of this power apparatus, but could

not. Instead, a sense of resignation with the existing system was described. Much like the patients described by Horberg et al. (2012), nurses came to accept the realities of the setting and resigned themselves to acceptance of the institutional rules.

Chapter 9 Conclusions

The purpose of this study was to explore the successes and struggles of nurses when working with patients perceived to be most challenging in the high security forensic mental health setting. In the literature this patient group is most often identified as being responsible for nurses' frustrations, fatigue, injury, and burnout and effective strategies for working with these patients remain elusive. Utilizing a discourse analysis methodology, the objectives of this study were to identify the behaviours and actions that nurses found most challenging, to explore the range of strategies nurses employed when working with these patients, and to consider these behaviours and strategies within the framework of the power dynamics of the high security setting.

The nurses interviewed in this study described two groups of patients as most challenging in the high security forensic mental health setting. The first group included patients with psychotic disorders. Patients in this group were predominantly diagnosed with schizophrenia, which had not responded to all attempts at treatment. Behaviours described as challenging related primarily to their unpredictability and their potential for aggression and violence. Strategies for working with these patients focused on the provision of quality of life measures within the confines of effective risk management. The second group of challenging patients were those described as antisocial. These patients were defined by their diagnosis of antisocial personality disorder or as possessing antisocial traits and characteristics. Behaviours described as challenging related to their unwillingness to follow unit rules, manipulation and pushing of boundaries, substance use, and an inability to progress through the forensic mental health system. Strategies for working with this patient group focused on building therapeutic relationships, providing rationale for denied patient requests, acknowledging the restrictions of the setting, and,

to some, a willingness to selectively enforce the rules. Both groups of patients were noted by their long stays on the forensic mental health hospital, which could span decades.

A discourse analysis methodology allows for an examination of the construction of patient subjectivities by nurses and the impact these constructions have on the nurse's approach to patient care. Patients with psychotic disorders were constructed as lacking the rationality and self-control necessary to achieve the level of autonomy expected of patients in this setting. They were constructed as victims of their mental illness. An inability to understand their realities led to frustration and acts of violence. Their lack of rationality renders them perpetually dangerous. To maintain safety for nurses and other patients, a risk management approach was viewed as necessary, leading to extensive use of restraints. Nurses expressed sadness and sympathy towards this patient group, noting their positive experiences with them, despite the ever-present threat of aggression. Highly restrictive measures were viewed as necessary and indefinite, but nurses persisted in their attempts to provide quality of life measures wherever possible.

Patients diagnosed with antisocial personality disorder were constructed as possessing the rationality and autonomy to take responsibility for their actions, but as perpetually unwilling to do so. Nurses described these patients in relation to their tendency to push boundaries. They were also constructed in relation to difficult histories of trauma, abuse, and substance use. These histories produced a distrust of authority and a tendency towards the escalation of conflicts. Nursing strategies focused on attempts to build relationships, despite being perceived as an authority, at the prevention of misbehaviours, and the de-escalation of misbehaviours when they appeared. Selective rule enforcement was viewed, by some, as an effective strategy for positive outcomes. This behaviour management approach was tied to structured patient care plans, which outlined the specific steps and expectations for patients to achieve to move on to a less restrictive

setting. Participants were pessimistic about the sustainability of patients meeting these expectations, noting that most progress was quickly undone.

Participants expressed a sense of resignation with respect to both groups of patients. Nurses acknowledged that patients diagnosed with psychotic disorders would never improve to a point where transition to a low security unit or community setting was realistic. Despite this, nurses did not give up on attempts at therapeutic intervention. They emphasized the importance of providing patients with a semblance of quality of life, aiming to reduce the use of restraints whenever possible. McKeown et al. (2016) noted the importance of meaningful patient engagement in high security settings, which the nurses in this study aimed to provide. Völmm et al. (2016) reached similar conclusions with long-term forensic mental health patients. These patients were not simply warehoused; nurses continued to provide therapeutic interventions, regardless of its effectiveness.

The sense of resignation nurses in the present study expressed towards patients diagnosed with ASPD differed from that of the patients with psychotic disorders. Nurses described cycles of pseudo-progress during which patients diagnosed with antisocial characteristics temporarily adhere to expectations and transition off the high security units, but subsequently failed to maintain that adherence and return to the high acuity unit. This repetitive cycle of adherence and non-compliance was a significant source of frustration for nurses and left them wondering if this group of patients had any desire to ever transition into the community. Here the failure to transition to a community setting was viewed as a choice. A sense of fatigue and potential for burnout was attributed to these ongoing challenges with this group of patients.

Power dynamics permeated all areas of practice in the high security forensic mental health setting. Foucault's concept of power is productive, allowing for the production of certain

types of knowledge (Cheek, 2004). This knowledge is enacted through discourse, including how patients in the setting are constructed (Berring et al., 2015). Patients perceived to be challenging in this study were constructed as dangerous and untrustworthy. The restrictive measures utilized to work with – and manage – these difficult patients are a product of the power relations of the setting. Most relevant to the high security forensic mental health units considered in this study is Foucault's (1995, 2006) conception of disciplinary power. Disciplinary power is all-encompassing, it is totalizing. It relies on constant supervision and surveillance. Strict expectations of what is normal and acceptable are placed on those under supervision. Disciplinary power aims to prevent misbehaviours from happening; when they do, punishments are dealt. Those who consistently fail to adhere to expectations – the anomalies – are subjected to increasingly strict new attempts to capture them into the disciplinary fold. The high security forensic mental health setting is highly restrictive and regimented. Patients must adhere to unit and institutional rules and expectations, and are further restricted by their Review Board dispositions. Beyond the provision of therapy, nurses in this setting are charged with ensuring patients follow the rules. The challenging patients described in this study are these disciplinary anomalies. They consistently fail to meet the expectations of the setting, and nurses are there to enforce the disciplinary order.

This disciplinary order creates significant tension for both patients and nurses. Patients resist the disciplinary order by not following the rules, by creating conflict with the nurses expected to enforce this order. Nurses in this study acknowledged their role in creating this conflict. In their own acts of resistance, nurses aimed to release tension through the selective enforcement of unit rules. But the nurses, too, are subjected to the disciplinary order. Failure to enforce the rules could lead to punishment from unit managers. It was even frowned upon by

other nurses. Holmes (2005) and Holmes and Federman (2006) explored this role complexity, constructing nurses as both subjects and objects of power.

The strategies offered by nurses in this study for working with the most challenging patients, these Foucauldian anomalies, mostly fit within the confines of the disciplinary power apparatus. For patients diagnosed with psychotic disorders, this meant making efforts to provide quality of life within the restrictions of risk assessment and risk management. For patients diagnosed with ASPD, this meant attempting to get them to adhere to the rules long enough to meet the expectations for transfer to the rehabilitation unit, even for a short time. Other strategies described or suggested fell outside the confines of the disciplinary power apparatus. Selective enforcement of rules allowed for the temporary release of patient-nurse tensions and the development of less-antagonistic relationships. This resistance to the disciplinary order was not endorsed by all participants. Other suggestions for patient strategies fell entirely outside the logic of the disciplinary system. A harm reduction approach to substance use was proposed, but was subsequently dismissed as not possible within a secure forensic setting. When the primary mandate of nursing as a general practice is the provision of therapy, the provision of care, the restrictions of the forensic mental health setting push nurses towards more custodial practices, which they have no choice but to uphold.

The majority of patients in the forensic mental health setting are committed to the goals of recovery (McKenna et al., 2014; McKeown et al., 2016). Drennan and Alred (2012b) outlined the opportunities for recovery in the forensic milieu, wherein patients aim to build hope, and to overcome the dual stigma of mental illness and criminality. Patients work towards taking responsibility for their crimes, and to taking responsibility for the management of their mental illness. Nurses working in these settings have tremendous success in facilitating these recovery

journeys, in partnering with patients to centre their care (Livingston et al., 2012; McKenna et al., 2014). These patients, however, are not perceived to be challenging. The challenging patients described by nurses in this study continually fail to engage in this recovery process. The nurses themselves made little reference to the use of recovery. Those that did perceived recovery as unrealistic in the high security setting. It was clear that recovery did not factor into the practice of the nurses in this study, perhaps suggesting a lack of understanding or training in its use. Instead, participants in this study focused primarily on the management of risk and the potential for patients to transfer to lower acuity units. In this setting, patients perceived to be challenging do not progress through the goals of the forensic system towards successful community reintegration. They languish in a system that will not release them without adherence to these goals. They feel trapped, they act out in anger and frustration. Nurses, being responsible for the care of these patients, bear the brunt of these frustrations. In the enforcement of institutional rules they perpetuate the conditions that produce these challenging patients' misbehaviours, even if they recognize this role. As Foucault (2006) noted, these patients are the anomaly of the system. They do not fit. They expose the margins of the disciplinary forensic mental health system. Yet patient dispositions, in the interests of public safety, do not allow them to go anywhere else. To escape the realm of punishment with this small group of patients, a radical re-thinking of treatment options – outside the conventional disciplinary system – is necessary. It is clear in this study that a greater focus on recovery would allow for greater inclusion of patients in their care, and could alleviate some of the challenges nurses face in providing care. Yet with some of the most challenging patients, recovery is not enough (McKeown et al., 2016). Barlott et al. (2020) turn to the work of Deleuze and Guattari in their critique of recovery as implemented with those with a long history of confinement. They suggest deterritorialisation as a way

forward, wherein "transformation occurs by cautiously dismantling and disorganising the rigid segmentation of the major from within, generating small fissures" (p. 1341). In this study, some participants already engaged in this process in their selective enforcement of institutional rules. Perhaps a way forward is to embrace, rather than criticize, these minor acts of resistance. To grant nurses the autonomy to explore new opportunities to practice – to release not only patients, but nurses from the rigid grasp of the disciplinary apparatus.

9.1 Strengths and Limitations

Many of the participants in the present study spoke very openly and candidly about their experiences in the high security forensic mental health setting. They spoke of their institutional frustrations and desires to provide care modalities not permitted in a forensic environment. They spoke of their ongoing commitment to providing compassionate and therapeutic care for patients they expected to never leave the setting. They spoke openly of their frustrations in working with some patients, and their willingness to break the rules they were expected to follow.

As previously mentioned, I had worked on one of the units included in this study, and had worked with some of the participants. This could have presented potential for ethical concerns. To ensure the integrity of interviews, I adhered to a set of guiding questions (Appendix C) and allowed participants to lead the direction of the discussions. Participants were not directed or influenced towards any specific conclusions or statements. Furthermore, it is my belief that pre-existing relationships with some participants provided opportunity for open and candid exploration of their practice. A sense of trust had been pre-established, wherein participants felt comfortable to provide some of the (at times) blunt, honest, and often critical perspectives on their practice and the challenges they face. Research looking specifically at nursing strategies for working with patients perceived to be challenging in the forensic mental health milieu are scarce.

This study provides insight into this realm. It highlights the realities that some patients in these settings may never be deemed fit or safe to exist anywhere else, and that nurses find opportunities to provide quality of life interventions within the highly restrictive environment. It also illustrates how nurses exist within a highly disciplinary system, where their own practice is subject to restrictions. Despite this, some nurses looked for opportunities to break from these restrictions in attempts to build better relationships with patients, and provide them with opportunities and small pleasures they would not otherwise enjoy.

On 11 March, 2020, the World Health Organization declared a pandemic related to the COVID-19 outbreak (World Health Organization, 2020). The pandemic declaration limited my ability for in-person recruitment of participants beyond my initial visit to the units of study to speak with nurses. After this visit, recruitment was limited to the posters placed on the units, and snowball sampling. While the participants recruited provided a diversity of perspectives sufficient to meet the requirements of the methodology, further in-person recruitment opportunities may have yielded a greater number of participants. While the present study's initial design and ethics approval allowed for both in-person and telephone interviews, after the pandemic declaration the provincial ethics board mandated that all interviews be conducted by telephone. As a result, I was unable to conduct any interviews in person. Though the telephone interviews did provide sufficient data for this study, it is my belief that in-person interviews may have yielded richer, more extensive data, especially from some participants who participated in shorter interviews.

Though not within the scope of this Master of Nursing thesis study, follow up interviews with participants would have allowed for further in-depth exploration of topics discussed. In particular, participants devoted most of their interviews to exploring their challenges with the

patients described as antisocial. Further exploration of work with patients with psychotic disorders may have provided greater insight into working with this group of patients. Furthermore, though not the focus of this study, a greater exploration of participants' perspectives on – and knowledge of – recovery may have allowed for greater exploration of its implementation in the units of study.

9.2 Future Research

The present study provided an exploration of nursing strategies for working with patients perceived to be challenging in the high security forensic mental health setting. This study was limited to the forensic hospital milieu. Similar exploration in other forensic settings, such as correctional institutions would broaden nursing's understanding of working with patients perceived to be challenging. Furthermore, an exploration of this topic in a setting where recovery has been more thoroughly implemented may provide better insight into the role recovery may (or may not) play with this particular group of patients. In addition, the topic of patient use of illicit substances was addressed by a number of participants. While not within the scope of this research, a further examination of patient substance use in secure forensic settings could provide insight into this phenomenon, and the challenges it may pose to nurses and their practice.

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APPENDIX A

College of Nursing
University of Saskatchewan

PARTICIPANTS NEEDED FOR
RESEARCH IN FORENSIC MENTAL HEALTH NURSING

We are looking for volunteers to take part in a study of nursing strategies for working with patients that are perceived to be challenging.

As a participant in this study, you would be asked to participate in individual interviews, either at the hospital or over the telephone.

Your participation would involve a single interview session, which will take approximately 30-60 minutes.

Participants who conduct in person interviews will receive a beverage of your choosing, such as coffee, tea, soft drink or water.

For more information about this study, or to volunteer for this study, please contact:
James Johansson
College of Nursing
at
(780) 902-3646 or
Email: JAJ828@mail.usask.ca

This study has been approved by the Health Research Ethics Board of Alberta and the University of Saskatchewan Behavioural Research Ethics Board

APPENDIX B

Informed Consent Form for Participation in a Research Study

Nursing Strategies for Working with Patients that are Perceived to be Challenging: A Discourse Analysis

(Working with Patients Perceived to be Challenging)

Protocol ID: *HREBA.CHC-20-0009*

Researcher: James Johansson
College of Nursing
University of Saskatchewan
(780) 902-3646

Co- Investigator(s): Cindy Peternelj-Taylor (306) 966-6238

WHY AM I BEING ASKED TO TAKE PART IN THIS RESEARCH STUDY?

You are being invited to participate in a research study because nurses often encounter patients they perceive to be challenging in high security forensic mental health settings. It is recognized that these patients can be a source of stress and frustration for nurses. The purpose of this study is to help understand the behaviours and actions patients use that nurses find most challenging, and to explore the strategies used by nurses when working with patients that are perceived to be challenging

This consent form provides information about the study to assist you with making an informed decision. The researcher will discuss this study with you and will answer any questions you may have. You are encouraged to ask questions. When all your questions have been answered to your satisfaction, you can decide if you want to be in the study or not.

Taking part in this study is voluntary. You may choose whether or not you take part. If you choose to participate, you may leave the study at any time without giving reason or without penalty. Deciding not to take part or deciding to leave the study early will not result in any penalty or effect current or future care or employment.

If you decide to participate in this study, you will need to sign and date this consent form. You will receive a copy of the signed form.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

Up to 10 people will take part in this study. We plan to enroll about 5-10 people at Alberta Hospital Edmonton, Units 3-5 and 3-7.

WHAT WILL HAPPEN DURING THIS STUDY?

- This study will consist of a single interview, which will be approximately 30 to 60 minutes in length.
- The interview will explore what makes patients challenging to work with, and explore the strategies used to work with them.
- Interviews will be conducted at the hospital at your convenience, but in a private setting off your unit. Interviews can also be conducted by telephone if you prefer
- Interviews will be guided by a set of general questions, and will be audio recorded. Participants have the right to have the recording device turned off at any time without giving a reason
- Interviews will be transcribed by the researcher. Participants will have the opportunity to review and revise their interview transcripts if they choose.
- If a participant chooses to review their transcripts, they will be emailed to the participant. The participant will have 1 week from receipt of transcripts to submit any revisions. A transcript revision form will be sent with the transcripts with instructions for amending and returning the transcripts.
- Interested participants will contact the researcher by telephone or email. Interviews will be arranged at the participant's convenience.

This study should take 3 months to complete and the results should be known in about 6 months.

WHAT ARE MY RESPONSIBILITIES SHOULD I DECIDE TO PARTICIPATE IN THIS STUDY?

If you choose to participate in this study, you will be expected to:

- Contact the researcher via telephone or email to arrange an interview.
- Participate in a single interview lasting 30-60 minutes

WHAT WILL HAPPEN IF I CHOOSE TO WITHDRAW FROM THE STUDY EARLY?

You can choose to end your participation in this research study (called early withdrawal) at any time without having to provide a reason and without penalty. If you choose to withdraw early from the study without finishing the interview or follow-up, you are encouraged to inform the researcher. The research may also withdraw you from the study if he/she feels it is in your best interest.

Should you wish to withdraw, the interview will be stopped, and any data collected will be destroyed at your request.

If you would like to review or revise your interview transcripts, they will be provided to you via email. You will have 1 week from the receipt of transcripts to submit any revisions. A transcript

revision form will be sent with the transcripts with instructions for revising and returning transcripts. If no revisions are received within 1 week of receipt of transcripts, the researcher will assume that you are satisfied with the content of your interview transcript and it is ok for use in the study. Your right to withdraw data from the study will apply for 1 month after your interview has been completed. After this date, is is possible that some form of data analysis and write-up will have already occurred and it may not be possible to withdraw your data.

WHAT ARE THE RISKS/DISCOMFORTS OF PARTICIPATING IN THIS STUDY?

- Given that you may discuss situations where patients have been abusive, aggressive, or threatening, there is potential for emotional discomforts during and after the interview process.
- You have no obligation to discuss any situations or experiences you are uncomfortable with. You can choose not to answer any of the questions asked, and you are free to withdraw from the study at any time for any reason.
- The researcher is available to debrief after the interview is completed (this will not be recorded). In addition, the Employee and Family Assistance Program is available to all Alberta Health Services employees, and information for this will be made available to you.

WHAT ARE THE POTENTIAL BENEFITS OF PARTICIPATING IN THIS STUDY?

Participation in this study may or may not be of personal benefit to you. The aim of this study is to better understand the behaviours and actions used by patients perceived to be challenging when providing nursing care, and better understand nurses' strategies for working with these patients. However, based on the results of this study, it is hoped that in the long-term, patient care can be better understood or improved.

HOW WILL MY PERSONAL INFORMATION BE KEPT PRIVATE?

If you decide to participate, the researcher will only collect information they need for this study. They will do everything that they can to make sure that this data is kept private/confidential. Interviews will be conducted in private. You will be given a non-gendered pseudonym (false name) and any data collected will be identified with this false name. In publications or presentations, any direct quotations used will be identified using your given pseudonym. The hospital and units will not be identified by name in any publications. The hospital will be referred to as "a forensic mental health hospital in Western Canada" and the units referred to as "high security forensic mental health inpatient units" in any publications or presentations.

Because the participants in this study have been selected from a small group of nurses, most of whom are known to each other, it is possible that you may be identifiable to other people based on what you have said. Any direct quotes that may identify you or any other patient or staff member will be modified or reconstructed in a manner that ensures confidentiality is maintained.

No data relating to this study that includes your name will be released outside of the study site nor will it be published by the researcher. Sometimes, by law, the researcher may have to release information including names and therefore absolute confidentiality cannot be guaranteed. However, every effort will be made to make sure that your information is kept confidential.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated. Every effort will be made to keep your information be kept confidential, and to follow the ethical and legal rules about collecting, using and disclosing this information.

After the study is done, we will still need to securely store your data that was collected as part of the study. We will keep your data and study records stored for 5 years after the end of the study.

The audio recordings collected in this research will be stored in a secure location and viewed only by members of the research team. The recordings will be kept until they have been transcribed (turned into written records), and then they will be destroyed. All files will be stored on secure University of Saskatchewan, password protected computers. Any emails sent will be through secure University of Saskatchewan email. Consent forms, as well as any notes or physical copies of transcripts will be stored in a locked cabinet in a secure setting, per University of Saskatchewan protocols. Data will be retained for 5 years, after which it will be destroyed beyond recovery.

WILL THERE BE COSTS INVOLVED WITH PARTICIPATING IN THIS STUDY?

There will be no costs involved with participation in this study.

WILL I BE COMPENSATED FOR PARTICIPATING IN THIS STUDY?

All participants who participate in in-person interviews will be offered a beverage of their choice, such as coffee, tea, or soft drink. Participants who participate in telephone interviews will not receive any compensation.

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from this project for any reason, at any time with out explanation or penalty of any sort. Your participation, choice to withdraw, or non-participation will have no impact on your employment, access to services, or how you will be treated.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of these results, please contact the researcher.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form you do not give up any of your legal rights against the hospital, researchers, or institutions, nor does this form relieve these parties from their legal and professional responsibilities.

IS THERE ANY CONFLICT OF INTEREST RELATED TO THIS STUDY?

There are no conflicts of interest declared by the researchers.

WHO DO I CONTACT FOR QUESTIONS RELATED TO THIS STUDY?

If you have questions about taking part in this study you should talk to the researcher, co-investigator or study nurse. These person(s) are:

James Johansson	(780) 902-3646
Name	Telephone
Cindy Peternelj-Taylor	(306) 966-6238
Name	Telephone

If you have questions about your rights as a participant or about ethical issues related to this study and you would like to talk to someone who is not involved in the conduct of the study, please contact the Office of the Health Research Ethics Board of Alberta.

Telephone: 780-423-5727 Toll Free: 1-877-423-5727

UNDERSTANDING AND SIGNATURES PAGE

	Yes	No
Do you understand that you have been asked to take part in a research study?	☐	☐
Do you understand why this study is being done?	☐	☐
Do you understand the potential benefits and risks/discomforts of taking part in this study?	☐	☐
Do you understand what you will be asked to do should you decide to take part in this study?	☐	☐
Do you understand that you are free to leave the study at any time, without out having to give reason or without penalty?	☐	☐
Do you understand that we will be collecting information about you for use in this study only?	☐	☐
Do you understand that by signing this consent form that you do not give up any of your legal rights?	☐	☐
Do you feel that you had enough time and opportunity to consider the information provided to you by way of asking questions, having conversations with others and considering your options?	☐	☐

If a potential participant has answered "no" to any question above, please make sure to go over the relevant information with them until they do understand it. ***Only once they are comfortable with all the information can you accept their decision to participate in the study.***

By signing this form I agree to participate in this study.

Signature of Participant	Printed Name	Date

STUDY TEAM ACKNOWLEDGEMENT

I believe the person signing this form understands what is involved in this research study and has freely decided to participate.

Signature of Person Conducting the Consent Discussion	Printed Name	Date

You will be given a copy of this signed and dated consent form prior to participating in this optional research.

APPENDIX C

Sample Questions to Guide Interview

1. Tell me about the unit that you work on
2. Tell me about the patients that you work with
3. Are there any patients on the unit that you find challenging or difficult to work with?
4. If so, what is it about these patients that you find challenging or difficult? Can you provide an example?
5. What are some strategies or approaches you have used with these patients that have led to positive outcomes? Can you give an example? What was it that made this a positive outcome?
6. What are some strategies or approaches you have used with these patients that have led to more negative outcomes? Can you give an example? What was it that made this a negative outcome?
7. Is there a guiding model or philosophy you use for working with these patients? If so, can you describe it?
8. How do you feel towards these patients you find challenging or difficult to work with?
9. Why do you think these challenging or difficult patients act the way they do?
10. Is there anything else you would like to tell me about the setting, the patients, or the strategies you use when providing nursing care?