Forensic Nursing Culture and Recovery-Oriented Practice:

A Focused Ethnography

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Abstract

Providing Recovery-oriented practice in forensic settings is often a contentious issue. This thesis focused on Recovery with how it is influenced by the forensic population and how it is impacted by forensic nurses' attitudes and practices. Through a focused ethnography, I explored forensic nursing culture in an inpatient secure setting in Alberta, and the relationship with Recovery-oriented practice when working with the Not Criminally Responsible (NCR) population. Understanding the culture of forensic nursing and how forensic nurses experience and perceive Recovery for forensic patients provided insights into how Recovery can exist and how forensic nurses use Recovery-oriented practices to enhance nursing care in secure settings and facilitate successful reintegration back into community care and society. This research adds to the body of knowledge by demonstrating that there needs to be more Recovery-based training for forensic nurses and how the CHIME Recovery processes should be experienced by forensic nurses in order to move forward with implementation of Recovery-oriented practice, change cultural practices to reflect Recovery instead of rehabilitation, and incorporate a better understanding of Offender Recovery.

Keywords: forensic nursing culture, recovery, recovery-oriented practice, offender recovery, secure recovery, not criminally responsible

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Chapter 1: Introduction

The Recovery Paradigm and Recovery principles are widely heralded as the golden standard in psychiatric nursing. The concept of recovery has taken on new meaning within the Recovery Paradigm—I capitalized Recovery in this thesis to represent recovery from this paradigmatic perspective. The Mental Health Commission of Canada [MHCC] (2015) described Recovery as "living a satisfying, hopeful, and contributing life, even when there are ongoing limitations caused by mental health problems and illnesses" (p. 11). By extension, Recovery-oriented practice or a Recovery approach focuses on the facilitation of recovery that is collaborative, person-centred, and individualized; "Recovery-oriented approaches are inclusive, participatory and seek involvement of everyone to advance mental health and well-being" (MHCC, 2015, p. 11).

However, using a Recovery approach in the context of forensic nursing has proven to be a contentious and challenging issue. Ward and Birgden (2009) discussed one of the biggest sources of contention of Recovery in forensics as being the ethical dilemma of concern for the victims' rights for justice and/or community protection, and the role of punishment while considering the offenders' rights and entitlements to dignity, autonomy, and freedoms. Similarly, Drennan and Wooldridge (2014) also attributed challenges to the very nature of the treatment and control of forensic settings, which comes across as coercive because Recovery achieved by the service user is not simply a personal choice, but rather part of the imperative to reduce risk and protect the public. Turton et al. (2011) added to this statement and went as far as to argue that "the Recovery approach may be less appropriate in forensic practice, where therapeutic approach aims to change entrenched patterns of behaviour and identity" (p.128).

FORENSIC NURSING AND RECOVERY-ORIENTED PRACTICE

Forensic mental health patients (hereafter referred to as forensic patients in this thesis) are the individuals who are at the cross-section of having both a mental health illness and criminal offence. Forensic patients may include those who the courts have requested a forensic assessment (pre-trial/fitness, pre-sentencing, long-term offender, dangerous offender, and Not Criminally Responsible assessments), those who are on a temporary absence from the correctional system who have decompensated and require treatment, and those found Not Criminally Responsible due to Mental Disorder (NCR-MD) or Unfit to stand trial and have a court order to detain them.

The NCR-MD designation (also referred to as NCR) is a verdict reached when a judge or jury finds that while committing a crime, the person was suffering from a mental disorder where they did not have the capacity to appreciate their actions or know right from wrong at the time of the offence. This exempts the person from criminal responsibility, and the individual is neither acquitted nor found guilty and subsequently falls under the jurisdiction of a provincial review board. A person is deemed Unfit to stand trial if the person is unable to understand the court process, including the nature of proceedings, the possible consequences, or how to give direction to their lawyer (Greenspan et al., 2014).

Though Recovery has been thought to have a large positive impact to deter patients from future reoffending (and thus, it would be imperative for forensic nurses to include Recovery in their practice), I argue that it is only prudent to suggest that forensic patients are capable of achieving Recovery and have a right to treatment aimed at recovering personally satisfying lives.

Purpose

Understanding how forensic nurses experience and perceive Recovery for forensic patients in a maximum secure hospital will provide insights into how Recovery can exist or develop in secure settings, and how forensic nurses use Recovery-oriented practices to enhance care and facilitate the successful reintegration back into community care and society.

For the purpose of this research, I limited the focus of forensic nurses to those working with the NCR/Unfit population and excluded those working with assessment patients. Inclusion and exclusion criteria of research participants are further discussed in Chapter 3.

Research Questions

Through the use of a focused ethnography, I aimed to address the following questions: 1. How forensic nurses reconcile Recovery within secure settings and bring it to the forefront of forensic nursing care; 2. How forensic nurses prioritize approaches that promote Recovery principles such as collaboration, power sharing, inclusion, self-determination and a focus on strengths within a secure forensic mental health context; 3. How forensic nurses manage the ambiguous task of providing care and improving the patients' health and quality of life, while at the same time, protecting the public by supervising and containing the patient; and 4. To what capacity forensic nurses embody Recovery-oriented practices for their patients.

In Chapter 2, the literature on a Recovery Framework, Recovery in the forensic context, and forensic nursing culture is explored in order to understand how Recovery is defined and influenced by the forensic population, and what delineates forensic nursing from other areas of psychiatric nursing which may affect Recovery-oriented Practice. In Chapter 3, I discussed the

use of focused ethnography in nursing research, the philosophical underpinnings of this methodology, the research design, data collection process, ethical issues, and how data was managed and analyzed.

In Chapters 4 and 5, the findings from this research are detailed and discussed within the themes of finding a balance, managing risk, moving forward, stigma, the setting/system of practice, and Recovery in forensic settings. In Chapter 5, I also discussed of the use of a focused ethnography as a research methodology, the contextual background for this study, this study's strengths and limitations, the key findings in relation to the literature, implications for practice and administration, and recommendations for future research.

Chapter 2: Literature Review

The literature on a Recovery Framework, Recovery in the forensic context, and forensic nursing culture was explored in order to understand how Recovery is defined and influenced by the forensic population, and what delineates forensic nursing from other areas of psychiatric nursing which may affect Recovery-oriented practice. Firstly, to provide more clarity on the Recovery paradigm, I outlined a Recovery framework for Personal Recovery, which is the best aligned meaning of Recovery. Secondly, I delved into Recovery as experienced by forensic patients and offenders, additional layers of Recovery for forensic patients, and the risk paradigm of mental health and the impact on Recovery. Thirdly, I explored forensic nursing culture at various levels (personal, interpersonal, institutional, and systemic) to provide insights as to potential conflicts and barriers to implementing Recovery in secure settings, as well as the impact of risk from the forensic nurses' perspective. Lastly, I identified limitations in literature and offered suggestions as to what this research addresses and adds to the body of knowledge for forensic nursing.

Databases used for the literature review included PubMed, MEDLINE, and Elsevier, using search terms including Forensic Recovery, Offender Recovery, Secure Recovery, Forensic Mental Health, Models of Desistance, the Good Lives Model, and Forensic Nursing Stress.

Recovery Framework

Drennan and Alred (2012) discussed four principle meanings of Recovery in mental health: Clinical Recovery (absence of the signs and symptoms of illness/disease; return to a state of health that preceded the onset of clinical symptoms), Functional Recovery (restitution of the functional capabilities for undertaking life tasks), Social Recovery (social inclusion at a societal

level and informal/non-professional social networks of support among friends) and Personal Recovery (a personal process of changing one's attitudes, values, feelings, goals, skills and/or roles).

Amongst the four principle meanings, Clinical Recovery seems to be the most prominent and important concept of Recovery for mental health practitioners. Le Boutillier et al. (2011) stated that mental health practitioners "often consider recovery in terms of symptomatology and view it primarily as an improvement in mental health outcomes" (p. 1470). Likewise, Drennan and Alred (2012) stated that there is a powerful tendency in forensic mental health services to treat the apparent symptoms of mental illness and presume that this simultaneously addresses the potential for future offending. Recognizing that many practitioners focus on Clinical Recovery provides insights into how Recovery and Recovery-oriented practice may be misconstrued which would therefore alter the focus of care.

MHCC's (2015) definition of Recovery and the Recovery Paradigm, however, align more with Personal Recovery. To provide some context and clarity to the term Recovery in this thesis, I referred to a conceptual framework of Personal Recovery put forth by Leamy et al. (2011), which consists of characteristics of the Recovery journey, Recovery processes, and Recovery stages. Specifically, I referred to Recovery-oriented practice as the practices which support and are consistent with Leamy et al.'s (2011) Recovery processes: "connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME)" (p. 449). These processes can be understood as measurable dimensions of change during Recovery and reflect Recovery outcomes, therefore practice should be evaluated in relation to its impact on these processes (Leamy et al., 2011).

Recovery in the Forensic Context

There is a lack of knowledge of Recovery for mentally ill individuals who have committed criminal offenses; and within the criminal justice domain, Recovery has mainly been theorized and studied in relation to desistance research, where the focus is on how forensic and legal systems can prevent offenders from reoffending (Aga et al., 2017).

Barnao et al. (2016) suggested the Good Lives Model (GLM) of offender rehabilitation as a way of enhancing forensic service users' experience of rehabilitation. The GLM focuses on promoting individuals' personal goals while reducing and managing their risk for future offending and aims to equip offenders with capabilities and resources to obtain goals in socially acceptable ways. Vandevelde et al. (2017) noted three different paradigms within forensic psychology: a risk paradigm which is situated within a criminal justice approach, focusing on assessment and management of the risk of reoffending; a psychopathology paradigm which is situated in the mental health approach, focusing on the treatment of the mental illness; and a blended approach which can be problematic as both paradigms adopt different and even conflicting values, assumptions, and aims. Both Barnao et al. (2016) and Vandevelde et al. (2017) noted that the utility of the GLM is still premature in the forensic mental health context and rarely used for offenders with mental illness.

Though studies have shown that Recovery does exist in secure settings similarly to Mental Health Recovery (Aga et al., 2017; Barnao et al., 2015; Clarke et al., 2015; Mezey et al., 2010), it still tends to have a limited capacity. The limited sense of Recovery is due to the patients' feelings of powerlessness and oppression which are part of the subjective experience of being a forensic service user where people are often detained and treated against their will

(Barnao et al., 2015). Mann et al. (2014) also noted systemic obstacles to Recovery including power differences between patient and staff, the difficulty of prioritizing hope and social inclusion, and the stigma from the public which focuses on fear and a need for retribution. Moreover, Drennan and Wooldridge (2014) stated that the Recovery ideas of "empowerment," "choice," "self-determination," and "participation" are often seen as impossible in forensic settings.

In terms of how forensic patients experience Recovery, it was worth noting that patients described important indicators for Recovery as being symptom reduction, feeling better about oneself as a person, being accepted by and making a useful contribution to the community, getting work or education, finding a home, settling down with a partner, not re-offending, and simply being able to lead an ordinary life. Discharge from hospital was also noted as an important indicator of recovery but was also described as a potential destabilizer which could set back recovery (Mezey et al., 2010).

Aga et al. (2017) reported that there are several factors which facilitate Recovery including feelings of safety, security, and hope; the availability of social networks; progress in terms of identity change, gaining a sense of connectedness and self; coming to terms with the past; and experiencing freedom and symptom reduction through pharmacological and psychotherapeutic interventions. In a study by Skinner et al. (2014), they noted there are clear limits on Recovery components such as hope and control, however, service users were generally able to navigate these challenges and develop their own realistic hope and awareness of areas where they could have control. It seems that forensic patients are able to make some sense of Recovery in their lives and identify resources which facilitate their Recovery within secure

settings, but that overall, Recovery is still impacted by the judicial system and the stigma of their offence.

Drennan and Alred (2012) disagreed with the view that Recovery processes in forensic psychiatry has minimal differences compared to generic services and argued that Recovery poses as a profound challenge in forensic services, citing their concerns both from a Recovery as a service model (Recovery-as-policy) with how organizations change in terms of positive risk-taking, trust, and choice for service users, and concerns related to the nature of the personal journey for mental health service users who have committed a serious offence (Recovery-as-experience).

One concept which was introduced in the literature by Drennan and Alred (2012) was the concept of Offender Recovery. Offender Recovery refers to "the subjective experience of coming to terms of having offended, perceiving the need to change the personal qualities that resulted in past offending, which also create the future risk of reoffending, and accepting the social and personal consequences of having offended" (Drennan & Alred, 2012, p.15). Though there are many similar features to Personal Recovery such as taking responsibility and coming to terms with the effects on one's self-identity, Drennan and Alred (2012) noted that these tasks are much more significant with the extent of trauma to oneself that the offence has caused, as well as with "redefinition of the self in the wake of the offending, and the rediscovery of a positive sense of self in spite of what one did" (p.15). It was notable that forensic service users reported that recovering from the offence was seen as a greater barrier to achieving Recovery than recovering from their mental health symptoms, which is highlighted by Drennan's (2018) statement:

> It is often the case that recovering a meaningful life with a positive sense of self and hope for the future is more difficult to achieve in the face of a grievous offence than it is in the face of an enduring illness. (p.187)

Clarke et al. (2015) added to the discussion to state, "Recovery in this client group is therefore more complex, as it must encompass the features of traditional recovery as well as offender recovery" (p. 40) .also found that the theme of "coming to terms with the past" was not found in general literature with forensic mental health patients' perceptions of Recovery, but it was a unique feature of "Secure Recovery" which incorporates both the typical experienced histories of abuse and needing to come to terms with their own harmful behaviour.

The concept of risk was paramount to forensic patients with Recovery. "For those experiencing mental health problems themselves, being subject to the measures put in place to control risk can be damaging and ultimately inhibit their recovery" (Felton, 2014). Though this statement is meaningful for mental health patients in general, I would argue that this is even more significant for forensic patients who are subject to further stigmatization from committing an offence, and who are constantly being assessed for risk, specifically, risk for violence, recidivism, and overall risk to the public. A Recovery orientation suggests that people should have the "dignity of risk," or the person's right to take risks as part of personal growth (MHCC, 2015), but this is not readily accepted in forensics. Forensic nurses' perception and tolerance of risk will be addressed in the next section.

Forensic Nursing Culture

Perhaps it was most poignant for nurse philosopher, Gadow (2003) to describe forensic nursing by stating, "In no other setting do health professionals legitimately, deliberately, and

necessarily work against the value of the system in which they practice" (p. 162). Burnard (1992) also discussed how the forensic psychiatric role must take on various 'opposing' functions and as such to "consider illness, crime, morality, treatment, containment, and possibly punishment" (p. 139). Hörberg et al. (2012) further discussed how forensic care is characterized by being paternalistic and focuses on changing behaviour, which is why patients describe how they are exposed to the exertion of authority, power, punishment, and offensive behaviour and, at the same time, lacking caring care. Ward and Birgden recognized the role of punishment in forensic nursing practice, as:

> Punishment communicates to the offender and the community the harm caused by the crime, the need for offender accountability, and the necessity of repairing harm caused by the crime. However, punishment does not provide the offender the necessary tools to change (p. 229).

Some obvious differences that separate forensic nursing from other areas of psychiatric nursing include the increased exposure to violence and working with some patients with abhorrent offences such as homicides and sexual offences. Working with this special population has the potential to cause feelings of fear and even abjection. Vicarious trauma was also an identified stress when forensic nurses had to address the index offence (the offence which brought the accused to a review board) in their clinical practice, as well as dealing with scenarios which re-enact or parallel reoffending. In Harris et al.'s (2015) study of forensic mental health clinicians' experiences and attitudes with working with patients who had killed another person/persons while experiencing mental illness, they found that vicarious traumatization has a significant impact on the development of therapeutic relationships between clinicians and the

forensic patient; some clinicians described instances of wanting to debrief and discuss their feelings and responses with other clinicians but that they felt unable to informally or formally do so, which affected their ongoing work performance. Clinicians felt that some forensic patients only received superficial attention, with meaningful interactions frequently avoided in attempt to protect themselves from having disturbing images of the crime. Cashin et al. (2010) noted forensic nursing culture was subject to a high risk of burnout, from experiencing decreased motivation and job dissatisfaction as a result of associating their work to containment rather than caring, and the nature of patient offending behaviour which negatively impacts the attitudes of the forensic nurse resulting in therapeutic nihilism.

Within the nurse-patient dynamics, there was a consistent theme that patients felt the therapeutic relationship with staff was of utmost importance towards having a sense of Recovery (Barnao et al., 2015; Bressington et al., 2011; Marshall & Adams, 2018; Rask & Brunt, 2007; Schafer & Peternelj-Taylor, 2003; Slade et al., 2014). However, there is a constant underlying sense of mistrust in the interaction between forensic nurse and forensic patient, related to practitioners recognizing an inherent "untrustworthiness" of patients, and patients recognizing practitioners' obligations to institutional and public safety and therefore not always holding the patient's interest as their first priority (Austin et al., 2009). The nurse-patient relationship was also influenced by hostile and manipulative behaviour towards staff, which made nursing staff feel as if they needed to "get tough" with all prisoners (Weiskopf, 2005). Marshall and Adams (2018) on the other hand, found that forensic mental health staff shared fairly positive experiences with their therapeutic relationships, and that staff commonly consider how their relationships and interactions affect their patients.

The forensic setting itself also seems to be fraught with issues when it considers the professional dynamics of the practice setting. Aside from some problematic interactions between forensic nurse and patient (described by forensic nurses to be distant, aloof, suspicious, and stressed by the patients' likely lifelong patterns of exploitation, intimidation, pathological manipulation and perverted intimacy), it was noted that there was potential for negative dynamics amongst forensic nurses, non-clinical forensic staff such as security officers, and other disciplines such as psychologists, social work, and psychiatrists. Cashin et al. (2010) reported that the relationships between nursing and the custodial officers were cited as an additional form of stress. Weiskopf's (2005) study of the experience of caring for patients in a correctional setting showed that nurses voiced feelings of frustration because of "custody" enforced rules, such as not permitting the nursing staff to touch patients or disclose personal information about themselves. Relationships between the nursing staff and correctional officers were seen as critical to their experience of caring, and some participants felt like it was a constant fight with custody. However, it was just as important for Weiskopf (2005) to highlight a major problem with the non-caring attitudes of some nursing coworkers, and it was noted that one of the biggest sources of stress and negativism was working with other nursing staff.

The concept of Dual Agency is particularly salient as a unique component of forensic nursing culture, where forensic nurses may need to act as forensic experts in one setting, but as citizens and parents in others (Candilis & Neal, 2014). Ward (2013) also described it as the dilemma of conflicting expectations or responsibilities, between the therapeutic relationship on one hand and the interests of third parties on the other, as well as the broader dual relationship problem of the conflict between the two sets of professional norms: those concerned with community protection versus the norms related to offender/defendant wellbeing. Hence, there is

a need to explore how forensic nurses manage these competing values and the impact this has on the capacity to which forensic nurses advocate their patients' values, hopes and wants.

Olsson and Porskrog Kristiansen (2017) explored the experiences of forensic nurses with the inpatient risk assessment process while trying to establish interpersonal relationships for positive meetings with the patient. From their study, they discovered two themes: The first theme showed that the risk assessment was a factor which enhanced the quality of forensic care, discussing the importance of the HCR-20 instrument, and supporting the objectivity of the assessment. The second theme showed that the risk assessment did not have an impact on daily forensic care and did not guide or help the nursing staff establish interpersonal relationships with the forensic patients. There was also a reluctance to use the risk assessment based on the combined role of being both a care provider and assessor of risk. Olsson and Porskrog Kristiansen (2017) also went on to argue that risk assessment was a crucial component to forensic nursing, otherwise, forensic work can be seen as unnecessary or illegitimate, and contradictory expectations cause role conflicts.

As previously mentioned, the topic of risk is not only limited to affecting the interpersonal relationships between forensic nurse and patient, but that it has detrimental effects on the patient's overall sense of Recovery. However, avoidance of risk is the accepted norm within society and therefore taking risks becomes abnormal, something to be avoided (Felton, 2014). With the responsibility to manage risk and the expectation of public safety, it would be easier for forensic nurses to justify containment of those who are perpetrators of risk or dangers to society. Mann et al. (2014) noted that restrictive practices at the expense of Recovery may become the dominant model because of professionals feeling anxiety related to their duty of

public protection and the consequences if an incident occurs such as media coverage, public opinion, internal enquiries, and damaged reputations. Hence, the way risk is perceived by forensic nurses impacts the extent to which positive risk-taking is tolerated, and how they manage the balance of the interests of the patient and the interests of the public.

Though Recovery has been explored through the perspective of forensic patients, and there is a wealth of information of forensic nursing culture to suggest why Recovery is challenging in secure settings, there remains the obvious limitation in the literature of forensic nurses' attitudes and firsthand experiences with Recovery and how they utilize Recovery-oriented practices in their care. By exploring forensic nursing culture and the relationship with Recovery, I was able to provide insights into how Recovery can exist within secure settings.

As further explored in Chapter 3, the use of a focused ethnography was useful in gaining insights into the complexity of Recovery and Recovery-oriented practice in forensic settings. These insights have the potential to allow for impact at various levels: individual nurses can examine and change their practice, institutions can provide enhanced Recovery-sensitive training for forensic nurses, and the larger forensic system can embrace and promote a more holistic sense of Recovery, including the important facet of Offender Recovery.

Chapter 3: Research Design

To explore forensic nurses' attitudes and first-hand experiences with Recovery and how they utilize Recovery-oriented practices in their care, I chose to adopt a focused ethnographic approach. Additionally, because I am a practicing forensic nurse and a member of the culture being studied, elements of practitioner ethnography were taken into consideration, such as aims of research, access to participants, and ethical concerns. Focused ethnography and practitioner ethnography were both considered and discussed as they share the characteristic that the researcher has an intimate knowledge of the fields to be studied, but ultimately, focused ethnography was chosen as the overall methodology because I refined the focus to one element within the culture.

Murphy et al. (2014) suggested that ethnography as a research approach is very useful to understand the complexity of nursing work. Barton (2008) stated that practitioner ethnography has the view that research should have practical and direct relevance for practitioners and a potential to provide substantive outcomes that will influence clinical practice, health related strategies and wider policy-making. Therefore, insights generated from ethnographic examination can be very insightful for individual nurses examining their own practice as well as for administrators, educators, and policy makers.

Focused Ethnography as a Research Method

Cruz and Higginbottom (2013) defined focused ethnography as an applied research methodology which explores a distinct issue or shared experience in cultures or sub-cultures and in specific settings. Knoblauch (2005) also noted that focused ethnographies focus on small elements of one's own society. Focused ethnography in nursing research allows for

understanding and enhancing nursing practice, as it allows the researcher to better understand the complexities surrounding issues from the participants' perspectives (Cruz & Higginbottom, 2013). The three main purposes of focused ethnographies for nursing research are to: discover how people from various cultures integrate health beliefs and practices into their lives; understand the meaning that members of a subculture or group assign to their experiences; and study the practice of nursing as a cultural phenomenon (Roper & Shapira, 2000).

Roper and Shapira (2000) stated:

> Focused ethnographies share with classical ethnographies a commitment to conducting intensive participant observation activities within a naturalistic setting, asking questions to learn what is happening, and using other available sources of information to gain a complete understanding as possible of people, places, and events of interest. (p. 7)

Hence, using a focused ethnographic approach is underpinned by naturalistic philosophy. Streubert and Carpenter (2011) stated, "The naturalistic setting in which ethnographic research is carried out supplies nurses with the view of the world as it is, not as they wish it to be" (p. 175). This statement was important to the researcher as it underscores the need to capture the reality of the current state of the culture, which may include conflicts or struggles.

With regards to reflexivity, or "the struggle between being the researcher and becoming a member of the culture" (Streubert & Carpenter, 2011, p. 174), ethnography makes it difficult for researchers to hold a completely detached view, and therefore, difficult to maintain objectivity in the research process. Cruz and Higginbottom (2013) argue that reflexivity is particularly of importance for focused ethnography, especially when the researcher is familiar with or who may have personal experience of the culture being studied. Barton (2008) stated that practitioner

ethnographers must also be aware of and acknowledge the connection between their intimate understanding of the research aim and their relationship with the research sample and must consider how this may affect the outcome. Streubert and Carpenter (2011) also argued that because the researcher affects and is affected by the phenomena they seek to understand, reflexivity leads to greater understanding of the dynamics of particular phenomena and relationships found in cultures.

Research Design

Streubert and Carpenter (2011) outlined the steps of conducting ethnographic research which include 1. Participant observation; 2. Making an ethnographic record; 3. Making descriptive observations; 4. Making a domain analysis; 5. Making a focused observation; 6. Making a taxonomic analysis; 7. Making selected observations; 8. Making a componential analysis; 9. Discovering cultural themes; 10. Taking a cultural inventory; and 11. Writing an ethnography.

Knoblauch (2005) differentiated focused ethnography from conventional ethnographies in respects to the demands on time, with focused ethnographies being short-ranged and not continual but compensated for by being data intensive. In terms of field visits, Knoblauch (2005) also noted that focused ethnography restricts itself to certain aspects of fields, stating “the entities studied in focused ethnographies are not necessarily groups, organizations or milieus but rather situations, interactions and activities” (p. 11). Cruz and Higginbottom (2013) stated that since focused ethnographies tend to have pre-selected topics of enquiry, interview topics are highly structured around the issues, and can either limit or remove participant observation from the research process. Barton (2008) also noted that practitioner ethnographers fulfil the demands

of prolonged engagement and persistent observation, but that it is the triangulation of data which is the challenge for the validity of the study.

Sampling and Data Collection

The data was collected through semi-structured interviews with Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), and Licensed Practical Nurses (LPNs), who work with Not Criminally Responsible patients in secure inpatient settings. The inclusion criteria for the participants in this study was broad in terms of the nurse's professional background (RN, RPN, or LPN), job class (Full-time, part-time, or casual), and shift class (days, evenings, nights, and weekends), but that participation required them to only reflect on their experiences with NCR patients. As previously stated in Chapter 1, I excluded forensic nurses who work with assessment patients. This was partly due to the limited length of time with assessment patients (usually about 30 days granted by the court), but also due to the nature of the difference in the nurse-patient relationship when a patient is undergoing assessment and not involved in treatment or rehabilitation. It is important to recognize that the forensic nurse who works with assessment patients is focused more on observations and assessments of the patients for the purposes of the legal system, and therefore, may be more inclined to view the patient through the lens of dangerousness to the community, malingering behaviours, and culpability for the patient's crimes.

The interviews were focused on the forensic nurse's attitudes and experiences with Recovery in their practice, what specific challenges or barriers they faced with implementing Recovery-oriented practice, and how they managed with these challenges to still incorporate Recovery into their practice. I did not assume that participants have an in-depth working

knowledge of Recovery and first asked how they define or view Recovery/Recovery-oriented practice, and then prefaced participants with a brief explanation of the MHCC (2015) definition and Leamy et al.'s (2011) CHIME Recovery processes before continuing on to the interview questions (See Appendix C for list of Guided Questions). The purpose of asking about their knowledge of Recovery first was to identify if forensic nurses focus on Clinical Recovery, as Le Boutillier et al. (2011) and Drennan et al. (2012) suggested.

Recruitment of study participants was through purposive sampling, with posters, an email to the forensic nursing group, and through word of mouth (see Appendix A for recruitment poster and email drafts which were sent to senior management and the nursing staff). Because focused ethnographies are mini- or micro-ethnographies (smaller scale and narrow or specific in focus), I aimed to have a sample size of approximately 10 participants over a course of 3 months. As I later discuss in Chapters 4 and 5, a total of nine participants were included in this study.

Gaining Access to Participants

I chose to refine the aim of the study to focus on a single social institution: nurses who work with NCR patients in an inpatient setting. As previously stated, I am also a practicing forensic nurse, and therefore any issues with the process of gaining access to participants was not anticipated. When promoting the research study and encouraging coworkers to participate, I was clear with the intent of the research purpose (including informing participants that positive and negative experiences of Recovery would be explored, respected, and valued) and how participants' confidentiality would be protected in order to gain trust of the study participants.

As part of maintaining confidentiality for the participants, information related to demographics such as their age/years of experience, professional designation, and gender were

not collected. This was due to the small sample size and the possibility that they could be identified by coworkers through demographic information.

Ethical Considerations

Prior to beginning the data collection, I obtained ethics approval from both the Brandon University Research Ethics Committee (BUREC) and with Alberta Health Services through the University of Alberta Health Research Ethics Board. Since I used interviews as the method of data collection, consent to participate in the study was a much more formal process and eliminated the issues of having to obtain consent in the field or with covert participation. When meeting with interested study participants, I explained the purpose of the study, how data and confidentiality would be managed and protected, and described any potential risks and benefits of participation (see Appendix B for informed consent letter).

During the data collection period, there was an adverse event which occurred in the workplace where a psychiatrist was assaulted by a patient, which had the potential for participants to change their opinions/perspectives, and therefore, ethics amendments were obtained to complete a second interview with some of the participants who had participated in the study prior to the incident. The participants were informed about the purpose of conducting a second interview and were provided with an additional informed consent letter (see Appendix B2). Of the six participants who were interviewed prior to this adverse event, four participants provided consent to participate in the second interview. Any of the participants who took part in the study after the adverse event were asked this additional question (Question 14 in the Guided Questions, Appendix C) during their interview. Any differences noted between the participant responses pre- and post-incident will be discussed in the next chapter.

With regards to the ethical considerations with seeking to do research in my work environment, researcher bias and issues of power were of notable concern. I mitigated the concerns with researcher bias by maintaining a reflective journal, ensuring regular debriefing sessions with my thesis committee members, and clearly identifying when my role was that of a researcher versus the role of a coworker/employee, such as having specific days scheduled off work which was reserved for data collection. For issues of power, I noted that I was not, and am not, in a position of authority with the participants and assured participants that this research was by no means an evaluation of their job performance, and therefore had no risk to their employment. Participants were offered the opportunity to choose the location of the interview if they did not feel comfortable with using a private office space in the work setting.

I also explained the measures which were taken to ensure confidentiality and anonymity of participants, including: i) using "P" for Participant and "R" for Researcher to denote the speaker in the transcription of the audiotapes, ii) storing and keeping any raw data in a locked filing cabinet, and iii) keeping the electronic copy of the transcript on a computer which was password protected.

Data Management

The interviews were audio recorded and the electronic copy of the transcript was transcribed by me. I also requested that the interview participants refrain from using patient and co-nurses' names when discussing specific situations in order to protect privacy, and that if names were used, they would be omitted in the transcriptions. Raw data and consent forms were kept in a locked filing cabinet, and electronic data was stored on a computer that was password protected. Participants were also informed that the transcriptions and consent forms would be

kept for up to 5 years after completion of the research project and thesis defence (participants were given an estimated date of October 2025) before being deleted/shredded. A copy of the transcript was provided to the study participant 1-2 weeks after the interview (in a password-encrypted Word document) to ensure accuracy and provide them with an opportunity to review, clarify, and provide additional information as needed. Any new or amended data from the transcription review was incorporated into their original transcript so they became a part of the data that was analyzed, and I ensured that ongoing consent was obtained if the study participants provided new data (such as with the second interview consent form). The final copies of the transcripts were shared with the thesis advisor (J. Karpa) for review and used in the data analysis.

Data Analysis

I kept a reflective journal to document my thoughts and feelings during the research process, as well as regularly debriefed with my thesis advisor. I used a semiotic interpretation, which focuses on gaining access to the native's viewpoint (Streubert & Carpenter, 2011), as well as an overall ethnonursing interpretation (Leininger, 1985), which has the primary goal to "discover nursing knowledge as known, perceived, and experienced by nurses and consumers of nursing and health services" (Leininger, 1985).

Initially, I used NVivo12 to define categories and codes. However, being a novel researcher, I categorized data into the CHIME Recovery processes defined by Leamy et al. (2014): Connectedness (how forensic nurses related to their patients), Hope and optimism about the future (seeing forensic patients moving forward), Identity (how forensic nurses fit into the forensic culture/environment), Meaning (how forensic nurses saw their purpose), and Empowerment (how forensic nurses promoted power and choice for their patients as well as how

they experienced power/lack thereof). The data seemed to fit within these contexts but was based on my interpretation of the participant's responses. This novice error was due to neglecting to take my pre-understanding of the research topic into consideration, and therefore, tried to fit the data within a pre-existing model. After discussion with my thesis advisor, I wanted to be more mindful of the participants' perceptions and language, therefore, the decision was made to approach the data analysis differently.

I returned to reviewing data analysis using qualitative content analysis as outlined by Graneheim and Lundman (2004) to review and analyze the collected data from the interviews. As suggested by Erlingsson and Brysiewicz (2017), I kept the research aim and questions in focus by keeping a physical copy of the written research questions in view and frequently referring back to it when reading through the transcripts. Transcripts were read through several times, and I took note of recurring keywords and phrases, taking stock in the participant's views, experiences, perspectives, and knowledge in order to provide a lens into an emic view of forensic nursing. I then highlighted the text in different colours, which created a better visual representation of the information. Participant responses were thoroughly reviewed until data saturation was reached and there was no new information emerging. This text was then condensed into meaning units and sorted into six content areas in an Excel document: finding a balance, managing risk, moving forward, stigma, the setting and system of practice, and Recovery in forensic settings. I had to sort codes into narrower categories afterwards to define subthemes. These subthemes and themes were then shared with the thesis advisor for confirmation before continuing on to writing the findings.

As previously stated, the data analysis was performed using a content analysis approach to discover the themes related to a forensic nurse's perceptions and experiences with Recovery when working with NCR patients in secure settings. In Chapters 4 and 5, the themes of finding a balance, managing risk, moving forward, stigma, the setting and system of practice, and Recovery in forensic settings are explored in detail and how they relate to what is currently known about Recovery in forensic settings and how forensic nurses use Recovery-oriented practice.

Chapter 4: Findings

The purpose of using a focused ethnography was to explore how Forensic Mental Health Nurses used Recovery-oriented practice when working with the NCR population. In this chapter, the proposed research questions are revisited and a sense of working in the forensic setting was illustrated. Participants were interviewed individually, with questions related to their experiences and perspectives they had with Recovery in their practice setting.

Research Questions

As previously discussed in Chapter 1, the purpose of this research was to provide some insight into the following questions: 1. How forensic nurses reconcile Recovery within secure settings and bring it to the forefront of forensic nursing care; 2. How forensic nurses prioritize approaches that promote Recovery principles such as collaboration, power sharing, inclusion, self-determination and a focus on strengths within a secure forensic mental health context; 3. How forensic nurses manage the ambiguous task of providing care and improving the patients' health and quality of life, while at the same time, protecting the public by supervising and containing the patient; and 4. To what capacity forensic nurses embody Recovery-oriented practices for their patients.

In order to provide some understanding to these questions, I asked participants the questions in the attached questionnaire (Appendix C). In each interview, the participant was provided the Mental Health Commission's definition of Recovery, as described in Chapter 1, so that all participants understood the framework which I was referring to. Through the data from the participants' responses, I was able to glean an emic view of what it is to work as a forensic nurse and provide Recovery-oriented practice.

Participant Group

I had anticipated about 10 participants to participate in the study. The approximate number of eligible participants according to the inclusion criteria was 20, so I felt that there might be half the eligible participants who would agree to participate. Participants had either approached or emailed me when they agreed to participate in the study.

There was a total of nine participants who participated in this study, which included a mix of Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), and Licensed Practical Nurses (LPNs), who were a mix of full-time, part-time, and casual employees. The participants also had different nursing experience other than forensic nursing, with most having some extent of experience in general mental health nursing, one with geriatric nursing, and one who was also an educator. Of the group, there were six participants who were requested to participate in a second interview for an additional question (Question 14 in Appendix C), following an incident which occurred in the workplace midway through the collection period, which potentially could impact or change the participant's perceptions. Four of those participants participated in a second interview, and they were asked if the incident had influenced or changed their perspectives on Recovery.

Because of the small sample size, there was the possibility for other colleagues to be able to identify the participant with demographics such as gender, age, or years of experience; therefore, participant demographics were not collected and are not shared in this thesis to protect the participant's anonymity.

Emerging Themes

As seen in Table 1 below, emerging themes from the data included: 1. Finding a balance, with subthemes of internal processes and managing as a team; 2. Managing risk, with subthemes of how it impacts the nurse-patient relationship and how risk was managed as a systemic process; 3. Moving forward, with subthemes of how the nurses saw moving forward for their patients and the future of the NCR program; 4. Stigma, with subthemes of situational stigma, public perception, and stigma for forensic nurses; 5. The setting/system of practice, with subthemes of the physical space of the practice setting, the forensic system/NCR process, and working with colleagues/interpersonal relationships; and 6. Recovery in forensic settings, with subthemes of beliefs on Recovery, challenges, and the perception of the nurse's role. These concepts were also interconnected with one another and illustrated what it is like to work as a forensic nurse and how Recovery was seen in forensic settings.

Table 1

Themes and Subthemes of Recovery-Oriented Practice in Forensic Nursing

Themes	Subthemes
1. Finding a Balance	1. Internal Processes 2. Managing as a Team
2. Managing Risk	1. Impact on the Nurse-Patient Relationship 2. Systemic Risk Management
3. Moving Forward	1. For the Patient 2. For the NCR Program

4. Stigma	1. Situational Stigma 2. Public Perception 3. For Forensic Nurses
5. Setting/System of Practice	1. Physical Space of the Practice Setting 2. Forensic System/NCR Process 3. Colleagues and Interpersonal Relationships
6. Recovery in Forensic Settings	1. Beliefs on Recovery 2. Challenges 3. Perception of the Nurse's Role

1. Finding a Balance

Most predominant of the themes was the concept of trying to balance roles as a forensic nurse advocating for the client while also acting as a forensic professional and ensuring public safety. The sense of needing to find a balance was found both with the participants voicing a mix of complicated emotions for themselves, as well as with trying to find balance as a treatment team.

1.1 Internal Processes. In this first subtheme of finding a balance, many research participants spoke to feeling an internal struggle with finding a balance in their roles and having conflicting emotions in situations with Recovery. Words which were consistent in this subtheme related to participant's feelings such as times when they felt situations were particularly "challenging" or how they felt "conflicted." In this subtheme, participants also spoke to not always agreeing with the Recovery approach in all situations, such as how they felt about

allowing a patient more privileges while having concerns about the patient's mental health symptoms or residual symptoms being present. There was also an underlying sense of ambivalence where one might want to work with a Recovery framework, but still allow themselves to recognize their difficult or conflicting emotions and their role as a member of society. As one participant voiced, *"I may have a softer side for our patient population because I know the actual facts of what's happening, but I can also place myself in the position of being a fearful member of the public"* (Participant 3). Another participant echoed these sentiments, saying, *"There is that conflict of trying to put aside my own feelings as a parent, or community member, and then also being in the role of a nurse, or healthcare worker, and as a member of the team"* (Participant 4).

Other participants spoke to some of the principles of Recovery such as choice, self-determination, and empowerment, and how these principles were difficult to navigate in the forensic role. One participant noted, *"You want to take the person's decision-making, choice, beliefs, and background into account at all times, but sometimes the patient's behaviour is so problematic and it could perpetuate what got them into trouble, so you're in conflict"* (Participant 2). Likewise, Participant 1 noted:

> *Most of the challenge is trying to balance being compassionate and allowing for people to be self-directed or have that self-determination... It's trying to find where you draw the line and how strict you want to be. I'm trying to figure out how to balance being compassionate but also not feeding into bad behaviour which can be counterproductive or gets in the way of moving forward.*

Of note, when participants spoke about problems with the patient's "behaviour," it usually was referred to in a sense where the patient was "always getting what they wanted," having a sense of entitlement, or not following expectations of the unit and/or treatment team. Participant 9 spoke to how it was difficult to finding balance between keeping the patient invested in their own Recovery while recognizing the need for the forensic nurse to maintain control in the treatment as well. They stated:

> *There still has to be that element of control, and it completely is the opposite to the Recovery process... you want them to feel like they're the ones that are initiating their treatment in their Recovery, when we have to put those control measures in place, that's the most challenging*.

The concerns related to a patient's behaviour and the need for maintaining control significantly highlight the power differential between forensic nurses and patients, which is further explored in Chapter 5.

1.2 Managing as a Team. Another subtheme with finding a balance, was how participants discussed needing to find a balance amongst the treatment team. Participants spoke to having conflicting or opposing perspectives amongst the treatment team or nursing colleagues, which was seen as a challenge, but recognizing that it was also a positive aspect because it allowed for a more balanced approach. Instances where participants found the conflicting perspectives more difficult to manage included times when it was apparent that there were opposing beliefs with Recovery and Recovery-oriented practice. The strongest statement was when a participant stated:

> *There can be an internal conflict within our system of nursing and within nurses wanting to protect and keep folks safe, both patient and community.... that there is a struggle there with whether that patient is entitled to a Recovery-oriented approach, or whether they would be better served in the community or by a stricter adherence or more limited approach.* (Participant 3)

This statement illustrates just how extreme opinions can be with using a Recovery-oriented approach in a forensic setting when some staff question if a patient is entitled to that type of care. Other difficult situations were when the frontline nurses did not agree with decisions made by the psychiatrist, *"Occasionally patients, whatever it is that they decide, gets supported, their behaviours get supported, when we feel that maybe it shouldn't"* (Participant 7). Examples which were given by various participants included wanting to enforce a hygiene routine for the patient, a patient's choice to participate in or decline different programs, and the progression in privileges and moving into the community.

Participant 6 noted:

> *[Having conflicting opinions with colleagues] is hard because sometimes I personally get defensive about it. I do really care, and I get really invested with our patients. I think that, because I have worked with a lot of them for a long time and in different ways, sometimes I see it a different way than others do. But I am happy to share my opinion with colleagues. Sometimes it changes how they feel, and sometimes it doesn't.* (Participant 6)

However, it was also noted that participants mainly spoke positively about being able to have differing opinions, and though there might be some conflicting perspectives, participants

seemed to be comfortable with sharing their opinions freely with each other. In this sense, participants noted how it was important for the team to have a sense of balance between the patient's wishes and protection of the public. Participants also spoke to appreciating situations where other nurses and staff from other disciplines were able to lend a different lens into a situation and offer considerations which may have been overlooked.

2. Managing Risk

The second major theme involved the discussion of how participants perceived the concept of risk. The perception and management of risk was highlighted as a unique component to forensic nursing and was often seen as significant with how forensic nurses saw their role as different from nurses who worked in general mental health areas. Risk, of course, has a major impact on a patient's sense of Recovery (Felton, 2014), however, assessment and management of risk was an essential part of the forensic nurse role. Participants often commented how they felt the risk of mental health decompensation/relapse was related to the risk of reoffending. Subthemes were how managing risk affected the nurse-patient relationship and having a systematic reminder in place (the Alberta Review Board) to provide the larger picture of managing the risks with NCR patients in general.

2.1 Impact on the Nurse-Patient Relationship. In this first subtheme, participants spoke about how the management of risk affected the nurse-patient relationship. It was interesting to note that although the way risk is managed could be detrimental to a patient's Recovery, participants also spoke positively about how they tended to feel more comfortable with their patients, and perhaps this worked in favour of building rapport and strengthening the relationship. Participant 9 pointed out that there was benefits to working with the patient so that

they could recognize their early warning signs and take on the ownership of when they felt they were unsafe to manage their privileges:

> *As a nurse on the unit, we're the ones that are often suspending privileges, which, although it's not supposed to be looked at as punitive, it feels punitive to the patient and they've verbalized that. I think it can be detrimental to the relationship... it seems counterproductive to have that level of control over a patient... If they were able to make that choice [in suspending their privileges] and have that in their crisis plan, that might be more helpful towards Recovery when we're taking privileges away.*

Hence, the relationship between forensic nurse and patient was therefore predicated largely on the ability to openly communicate. As participants suggested, being able to point out the concern for safety/risk was the most impactful in maintaining a therapeutic relationship while also managing risk. This was strongly evidenced by the statements:

> *Safety supersedes everything for me. How would I manage that? I think just being honest and forthcoming with the patients as possible... just providing a different perspective, and that's all built on a trusting relationship with the client. If you have a good relationship with the client, you're able to say things sometimes that are difficult for them to hear.* (Participant 8)

> And:

> *Just communicating with the patient with what is happening. We're not trying to be punitive, but we want to make sure that everybody is safe; "let's do some planning on if*

> *you were feeling this way in the future, what would you do instead?" Again, trying to engage them in how they can manage their behaviours in the future.* (Participant 9)

I wondered if the idea of personal risk was considered in the forensic nurses' daily interactions with their patients. Most participants spoke about how their relationships with the patients also led them to sometimes forgetting or minimizing the risks of patients: *"There are times that I possibly underestimate the amount of risk that there is within the NCR population. We get—and I hate to say it—a little bit complacent"* (Participant 2); *"I understand we can get a little bit glassy-eyed because we know them in a whole different setting, and we know them on a personal level"* (Participant 7). Participant 4 also noted:

> *We are in a Recovery-based practice where we're giving them more privileges and freedoms, building rapport, and trying to have some normalcy between us... you do let your guard down and I think you have to let your guard down a bit, because you have to give them a little bit of trust... but at the same time, you do still have to be cautious.*

With participants who participated in the second interview following an adverse incident in the workplace, all but one noted that their views or feelings of Recovery and Recovery-oriented practice had not changed overall, however, it invoked a sense of vulnerability and a need to remain vigilant to risks. The remaining participant commented how they were initially worried about the patient's suitability to stay with the NCR program and how the team would be able to work with this patient to move them forward.

Participant 5 spoke to the idea of "Positive Risk Taking," where they noted the importance of allowing some risk and having the patients learn from "making mistakes." They

felt that risks could still be managed by working with the patient to identify potential situations which might be considered risky and strategize ways of how they would manage.

2.2 Systemic Risk Management. This second subtheme with managing risk was related to the greater scope of risk management, and the purpose of recognizing the role of protecting the public. The forensic nurse who works with the NCR population also works under the auspices of the Alberta Review Board, therefore it was essential for forensic nurses to talk about the role of the review board and how the Alberta Review Board managed risk. Of note, participants recognized the negative impact of subjecting one to measures of risk management, but overall, participants seemed to also appreciate that there was a governing body which considered risk: *"Some of the patients think the process of the Review Board is too slow for them... [the patients] want it and they want it now. That puts a strain in the relationship. But that part of the process is beyond us"* (Participant 5).

One participant noted: *"No matter what, risk is big and it's a scary area with managing and projecting what the risk of an individual may be. The Alberta Review Board has a very onerous job, and so no matter what, society is part of their decision-making"* (Participant 2), however, also feeling that, *"I think we could evolve a bit; maybe the Board will evolve in terms of allowing more risk"* (Participant 2). *"I think [the Alberta Review Board] is tough. They have a reputation for being tough and safety oriented"* (Participant 7). Another participant considered that it helped for an external body, rather than the treatment team, to make some of those decisions how risk was managed: *"They're supposed to be a non-partisan and objectively looking at the data, and then making a decision based on some parameters, precedence, and so forth"* (Participant 8).

Alternatively, some participants felt that the Alberta Review Board and the overall forensic system had also promoted Recovery, with one participant speaking to an example of how the Alberta Review Board allowed a patient to move to another hospital as his progress was stagnated because of many external influences, and how the Review Board considered what was in the patient's best interest in their decision. Another participant spoke to the benefit of how the forensic system allowed for more patient support:

> *The follow-up with clients in forensic settings is a lot more intense... it's a longer process, so it can help with their Recovery, and for recidivism. They're supported more in a forensic setting than if they were to go with the mental health route and then end up back in the community.* (Participant 9)

One participant stated, *"I do recognize that there is a risk, but there's risk in a lot of areas... There are a lot of dangerous people already out there who aren't a part of our system, and it's way riskier than our population"* (Participant 6). This statement provided a different perspective to the argument that Recovery in forensic settings is impossible; if Recovery is applicable in other areas where risk is also a factor, then forensic settings is no exception. This argument is consistent with the Mental Health Commission of Canada's (2015) statement, "The underlying principles and philosophy of a Recovery approach are applicable to all providers of mental health services, regardless of setting or type of mental health problem being addressed" (p. 11).

3. Moving Forward

The third major theme was on the concept of moving forward. When asked about positive experiences where the participant experienced or witnessed Recovery for their patients, many

spoke about a future-oriented situation. For participants, Recovery seemed to be synonymous with having a "normal" life and no longer being in hospital. Some participants reflected on previous NCR patients and how radically they had changed over the course of being an NCR patient; while others thought about the potential and future for their patients and for the program. Moving forward was consistent with the language of "progression," "moving into the community," and "moving to the next step." Involving the patient's family system was also noted to be a critical factor for moving forward, both for the patient and for the NCR program.

3.1 For the Patient. In the first subtheme, it was notably important for forensic nurses to be able to witness Recovery for their patients, which participants described as seeing the NCR patients progress through the NCR program/process and reintegrate back into the community. Forensic nurses were sensitive to when they felt that the patient had either stagnated in their recovery or had decompensated in their mental health. However, the impact of seeing patients progress and move on from the inpatient setting seemed to reinforce and encourage the use of Recovery-oriented practice. As one participant noted:

> *That's what I like about working with the NCR population... seeing people successfully transition to the community is so wonderful. I worked with a patient who was here for a very long time. Seeing him move forward and figure out the program, figure out what the Board wanted, figure out how to work in the community and how to move forward from here. Then watching him leave... he was so happy, and everyone was so proud of him and happy for him.* (Participant 6)

Another participant stated:

> *That was very valuable... to see people who have blossomed and they're developing their life, some of them have relationships, they are getting jobs, they're looking forward to moving out on their own. It's just so nice to see them go from being very, very sick when they come in, to the possibility of being on their own and being independent and being healthy.* (Participant 7)

Being able to appreciate some of the positive aspects of the forensic setting was important for forensic nurses, and it suggests a way to combat the sense of therapeutic nihilism which Cashin et al. (2010) described. *"One of the positives is, because it is a forensic setting, they are here for a long time and you can really build significant relationships. And to be able to see that progress in that success, it helps as a nurse to see the positives in the forensic setting"* (Participant 6).

A number of participants spoke positively about the impact family systems had for the patient's Recovery, noting the value of the outside support system, empowering families to recognize early warning signs and build the confidence to manage their new "normal." One participant spoke to how patients tend to recover faster when involving family. *"When patients have had high family influence and their families have been interested, connecting, participating actively and consistently with the patient in their progress, our patients tend to recover faster, take bigger leaps towards Recovery"* (Participant 3). Other participants recognized that sometimes the patients' families had difficulty with navigating the general mental health system before their loved one's offence which led to them becoming involved in the forensic system, but

that families also experienced a sense of relief and hope when the patient was detained and managed by a team of professionals external to the family system.

3.2 For the NCR Program. In the second subtheme of moving forward, it was very interesting to note how forensic nurses envisioned the future of the forensic program and the potential it has for Recovery-oriented practice. One participant had reflected on how mental health care practices had changed over a few decades and wondered about the potential impacts if forensic nurses had more of an open forum to educate society on what happens in the rehabilitation process.

A few participants spoke to how relatively new the NCR program was at the inpatient centre and the culture change which occurred with the induction of the program. *"I think the NCR program is relatively new... and this Recovery-oriented practice within our forensic population is newer conceptually, within our system. And so, I think that we are pioneers in this way"* (Participant 3).

Other participants spoke to needing to create an environment conducive to Recovery. Particularly Participant 7 had a lot of ideas of creating a better space, stating:

> *"If we have the tools, if we had the nice living room, if we had space where we could sit out and relax and chat... I think if we had a different setting, it would be relaxed, and it would be a much more settled environment. We have other parts of this building that we can open up, and I wish they could... this place has magical potential if you've got the money for it."* and *"[The patients] deserve better than what we're giving them and if we have to stay here, then we're just going to have to spend the money and make this place as safe as we can"* (Participant 7).

It was important to note that only two participants had mentioned using a Collaborative Problem-Solving (CPS) approach as part of their practice, despite the Addiction and Mental Health Leadership Team promoting and training mental health staff with this approach starting in 2016. Explanation of the CPS approach and how participants compared it to a Recovery-oriented approach will be discussed further in the next chapter. Aside from the CPS approach, the participants did not discuss involving other forms of approaches such as Trauma-Informed Care or using peer support groups to foster a better sense of Recovery in forensic services.

Along with the positive influence of family involvement for the patient, the participants also noted the benefits to the future of the NCR program and using the lived experience of families to develop the services to be more Recovery-oriented. Participant 8 stated, *"The general system and the forensic system both have been much more deliberate in involving families and supportive people, and peer support."* However, it was noted that other participants felt that there could be more intentional engagement with families, such as getting suggestions for helping their loved one move forward, and by providing psychoeducation for families so that they felt more confident in assisting their loved one in their Recovery. Though the forensic services have an extensive role with families, this may have been minimized, and this will be further discussed in the next chapter.

4. Stigma

The topic of stigma was most poignant in how forensic nurses defined barriers and challenges for their patients to achieve Recovery. Participants spoke about the general stigma of the patients being labelled a "forensic" patient or "NCR" and the impact it had on their situation. Public perception of NCR patients was also a large area which participants explored. Lastly, the

participants spoke about how they as forensic nurses still had to consider how they viewed their patients and always keeping the index offence in mind.

4.1 Situational. In the first subtheme with stigma, many of the participants spoke to the idea of the situation forensic patients faced with needing to navigate life with the dual stigma of having a mental illness and a forensic label. Participants noted that this dual stigma greatly limited the patient's opportunities to move forward in their lives, such as gaining employment, what programs they could attend, and housing in the community. Participants noted:

> *There's the label of being "forensic," meaning to do with the legal system, and even if you don't know the offence, it's insinuated in that, that they've done something that goes against societal norms. Even as people move beyond hospital and into the community, that stigma does follow forensic patients.* (Participant 2)

And:

> *There is less support for people that have offences or are in the forensic program. It can be with jobs, programs, and wanting them to feel safe as well—that they can transition without backlash or worrying that that stigma is following them all the time.* (Participant 4)

The idea of a patient being found NCR had an impact for the patient's Recovery when others did not appreciate the meaning of, or agreed with, an NCR finding. As one participant stated, *"People don't understand, and they feel like someone's "getting away with something." So, in terms of Recovery, that is challenging"* (Participant 8). In this sense, stigma was not only related to being part of the forensic or NCR system, but the stigma also extended to an extreme

wherein the assessment and court processes of finding a person to be NCR was controversial. The idea where others don't agree with an NCR finding certainly could have potential ramifications for one's Recovery. Unfortunately, this view is sometimes shared by some staff, which shifts the focus towards the criminal aspects of the patient's being and even suggests that they deserve to just be locked up, rather than work towards rehabilitation and Recovery.

4.2 Public Perception. With the second subtheme of stigma, participants spoke to the public perception of the patients and how this had an impact on being able to move a patient forward in their Recovery. One participant noted that even the idea of Recovery was misunderstood by the public: *"The public doesn't see [Recovery] on a continuum. It's binary; you're either well or you're not"* (Participant 8). Another participant echoed this idea, saying:

> *With someone who is very high profile or with a heinous index offense... it would be much more challenging to be Recovery-focused because there's going to be bodies and groups that are opposed to any type of Recovery. There will be people who will be looking at it from a more "correctional" view even though they're patients. There will be that perception that they shouldn't be within mental health, that they shouldn't be NCR, that they should be dealt with correctionally.* (Participant 2)

However, public perception also served as a reminder of why the NCR patient's privilege progression had to be slowed or stagnated at times, and recognizing the public perception was beneficial because; 1. It reflected on society's state of readiness for the patient to be reintegrated into the community, and 2. It reinforced the need to also protect the patient from those who may be seeking retribution.

Participants discussed the role of the media and how it also had an impact as there was a tendency to sensationalize certain cases and skew the perception of forensic patients. They noted: *"With an offence that is well known in the media, it would be even more difficult to achieve Recovery, because there are more limitations and not a lot of understanding or empathy for those patients"* (Participant 4); and, *"That fear of if he [had a relapse], what could happen... it was still so heightened and because of the media"* (Participant 6).

4.3 For Forensic Nurses. As opposed as forensic nurses might be to the stigmas of NCR patients, it was worth noting that forensic nurses were not immune to it. There was a piece of self-reflection with stigmatization, where participants talked about the need to always remember a patient's index offence and how it affected their ability to provide Recovery-oriented practice. Participants noted that the index offence had the potential to negatively impact the nurse-patient relationship. Participant 1 commented, "*I don't think that nurses can really forget why people are here or that they're here for a reason, so it affects our comfort level… It can be harder for nurses to be objective and therapeutic."*

Similarly, Participant 3 also stated:

> *We can't ignore the psychosocial impact of the offences that have been committed which can trigger the nursing staff in ways that they may or may not be aware of, and that influences our ability to have that "blanket" nursing compassion.*

The forensic nurse's perception and tolerance of risk were also impacted by dual stigma, as participants related the patient's illness to offending, and thus also the potential of reoffending. There was an underlying theme of the nurses' fears of the patient relapsing and/or reoffending, and the ramifications it might have for their licensure or reputation and for the NCR

program. They stated, *"The person in a forensic setting has had the past where their illness has led to an offence, and so, for always keeping that in mind can be good... you have to be aware of that"* (Participant 4).

And:

> *There are a lot of people who have serious mental health issues for long periods of time, who have never done a violent act in their life and probably never will. These ones, that is where their psychosis goes, and so you always have to keep that in mind.*
> (Participant 7)

However, one participant noted how forensic nurses could also overlook the impact of stigma for themselves as, *"typically with the higher severity offenders, they tend to gain insight and ensure treatment quicker, and are less likely to reoffend"* (Participant 6).

One participant talked about the impact of the overall offence and needing to consider the victims. *"Sometimes when you think of the severity of offences, naturally, your mind thinks about the victims and the victims' families, and the tragedy can never be underestimated"* (Participant 8). In this sense, empathizing and/or sympathizing with the victims and society could potentially complicate the nurse's approaches and desire to advocate in the best interests of the patient.

Forensic nurses also spoke about the stigma related to society's lack of understanding of the forensic nurse role and NCR process. They noted: *"[We need to] recognize the type of work we're doing is quite intense and we actually bury it a lot"* (Participant 2). One challenge was a sense that the forensic nurse acts as another perpetrator by being a part of the forensic system

and promoting the rights and desires of a patient. As one participant stated, *"It's a matter of the public not being caught up with the power of what we are doing and what Recovery-oriented practice can do for individuals who have offended"* (Participant 3). However, there was an overall sense that there needed to be more public awareness in all aspects with working with the NCR patient population, as Participant 4 stated, *"There's so much misinformation out there, and I'm still baffled that we don't see very much publicly about what it means to be NCR, what the program is, how people transition, the actual risk of reoffending."* Even with the explanation of the role within their social circle, one participant was still met with disbelief, stating, *"When I tell people where I work, they're shocked. They're shocked at the fact that our goal is rehabilitation, our goal is to successfully transition people back into the community"* (Participant 6).

5. Setting/System of Practice

Perhaps the best way to illustrate the challenges and limitations for Recovery and Recovery-oriented practice in forensic settings was explored in this fifth major theme: how forensic nurses described their work environment with its physical space, working under the auspices of the Alberta Review Board, and the workplace culture with the dynamics amongst colleagues. One participant summarized it simply as, *"There are things that I find disappointing that we can't do, or the structure and culture here are not as good as they could be. I understand that this is a maximum-security facility and there's all kinds of things, many things that people can't change"* (Participant 8).

5.1 Physical Space of the Practice Setting. In this subtheme, many of the participants envisioned an ideal situation with a separate unit for the NCR population. The need to change the

environment to make it less correctional, and more like a home setting, was a recurrent theme which participants felt was necessary to be able to provide Recovery-oriented interventions.

Most participants agreed that there was a need for the security measures and structure of the building, however, that this was not conducive to a sense of Recovery. One participant noted:

> *Sometimes it's the physical environments of forensic nursing spaces; they can be very different than non-forensic nursing environments, like the fact that we have really high and sometimes glassed-off nursing stations, or the ability to lock doors and we have the ability to physically restrain people through locking doors, and psychiatric chemical- and physical-restraints.* (Participant 3)

Other participants voiced similar statements such as, *"It's important to put aside the correctional aspect of it, even though it can be quite hard because of the setting that we're in, which is correctional-like. It's complicated because there is a need for that to some degree"* (Participant 4), and, *"It's tough because it's a locked building, there's security, there's locked doors everywhere. There are a ton of rules that we have here that you don't see at a hospital"* (Participant 6).

5.2 Forensic System/NCR Process. In this subtheme, the larger system wherein the forensic nurse works was explored. Although the Alberta Review Board was noted as the mainstay of managing risk, the participants acknowledged that it also made it challenging to promote Recovery within the forensic system. As one participant stated, *"The Alberta Review Board, for our clients in particular, is seen as an entity that doesn't necessarily include Recovery in their dialogue and in their decision making"* (Participant 2).

> *We're looking at such a huge system here; Forensics is not one system. There's the jail piece, there's the mental health piece, there's families, there's individuals, there's all the different disciplines, there's culture, there's where we are. It's challenging to really have any sense of autonomy and ability for our clients to have meaningful existence within these systems.* (Participant 2)

As the forensic nurse works under the auspices of (and ultimately reports to) a provincial review board, the idea of Recovery-oriented practice could be viewed as a directive from the review board to get the patient to progress through the NCR process. However, participants also noted that there was a sense of scrutiny for the forensic nurse's role, with participants stating:

> *Our ability to provide Recovery services is determined by the Alberta Review Board. It's like everything we're doing is working to prove to the Review Board that this person is entitled to, or deserves, the next level of their own well-being and autonomy to be returned to them.* (Participant 3)

And:

> *The Alberta Review Board is kind of negative, not because of them, but it just feels like we are always worrying, 'what's the Board going to think? What's the Board going to do? What's the Board going to give you?' They are kind of the be-all, end-all, and can feel like the judge of everything that people do all year.* (Participant 6)

Interestingly, both of the above statements allude to how the forensic nurse can feel a greater sense of responsibility to the Alberta Review Board and the need to justify or explain decisions made in their nursing practice.

5.3 Colleagues and Interpersonal Relationships. In this subtheme, participants spoke to the overall workplace culture and how relationships between nursing staff and other disciplines, as well as between the nursing staff, had an impact on how forensic nurses were able to practice. One important feature the participants voiced needing for the practice setting was having unit-dedicated staff (rather than cross-trained or having staff pulled to another unit) who would promote Recovery. Although I had previously mentioned positive aspects to conflicting or opposing perspectives, it seems that participants spoke differently when the opposing perspective of Recovery was negative. Lindqvist and Skipworth (2000) commented that much like how patients see their involuntary commitment to hospital as a punishment, some professionals shared the same view—this concept had impacts on how forensic nurses were able to provide Recovery-oriented practice. As one participant stressed:

> *People's own professional and personal judgements, feelings or theories, can make it a difficult environment. To somebody who wants to play a role in their Recovery... it can feel negative like there's no support there, and that there's not understanding. Sometimes you can feel like you're one of the few of the ones who are interested in their Recovery.* (Participant 4)

However, despite the collective voice or sense of the culture, the participant also noted that individual nurses could have a positive impact for other nurses to see: *"Some nurses who have the understanding use Recovery processes in a very positive way to help the patient recover. It depends on where they're coming from and they do affect the process, either positively or negatively"* (Participant 5).

6. Recovery in Forensic Settings

Participants shared their perspectives and beliefs about Recovery and how they understood it in their practice. Most of the participants spoke positively about Recovery; albeit also noting that there were still challenges and inherent issues with promoting and utilizing Recovery-oriented practice in forensic settings.

6.1 Beliefs on Recovery. In this subtheme, participants talked about how they perceived Recovery in forensic settings, and why they felt it was important to the forensic nursing culture. Most participants spoke to how Recovery was an intrinsic tenet of the rehabilitation process and getting the patients to be at the optimal level of functioning in the community. Participants said:

> *I don't think you can have a successful program in forensics where you're working to transition people back into the community, unless it is Recovery focused. The patient needs to have a choice and believe in what they're doing. If they're just told what to do, they get into the community and are not able to manage as a unique individual.* (Participant 2)

And:

> *Patients being in forensics shouldn't be an obstacle for us to practice a Recovery-oriented type of care... the principles still apply, wherever you are. Clinicians need to understand what the Recovery process is about, understand the concepts, and they need to subscribe to it.* (Participant 5)

Others focused on the purpose of rehabilitation as a part of Recovery: *"Recovery is so important in forensics, and everyone is capable of recovering, of living with mental illness, and*

of having a great, successful life in the community" (Participant 6); *"The NCR program is a perfect program for [Recovery] because we have the intention of taking people who are ill and making them as well as they can be and reintegrating them back into the population and community"* (Participant 7).

One participant spoke to how working with Recovery encompassed other features, much like with Offender Recovery, such as dealing with trauma, stating, *"Particularly in forensics, it's not just recovery from the illness and illness symptoms. In my mind, it's recovery from the multi-layered trauma of whatever the offence was"* (Participant 8). They also stated:

> *The psychological circumstance of the offence... the victims of the offence, their families and friends around that. It makes it much more challenging and far more poignant to utilize something like a Recovery model and to engage as much as you can with outsiders to help along.*

6.2 Challenges. In this subtheme, participants noted what they saw as challenges to having Recovery in forensic settings, and as noted in the literature review, there were multiple levels which potentially impacted the ability to provide Recovery-oriented practices (personal, interpersonal, institutional, systematic). On a personal level, one participant noted:

> *It feels unnatural to a lot of people who work in forensics. For example, letting patients have more privileges seems counterintuitive when you work in a forensic setting... you want to rehabilitate them, but there's also more of a punitive approach. Having privileges and passes would be beneficial to the Recovery process, but this can be counterproductive to those in jail where people may feel they are being rewarded for bad behaviour, rather than seeing it as moving forward.* (Participant 1)

Some other personal challenges included statements such as,

> *It's a lot of work... it's really easy to say, 'Here are the rules, this is how we do things, and you're going to do it my way,' where there's not so much thinking involved, not a lot of give-and-take; it's not dynamic. The Recovery model isn't easy, it's not for the faint-of-heart. When you're not really comfortable or knowledgeable about the Recovery model, you have a tendency to put your own views like what you think the patient needs.* (Participant 2)

On an interpersonal and at times, institutional level, challenges were related to having differing opinions and approaches to providing care. As one participant stated, *"We've got a treatment unit and an assessment unit; and even though we supposedly have one philosophy, we've kind of created two unwritten philosophies that are different and in tension with one another"* (Participant 2). Another participant voiced similar challenges:

> *The greatest challenge is that, if I don't have the concept [of Recovery], you don't expect me to work with those tools. If clinicians don't know, we will continue to use a patriarchal-type of care or the old medical model, because that's what we know and that's what we use in our practice.* (Participant 5)

Participant 8 spoke to the pragmatic duties of a forensic nurse and how it was a challenge when the role was very task-oriented: *"There are time factors, cultural factors within this particular facility, and other competing things for the nurse's attention during a single shift," and, "In this setting, we end up assessing, treating, giving meds, ensuring they take their meds... there's not a lot of opportunities structurally to do other things."*

6.3 Perception of the Nurses' Role. In this subtheme, Recovery was not seen as an all-or-nothing approach, as one participant spoke to being able to incorporate it in care planning with any patient, such as having a patient in seclusion wanting walks in the hall and being able to collaborate with the patient to try and reach that goal. Hence, this subtheme includes the data with what participants felt were crucial for the forensic nurse to do to promote Recovery and overcome challenges at a personal level, an interpersonal level, an institutional level, and a systematic level.

As an example of a personal task for forensic nurses, one participant stated, *"You have to be comfortable with dilemmas, ethical diversity, and being able to have your own set of morals and principles but also open to something that is very different"* (Participant 2). In this exploration of one's perspective and values, it was noted that the forensic nurse needed to additionally explore their role for Recovery, as participants stated:

> *The forensic nurse needs to do some exploration about what Recovery model is and verbalize that it's a priority. There needs to be a framework and a philosophy where everybody is saying, "Yes, this is what we're doing."* (Participant 2)

And:

> *I believe that forensic nurses have an impact on the Recovery process. For example, when I am doing a care plan with a patient, I really want to know what matters to them, and I incorporate that into my care plan.* (Participant 5)

The bottom line of the role of the forensic nurse with providing Recovery-oriented practice was to find ways to support their patients in achieving and maintaining their sense of Recovery. As one participant challenged*:*

> *Forensic nurses are responsible and have a responsibility to be creative in finding new ways to assist their patients in achieving that recovered sense of well-being, their new normal, or ways for them to contribute and find well-being within their new framework.* (Participant 3)

Overall, these findings paint a picture of an insider's perspective of the forensic nursing culture. The forensic nurses' attitudes, perspectives, and experiences of Recovery and Recovery-oriented practice provide an understanding of some of the hopes, challenges, and ways that Recovery currently exists in their practice. As explored further in Chapter 5, these themes were consistent with the literature suggesting how challenging it is to work as a forensic nurse. Participants, however, strongly believed that no matter how difficult it may be to work in a maximum-secure setting, Recovery remained a fundamental framework of how they directed their practice.

Chapter 5: Discussion

This chapter provides a critical review of this study through a discussion of using a focused ethnography as a research methodology, the contextual background of the research period, and the study's strengths and limitations. The second portion of this chapter focuses on the interpretation of the findings from Chapter 4's themes and subthemes, and key findings from this research are offered by comparing what is currently known in the literature. Lastly, implications for practice and administration are discussed, and recommendations for future research are offered.

Using a Focused Ethnography as a Research Methodology

As noted in Chapter 3, the three main purposes of focused ethnographies for nursing research are to: discover how people from various cultures integrate health beliefs and practices into their lives; understand the meaning that members of a subculture or group assign to their experiences; and study the practice of nursing as a cultural phenomenon (cited in Roper & Shapira, 2000). The use of a focused ethnography for this study was appropriate, as it allowed for the exploration of how Recovery was practiced and influenced by the beliefs, values, and experiences of forensic nursing culture.

Furthermore, a focused ethnography was useful in gaining insights into the complexity of Recovery and Recovery-oriented practice in forensic settings, and how the role and culture of forensic nurses can still support this approach for their patients. Murphy et al. (2014) suggested that ethnography as a research approach is very useful to understand the complexity of nursing work; this was meaningful when exploring what impacts forensic nurses and how they are able to incorporate Recovery-oriented practice into their practice.

One limitation of this research methodology was the limited scope of the study. Though it was of value to emphasize on one specific issue, situation, or "problem within a specific context amount and small group of people" living in a bigger society, as Roper & Shapira (2000) discussed; it is recognized that this study focused on the experiences of Recovery and Recovery-oriented practice with forensic nurses who work with Not Criminally Responsible (NCR) patients. Therefore, the findings of this study are difficult to compare to the experiences of other forensic nurses, or to any other area of nursing.

Contextual Background for this Study

As I reflected and journaled after each interview and after NCR program-related meetings, it became apparent that the period of research was done in a tumultuous time both in the NCR program at the inpatient forensic centre, as well as in Alberta and across Canada. There were events which occurred during the window of data collection which had potential impacts on the perspectives and feelings with Recovery, such as media scrutiny over a high-profile Canadian case, having new members serving on the Alberta Review Board, and an adverse event in the workplace where a psychiatrist was assaulted by a patient.

I took the opportunity to have regular debriefings with my thesis advisor during the data collection period, which allowed for exploration of the research aims and how to capture enriching data which otherwise may have been overlooked.

Study Strengths and Limitations

With the significant events during the time of research, the study's dependability was considered, which Bengtsson (2016) defines as "the extent to which the data change over time

and the alterations made in the researcher's decisions during the analyzing procedure" (p. 13). Certainly, there were benefits to having done the study in the chosen time frame, given that it allowed for more discussion on Recovery in forensic nursing practice, however, it also showed that there were a lot of external influences which impacted the research process.

One advantage that the research had was the opportunity to complete second interviews with some participants when an adverse event occurred where a patient assaulted a psychiatrist. This allowed for further exploration on how perspectives of Recovery could be affected depending on the priority of risk management and wanting to protect members of the culture.

It was recognized that while the study participants supported Recovery in their practice, they noted that there was often a conflict of philosophies with nurse colleagues at the same centre, where Recovery values and practices were not shared. Though participants spoke about the conflict of philosophies which existed, they did not share the other viewpoints of how other forensic nurses may be opposed to the idea of Recovery in forensic settings, and even opposed to the idea of privileges and freedoms for NCR patients. Certainly, being able to interview forensic nurses who had more assessment or correctional backgrounds would have an impact on the results of the study. The sample size of participants was small and therefore, results may be difficult to generalize to the forensic nursing culture.

Bengtsson (2016) noted in qualitative studies, it can be impossible and difficult to replicate the data because of the specific context of the research. This study was focused on the perspectives of Recovery with forensic nurses who worked with NCR patients in one selected inpatient setting in Alberta. Potentially, there could be similar results from another inpatient setting in an NCR program; however, it could be argued that the differences in the NCR program

experience, programming, and the number of patients could all have an impact on if the data if this study was replicated at the Edmonton site. Patton (2002) and Rolfe (2006) noted that in qualitative studies, "the researchers are more interested in depth understanding of a specific issue and in showing different perspectives rather than aiming at singular truth and generalization" (as cited in Bengtsson, 2016, p. 13).

Interpretation of the Findings

The findings of this study were consistent with the literature related to forensic nursing stress, risk management, and caring in forensic settings, as discussed in Chapter 2. Though the literature does not directly speak to Recovery in forensic settings, it addresses factors that influence the ability to provide Recovery-oriented practice in forensic settings. As discussed below, each theme and subtheme from the previous chapter are compared to what is in the current literature.

1. Finding a Balance

The sense of needing to find a balance was similar to the concept of Dual Agency (Candilis & Neal, 2014; Day & Casey, 2009; Ward, 2013), where forensic nurses had to face the dilemma of conflicting expectations or responsibilities between the therapeutic relationship on one hand and the interests of third parties on the other; as well as the broader dual relationship problem of the conflict between the two sets of professional norms: those concerned with community protection versus the norms related to offender/defendant wellbeing. As pointed out by Burnard (1992), the forensic psychiatric role must take on various "opposing" functions and as such to "consider illness, crime, morality, treatment, containment, and possibly punishment" (p. 139). This was also echoed by Hörberg (2015), where forensic nurses have the ambiguous

task of both providing care to improve the patients' health and quality of life, and to guard and contain the patient.

1.1 Internal Processes. It was apparent in the findings that many nurses felt an internal struggle with their feelings because of the conflicting responsibilities and trying to strike a balance in their roles. This subtheme was consistent with the literature as noted by Mann et al. (2014) discussing the feelings felt by professionals working with the forensic population, including feelings of anxiety, disempowerment, and demoralization, which were based on disagreements with Recovery principles such as adopting an individualistic approach, power sharing, and prioritizing hope and social inclusion. The feelings of anxiety, disempowerment, and demoralization could be related to a number of themes which the participants discussed including how they managed with their own trauma and fears (point 4.3), working with a difficult and complex population, and how they felt limited power within the forensic system (point 5.2).

1.2 Managing as a Team. Being able to find balance as a team was another important aspect which was explored by the participants as a means of how forensic nurses can cope with Dual Agency. By being able to voice various perspectives and discuss the course of action, there can be a better sense of balance between the opposing tasks of advocating for the patient and considering the safety of the public. Managing as a team was most akin to using a moral acquaintances perspective, as suggested by Ward (2013), as a way to reconcile the ethical dilemmas or conflicts in the forensic and correctional domains. The moral acquaintances perspective is based on looking for common/overlapping moral beliefs on an issue. This is

valuable when considering the differing values and approaches of forensic nurses and determining how Recovery can fit in a forensic setting.

However, participants did note that forensic nursing was a difficult area to work in, especially for new graduates or inexperienced nurses, which was consistent with Harris et al. (2015) in discussing how nurses who were new to the forensic specialty often felt unsupported and frustrated with their lack of power in confronting the system within the culture and leadership at the institution. This finding suggests that forensic nurses may be seen as unapproachable, inflexible, and unsupportive, which as Harris et al. (2015) explained, nurses may feel that they cannot speak their perspectives for fear that they would be rejected by the culture. Furthermore, this finding exposes the potential deficits in the working relationships amongst the NCR team, between the treatment team and direct-care nurses, between forensic nurses and other disciplines, as well as between other nursing colleagues, which will be further discussed in point 5.3.

2. Managing Risk

One consistent theme in the literature regarding the role of forensic nurses was the need to consider and manage risk. Olsson and Porskrog Kristiansen (2017) noted that risk assessment was a crucial component to forensic nursing; otherwise, forensic work can be seen as unnecessary or illegitimate. This was consistent with Drennan and Wooldridge's (2014) statement, "The management of risk is... fundamental to the success or failure of a forensic service aiming to support Recovery" (p. 12). As noted in the literature, the concepts of Recovery and risk assessment/management are at odds with each other, with both arguments that Recovery is seen as "opening up the possibility for risk management failures" (McKeown et al., 2016,

p. 238), and Roychowdhury (2011) stating that "a focus on risk can be seen as anti-Recovery" (p. 69).

All of the participants in this study agreed that their work involved risk management to some scale, whether it be in an interaction where they did not allow a patient to do something risky, to the overall reminder of the purpose of protecting the public. None of the participants felt that Recovery meant that they only had to act with the patients' desires in mind, and they recognized that there was a continuum which they fell in between the roles of advocating for the patient and doing so in a safe manner. Being able to hold space for both roles was an interesting perspective, given how much of the literature focused on a strict dichotomy between Recovery and risk management in forensic settings, and how forensic nurses aimed towards the latter at the expense of Recovery (Hinsby & Baker, 2004; Livingston et al., 2012; Mann et al., 2014). Mann et al. (2014) suggested that restrictive practices may become the dominant model because of professionals feeling anxiety related to their duty of public protection and the consequences if an incident occurs such as media coverage, public opinion, internal enquiries and damaged reputations. Likewise, Coffey (2000) cited one major source of stress for forensic mental health professionals: being held responsible for offending behaviour and the risk or threats of violence from the patient.

2.1 Impact on the Nurse-Patient Relationship. Holmes (2005) discussed the complex nature of nurses caring for and exerting control over psychiatric inmates. For forensic nurses to manage risk related to a patient's behaviour and maintain control significantly highlights the power differential between staff and patients. Though concerns of having to treat the patient against their will or suspending privileges/passes due to behavioural concerns would certainly

resonate with other areas of psychiatry, participants seemed to feel a heightened sense of responsibility for potential consequences, both for the nurse-patient relationship and for safety in the community.

It is noted that forensic patients feel that the therapeutic relationship with staff underscores a sense of Recovery (Barnao et al., 2015; Bressington et al., 2011; Marshall & Adams, 2018; Rask & Brunt, 2007; Schafer & Peternelj-Taylor, 2003; Slade et al., 2014), and the participants recognized that implementing restrictive practices impacted this relationship. However, participants felt that risk management did not necessarily have to be a negative experience for the patient and that the forensic nurse's role also encompassed ensuring safety for the patient. Participants noted that the concept of risk also required a consideration for the patient to be the one at risk and needing protection, which often clashes with the perception that forensic patients are always perpetrators rather than as a vulnerable population. As Adshead noted, "Despite acts of violence, many of the individuals in forensic mental health settings are also among the most vulnerable individuals in society," (as cited in Drennan & Wooldridge, 2014), which is due to the public also seeking retribution against the patient (Mann et al., 2014).

One participant spoke to the idea of empowering the patient by educating them on recognizing their warning signs of relapse and how they could take on the ownership of risk by informing the staff when their privileges should be suspended. Roychowdhury (2011) adds to this suggestion by discussing the service user's own perception of their risk to self and others which adheres to the Recovery value of recognizing the patient as "experts by experience." Mann et al. (2014) further added that lack of transparency with risk management causes issues as it limits the patient in the "knowledge or awareness of the factors that are keeping them in

hospital and what they may need to do to progress," which encourages passivity and a lack of responsibility with the patient. Hence, it was valuable for the participants to discuss the importance of communicating concerns and explaining the reasoning behind restrictive practices to maintain a more balanced relationship between the nurse and patient.

While the literature on Recovery supports the need for developing a positive self-identity (Aga et al., 2017; Drennan & Alred, 2012; MHCC, 2015; Youssef et al., 2016), one aspect which the participants did not discuss was how the way risk is managed impacts a patient's risk identity. In other words, if a patient is subjected to risk management strategies focused on containing the patient, it reinforces the message to the patient that they are dangerous. It makes it impossible for a patient to view themselves in a positive light when they are constantly viewed by others as a risk. Mezey et al. (2010) found that a forensic patient's positive self-identity included not committing further crimes and *no longer being seen as a risk* (italics added for emphasis).

2.2 Systemic Risk Management. Participants made statements alluding to how the forensic nurse can feel a greater sense of responsibility to the Alberta Review Board and the need to justify or explain decisions made in their nursing practice. The idea that the Alberta Review Board is seen as an adversarial body to Recovery was interesting, given that the very purpose of a review board is to provide privileges and freedoms which are the least restrictive and least onerous, "taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused" (Criminal Code, s. 672.54). The idea that the Alberta Review Board was seen as adversarial may have been attributed to concerns related to a shift in Alberta Review Board

members (see contextual background for this study) to a more conservative perspective, which is noted already to be more conservative than other provinces. Crocker (2009) noted that "the degree of systematization of the assessment and management of risk of violence, central to NCR-MD dispositions, can vary significantly from region to region and province to province," (cited in Crocker et al., 2010) which impact the trajectories of people found NCR, including time detained in hospital and time under the supervision of a Review Board (Crocker et al., 2015). Luettgen et al. (1998) noted in their study that Alberta had one of the lowest reoffending rates and one of the highest readmission rates reported, which was largely contributed to the Alberta Review Board recalling patients back to hospital when the patient had relapsed in their illness or substance abuse.

Moreover, this unspoken tension between the forensic nurse and Alberta Review Board contrasts to the evidence that review board decisions are highly correlated with the clinicians' opinions (Côté et al., 2012; Hilton et al., 2016). So, the statements that a patient's ability to achieve Recovery is determined or limited by the review board suggests that there is a greater sense of disempowerment experienced by forensic nurses within the forensic system. The participant's responses could be attributed to their opinions of the patient's risk and ramifications to accessing care, such as how Crocker et al. (2010) noted, "the ability to accurately assess violence risk has important repercussions on mental health policies, legislation, rights and liberties of accused individuals, the types of services and treatment provided, as well as social integration and public safety" (p. 50). Côté et al. (2012) noted that clinicians' opinions were "more likely to be influenced by a patient's insight into their illness and medication compliance" (p. 242), which is significant as Roychowdhury (2011) argues that "insight," "attitudes," and

"responsiveness to treatment" are difficult to define and are based on the view of the professional.

3. Moving Forward

For participants, Recovery seemed to be synonymous with having a "normal" life and no longer being in hospital. Moving forward was consistent with the participants' language of "progression," "moving into the community," and "moving to the next step," which aligned with the literature stating forensic service users described moving on from the hospital and living a meaningful life as a significant Recovery aspect of hope (Skinner et al. 2014).

Family involvement was noted by the participants as a key component to assist the patient along their Recovery journey, both by providing hope for healing and rebuilding relationships within the family systems, and by empowering families to support their loved ones. The literature was consistent in discussing the value of family involvement as a part of Recovery as it facilitates a sense of connectedness and social inclusion (Aga et al., 2017; McKeown et al., 2016; Mezey et al., 2010; Olsson et al., 2014; Rask & Brunt, 2007), however, it was also recognized that forensic patients often had disrupted relationship attachments from their childhoods and personal histories filled with inconsistencies and unpredictability (Drennan & Wooldridge, 2014; Lindqvist & Skipworth, 2000; Mann et al., 2014) which could pose a challenge of engaging families in the patient's care.

3.1 For the Patient. The examples participants gave for a situation where they witnessed or experienced Recovery which was positive, described cases where an NCR patient went from being very debilitated by their illness and offence, to a point where they were able to function in the community and ultimately be discharged from the Alberta Review Board. However, one

element which the participants did not talk about was the impact of how discharge from hospital or discharge off the review board could be destabilizing and set back Recovery (Mezey et al., 2010). One potential reason for lack of discussion in this area may be due to forensic nurses assuming that the patient's end goal is to be discharged and not being subjected to control by the forensic system, whereas Lindqvist and Skipworth (2000) noted the importance to include "the patient's preparations and perceptions of post-discharge life with the ultimate goal of forming a realistic, productive, and hopeful future" (p. 322).

Mezey et al. (2010) noted that forensic patients reported important indicators for Recovery as symptom reduction, feeling better about oneself as a person, being accepted by and making a useful contribution to the community, getting work or education, finding a home, settling down with a partner, not re-offending, and simply being able to lead an ordinary life. However, only a couple of participants spoke about a patient's wishes or goals of getting a job, being in a relationship, and living independently, which suggests that the forensic nursing culture still puts more emphasis on the perspective of the forensic system and not of the patient.

It was noted that although hope for the patient's future was positive, there could also be a mix of emotions. Though participants did not directly speak to the termination of relationships with their patients, one participant spoke about other forensic nursing colleagues who worked in the community, and that when patients had been discharged off the Alberta Review Board, there was a sense of grief. Whether it be because of the significant time that the nurse put into building a relationship, or the change in the dynamic where the patient chooses not to follow through with regular outpatient care when no longer mandated to, grief seems to be an important emotion to recognize for forensic nurses. The literature stresses the need for developing high quality,

trusting, therapeutic relationships to promote Recovery (Barnao et al., 2015; Bressington et al., 2011; Drennan & Wooldridge, 2014; McKeown et al., 2016; Schafer & Peternelj-Taylor, 2003) however, it does not offer any suggestions as to how forensic nurses can cope when the patient's Recovery journey continues without the support of the forensic system. The idea where the patient may see the forensic nurse as agents of the Review Board could potentially impact the identity of the forensic nurse, which is discussed with implications for practice.

3.2 For the NCR Program. Collaborative Problem-Solving (CPS) is an evidence-based and trauma-informed approach which was discussed by participants as an approach which they incorporated into their practice (Think:Kids, n.d.). CPS was not directly compared with Recovery-oriented practice; however, participants used this as an example when advocating similar principles with providing choice, making care plans which were individualized, and finding out what was most important for the patient. Though there is not current literature discussing the use of CPS in forensic services, it was noted that the participants appreciated that the CPS models had specific worksheets to guide their practice, which suggests that a Recovery approach may feel more abstract and intangible—this will be further discussed under the key findings of this study. Participants pointed out that they felt resistance from other nursing colleagues to using a CPS approach with patients and suggested that the forensic atmosphere was still dominated by a custodial/correctional approach.

As previously noted, aside from the CPS approach, the participants did not discuss involving other forms of approaches such as Trauma-Informed Care, Good Lives Model, or using peer support groups to foster a better sense of Recovery in forensic services. It could have been because this research was focused from a point of Recovery and Recovery-oriented practice

as the approach that participants felt they could only speak to that. It would be worth exploring participants' perspectives of other approaches which they felt were more appropriate or more applicable to the forensic setting.

Participants recognized family involvement as being paramount in forensic settings, though not all of the participants were aware of what programming was offered to families of NCR patients such as family therapy sessions, family psychoeducation, and being included in developing a relapse prevention plan with the patient. This finding suggested that there may need to be further education and involvement of direct-care nurses in more of a therapeutic role with the patients, rather than focusing on daily practical tasks and routines which Cashin et al. (2010) discusses as a part of forensic nursing culture.

4. Stigma

Though the concept of stigma was not explicitly explored in the literature, it was noted that forensic patients identified elements of their self-esteem and self-image as obstructions to Recovery, such as how they were treated by staff, their judicial status or label, and their social desirability (Aga et al., 2017). As noted by the Mental Health Commission of Canada (2015), stigma and discrimination "negatively impact almost every area of their lives and can frequently be more harmful than the illness itself" (p. 40), and therefore requires healthcare systems to address and challenge stigmas to promote social inclusion and support Recovery.

Drennan and Wooldridge (2014) stated that challenges in applying Recovery in forensic settings involves the idea of how the forensic patient differs from other people, which is significant when forensic nurses try to address stigma, while at the same time they end up reinforcing that there is a difference that comes with the forensic label. The findings of this study

suggest that forensic nurses can also stigmatize their patients based on the index offence, which is consistent with current literature (discussed in point 4.3). However, one participant recognized, *"typically with the higher severity offenders, they tend to gain insight and ensure treatment quicker, and are less likely to reoffend"* (Participant 6), which is similar to Bonta in stating that the index severity is not associated with risk for violent recidivism (cited in Wilson et al., 2015). However, inclusion of the severity of the index offence in assessing risk is related to how review boards need to take into account the "balance between public safety and the individual rights and freedoms of accused mentally ill individuals" (Crocker et al., 2014) and how the public perceives and responds to high profile cases.

4.1 Situational. Participants frequently pointed out the stigma which forensic patients face and how this was one of the greatest barriers to Recovery. The participants acknowledged that their patients face dual stigmas with both mental health and with involvement in the justice system, which is consistent with Drennan and Wooldridge (2014), and Marshall and Adams (2018) in describing dual stigma for the forensic patient population.

Participants found it difficult to suggest a way to mitigate the dual stigma, other than potentially having a more public forum to talk about how forensic/NCR patients are managed. Significant work needs to be done with community agencies to ensure that they have more understanding of the NCR program and the supports which are in place for the patients. Crocker et al. (2010) described it best by commenting on "the increasing pressure on non-forensic mental health organizations to provide services to this population, without all the necessary expertise in assessing and managing risk for violence and reoffending" (p. 52) which needs to be considered when trying to get NCR patients the appropriate treatment and resources.

As an example of mitigating stigma with community resources, currently there are extensive efforts put forward by the NCR team to liaise with community housing agencies to develop a good working partnership and trust. In other words, even if the team cannot change the stigma associated with the index offence, there still can be work done to change the perspective of the situation.

4.2 Public Perception. Mann et al. (2014) noted that restrictive practices at the expense of Recovery may become the dominant model because of professionals feeling anxiety related to their duty of public protection and the consequences if an incident occurs such as media coverage, public opinion, internal enquiries, and damaged reputations. This anxiety can translate to how forensic nurses ultimately feel protective of their practice.

As participants had pointed out, the media played a large role into fueling stigma and fears. Alternatively, there have been positive stories and radio segments (such as the CBC Radio Calgary Eyeopener podcast, October 3, 2019) which are also available to the public and can generate good discussion about the NCR finding and how a patient works towards Recovery. Despite the positive stories or education which is put forth, it does not guarantee that this changes how the public may feel.

It was important to note that there is more of an impact in addressing public stigma when forensic services engage the primary or secondary victims of the index offence (the victim or the family of the victim) which then in turn takes care of the tertiary victims (the public) (S. Santana, personal communication, October 12, 2018). This statement is supported by the concept of Restorative Justice (Cook et al., 2015) which is “an approach to justice which strives to repair harm to all parties affected by an offense or wrongdoing” (p. 510) including the victim, offender,

and those in the community. Hence, it would be worth arguing that addressing stigma through a Recovery orientation would include care for all those involved in an offence.

4.3 For Forensic Nurses. Harris et al. (2015) noted that clinicians often expressed conflict when working with a forensic patient who they perceived as unwilling to work towards their release and the conflict with being caring and compassionate towards someone who committed a crime they found so abhorrent. This theme was also noted by Rose et al. (2011) stating that "nurses can morally struggle with respecting patients who have committed heinous offences, which can lead to the patient being depersonalized and dehumanized" (p. 3). Jacob et al. (2009) discussed forensic nurses' feelings of fear and abjection toward people receiving forensic mental health services, which may encourage the use of restrictive interventions in a forensic setting. The fear and feelings of abjection which Livingston et al. (2012) described was reflected in the participants' thoughts that forensic nurses had to keep the index offence in mind or that some index offences were more difficult to work with. Furthermore, Harris et al. (2015) argued that forensic nurses face ongoing exposure to overt aggression and vicarious aggression which causes trauma and fear, and that these emotions negatively influence nurses' capacity to respond therapeutically, which echoes the sentiment where forensic nurses need to take control to manage risk/perceived risk.

This suggests an underlying fear of the patient and what could happen should the patient relapse. Drennan and Wooldridge (2014) commented that because of the link between illness and offending behaviour, supporting a service user to achieve a positive sense of self, a sense of purpose, and hopefulness about the future was a much more difficult task in forensic settings.

Furthermore, it is noted that forensic nurses also fail to recognize the fact that a patient is always reminded of their index offence. Adshead et al. (2015) discussed how an offence has "an impact on an offender's identity; both with the way he thinks about himself, now and in the future," further adding that an index offence of homicide "had a huge impact on one's previous identity and the experience and perception of everyday reality" (p. 75), such as how they have "become a murderer" and how people act differently around them because of their index offence.

5. Setting/System of Practice

The findings that the overall physical environment/atmosphere and negative relationships and interactions impedes Recovery corresponds to the work of Mezey et al.'s (2010). Though the participants did not express as much concern with the physical environment limiting their ability to provide Recovery-oriented practice, the overall workplace culture and interactions with colleagues was noted to have the most negative impact.

5.1 Physical Space of the Practice Setting. As the participants all noted and described, the physical space was not seen as friendly and remained very jail-like despite efforts to make it more "homey," which showed an appreciation of how Recovery is impacted by the way patients perceive the homeliness of their environment (Marshall & Adams, 2018). However, participants felt that the environment did not affect their ability to provide Recovery-oriented practice, similarly how the literature finds Recovery was still present in forensic settings despite the environment (Hörberg et al., 2012; Livingston et al., 2013; Rask & Brunt, 2007; Skinner et al., 2014). More importantly, participants even noted benefits to having a patient being admitted in an inpatient forensic centre, such as being able to provide much needed monitoring and support for mentally unwell patients. Mezey et al. (2010) similarly noted how the majority of

the patients in their study felt that detention in a secure unit was helpful and even necessary for Recovery.

Participants identified the impact that the structure and routines of the unit had on Recovery, which was consistent with the lack of control experienced by forensic patients in being able to make simple decisions about their day (Barnao et al., 2015; Turton et al., 2011). Kitchiner (1999) also discussed how patients often perceive nursing interventions such as the use of privilege systems, seclusion and restraint, and medication as humiliating, punishment or forced containment.

The participants did not discuss the camera system (Closed-Circuit Television or CCTV) of the environment and how it may impact their practice. This might have been because the participants were acclimatized to this aspect of the setting. Holmes (2001) discussed the idea of panopticism, which refers to the ability to maintain surveillance through audiovisual equipment such as cameras and microphones, while at the same time preventing those being observed to see who is watching. This aspect of the forensic setting has negative impacts on Recovery with patients feeling observed, disciplined, and objectified by surveillance devices, and perceiving their daily lives violated under the guise of care (Holmes, 2001). Holmes (2005) noted that there are parallels between inmates' living conditions and nurses' working conditions, with nurses also being subjected to the observation by other staff and being exposed to scrutiny of colleagues (see point 5.3), which also forced them to conform to prison norms.

5.2 Forensic System/NCR Process. As previously discussed under point 2.2 (Systemic Risk Management), participants felt that the Alberta Review Board was an adversarial body who they had to report to. However, there was also a paradoxical effect as well, with the potential for

nurses to see themselves as part of "the system," and therefore reinforces the power differences between forensic nurses and patients which pose as an obstacle to Recovery (Hörberg et al., 2012; Mann et al., 2014; Rose et al., 2011). Austin et al. (2009) further elaborated how patients recognize practitioners' obligations to institutional and public safety and therefore did not always hold the patient's interest as their first priority.

The findings in this subtheme suggest forensic nurses define an end goal/success being that a patient receives an absolute discharge from the Alberta Review Board, which also supports the misperception that there is an end to Recovery when the patient is no longer engaged in forensic services. Drennan & Wooldridge (2014) recognized that often people find the most helpful supports in their Recovery are not professionals, but friends, peers and families (cited in Davies et al., 2012) which suggests that the forensic nurse only plays a temporary role in a patient's Recovery. There is little information in the current literature about terminating the relationship and continuing a journey of Recovery outside of the forensic system, as noted that many articles on Recovery-experienced forensic patients focus on the therapeutic relationship with the nurse and fail to mention what happens once they are out of the forensic system.

5.3 Colleagues and Interpersonal Relationships. Participants stressed the relationships with co-staff as being a challenge to providing Recovery-oriented practice, which is consistent with the literature in noting the stress and conflicts which arose from staff's negative attitudes with caring for inmates or forensic patients (Cashin et al., 2010; Cooke et al., 2017; Holmes, 2005; Rose et al., 2011; Weiskopf, 2005). There is an inherent tension between assessment and treatment philosophies between staff units which can be difficult to navigate as a culture as a whole. Promoting a Recovery focus becomes a much more difficult task when forensic nurses

wish to fit in with the culture. Jacob et al. (2009) discussed the use of othering practices in which forensic nurses attempt to distance themselves from their patients, including personalizing their patients by using negative or deeply stigmatizing language, or avoiding contact altogether, and that this exclusionary action "disrupts nurses' ability to engage in reciprocal interactions with patients by shifting the emphasis from therapeutic to custodial practices" (p. 156)

Mason et al. (2008) commented that forensic settings attract clinicians with strong personalities who might perpetuate non-professional behaviours, such as bullying, coercion, and disengagement. Certainly, this aspect of the forensic nursing culture has significant ramifications to the working culture and the ability to facilitate culture change.

It is difficult to voice a Recovery-oriented perspective if the majority of staff approach care with a punitive attitude; for one to question the punitive approach is seen as being naïve, easily manipulated, and even incompetent to work in a maximum-security facility (Cooke et al., 2017). Weiskopf (2005) additionally noted that caring for inmates came with both real and potential physical and psychological risks, especially when trying to make changes in the system or advocating for prisoners when some nursing and correctional staff felt that inmates were not deserving of care. Weiskopf continued to say that trying to intervene in custody matters led to some nursing staff to feel unsupported, alone, frustrated, and angry in trying to advocate appropriate health care for patients, which also lends the argument of why it is difficult to adjust to a Recovery approach instead of a custodial or punitive approach. Holmes (2005) also noted, "Nursing staff must constantly 'nurture' the relationship with correctional officers in order to avoid possible personal or ideological conflicts that may interfere with their professional practice" (p. 11). Therefore, it could be suggested that a forensic nurse may try to placate their

negative feelings and avoid conflict by trying to fit in as a member of the forensic nursing culture and adapt their practice to a more correctional or custodial approach.

6. Recovery in the Forensic Setting

Participants described Recovery as a process or journey to restoring health, wellness, and functioning despite mental illnesses, and consistently spoke to Recovery-oriented practice being collaborative, person-centred, and individualized with "providing choices," "finding out what was important to the patient," and "working with the patient." However, many of the participants likened Recovery-oriented practice to how they provided nursing care and not necessarily how they worked towards facilitating a sense of Recovery with Leamy et al.'s (2011) CHIME Recovery processes. Regardless of the different meanings which participants attributed to Recovery, participants felt that the care they provided to the patients was similarly met with an opposing paradigm of care which focused on the punitive/custodial aspects of forensic nursing.

In the sense of caring, Weiskopf (2005) discussed providing unique, one-to-one caring relationships with the inmate patients, and described nursing care as "being there, acknowledging the inmate's suffering, letting them know they cared through a non-judgmental manner, showing compassion, respect and concern, taking time to listen to get to know them, and helping them through difficult situations" (p. 340). These examples of nursing care were consistent with the participant's views of needing to be nonjudgmental, compassionate, and building a relationship with the patient in order to promote Recovery.

6.1 Beliefs on Recovery. As previously stated in Chapter 4, participants talked about how they perceived Recovery in forensic settings, and why they felt it was important to the forensic nursing culture. Most participants spoke to how Recovery was an intrinsic tenet of the

rehabilitation process and getting the patients to be at the optimal level of functioning in the community. However, there were times when the focus was solely on *rehabilitation,* and "getting the patient to the best of their functioning." This was also evidenced by a participant stating, "*We have the intention of taking people who are ill and making them as well as they can be and reintegrating them back into the population and community,"* which also suggests that nurses may feel that Recovery is something that is "done to" a patient rather than as a process that the patient experiences. This adds to the discussion by Drennan and Alred (2012) which considers Recovery as a service model with how organizations change in terms of positive risk-taking, trust, and choice for service users, and Recovery as an experience related to the nature of the personal journey for mental health service users who have committed a serious offence.

There may have been some misled ideas to linking Recovery-oriented practice with rehabilitation, which alludes to Drennan and Wooldridge's (2014) and Turton et al.'s (2011) findings that the Recovery for forensic patients is not simply a personal choice, but rather part of the imperative to reduce risk and protect the public, and where therapeutic approach aims to change behaviour and identity. Though rehabilitation is central to forensic mental health practice (Lindqvist & Skipworth, 2000), the emphasis comes from a position of assessing and managing an individual's level of risk (Mann et al., 2014). The literature consistently refers to rehabilitation in the sense of "Offender Recovery" and "offender rehabilitation," (Adshead et al., 2015; Aga et al., 2017; Barnao et al., 2016; Drennan & Alred, 2012; Vandevelde et al., 2017; Youssef et al., 2016) which may also skew the perception of patients to fit within the correctional/custodial schemata.

6.2 Challenges. Drennan and Wooldridge (2014) also noted challenges in applying Recovery in forensic settings encompassed the idea of how the forensic patient differs from other people with Recovery. It was significant that participants noted various levels which posed as challenges to Recovery in forensic settings, all of which were connected to perceptions of the forensic patient. At an internal level, participants talked about feeling conflicted at times between promoting Recovery and managing risk (refer to point 1.1); interpersonally, there were challenges with navigating the relationships with co-workers in the forensic setting who did not agree with Recovery (refer to point 5.3); institutionally, participants described the physical structure and rules of a maximum secure hospital as not being conducive to Recovery (refer to point 5.1); and systematically, they noted that the dual stigma forensic patients face (refer to points 4.1 and 4.2) posed as the greatest challenge.

6.3 Perception of the Nurse's Role. Participants recognized the role of the nurse to be creative in assisting patients to achieve Recovery within a forensic context. Developing and sustaining therapeutic relationships with patients was also noted as being a foundation for Recovery, which they identified as being open, honest, and incorporating the patient's wishes. The participants' views of relationships parallel the literature on relationships built on trust, respect, and advocacy (Forchuk et al., 2003; McKeown et al., 2016; Rask & Brunt, 2007; Rose et al., 2011). Participants also commented on the need for forensic nurses to have a nonjudgmental approach, though this was difficult at times when considering index offences, as Rose et al. (2011) similarly reported that forensic nurses "universally express that nurses ought not to judge patients, but that they struggled to maintain a nonjudgmental stance." (p. 8)

Participants also spoke about the need for self-reflection and reflective practice as a team to explore their approaches to Recovery-oriented practice. Austin et al. (2009) succinctly described the need for professionals to "reflect on their practice in order to cultivate ethical sensitivity, be attentive and thoughtful to the relational context of the environment of care, and to embrace the potential vulnerability of their patients and themselves" (p. 846).

Key Findings in Relation to the Literature

A key finding of this research suggests that while forensic nurses have a theoretical understanding of the Recovery paradigm, translating the intent of the principles into practice is challenging. This key finding agrees with McKeown et al.'s (2016) statement: "The turn toward an affinity for a Recovery model was treated with skepticism... because this presented too many challenges or dilemmas to be effectively translated into meaningful practice" (p. 238). One suggested reason for the challenges of implementation is how forensic nurses are greatly impacted by the overall forensic culture with competing philosophies, which reinforces a sense of fear and vulnerability to risk which impacts the ability to fully practice in a Recovery-oriented manner.

Another key finding is that forensic nurses emphasize rehabilitation for their patients in their practice; however, rehabilitation does not necessarily align with Recovery principles. This was evidenced in the language of how forensic nurses "take patients and make them better," or that the goal of forensic nurses is to "successfully transition people back into the community." This key finding is consistent with the idea where the Recovery of NCR patients is an imperative of the forensic system to prevent them from reoffending, and not as a personal choice of the patient (Drennan & Wooldridge, 2014; Turton et al., 2011).

The last key finding is that forensic nurses minimize the impact of Offender Recovery, or assisting the patient with coming to terms with and making sense of their index offence. This was evidenced by the lack of involvement in and/or recognition of current and past innovations for treatment in the NCR program, including family therapy interventions and drama therapy group. Notably, as a culture, the focus of Recovery is more on moving the patient forwards, rather than working on making sense of the past. As suggested by Harris et al. (2015) and Lee et al. (2015), vicarious trauma related to the index offence is a significant concern for forensic health professionals.

Implications for Practice and Administration

I suggest that for forensic nurses to be able to practice with a Recovery focus, they similarly need to experience Leamy et al.'s (2014) CHIME Recovery Processes (Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment) as discussed below, for themselves. As Leamy et al. (2011) argued, these processes can be understood as measurable dimensions of change during Recovery and reflect Recovery outcomes, therefore practice should be evaluated in relation to its impact on these processes.

The arguments below are focused on how to assist the culture to move forward with implementation of Recovery-oriented practice, change cultural practices to reflect Recovery instead of rehabilitation, and incorporate a better understanding of Offender Recovery.

Connectedness

Olsson et al. (2014) argue that the work with Recovery is highly dependent on the forensic nursing staff who are working closest with the patient. Connectedness is predicated on

having good relationships and being connected to other people in positive ways. A forensic nurse must feel that they have a meaningful, trusting, and nonjudgmental relationship with the patients. The relationship between a forensic nurse and forensic patient could be strained at times, especially when the patient feels that a nurse may be acting from a punitive stance, such as with the example of suspending patient privileges. It is therefore only prudent to ensure dedicated time to debrief with the patient and allow for the rebuilding of therapeutic rapport. Another important component for forensic nurses to develop stronger therapeutic relationships with their patients is to involve them in facilitating patient groups (such as psychoeducation groups) and working on addressing the index offence.

Aside from feeling connection in the nurse-patient relationship, it is also imperative that the nurse feel connection with the treatment team. Several suggestions came from the research participants to improve a sense of connectedness and belonging with the treatment team, including needing to attend patient conferences, debriefings, reflective practice sessions, and workshops/in-services on Recovery. Harris et al. (2015) argued that there must be more support for forensic mental health nurses transitioning into the environment, including the need to provide clinical supervision, team support, improving communication, and enhancing the functioning of multidisciplinary teams. Drennan and Wooldridge (2014) similarly argued, "A Recovery-oriented service that has a focus on the quality of relationships will need to offer a range of staff supports, such as clinical supervision groups, team reflective practice, and individual supervision, to promote reflective thinking and adaptation by staff in relation to the challenges that arise" (p. 10). Having more of a cohesive goal and philosophy in mind would allow for a culture of forensic nurses to feel connected with each other.

Hope and Optimism

Hope and optimism fall into two categories; one being the importance of nurses being able to witness Recovery in action and for their patients; and the second being having hope and optimism for the NCR program and for the future for forensic nursing. Reminding forensic nurses of the impact that they have in all their day-to-day interactions and throughout the course of a patient's NCR status, plays a pivotal role in empowering forensic nurses to use Recovery-oriented practice.

With being able to witness the NCR patient progress through the NCR program/process and reintegrate back into the community provides an antidote to the sense of therapeutic nihilism sometimes experienced by forensic nurses. Though the participants worked at the inpatient forensic site, one commented about how they filled in at one of the group homes and was able to witness the growth and change for patients in the community. Thus, it may be worth exploring having forensic nurses to be cross-trained across all areas of the NCR program and the trajectory of the NCR pathway.

Identity

Firstly, it is important to acknowledge the forensic nurse's identity within the culture. "Nurses felt that they had to demonstrate collegiality toward custody officers, but also they felt that they must acknowledge that their role as a nurse differed from custody" (Weiskopf, 2005, p. 339). In a study by Jacob and Holmes (2011) which explored how fear impacts nurse-patient relationships in forensic settings, they noted a distinct identity that is formed and valued around the control of emotions (including fear) as well as the control over the unstable environment.

Though the forensic nursing culture may identify this control as a value, it also seems to paradoxically alienate forensic nurses from one another and prevent proper debriefing.

The knowledge about the area of forensic nursing and the NCR process is limited and often misunderstood by the public. Being able to have a more public forum for forensic nurses to advocate for their role and the process of rehabilitating NCR patients would be recommended. The idea where the patient may see the forensic nurse as agents of the Alberta Review Board could potentially impact the forensic nurse's perception of their role within the system. Alternatively, patients have been able to make the delineation between the treatment team and the review board, noting that the team is acting as their ally against the Alberta Review Board. The dynamic position of the forensic nurse between the patient and the system has benefits to both relationships, but this also adds layers which confuse and complicate the identity of the forensic nurse.

Lastly, it is important to recognize the external obstacles such as the stigma of working in forensic mental health and its negative impact on the nurse's professional reputation, suggesting that a nurse's employability or desirability for future job prospects is also impacted (Harris et al., 2015). Additionally, Chaloner and Kinsella (1999) suggested that forensic nurses deal with recurrent criticism and negativity concerning their professional roles, which affect the forensic nurses' self-perceptions, such as being less therapeutically oriented than other mental health nursing. Their statement could be extended to how forensic nurses similarly perceive their ability to practice with a Recovery focus. Thus, it would be beneficial for nursing administration and education to consider or offer ongoing Recovery training within the context of forensic settings.

Meaning

Laschinger et al. (1999) found that perceived empowerment comes with meaning and purpose built into nurses' work. Important aspects of building meaning are a developed understanding of role clarification, opportunity to participate in making decisions, access skills-based learning enhancements and performance-improving resources, and support to improve confidence in practicing at the fullest scope.

Assessing and managing risk, although counterproductive to the patient's Recovery, were still noted to be inherent and crucial components to forensic nursing. This echoed the sentiments of Olsson and Porskrog Kristiansen (2017), who noted that without considering risk, forensic work could be seen as unnecessary or illegitimate. If the forensic nurse can shift the risk management focus to how to mitigate or minimize risks, this allows the patient to have a sense of normalcy and personhood, and potentially dispel the ambivalent feelings where nurses feel conflicted or have difficulty finding balance in their practice.

Drennan and Wooldridge (2014) noted, "A Recovery-oriented approach to risk assessment and management should move explicitly from external control towards the person demonstrating they can use internal mechanisms to take back control themselves" (p. 13), which also suggests allowing for more ownership of risk and responsibility be put back on the patient and not solely on the forensic nurse or treatment team. Certainly, the language used as a culture has an impact on the perceptions of risk. As Drennan and Wooldridge (2014) noted, even the term of "positive risk taking" had implications on perceptions of risk because it invites the perception that such activities were "risky" and therefore needed to be avoided. Furthermore,

they offered an alternative term, "safety-testing," which describes a different approach to risk management where the emphasis is on helping the person pursue their chosen goals safely.

Empowerment

Empowerment falls into two categories: psychological empowerment and structural empowerment. Spreitzer (1995) argued psychological empowerment is comprised of four components: meaning, competence, self-determination, and impact.

Akin to feeling hope and optimism, forensic nurses need to feel that they are making a difference in their patients' lives. The examples participants gave for a situation where they witnessed or experienced Recovery which was positive, included cases in which an NCR patient went from being very debilitated by their illness and offence, to a point where they were able to function in the community and ultimately be discharged from the Alberta Review Board. Reminding forensic nurses of the impact that they have in all their day-to-day interactions and throughout the course of a patient's NCR status plays a pivotal role in empowering forensic nurses to use Recovery-oriented practice.

With regards to structural empowerment, it is also important to recognize the power that the nurse has in the forensic system. Having access to necessary information and resources, feeling supported, and experiencing the opportunity to learn and grow (Kanter, 1993) are key to the empowerment of staff. Examples of structural empowerment in forensic settings include providing opportunities for the nurse to gain experience with writing Review Board nursing reports, attending family sessions, and being involved in groups with other modalities of treatment.

Recommendations for Future Research

Future research should take consideration of culture change in forensic nursing and if there are interventions which could influence Recovery-oriented practice in maximum secure settings. The power differential between forensic nurse and patient should also be explored to see if there can be a shift towards power sharing. My research study focused on the forensic nurses who work with NCR patients in secure inpatient settings, and therefore it would be worth exploring the care trajectory as the patient moves into the community and ultimately is discharged from the Review Board.

Cashin et al. (2010) suggested that there should be further progress in developing practice in an emancipatory framework, looking at the power in culture and considering the factors in the environment that constrain forensic nursing practice.

Conclusion

By exploring forensic nursing culture and how Recovery and Recovery-oriented practice is perceived, experienced, and incorporated into practice, the following key findings emerged: 1. Though forensic nurses have a theoretical understanding of the Recovery paradigm, translating the intent of the principles into practice is challenging; 2. Forensic nurses emphasize rehabilitation for their patients in their practice, however, rehabilitation does not necessarily align with Recovery principles, and this suggests a focus from a systems approach to manage risk; and 3. Forensic nurses minimize the impact of Offender Recovery and require support in navigating the vicarious trauma related to the index offence. This research adds to the body of knowledge by demonstrating that there needs to be more Recovery-based training for forensic nurses and how the CHIME Recovery processes (Leamy et al., 2011) should be experienced by

forensic nurses in order to move forward with implementation of Recovery-oriented practice, change cultural practices to reflect Recovery instead of rehabilitation, and incorporate a better understanding of Offender Recovery.

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Appendix A

Forensic Nursing Culture and Recovery-Oriented Practice

Monica is looking for Forensic Nurses (RNs/RPNs/LPNs) to discuss their experiences and perspectives with Recovery and Recovery-oriented practice when working with the NCR population in secure inpatient settings. You may be asked to describe your experiences with Recovery and personal challenges you witnessed or encountered with delivering care. The research is not anticipated to cause distress, and you may find it therapeutic to discuss your experiences.

The knowledge gained from this study may help with providing insights into how Recovery can exist or develop within secure settings and facilitate successful reintegration for Forensic Patients in the community.

You are invited to participate in an interview (approximately 30-60 minutes in length) which will be audio-recorded. Participation in this study is voluntary and your decision to participate or not participate will have no effect on your employment status. You will be provided with a copy of the transcript of the interview approximately 1-2 weeks after the interview to ensure accuracy, and provide an opportunity for you to review, clarify, and provide additional information as needed.

Monica Ginn Forsyth

Contact ginnm19@brandonu.ca to request further information and arranging an interview time.

From August 1-November 1, 2019

This Research Study has approved by the Brandon University Research Ethics Committee (Research Ethics # 22474) and the University of Alberta Health Research Ethics Board (Pro00092704)

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Alberta Health Services

Appendix A

Email to request consent to email nursing staff invitation to participate

To [Manager/Director of Forensic Services]:

My name is Monica Ginn Forsyth and I am a graduate student in Brandon University's Master of Psychiatric Nursing (MPN) program. For my thesis, I have chosen to explore Forensic Nursing culture and Recovery-oriented practice.

I am looking for Forensic Nurses (Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses) to discuss their experiences and perspectives with Recovery and Recovery-Oriented Practice when working with the NCR population in secure inpatient settings. I will be conducting individual interviews with participants over a 3-month period (August 1-November 1, 2019). Participants may be asked to describe their experiences with Recovery and personal challenges they witnessed or encountered with delivering care. The knowledge gained from this study may help with providing insights into how Recovery can exist or develop within secure settings and facilitate successful reintegration for Forensic Patients in the community.

The purpose of my email is to request permission from you to send an email to the Forensic Nursing listserv group with an invitation to participate in this study, and to post recruitment posters in staff areas at the Southern Alberta Forensic Psychiatry Centre.

Participants will be asked to participate in an interview (approximately 30-60 minutes in length) which will be audio-recorded. Participants will be provided with a copy of the transcript of the interview for them ensure accuracy, and provide an opportunity to review, clarify, and provide additional information as needed.

This study has been approved by the Brandon University Research Ethics Committee (Research Ethics #22474) and the University of Alberta Health Research Ethics Board (Pro00092704).

Please feel free to contact me if you would like further information about this study. Please find the attached recruitment poster/invitation to participate which will be emailed to staff, pending your approval.

Thank you,
Monica Ginn Forsyth
ginnm19@brandonu.ca

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Appendix A

Letter of Invitation to Nursing Staff

Dear Esteemed Colleagues:

As many of you may know, I am a graduate student in Brandon University's Master of Psychiatric Nursing (MPN) program. For my thesis, I have chosen to explore Forensic Nursing culture and Recovery-oriented practice.

I am looking for Forensic Nurses (Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses) to discuss their experiences and perspectives with Recovery and Recovery-oriented practice when working with the NCR population in secure inpatient settings. You may be asked to describe your experiences with Recovery and personal challenges you have witnessed or encountered with delivering care. The knowledge gained from this study may help with providing insights into how Recovery can exist or develop within secure settings and facilitate successful reintegration for Forensic Patients in the community.

I will be conducting individual interviews with participants over a 3-month period, from August 1- November 1, 2019. You are invited to participate in an interview (approximately 30-60 minutes in length) which will be audio-recorded. You will be provided with a copy of the transcript of the interview approximately 1-2 weeks after the interview to ensure accuracy, and provide an opportunity for you to review, clarify, and provide additional information as needed. Participation in this study is voluntary and you are not obligated to participate. Your decision to participate or not participate will have no effect on your employment status.

If you have further questions or if you are interested in participating in this study, please feel free to contact me.

Thank you,
Monica Ginn Forsyth
ginnm19@brandonu.ca

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Alberta Health Services

Appendix B

Interview Informed Consent Form

Research Project Title: *Forensic Nursing Culture and Recovery-Oriented Practice: A Focused Ethnography.*

Researcher(s): Principle Investigator Monica Ginn Forsyth, RN, BN, CPMHN(C), & Thesis Advisor Jane Karpa BA, RPN, CMHW C/A, MMFT, PhD(c)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You are being invited to participate in a research study through Brandon University and Alberta Health Services. Participation in this study is voluntary and you are not obligated to participate. This research study will explore Forensic Nurses' experiences and perspectives on Recovery-oriented practice with Not Criminally Responsible (NCR) patients in secure inpatient settings. Using a Recovery approach in the context of Forensic Nursing has proven to be a contentious and challenging issue. The knowledge gained from this study may help with providing insights into how Recovery can exist within secure settings and facilitate successful reintegration for forensic patients in the community.

For this research study, you are asked to participate in a 30-60 minute interview, which will be audio-recorded. You may be asked to describe your experiences with Recovery and personal challenges you witnessed or encountered with delivering care. You will be provided with a copy of the transcript of the interview (transcribed only by the principle investigator) in a password-protected Word document approximately 1-2 weeks after the interview to ensure accuracy, and provide you an opportunity to review, clarify, and provide additional information as needed. Any new or amended data will be incorporated into your original transcript so they become a part of the data that will be analyzed. The final copy of the transcript will be shared with the thesis advisor (J. Karpa) for review and used in the data analysis. The knowledge gained from this research will be presented in fulfilment of the researcher's thesis defence, as well as submitted to a peer-reviewed journal for publication.

Confidentiality regarding your participation in the study will be maintained. Measures to ensure your confidentiality and anonymity include: i) using "P" for Participant and "R" for Researcher to denote the speaker in the transcription of the audiotapes, ii) the raw data will be stored and kept in a locked filing cabinet, and iii) the electronic copy of the transcript will be on a computer that is password protected. During the interviews, you are asked to refrain from using patient and co-nurses' names when discussing

specific situations. If names are used, they will be omitted from the transcript. The researcher will translate the data results from the interviews into broad/contextual themes, and these themes will be discussed in the dissemination of results. Any specific information which could be used to identify participants will not be shared. Should the researcher use quotes in publications and presentations of the study, the participant identity will remain anonymous. The data collected from this study, including the audio-recordings, transcripts, and Informed Consent letter will be kept for 5 years following the completion of the study (until October 2025) and then will be deleted/shredded.

There are no anticipated risks to you, however, the researcher recognizes that it may be distressing for one to discuss negative experiences which you were involved in or witnessed, and that this has the potential to bring up negative memories and/or emotions. You are free to not respond to some of the questions. There are no direct benefits to this research, though you may find it therapeutic to discuss your experiences. The contact information for the Employee and Family Assistance Program (EFAP) has been included in this letter as well.

You may withdraw at any time up until the time when the interviews have closed (November 1, 2019). This research is in no way an evaluation of your job performance, and therefore has bears no risk to your employment. Your decision to participate or not participate in the study will not have any repercussions to you or your employment status. Participation in the interview and anything you say will be kept confidential from the Director and Manager of forensic services.

The researcher will also inform all of you that she is required by law to report disclosures of abuse. For a report of abuse (sexual, physical, emotional) involving an individual under the age of 18, the researcher will contact Child and Family Services. For a report of elder abuse (sexual, physical, emotional and or financial) the researcher will contact the Calgary Elder Abuse Resource Line.

This research will not be used for commercial purposes.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities.

Monica Ginn Forsyth
RN, BN, CPMHN(C)
(403) 618-5925
ginnm19@brandonu.ca

Jane Karpa
BA, RPN, CMHW C/A, MMFT, PhD(c)
(204) 772-0377 extn 223
karpaj@brandonu.ca

Signature of Participant and date

Signature of Investigator and date

This research has been approved by the Brandon University Research Ethics Committee (Ethics Research file #22474) and the University of Alberta Health Research Ethics Board (Pro00092704). If you have any concerns or complaints about this project you may contact any of the above-named persons, the Brandon University Research Ethics Committee (BUREC) at burec@brandonu.ca or (204) 727-9712, or the Research Ethics Office at the University of Alberta at (780) 492-0459. A copy of this consent form has been given to you to keep for your records and reference.

Alberta Health Services Employee and Family Assistance Program (EFAP): 1-877-273-3134

Appendix B-2

2nd Interview Informed Consent Form

Research Project Title: *Forensic Nursing Culture and Recovery-Oriented Practice: A Focused Ethnography.*

Researcher(s): Principle Investigator Monica Ginn Forsyth, RN, BN, CPMHN(C), & Thesis Advisor Jane Karpa BA, RPN, CMHW C/A, MMFT, PhD(c)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. Please consider this consent form as an attachment to your original consent form, signed on _____. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You have been invited to participate in a 2nd interview with the researcher, as you have previously participated in an interview and there is a possibility that a recent adverse event at the workplace may affect your previous responses and/or perspectives of Recovery for Forensic Patients. Your decision to participate in the 2nd interview is voluntary and does not affect the previous data you provided should you choose not to participate.

You are asked to participate in an additional 10-15 minute interview, which will be audio-recorded. You will be asked questions related to the incident which occurred at the Southern Alberta Forensic Psychiatry Centre on September 9th, 2019. You will be provided with a copy of the transcript of the interview (transcribed only by the principle investigator) in a password-protected Word document approximately 1-2 weeks after the interview to ensure accuracy, and provide you an opportunity to review, clarify, and provide additional information as needed. The knowledge gained from this research will be presented in fulfilment of the researcher's thesis defence, as well as submitted to a peer-reviewed journal for publication.

There are no anticipated risks to you, however, the researcher recognizes that it may be distressing for one to discuss negative experiences which you were involved in or witnessed, and that this has the potential to bring up negative memories and/or emotions. You are free to not respond to some of the questions. There are no direct benefits to this research, though you may find it therapeutic to discuss your experiences. The contact information for the Employee and Family Assistance Program (EFAP) has been included in this letter as well.

You may withdraw at any time up until the time when the interviews have closed (November 1, 2019).

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities.

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Signature of Investigator and date

This research has been approved by the Brandon University Research Ethics Committee (Ethics Research file #22474) and the University of Alberta Health Research Ethics Board (Pro00092704). If you have any concerns or complaints about this project you may contact any of the above-named persons, the Brandon University Research Ethics Committee (BUREC) at burec@brandonu.ca or (204) 727-9712, or the Research Ethics Office at the University of Alberta at (780) 492-0459. A copy of this consent form has been given to you to keep for your records and reference.

Alberta Health Services Employee and Family Assistance Program (EFAP): 1-877-273-3134

Appendix C
Guided Questions

1. Can you describe what Recovery/Recovery-Oriented Practice means to you?
   (Author will then explain MHCC (2015) definition as well as Leamy et al.'s (2011) CHIME Recovery processes of connectedness, hope and optimism about the future, identity, meaning in life, and empowerment)

2. In what ways do you think forensic nurses currently have an impact on Recovery processes?

3. How can forensic nurses prioritize Recovery principles such as collaboration, power sharing, inclusion, self-determination and a focus on strengths in a forensic context?

4. Can you describe a situation when you encountered or witnessed Recovery in your practice that was a positive experience or that you appreciated?

5. Can you describe a situation when you encountered or witnessed Recovery in your practice that you felt conflicted with or disagreed with? What made it challenging for you?

6. How might Recovery be different when working with Forensic Patients as compared to mental health patients?

7. Are there certain characteristics (personality, severity of index offence, insight, adherence to treatment, etc) of forensic patients which make Recovery-oriented approach easier or difficult?

8. How do you think the nurse-patient relationship is affected by the forensic setting/environment?

9. How do you feel other disciplines in forensic services and the Review Board influence Recovery?

10. How do you think family involvement in the forensic services influences Recovery?

11. What do you feel are the greatest challenges of having a Recovery-oriented approach in forensic nursing (personal, interpersonal, institutional, systematic)?

12. What do you see as advantages of having Recovery in forensic settings as opposed to general mental health areas?

13. How do you manage your role as a forensic nurse with competing interests (patient desires vs. protection of the public?)

14. When an adverse event occurs in your workplace (such as the incident on September 9th, 2019, when an NCR patient assaulted a staff member), does it change or affect your perception of risk and/or your ability to provide Recovery-oriented practice?