

The Forensic Mental Health Nurse: Confusion, Illusion or Specialization?
A Scoping Literature Review

By

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Abstract

There is considerable confusion surrounding the role and responsibilities of forensic mental health nurses. There are a plethora of definitions and inconsistencies in the use of the term making it difficult to determine whether or not forensic mental health (FMH) nursing can be considered a specialty within nursing. The aim of this project was to determine what is known about forensic mental health nursing and to broaden our understanding of the debate concerning specialization status of forensic mental health nursing. In particular, my intent was to explore whether confusion surrounds our understanding of the forensic mental health nurse, whether such a nurse exists only as an illusion, and whether, if it does in fact exist as a distinct entity, can forensic mental health nursing be supported and worthy of recognition as an area of nursing specialization. Eight themes were identified: environment, skill set, personal traits, competing philosophies, political and social influences, stress and burnout, interdisciplinary team functioning, and education. The literature reflects no consistent terminology used to refer to forensic mental health nurses, or the work they do. The theoretical underpinnings and scope of practice of forensic mental health nursing are unclear, resulting in debate about its appropriateness as a speciality area of practice. Because of these factors, forensic mental health nursing is effectively constrained within a global context that would promote dialogue, collaboration and research.

The Forensic Mental Health Nurse: Confusion, Illusion or Specialization? A Scoping Literature Review

Within the field of nursing, there is considerable debate about the salient aspects of the Forensic Mental Health (FMH) nursing role and the titles used to refer to nurses doing this work. Further it is not clear if FMH nursing work is sufficiently exclusive to be considered a specialty area of practice. Confusion about the role exists because the language and terms used to refer to forensic mental health nurses (FMHNs) work are inconsistent and there is wide disparity in the scope of the role in practice. There is ongoing debate amongst those in the field about what are important factors when determining whether it merits specialty status.

This exploration of the context of FMH nursing is meaningful because failure to understand the role has the potential to marginalize the contributions of nurses and inhibit development of new knowledge to guide this nursing practice. It is necessary to articulate the work of FMHNs in order to establish a global understanding of the context and enactment of the role. Clearly defining FMH nursing would facilitate dialogue and advance collaborative exchanges, promoting ongoing exploration through research and consultation. Further, it is through distinguishing the role from that of generalist mental health nurses that entitlement to specialty status could be determined.

In this project, I synthesized the research literature (Appendix A) using scoping review methodology and inductively identified eight recurring themes, which I will use as a framework for exploring the context of the *forensic mental health nurse* later in this paper. The themes are: environment, skill set, personal traits, competing philosophies, political and social influences, stress and burnout, interdisciplinary team functioning,

and education. Though there is certainly overlap as the themes are highly interrelated, this framework is an organized way to explore this complex area of nursing practice.

I begin by outlining the background to this project, and then describe the purpose and objectives as well as methodology guiding this project. The discussion begins with a review and discussion of definitions for FMH nursing and related terms including *specialty status*; *adding forensic to nursing*; and *forensic mental health nursing*. Finally, I provide an interpretation of the results and the context of the FMHN, and the debate about specialty status. In concluding, I will discuss the implications for future consideration in practice, research and education.

Background

Initially I intended to conduct a literature review to learn about the outcomes experienced by nurses working in forensic mental health nursing. I had the idea that the interrelated conditions (context) in which FMHNs worked contributed to nurses developing in response to different factors than other mental health nurses. I suspected that nurses who undertake this type of nursing practice experience different stressors, and perhaps develop particular outlooks or attitudes that differ from mainstream mental health nurses (MHNs). Though I was interested in this aspect of FMH nursing, it became clear that I first needed to learn how the construct of a FMHN was presented in research and anecdotal literature. As I turned to the published literature to understand and appreciate the FMHN, I noted an indistinct definition (confusion) of what comprises the role and how their work is identified (Gillespie & Flowers, 2009). I further realized I had made assumptions that may have contributed to an erroneous view (illusion) of what FMHNs are, and I had no viable opinion on whether this role is distinctive enough (worthy of specialization) from others to be exclusive. As a result, I altered the purpose

of the literature review to address what I saw as a more fundamental inquiry, which was to learn about the work of the forensic mental health nurse, the variables that affect those in the role and explore the elements of practice that could lead to specialty recognition.

Purpose and Objectives

My purpose in conducting this scoping review was to gain an understanding of the overall state of knowledge about the FMHN role and better understand features that frame it according to existing literature. The objectives were to:

1. determine what is known about forensic mental health nurses in the published literature,
2. broaden our understanding of this nursing role, and
3. shed light on the debate concerning entitlement of FMH nursing to specialization status.

Methodology

I selected the scoping review framework by Arksey and O'Malley (2005) because it provided a clear structure that was easy to follow. The framework includes five steps: identifying the study objectives, identifying relevant studies, study selection, synthesizing the data, and summarizing results.

Search Strategy

When considered globally, inconsistencies in the terminology used to refer to the work of FMHNs created an obstacle to accessing the full complement of targeted literature for reviews such as this one. Often the term *forensic* is ignored, and instead the descriptor is the location of practice (correctional, high secure hospitals) or the legal

status of patients (mentally disordered offenders, not criminally responsible) that is used. There are occasions when reference to mental health does not exist, and only the title of *forensic nurse* is used, even though the work is clearly in the mental health context (BouHaidar, Ruddy & Ruddy, 2004; Burnard, Morrison & Phillips, 1999). This resulted in the need to employ a considerable number of keywords and combinations in the search to be as inclusive as possible.

For purposes of the integrity of this literature review, it was not sufficient to rely solely on search parameters using the term *forensic*, which would have excluded a substantial amount of literature that identifies nurses by the location in which they work. For example, literature search revealed that other terms (e.g., correctional) yielded more results than using the term forensic mental health nursing or forensic psychiatric nursing. To ensure the inclusion of all appropriate scholarly literature in this study, and to maintain a consistent focus, a definition of the term *forensic mental health nurse* is required as a parameter and is explored shortly in this paper as a foundational definition. I have included descriptive accounts and primary research in this scoping review. Evaluation of the methodological quality of the studies is not a feature of a scoping study and thus this review does not include evaluation of the empirical articles reviewed (Arksey & O'Malley, 2005).

I searched the following databases for relevant articles; CINAHL; PSYCH INFO; Cochrane Database of Systematic Reviews (CDSR), MEDLINE and JUSTOR. Searches were guided by terms such as: forensic nurs*, high secure nurs*, forensic psychiatric nurs*, forensic mental health nurs*, acute mental health nurs*, correctional nursing*. I attempted various permutations of these terms in an effort to access a wide

range of data. In order to obtain the broadest possible search, combinations of key words such as; *mental health nursing + corrections; nursing + special hospitals* and *psychiatric nursing + security* were used.

I screened reference lists of articles obtained in full text to identify background work that had been done prior to the study being reviewed, and to ensure that foundational work (despite its relative age) was reflected in this scoping study. Noting the CINAHL data base results below for selected keywords provides an example of the breadth of responses to the various terms. This demonstrates that there is a need to define the parameters of the terms being studied.

Forensic mental health nurse: CINAHL (9)

Forensic psychiatric nurse: CINAHL (39)

Forensic nurse: CINAHL (1020)

Correctional Nursing: CINAHL (50)

Correctional Mental Health Nursing: CINAHL (2)

I hand searched websites and key journals to rule out data that may have been missed in web searches of the databases. The journals/websites included: American Nurses Association (ANA) <http://www.nursingworld.org/>; Canadian Nurses Association (CNA) http://www.cnanurses.ca/CNA/default_e.aspx; College of Nurses of Ontario <http://www.cno.org>; International Foundation of Forensic Nurses <http://www.iafn.org/> . The Forensic Nurses Society of Canada (http://www.forensicnurse.ca/web_resources/books.htm), is not yet a well-developed site and was not helpful except to acknowledge they were approved as an emerging special interest group of the Canadian Nurses Association in July 2007.

Inclusion and Exclusion Criteria

As I became familiar with the literature, I inductively refined my inclusion and exclusion criteria. It became necessary to include only those sources that explicitly described the work of nurses engaged in forensic mental health/psychiatric services as opposed to the larger category of nursing work in a secure setting in general. Inclusion criteria were:

1. Only published literature and dissertations available in English,
2. Research reflecting data generated from or about qualified nurses,,
3. Data reflecting mental health nursing and/or mental health nurses, and,
4. Settings representing some level of security in the environment.
5. Literature published within the date range 1986-2009, with one exception. The 1978 article by Pines and Maslach provides early acknowledgment of the term *detached concern* in the literature. Otherwise, the date range was selected in order to reflect foundational work that would have been missed if a shorter span of years were used, and in response to the ebb and flow of published work on this subject appearing in journals and books.

The searching mechanisms generated a total of 125 references identified as relevant and these were used in this review.

Out-patient or community forensic mental health work was excluded because in this study I sought to address FMHNs at a level of commonality represented by some level (maximum, high, medium, locked) of security. In addition I used the term *forensic* to refer to in-patient settings only. I used the terms *forensic mental health nurse* and *forensic psychiatric nurse* synonymously within this paper. I used the term *patient*

because it is consistent with the literature and is less problematic than offender, prisoner.

Findings

Definitions

Specialty status. As I reviewed the literature for identifiers of the interrelated conditions affecting development and recognition of the FMH nursing role, I was mindful that the question of entitlement to specialty recognition is also a focus of this review. Specialty areas of practice in nursing exist in many countries. The Canadian Nurses Association endorses psychiatric/mental health nursing as a specialty area of practice and offers recognition through certification for those nurses who meet the criteria. Currently there is no recognition of FMH nursing as a distinct specialty area of practice. This prompts inquiry about what constitutes the basis for recognition of a specialty area of practice. The College of Nurses of Ontario (2003) provides the following definition:

The American Nurses Association (ANA) suggests that specialty nursing is "nursing practice that intersects with another body of knowledge, has a direct impact on nursing practice, and is supportive of the direct care rendered to patients by other nurses. (Specialty Practice terminology # 2)

The Canadian Nurses Association (2008) describes specialized practice as "practice that concentrates on: a particular aspect of nursing, related to the client's age...problem...diagnostic group...practice setting or type of care" (p. 41).

The American Board of Nursing Specialties (2007) Accreditation Standards (Appendix B) provides detailed criteria for acceptance as a nursing specialty.

These definitions provide a basis against which the reader may assess the entitlement of forensic mental health nursing to specialty status recognition.

Adding forensic to nursing. The term *mental health* or *psychiatric nurse* holds some kind of meaning for most people. This may be due to life events that have provided them with a personal definition based on that experience. It may also result from public campaigns on television, radio and posters that have addressed mental health conditions, such as depression, and have portrayed the nursing roles. However, the same cannot be assumed of the FMH nurse. Television portrays many forensic roles relating to criminal investigation or evidence processing that are based in science but not the science of nursing. At best, FMH nursing brings to mind nurses working with violent, dangerous individuals, within an overarching mandate to protect the public. What tends to be obscured in such portrayals are the therapeutic, caring aspects of nursing. So what does adding the term *forensic* (to mental health nurse) really mean? As previously discussed, during the literature searches, the term *forensic nurse* yielded substantially more results than any other search term used and so that is where I began.

The International Association of Forensic Nurses (IAFN) has defined *forensic nurse* on their website as:

the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents. The forensic nurse provides direct services to

individual clients, consultation services to nursing, medical and law related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing (para.1).

This is, of course, an umbrella definition under which many nursing roles are presented; it does not provide clarity for the FMHN nurse specifically, or distinguish it in any way from the other nursing roles. Although forensic matters are addressed, what is missing is the mental health aspect of the role.

A global perspective confirms that when considered internationally the definition differs in meaning and application. The Canadian view of *forensic nurse* includes the same roles as the IAFN, adding the emerging role of forensic nurse educator (Anderson, 2007). In the American context (Boersma 2008), the term refers to the most widely recognized forensic nursing role, the "...sexual assault nurse examiner [SANE] in part because sexual assault and rape are epidemic" (p.32). In the United Kingdom, a *forensic nurse* is taken to be one who practices mental health nursing (BouHaidar et al., 2004), in spite of the absence of any reference to psychiatry or mental health in the title. Thus, there is considerable variance in identifying this group of nurses.

Recognition of this inconsistency is not new, and calls into question the value or validity of using the term *forensic* at all. Blackburn (1996) proposed rejecting the term as problematic and undesirable, on the basis that it refers to the environment or legal status of the patient rather than the type, quality or nature of the nursing work itself. Mason (as cited in Maeve & Vaughn, 2001) has cited the absence of critical dialogue about the implications of using the term *forensic*, as justification for rejecting it. In

contrast, Evans and Wells (2001) support continued use of the term, asserting that “the invisibility of forensic nurses within the health care field, and even within the profession of nursing... is heightened when forensic nurses are unable to signal their specialty by having the word forensic in their position description or title” (p.44).

Because of these variations, and the resulting confusion, using the term *forensic* provides information about a nursing role only inasmuch as it indicates one of several potential environments. It vaguely refers to the involvement of the criminal justice system in some way, but it does not clarify whether the patient is a victim or an offender, leaving considerable room for (mis)interpretation. Nonetheless, despite the problems inherent in the term *forensic*, identifying the mandate and accountabilities of the FMHN role may actually help to determine the usefulness of the term.

Defining forensic mental health nursing. The difficulties in defining forensic mental health nursing do not arise solely from the cumbersome terminology already identified. The literature reflects debate about the substance of the role. Some authors have offered definitions of what they conceptualize forensic mental health nursing to be, albeit not without some lack of precision or exclusivity. Peternelj-Taylor and Hufft (1997) define forensic mental health nursing as: “the integration of mental health nursing philosophy and practice, within a socio-cultural context that includes the criminal justice system to provide comprehensive care to individual clients, their families and their communities” (p.772). This definition situates the FMHN solidly in the practices attributed to mental health nurses and maintains that the provision of care is the nursing focus. It further highlights the socio-cultural context, however, it remains unclear to what

degree the criminal justice system must be involved before the nursing work could be legitimately considered *forensic* and what comprises the salient aspects of that care.

The literature also reflects a critical view of the term forensic mental health nurse such as Mason (as cited in Maeve & Vaughan, 2001, p. 54) who asserts that:

“There is a certain heroic and ‘sexy’ attachment to the title of forensic psychiatric nurse that only assured its uncritical acceptance.” For Mason, the term forensic mental health nurse is problematic.

There is concern that the context of the nursing work being done by FMHNs is all but lost in consideration of the legal status of the patient and evidence probative to those legalities. Does the nursing focus rest on satisfying the requirements of the forensic mental health system processes as opposed to focused on the care and treatment of the person experiencing the mental illness condition? Use of the term forensic in the title of these nurses is an acknowledgement of the social control mandate, and risks further distancing the nursing from the patient. This illustrates the resultant competition between the philosophies of social control and caring that is heavily represented in the literature. Recognition of the magnitude of this tension is addressed under the theme of *competing philosophies* later in this review

One would expect the substance of any nursing role to be solidly rooted in the types of work generally associated with nurses, which is to say, a patient focused helping role. However, an element of concern emerges when the role of the forensic psychiatric nurse is articulated (Lynch 2006) as one focused on assessment or court mandated psychiatric evaluation with a population defined by criminality. This ignores the work of FMHNs in ameliorating the psychiatric illness conditions through therapeutic

engagement – the human context. It reinforces assessment functions targeting criminality, which are not necessarily the same as therapeutic engagement. Therapeutic engagement speaks more directly to the mental health nursing work of engaging the patient in meaningful and insightful dialogue, whereas *assessments* may consist of merely observing the patient or completing an evaluative tool or checklist.

There are many concerns that emerge when a solid, clear definition for this role is lacking. This includes an inability to articulate the nursing work that is rooted in a concern for the person associated with, yet separate from, behaviours. Ultimately, the risk is that without a defined and accepted nursing component to the role, the nurse may be positioned as an agent of supervision and control instead of an agent of caring. Without solid theoretical developments, it remains challenging to define and ground the forensic mental health nursing role. A related concern is that if the demands, competencies, skills or attributes of the role are unidentified, there can be no recognition of when a nurse is adequately prepared educationally or experientially.

Further concern is the lack of educational opportunities to develop and enhance skills that remain not well articulated. These issues ultimately have implications for recruitment and retention of nurses in this area of practice, particularly if the role cannot be clearly established as a nursing and not custodial role.

Therefore, the definition used in this paper for the FMHN is one who: *integrates nursing philosophy and theory with knowledge and skill of mental health and potentially dangerous behaviours, and where the location contains enhanced security, for patients held under the authority of the criminal justice system.* This definition is clearly anchored in the science of nursing, indicating knowledge and skills required in mental health and

dangerous behaviours, while acknowledging the environment and patient legal status. It is the lens for assessment of the literature for appropriateness of inclusion.

Distinction from Other Mental Health Nursing

Given the lack of clarity arising from the term forensic mental health nurse, is use of it at all helpful? The debate in the literature includes assessing for any substantive differences between the FMHN and a MHN working in another setting or with a different population. The two opposing views of FMH nursing are articulated by Mercer, Mason and Richman, (2001) as: "... i) those that consider the practice to be underpinned by a unique body of specialist knowledge, and ii) those who see it as general psychiatric nursing skills applied to a specific target group" (p. 109). The crux of the debate relies heavily on being able to identify knowledge or skills required by the FMHN, and demonstrating how they would differ from what is required of a MHN who is not in the forensic context. Failing that, FMH nursing would be mental health nursing in a particular environment or with a particular population and not seen as specialist practice.

The literature exploring role distinctions between FMHNs and MHNs includes both research-based and anecdotal accounts. It has been suggested that in a general sense the FMHN role can give the impression of being more task oriented (Bowring-Lossock, 2006; Burrow, 1993a; Mason, 2002) than focused on the interpersonal processes thought to be the bedrock of nursing practice. Functions such as searching the patient, supervising patients using sharps (razors, scissors), monitoring phone calls and mail, escorting patients within the facility, and enacting security routines may support that perspective. Conducting assessments is also heavily identified with the role

of the forensic mental health nurse, yet the blanket term *assessment* does not reveal whether this is a task or a process. That is to say, the degree of interpersonal engagement inherent in the assessment varies with the purpose and method of the assessment.

Knowledge required for the FMHN is expected to lie in the domains of biological nursing, the criminal justice system, legislative mandates, mental health—mental illness and wellness, societal norms of behaviour, security, and working with individuals who are potentially violent, antisocial, or resistive to treatment. Yet Parker (1997) maintains that any nurse is “positioned between sets of contesting temporalities constituted by medical treatment regimens, institutional requirements for productivity and increased throughput with measurable outcomes, the pressingness of the patient’s needs and the designated nursing work load for the rostered shift” (p. 22). As a result the variables that affect the work of the FMHN may not sufficiently distinguish it from other mental health nursing work.

Defining the Patient Group

In the literature, FMH nursing is often defined in terms of the patient population (Bowring- Lossock, 2006; Shelton, 2009), thus it is important to consider the people for whom FMHNs provide care. The forensic mental health system in Canada addresses specific issues related to the intersection of mental health/illness and the law. The system considers a person’s fitness to stand trial, criminal responsibility in the commission of a crime, and dangerousness, as well as risk to the public due to mental causation. A person in the forensic mental health system is most often held under the Criminal Code of Canada (CCC), Section XX.I (mental disorder provisions), at least

initially, so that forensic mental health professionals can determine the presence or absence of a mental disorder. Forensic mental health patients are individuals who: a) became mentally ill after being arrested or incarcerated, b) were mentally ill at the time of the offense and were found not criminally responsible [NCR]; or c) are unfit to stand trial due to mental illness. Under the requirements of legislation, each province must establish Review Boards to: a) oversee the rehabilitation and supervision needs of the person, and b) reassess the disposition of those found NCR or unfit to stand trial. Members of the Review Board assess the patient's level of control and insight annually for purposes of determining his or her disposition and placement. In determining placement, the standard is the *least onerous and restrictive option* considered appropriate, and could range from correctional facilities and/or secure hospitals, to communities. It must be understood that secure forensic facilities also, on occasion, accommodate people who are civilly (as opposed to criminally) committed under provincial Mental Health Act legislation and who pose a significant risk of danger, requiring a secure environment for the safety of self or others. Thus, the patient group that FMHNs work with can be quite varied.

Impact of Environment

Exploration of environment considers a number of interrelated conditions which have an output affecting all those who work/live within. Sub-headings are used to acknowledge these aspects of environment and include; physical environment, culture, power issues, caring and risk, patients and treatment, and perceived safety.

Physical environment. The most obvious feature in secure forensic settings is the physical environment. Holmes (2005) described the impact of environment on new

forensic nurses as “cultural shock” when they experienced the secure forensic environment. Participants in the study felt that the conditions of the locked and heavily controlled environment made it impossible to achieve the quality of psychiatric care that would have been available in non-forensic environments. Features of secure environments are: locks in heavy doors, basic furnishings often bolted to the floor, bars on windows and/or doors, and restricted access. High levels of constant observation are provided by staff using monitoring routines or by camera surveillance. FMHNs working with patients in high security environments do not have keys that will permit exit from the building, and are released from the facility by those in a separate area authorized to do so, thus reducing the risk of hostage taking by a patient, in order to gain exit.

Culture. Constraints of the physical environment itself (security and restrictiveness) and the dynamic characteristics that develop (culture, atmosphere, and composition of the patient group) are significant considerations. As a result, considerations of environment represent more than the building itself, and have a role in power dynamics, levels of violence and psychological challenges, and the cumulative dynamic of the patients and staff who are in the facility. The very basis of the forensic mental health environment is one of security, whether it is a correctional centre, a locked hospital ward, or a dedicated psychiatric hospital. Locks and security routines do not only restrict movement, but they have a psychological impact on those within and provide a new frame of reference for enacting aspects of nursing work.

Power issues. The forensic mental health environment reflects a power dynamic that requires the nurse to situate his/her nursing approaches in recognition of those parameters (rules, security and constraints) and to negotiate therapeutic endeavours

within those constraints, knowing that the therapy is seen as less important than the security by all but the nurse (Kettles & Walker, 2007; Robinson & Kettles, 1998). This refers, in part, to how the constraints of the security in the environment affect routine therapeutic care and treatment options. For example, it is a common therapeutic strategy for individuals with mood disorders to keep a diary to reflect how their mood may fluctuate over a period of days so that it might reveal patterns. These patterns may help to identify triggers for depression, and assist with selecting suitable individualized therapeutic interventions such as medication dosing times within a 24 hour period. However, in a secure facility, a patient cannot maintain a pencil while in the general milieu, because it represents a potential weapon. This constraint requires innovation on the part of the FMHN to devise alternate strategies to achieve therapeutic outcomes while being ever mindful of the security and safety protocols.

Another consideration of power is concerned with whether or not security/correctional staff provide physical restraint or whether that function is part of the nursing role. Often there are requirements that during all nursing care, security staff must be present. This contributes to an “overseer” context, where the nurse and the patient are not able to interact without security staff present. Not only does this strain the establishment of the therapeutic relationship, but it also introduces an element of scrutiny and potential interference into the way in which the nurse may choose to structure care for the patient. In this environment, security routines are the primary authority under which nursing care is a secondary consideration. Nurses may need to show deference to security staff to enlist their collaboration when clinical care needs are being met (Holmes, 2005). This is congruent with my past practice experience, and

failure to successfully negotiate with security staff could jeopardize a nurse's own safety in an emergency.

Caring and risk. The *caring* attributes of being non-judgemental, nurturing, and empowering so identified with the nursing role are potentially problematic in these settings in a way that is different from what happens in hospitals. There is some evidence (Holmes, 2005) that these attributes may even be dangerous commodities, as demonstrations of care, empathy and attentiveness may leave nurses open to manipulation, thus compromising security. Holmes noted further that rules and routines exist without compromise in secure environments, and being conciliatory or allowing for variance in the rules, even for empathetic reasons, could result in judgments that the nurse is "a soft touch" or cause dissension between patients.

Patients and treatment. There is acknowledgement in the literature (Jacob, Gagnon & Holmes, 2009; Mason, Hall, Caulfield & Melling, 2009) that secure forensic settings contain a high number of patients diagnosed with personality disorders. Given the degree of disruption their behaviours cause in society this is not surprising. Forensic mental health nurses, non-forensic mental health nurses and members of other disciplines all reported (Mason, Coyle & Lovell, 2008) personality disordered patients as the most difficult in clinical practice. Patients with a diagnosis of personality disorder may demonstrate irresponsible, manipulative or thrill seeking behaviour for relief of boredom with no regard for consequences (Melia, Moran & Mason, 1999). These patients often view the world exclusively centred on their own needs and engage in behaviours that provide a distraction for them within the highly controlled environment. One of the most challenging personality disorder sub-classifications is the

Anti-social Personality Disorder (ASPD). According to the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) “the essential feature of ASPD is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood...deceit and manipulation are central features” (p.645).

As we have seen, the authority for a patient to be in forensic mental health care most often stems from the criminal justice system. And, despite the patient progress from a psychiatric and therapeutic perspective, the legal system may continue to have a concern for the safety of the community and not permit the patient to progress to a less secure facility, which may represent a significant stressor for both patients, and nurses working with the forensic populations (Miller, Maier, Vann Rybroek & Weidemann, 1989). Therefore, clinicians working in forensic settings have to be aware that the parameters concerning release of the patient are different from other psychiatric hospital settings, and patient psychiatric progress is one, but not the only dimension considered. This is another example of the power dynamics within the system and the effect on patients and nurses.

Perceived safety. Caplan (1993) found that both FMHNs and patients reported they were affected by the potential for violence in the secure forensic hospital. Caplan and Niskala (1986) both understand that nurses in forensic settings recognize the potential for danger in their patients, and emphasize compliance to rules and behavioural standards, as aspects of maintaining security in the environment. The environment of secure forensic facilities is designed to enhance safety by offering protection, limiting access and heightened observation of the patients. Chalder and

Nolan (2000) noted that security inherent in the environment of forensic hospitals in part contributes to FMHNs feeling safe and in control.

There are dissenting views in the literature about the impact of the environment on forensic mental health nurses and mental health nurses. Kinsella and Chaloner (1995) conducted a study in the UK exploring whether FMHNs, working in more controlled environments, held more conservative or custodial attitudes toward treatment than those working in less physically controlled areas. The conclusion was that there were no attitudinal differences between Regional Secure Unit FMHNs and mainstream MHNs or colleagues in other specialties, and no evidence that exposure to a secure environment (as opposed to a non secure environment) affects individual attitudes and orientation of nurses (forensic or non-forensic) differently.

However, differences in the perceptions of FMHNs (Mason, King & Dulson 2009) were revealed when in comparison between medium and low security environments; the high security environment had greater levels of transference and countertransference evident. These elements reflect the emotions experienced by both patient and nurses as they interact. Patients may behave in ways that trigger an emotional response in nurses who must then recognize and deal with those feelings in order to remain therapeutic. Patients often need help to refrain from projecting their emotions from other relationships onto the nurses who may be enacting authoritarian ways that remind them of others. Findings indicated FMHNs had a need to feel in control and believed they fail with patients more than they succeed. This may be reflective of the acuity of illness and the behaviours of the patients who composed the

high security patient group, but also may reflect the impact of a constrained environment on the nurses working in this area.

In trying to define MHN nursing, neither environment, even as the composite feature illustrated here, (Gillespie & Flowers, 2009; Lyons 2009,) nor patient diagnosis, is sufficient to rely upon. Whyte (1997) concluded that as a specialty, forensic nursing does not exist, because therapeutic incarceration does not confer entitlement to the use of the term forensic. He maintains that the work of all mental health nurses is affected by increasing amounts of criminal activity in society, and the presence of security exists in many mental health care venues now. It does seem simplistic to imagine that environment and the variables that stem from it alone could sufficiently define any type of nursing. However, the way in which the environment contributes to the enactment of FMH nursing is certainly an important element to identify and appreciate. As we will see as other themes are explored, the environment exerts a ripple effect, influencing other aspects of care in this arena.

Skill Set

This feature of inquiry rests on whether a cogent argument can be made that FMH nursing requires a unique, or at least substantially different skill set from other mental health nursing. If so, it would provide an impressive argument in support for forensic mental health nursing to be considered a specialty area of practice.

The literature reflects both support for (Whyte, 2000) and opposition to (Cashin, 2006) the view that FMH nursing is underpinned by unique knowledge or skills. Expressing opposition, Cashin asserted that FMH nursing is merely a sub specialty of psychiatric nursing, with a distinct environment or group of patients. Regardless, as this

scoping review progresses we will see that some other authors have noted unique characteristics of FMHNs.

Burrow (1993b) strongly advocates that FMH nursing is a specialty, citing the existence of a “range of phenomena which are sufficiently exclusive to confer a specialist status to the nursing role” (p. 903). These include control and custody; risk assessment; addressing behaviours; knowledge of illness conditions, criminal activity, therapeutic interventions, legal issues, custodial care, and offenders with psychiatric pathology. Lyons (2009) noted further that, although the knowledge base of the FMHN is no doubt substantial and incorporates nursing, mental health and criminal justice systems, the ability to utilize one’s skills under onerous and stressful circumstances (environment, risk, patient behaviours) is what really differentiates the practice from that of the MHN.

Some researchers have reported (Rask & Aberg, 2002; Rask & Levander 2001) that the use of confrontation skills is one of the most often used interventions of forensic psychiatric nurses. Peternelj-Taylor (2000) concurred, maintaining that it is used more in forensic psychiatric nursing than general mental health nursing. Although not exclusive to the skill set of FMHNs, the frequency of use of this skill may foreground differences in what are underlying beliefs about forensic mental health nursing practice and hint at how it may be distinguished from other mental health nursing.

Several authors (Martin 2009; Mason, Lovell & Coyle, 2008; Robinson & Kettles 1998) noted the need for special skills to work with the challenging behaviours of personality-disordered offenders, as necessary for the FMHN. Nurses in secure mental health services in the UK who participated in a survey (Dale & Storey, 2004) described

their relationships with personality-disordered patients as "...highly charged and emotionally intense with high levels of anger and hostility" (p. 177).

Those who advocate that the skills of the FMHN differ from mainstream mental health nursing have described it as, "quite different advanced skills from more traditional mental health workers" (Whyte, 2000. p.12), noting the need for "competence in mental health nursing and then needing to develop additional knowledge and skills" (Martin, 2009. p. 27). Kettles and Robinson (2000) saw FMH nursing as "not restricted to basic competency level, but included advanced practice" (p. 38).

The distinction of FMHNs is confirmed (Bowring–Lossock, 2006) as requiring skills highly focused on risk and danger. This is done by addressing aspects of security, assessment and management of risk, management of violence and aggression, knowledge of offending behaviour, and the culture of detention. Further, FMHNs are believed to need (Fluttert, Van Meijel, Nijman, Bjorkly & Grypdonck, 2009; Mason et al., 2009) skills in calming, defusing and de-escalating at a high level to intervene in tense situations. Rask and Levander (2001) suggested that it is possible FMHNs are encouraged to use psychodynamic interventions to a larger extent than MHNs possibly due to the turbulent histories of those who come into their care.

Those who do not support the claim of specialization for FMH nursing based on skill set (Hammer 2000; Martin 2001) do so largely because there is no evidence that the conceptual basis of practice differs from that of other mental health nurses. Martin (2001) maintains, "Incorporating knowledge and skills related to offending behaviour into their practice will contribute significantly to the development of forensic psychiatric nursing as a clinical specialty" (p. 31). Further opposition to specialist status rests on the

belief that, at the core, the skills needed to establish a therapeutic interpersonal relationship are required in all mental health nursing. Because caring is a value inherent in establishing such a relationship, there is insufficient evidence (Rask & Brunt, 2007) of a conceptual basis of forensic mental health nursing that stands alone. Defining differences in practice, and the manner in which any nurse displays caring, will always occur in response to the patient needs and choices and the nurse's skilled role is to provide individualized care regardless of the venue in which it may occur.

Personal Traits

Consideration of personal traits as a foundational aspect of suitability or success in many roles in society is common. Many people could easily identify their views of the attributes required to be a successful and effective teacher, doctor, or nurse. FMHNs may need particular personal traits in order to deal with the challenges of nursing in a forensic context. The unique emotional challenges are recognized as: a) prolonged difficult human contact with forensic patients whose model for relationships may be damaged (Aiyegbusi, 2008); b) the need to be suspicious and paranoid because of the patient population (Kettles & Walker, 2007); c) the need for security (Kettles & Walker, 2007); and d) the need to maintain neutrality and objectivity instead of being empathetic and supportive (Lyons, 2009).

Bowring-Lossock (2006) identified the importance of personal qualities in the forensic mental health nurse as those that may be taught, such as being calm or decisive, but acknowledged that many of the qualities might be innate. Robinson and Kettles (1998) saw traits such as honesty, maturity, nerve, awareness, reliability and common sense as the basic material of a forensic nurse. They asked nurses at 10 sites

in the UK to describe forensic (mental health) nursing and identify differences from fundamental mental health nursing. The results were that “the client group, the nature of the index offence, the potential of the clients to commit heinous offences, their history and the complexity of the person were all seen to make forensic nursing different” (p. 32). Understanding that FMHNs are not immune from feeling the horror, revulsion and dread resulting from knowledge of the criminal behaviour of the patient, this is understandable. However, it is not clear that this is necessarily any different from other MHNs, who may learn of some aspect of a patient history that is disturbing.

In order to move past an emotional response and enact therapeutic engagement, the FMHN must come to terms with the patient’s behaviours prior to hospitalization. Acknowledgement of this requirement is represented in the literature (Jacob, Gagnon & Holmes, 2008; Robinson & Kettles, 1998; Martin, 2001), and it is agreed that, for some nurses, this is not possible. The FMHN is required, on an ongoing basis, to contain negative feelings and cope with fear for one’s own safety while engaging forensic patients. Assessing a patient during an interaction requires noting the quality of the interaction, as a gauge of both the patient’s mental health status, and paying attention to cues that could signal impending violence.

The FMHN must have, or cultivate, personal traits that allow for interpretation and reconciliation of the demands of the work with the abilities of the nurse. The literature is replete with personal traits the FMHN must be able to draw on to be successful in this type of work. Several authors note attributes such as being: a) “self reflective” (Lyons 2009, p.54); b) “open, direct, unpretentious” (Edwards-Fallis, 2007,

p.49); and c) “more stable” (Robinson & Kettles, 1998, p.216), as required by the forensic mental health nurse.

Detached concern is a term (Pines & Maslach, 1978; Fluttert et al., 2009) that reflects the stance nurses cultivate between objectivity and emotional involvement with patients. Fluttert et al. (2009) compared forensic and non-forensic mental health nurses, and found “that staff members working with forensic patients as a group scored significantly further toward distance on the detached concern spectrum when compared with staff members working in general (non-forensic) mental health” (p. 7). This illustrates that FMHNs cultivate a position of intentional distancing from the patient, reflecting detachment. *Detached concern* is being able to moderate compassion by emotional distancing. Betgem (as cited in Fluttert et al., 2009) explained that it means staff have to “neutralize the emotional appeal of patients by an attitude of objectivity and at the same time show emotional involvement in which cynical and distant reactions are avoided” (p.2). This explains another aspect of balancing seen as vital for FMHNs. Yet to be required to neutralize emotions while at the same time showing emotional involvement would seem an almost impossible task.

Also addressing relationships with patients, Swinton and Boyd (2000) wrote that one of the ethical dilemmas that forensic mental health nurses face involves the concept of personhood, as discussed below:

...on the one hand they are faced with the difficult reality of having to respect the personhood of individuals who show little respect for themselves or for others; who are frequently aggressive and violent, sometimes dishonest, often deceitful and who may appear to have little or no remorse for the antisocial acts they may

have perpetrated. On the other hand, their professional role means that it is not possible for them to offer any kind of meaningful nursing care if they do not or cannot respect the personhood of the other (p.136).

Currently there is no theoretical grounding specific to forensic mental health nursing practice that could offer FMHNs a framework for coping with these challenges in their practice, and so it rests with the individual nurse to devise a personal method of reconciling emotions, attitudes, and ethics with the expectations of the forensic mental health nursing role.

The literature reflects a number of study findings rejecting the argument that personal traits of a forensic mental health nurse differentiate the role from its mental health nursing counterpart. For example, Mason, Lovell and Coyle (2008) revealed that the forensic nurses' main strength was identified as life experience, which was rated higher than clinical experience and non-forensic nurses' responses were the same, illustrating it is a common feature of both nursing viewpoints.

In further support of the opinion that forensic mental health nursing at its core is not unlike mental health nursing, Rose (2005) maintains that when FMHNs view incarceration as undeserved or with mitigating circumstances, advocacy and promotion of leniency by the nurse creates a relationship very much like that of MHNs.

Competing Philosophies

Two overarching philosophies create the practice arena of the forensic psychiatric nurse. One is representative of the criminal justice system, with a mandate of supervision, disempowerment and containment, and the other reflects the caring, patient-centred mandate of health care and nursing. What is it that distinguishes

forensic mental health nurses from being agents for surveillance and control (assessment and custody), as opposed to therapeutic engagement (caring) with ill persons? Highlighting the ethical tensions for nurses working in forensic mental health, Williams (2007) asks, "Does the forensic nurse have a greater duty to the wellbeing of the offender/patient or to society under the ethics of care system? In other words where does the greater nursing relational duty exist- with society or with the offender?" (p. 94).

This dichotomy of focus for the FMHN is well articulated in the "custody versus caring" literature (Austin, Bergum & Goldberg, 2003; Burrow, 1993a; Fisher, 2007; Peternelj-Taylor, 1999; Walsh, 2009) as central to many of the conflicts that contribute to stress in the nursing role. These competing elements represent a unique stressor for forensic mental health nurses in that nursing philosophy is grounded in the nurse's role of empowering patients, supporting rather than directing, and recognition of the supremacy of patients making decisions in their own lives. The custodial mandate is the antithesis of this nursing foundational belief. Because of this, recognition of solid theoretical underpinnings for forensic mental health nursing would clearly differentiate and situate the nurse in relation to other health care and criminal justice system services. Without such theory, nurses risk being merely an agent of the custodial mandate, and nursing itself risks marginalization through a failure to fulfill the professional mandate. Additionally, because some tasks (e.g., security searches, supervision of visits, escorting) done by nurses in the forensic mental health nursing role do not represent nursing work, it is important to be able to identify what it is that makes this work appropriate for nurses at all.

Many authors (Fisher, 2007; Mercer, Mason & Richman, 2001) express concern regarding the dilemma experienced by FMHNs in balancing therapeutic engagement with security and the powerlessness of the patient in the context of their detention. The Canadian Nurses Association (2008) *Code of ethics* explains that moral distress arises “in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm” (p.6). Moral distress is a potential outcome for FMHNs because they practice in settings under the weight of an ideology of incarceration, security and disempowerment that constrains their nursing actions, often without the power to successfully negotiate a viable compromise between the two.

Political and Social Influences

Political and social influences create the wider context in which forensic mental health nurses work. Certainly, the public wants to lock away persons who demonstrate violent or dangerous behaviours or who victimize society. There is a sense of justice in incarcerating someone who has acted against another person in our society, as a form of punishment. This becomes blurred when an individual acts out and is judged to have a mental condition rendering him or her unable to understand or appreciate that what they did was wrong or immoral.

Governments have successfully directed social marketing toward mental health conditions that engender compassion and reflect the patient as a victim of an illness condition. The government has not launched campaigns targeting mental health conditions other than depression and substance abuse. The public, given the stresses that are prevalent in society today, easily conceptualize both conditions. Neither is linked to expected violence, and any harmful behaviour is more often turned inward for

those individuals. In addition, major mental illnesses continue to be sensationalized in the media, and public education that could promote better understanding and less stigmatization is lacking. Thus, for the forensic mental health patient population, fear, ignorance, and stigmatization, coupled with a mentality of relief that these people are “put away”, prevail in the public consciousness. It is logical to assume that the public would not advocate or lobby on behalf of a population whose behaviour they do not understand and from whom they want protection. It is difficult for much of the public to envision someone who has committed violence as a victim, even though it is certainly the case for these patients.

Political and social stances that marginalize this population contribute to devaluation of the patient, and by extension to those who provide treatment and care. When nursing work targets a disadvantaged and stigmatized patient group nurses sometimes feel, by association (Halter, 2008), a lack of recognition for their efforts and a distancing from what prompted them to enter nursing.

As we noted earlier in this paper, the degree of attention paid to the pressures on FMHNs emanating from competing philosophies of custody and caring are powerful occupational stressors. Fisher (2007) suggested that striking a balance between custody and therapy is less problematic in environments that are appropriately resourced, secure and specialized. Thus the necessity for government funding, which could potentially mitigate some of this pressure is acknowledged. Public sentiment has the power to influence government priorities and subsequently where funding dollars are directed.

The legal language government utilizes (as embodied in the Ontario Mental Health Act) to describe placement and accommodation of the forensic mental health patient in Ontario is revealing. The standard for deciding the appropriately secure level of a facility for a forensic patient is the *least onerous and restrictive alternative*, and determination of that placement occurs in a *disposition* hearing. This results in the “*disposing*” of the patient to a suitable level of supervision. The Oxford English Dictionary on line provides the following definition of disposition: “...The action of disposing of, putting away, getting rid of, making over” (*disposition*, n.d.). The very fact that such language is seen as appropriate in a system targeting care and management of those with a severe mental illness is revealing. At this nexus of criminal justice and health, the language clearly indicates which element prevails.

Government planning and decisions about treatment are often contradictory and reflect the prevailing public opinion, even if that is a lack of concern for the individual and a protectionist stance in favour of public safety (Peternelj-Taylor & Johnson, 2005). In the United Kingdom, Kettles and Robinson (2000) point out that “forensic care and especially high secure services have been crisis-led going from one political investigation to another with little vision and a decided lack of social policy....which has restricted the growth of the [forensic mental health nursing] profession” (p.28).

Both the political climate and societal attitudes affect education for all mental health nurses. Prevailing social and governmental attitudes underscore policies that influence curricula and the length of the programs, and of course, funding dictates many of these parameters. Cutcliffe (2003) noted that influences that shape mental health

nursing education address the political climate of the time, the philosophical view of mental health/mental illness, and the overarching mental health policy framework.

It is certainly true that the public, other nurses and members of other disciplines often hold negative perceptions of psychiatric nursing (Gillespie & Flowers, 2009; Halter, 2002). Halter (2008) demonstrates this negative attitude directed toward mental health nurses with a study finding that: “nurses practicing in psychiatry scored lowest in terms of being skilled, logical dynamic, and respected. In ranking relative to the other specialties, they were also likely to be identified as introverted, dependent, disinterested, and judgmental” (p.23).

The negative image that forensic nursing holds within the profession (Polczyk-Przybyla & Gournay, 1999) is also a significant factor for consideration. Some nurses hold the view that mental health nursing in general is not *really* nursing. There is little in the way of biological intervention, few highly skilled psychomotor tasks, and no complex equipment routinely used in practice. There is a perception that nurses working in psychiatry do not maintain skills that are useful in the more generic practice of nursing. Anecdotally I recall a time when a medical unit was short of staff but maintained they would rather work short than be sent a “psych” nurse to fill in.

The nursing shortage has long been recognized (Pullan & Lorberg, 2001) as impeding the recruitment of qualified nurses. In the forensic mental health environment, however, it is even more difficult, given the nature of the patient population, the restrictive environment, the potential for violence, and the associated stigma (Martin & Happell, 2001). Specifically, recruitment into FMH nursing positions has been compromised (Pullan & Lorbergs, 2001) because “prestige and professional status often

are associated with more 'glamorous' areas of health care" (p.19). Political and social influences in our world help shape what is seen as worthy and consequently what is valued and deserving of status or prestige.

The perceptions held by student nurses are very important as an indicator of recruitment potential into FMH nursing. Both Halter (2002, 2008) and Happel (2002) found that there is a lack of appeal for student nurses to select this area of nursing work. In an Australian study, Happel (2002) found that students ranked psychiatric nursing as the eighth of nine specialty choices in terms of desirability, a ranking that remained after graduation. The rationale offered was that the field was not sufficiently rewarding or exciting. Role ambiguity (Maeve & Vaughn, 2001) contributes to the lack of a strong FMH nursing identity and perhaps if role definition were clear, the perceptions of others may change.

Stress and Burnout

In a general survey of 667 Canadian nurses, Leiter and Maslach (2009) found cynicism to be the key burnout dimension for turnover, and the most critical areas of work life were value conflicts and inadequate rewards. The authors explain that, "the primary issues for cynicism are: 1) exhaustion as a function of unmanageable workload, 2) value conflicts and unfairness in settings that do not support a nursing model of care, and 3) inadequate reward systems" (p. 337). Although not specifically reflective of either FMH nursing or mental health nursing in particular, these results certainly hold implications for the practice of FMHNs. As we have learned, FMHNs manage and attempt to balance the value conflicts of custody and caring in their practice at a foundational level on a daily basis. Secure facilities in which they work are rooted in

containment models of secure care and a theoretical basis of forensic mental health nursing practice, which may be of help to them in managing these pressures, does not yet exist.

There are, of course, different perspectives in the literature concerning the degree of stress or burnout experienced by FMHNs in relation to their mental health nurses counterparts. Dickinson and Wright (2008) identified that the main stressors for FMHNs are inter-professional conflicts, workload, and lack of involvement in decision-making. In terms of the weaknesses of their jobs, forensic nurses put frustration at the top of the list (Mason, Lovell & Coyle, 2008). Ewers, Bradshaw, McGovern and Ewers (2002) identified a risk for clinical burnout syndromes for FMHNs working with clients with enduring and profound illnesses. Yet, in a 1995 study, Kirby and Pollock found that FMHNs in maximum security environments were actually less stressed than their medium secure non- forensic counterparts were. These findings were confirmed by others (Chalder & Nolan, 2000; Happell, Martin and Pinikahana, 2003), who also compared the two groups of nurses. It seems the degree of security in the environment, in part, contributes to forensic mental health nurses feeling safer and more in control in high security environments, and therefore less stressed.

Physical assault is a risk when working with patients who have difficulty controlling their behaviour, have a significant history of violent acting out, or who may experience perceptual disturbances. Staff injuries are more common and serious in forensic settings than in other high-risk settings (Carney-Love & Hunter, 1996; Zimmer & Cabelus, 2003). Not surprisingly, institutional violence in forensic settings affects both nurses and patients. Holmes, (2005) and Reininghaus, Craig, Gournay, Hopkinson and

Carson (2007) found that physical assault has a statistically significant effect on psychological distress. Inward violence, in the form of self-injurious behaviours, is prevalent in forensic settings (Gough, 2005) and results in high anxiety for staff. Likewise, for many forensic mental health nurses there is stress associated with using physical restraint when that is a feature of the role. Nurses described (Sequeira & Halstead, 2004) how they disliked restraint and seclusion, and experienced feelings of anxiety, distress and anger when those situations arose.

Previously in this review, the relationship of the FMHN with philosophically conflicting principles and the security of the environment have been identified. The forensic psychiatric nurse working in a correctional setting must also establish a relationship of compromise with the correctional guards (Holmes, 2005) who must be present when the nurse is interacting with a patient. Holmes points out that ethical violations are more likely to happen in forensic psychiatry settings because nurses try to co-operate with guards and coexist with security mandates, both of which originate from the orientation of “jailer”. Guards focus entirely on rules, security and safety, with no concern about reconciling a competing philosophical mandate of providing care, which is not the case for the nurse. One might believe that when security functions are incorporated into the role of the nurse it is less stressful. However, maintaining the balance between security and therapy may result in nurses struggling to establish a respectful therapeutic alliance, while enacting custody and security mandates that constrain and disempower the patient (Dale & Storey, 2004; Holmes, 2005). What is required is to reconcile the values nurses are taught, with the realities of the constraints and competing philosophies in the setting, and determine what the nurse realistically

can do to address the chasm between the two. Allen (2004) warns that a “mismatch between the culture and ideals of nursing and the structure and constraints of the work setting is a chronic source of practitioner dissatisfaction” (p. 475). One can easily extrapolate how these stressors may affect FMHNs and ultimately affect recruitment and retention of nurses in these settings.

Job satisfaction is a variable reflecting, among other things, stress. Burnard, Morrison and Phillips (1999) explored 40 nurses’ perceptions of job satisfaction on a secure forensic unit in Wales. Although too small a study to be generalizable, there are still implications that are relevant for practice. The researchers found the nurses felt strongly that the job needed specialist skills and they were frustrated with the amount of paperwork and administrative type work required. They reported high levels of satisfaction with the doctor nurse relationship, and they enjoyed good levels of autonomy.

Certainly, no one would dispute that there is stress in the forensic mental health nursing role (Encinares & Pullan 2003) in a secure practice arena. However, in order to consider entitlement to specialization, the question is not whether the FMH nursing role is stressful, but whether these conditions create for the FMHN a significantly different, or more intense, practice than those experienced by other MHNs.

Functioning Within a Multidisciplinary Team

Both FMHNs and MHNs interact with patients and provide care no matter how negative the behaviour may be or to what intensity psychiatric symptomatology presents. This is not the generally expected commitment of other members of the clinical team. Often the very nature of the therapeutic involvement of social work,

psychology, occupational therapy or recreation, is predicated on a level of self-control the patient can exert. This can create a rift in the cohesion of an interdisciplinary team.

The depth of relationship FMHNs have an opportunity to establish with patients differentiates them from other team members and is seen as unique (Aiyegbusi, 2009; Lamont & Brunero, 2009), given they are in contact with patients longer than other team members. It also may contribute to conflict in the team when nurses do not see things in the same way as other team members who spend less time with the patients (Chalder & Nolan, 2000). This reflects either a loss of objectivity by the nurse, or too distant a view by another team member, and often results in conflict.

Robinson and Kettles (1998) reported on a study in which forensic nurses considered they provided “a link between disciplines which is a pivotal role and is central to communication” (p.217). They also reported that some nurses feel they have low status within the multidisciplinary team, reflected by poor pay and less autonomy than other team members. Where nursing roles are well articulated and multidisciplinary team composition reflects clear boundaries of the scope of practice for all its members, one might expect more collaboration and fewer turf battles to result. Stress results from working with people who do not share one’s professional values and when role blurring and role conflict exist within a multidisciplinary team (Chalder & Nolan, 2000).

Mason (2002) identified boundary issues that both mental health nurses and forensic mental health nurses experience with other multidisciplinary team members. Shelton (2009) specifically points out that there is a necessity to “develop clinical evidence reflecting issues of day to day clinical management of patients to differentiate specific nursing interventions from those of the clinical team members” (p.140).

Mason, Lovell & Coyle (2008) found that serious conflicts existed between forensic and non-forensic nurses, as well as other disciplines. The conflicts seemed based upon how they perceived FMH nursing. Findings indicated that nursing groups tended to focus on personal qualities of the nurse or patient, whereas members of other disciplines saw the nursing role defined in terms of the organizational structures.

Among the clinical team in general, the uniqueness of the role of FMHNs, and what support they require from management is presented by Aiyegbusi, (2009) as:

Nursing occurs within a team context however the extent to which nurses remain in interpersonal contact with patients makes their role unique...general management within these services can support the work of nurses by recognizing their work as emotionally challenging and as a result by validating and prioritizing the supportive structures required to enable effective clinical work to take place within the emotionally complex world of forensic mental health services (p.35/36).

Although stress was considered previously in this paper, interprofessional conflicts are identified in the literature as stressors for FMHNs. In a study comparing the stress of forensic and acute mental health nurses (Chalder & Nolan, 2000), the author revealed that FMHNs experience more stress from inter-professional conflicts than do their mental health nurse counterparts, while also acknowledging that FMHNs often have strong personalities and are assertive. Interestingly, we learned in the earlier exploration of personal traits in this paper that such attributes are seen as desirable for FMHNs.

Education

Before exploring the needs of the forensic mental health nurse with respect

to education, a Canadian inconsistency exists in the mental health/psychiatric nursing workforce. In the provinces of Manitoba, Saskatchewan, Alberta and British Columbia, a position called Registered Psychiatric Nurse (RPN) exists. Yet in other jurisdictions such as Ontario, the Registered Psychiatric Nurse role does not exist. Instead there is a different role in the nursing workforce, *Registered Practical Nurses* (RPN) who are trained at a generalist level, and there is no recognition of the western Canadian psychiatric nursing qualification. It is unfortunate that use of the same acronym refers to two separate and distinct nursing roles contributing further to confusion within the same country.

It would seem a logical conclusion that if a FMHN is somehow fundamentally different from a MHN, then there should be some reflection of that difference in their educational needs. The lack of formal educational preparation or a delineated educational pathway specific to forensic mental health nursing may increase the potential for role conflict because there is no foundational knowledge upon which to build one's practice. It may also hamper the existence of an autonomous nursing presence within the team and delay the ability of a nurse to develop self-confidence and strong decision-making skills (Gillespie & Flowers, 2009).

Although Niskala (1986), in her landmark work, did not define forensic nursing, in her study of nurses working in forensic areas in British Columbia, she identified competencies and skills (Appendix C) that were required. Several more authors (Dale & Storey, 2004; Kettles and Robinson 2000; Pryke, 2005) have identified competencies required in FMHN education, relating to skills such as therapeutic relationships, recognizing diversity, managing aggression, management of risk, and substance abuse.

Yet most of these do not appear in generalist nursing education. Stressing the need for education specific to the role, Kettles and Robinson (2000) maintain forensic nursing requires a clear career pathway with education addressing roles and the direction forensic nursing is taking.

The International Association of Forensic Mental Health Services (IAFMHS) special interest group (FMHNs) newsletter (March 2007) revealed that a group of nurses in Australia created forensic psychiatric nursing standards to attempt to identify the nursing contribution to work with forensic patients. This group acknowledged difficulty in capturing what was particular to FMH nursing as opposed to mainstream psychiatric nursing knowledge and skills, as well as difficulty in trying to capture the various venues (courts, community and hospitals) and populations (juveniles, personality disordered persons) where this nursing work is done. Unfortunately, dissemination of this work has been limited and has not resulted in a larger movement to establish these standards more broadly.

Pullan and Lorbergs (2001) advocated educational interventions necessary for forensic mental health nurses in addressing any attitudes that may reflect punitive and custodial values, stigma and myths. In a pilot survey of forensic nurses in Australia, New Zealand, the United States, and the United Kingdom, Evans and Wells (2001) examined forensic nursing practice, role definition, and role identity. Approximately half of the respondents had no forensic-specific nursing qualifications, and more than half of the respondents were not identified as forensic nurses by their position title, even though they were. The lack of specific qualifications serves to weaken recognition of forensic mental health nursing as an area of legitimate specialty.

In a comparison of FMHNs and MHNs with respect to assessment of risk, Whitehead and Mason (2006) identified that FMHNs need high levels of skills and competencies in risk assessments and clinical engagement. Fluttert et al., (2009) agree, adding that skills specific to handling/preventing aggression are also needed as ongoing education for FMHNs.

In a Swedish study by Rask and Aberg (2002), researchers found that special knowledge needs of the forensic psychiatric nurses were unmet in their basic professional training. The nurses in the study reported that they needed in-service training targeting ward specific problems, as well as specific knowledge and skills. This led to the conclusion that there could be a need for developing courses leading to formal qualification in forensic nursing care.

Both clinical supervision and clinical coaching/mentoring receive attention in the literature. There is considerable acknowledgement of the need for clinical supervision in forensic mental health nursing (Baxter, 2002; Dale & Storey, 2004; Gillespie & Flowers, 2009; Happel, 2002; Pryke, 2005; Rask & Aberg, 2002; Kettles & Robinson, 2000). Education, in the form of clinical coaching, was recently implemented at the medium secure forensic unit of Royal Ottawa hospital. The intent of the program (Thorpe, Moorehouse & Antonella, 2009) is to promote retention of veteran staff by recognition of their skills, and aid in recruitment of novice nurses who receive support as they enter the field. Perhaps this will help answer Cashin and Potter's (2006) concern that there is not yet a sufficient amount of data to support that mentorship was effective in recruitment or retention in the forensic setting. It may also help to address those gaps in

acquired knowledge and skills that currently have no formal educational component meeting the need.

The US government, since 9/11, has contributed to educational development by supporting specialist education. In Canada, as in the UK and Sweden, the model for education is that of generalist nursing at the baccalaureate level (Kent-Wilkinson, 2009), reflecting a different focus than the specialization model used in the US. Any specialization here is occurring at post baccalaureate and graduate levels. Existing education in forensic studies (Appendix D) in Canada is by no means widespread, reflecting perhaps a lack of demand or a lack of perceived need or value. The development of forensic nursing education has been limited (Sekula, Holmes, Zoucha, Desantis & Olshnsky, 2001) by the unresolved custody and caring tension, societal demands for punishment and retribution, and a lack of definition regarding forensic nursing.

Discussion and Conclusions

The intent of this scoping review was to determine what is known from existing literature and broaden our understanding of both the forensic mental health nurse and the debate concerning entitlement to specialization status for FMHNs. By doing this literature review, I learned that the term forensic is a nebulous one, and a source of consternation and confusion. In the UK, a forensic nurse is in fact a forensic mental health nurse, yet elsewhere in the world that term may refer to a nurse working in a secure environment who does not practice mental health nursing at all. Without a common language to identify this role, it remains difficult to access an inclusive body of

literature, make meaningful comparisons, or replicate research studies to assess broad applicability. In short, there is confusion without internationally transferrable terminology.

In much of the literature, there is a concern that use of the term forensic (in relation to FMHN) serves to situate nurses' work in relation to the offending behaviour and the judicial system. Given this, one might ask where the direction and support for the nursing component of care originates and upon what it is grounded. Are nurses merely invited into the secure setting to perform distinct patient care tasks and expected to do so according to the rules, in exchange for their own safety and wellbeing?

What we now know from the literature is that forensic mental health nursing is a multifaceted area of practice with a need for the FMHN to be able to balance many competing factors. These include: a) philosophies of containment and caring, and all that emanate from each; b) emotional and attitudinal responses to possibly heinous behaviours of patients; c) collaboration with security staff while maintaining a solid nursing ethos; and d) need for skills in intervening with dangerous behaviour, including both physical and psychological risk and potential injury.

Emerging from this scoping review is a much fuller appreciation of the magnitude of the power dynamics that are so pervasive to forensic mental health nursing. Just as a general discussion of environment would not have sufficiently highlighted the various components within it, it is ultimately too simplistic to see the philosophies of control and nursing only as lofty mandates, which define the context of this work. Silent in such interpretations are the human costs to those who work within such environments. It is expected that ethical values guide the behaviour of nurses, however, when enacting those values is constrained by institutionalized obstacles, the

toll on the nurse can be profound. Discovering the value conflicts resulting from the various dominant discourses pervading this type of nursing work is a suitable focus for future research. The results from such research could inform practice and contribute to the formulation of curricula designed to address learning needs specific to FMHNs.

Discourses of *care* (humanistic, nurse-pt relationship); *containment* (security procedures); and *psychiatry* (assessment of mental status, language and diagnostic labels, expert knowledge of mental health) are some of those that join the direct discourses of power in shaping the work of FMHNs. It is unclear how we define or recognize ethical practice in oppressive environments where everyone is controlled and constrained. Further, it is difficult to know how we will ever determine what nurses *want* to do, when to speak about it openly may put them at risk (their credibility or safety) with other members of security staff or clinical team members. Finally, it is unclear how, then, the cost of these enforced silences could ever truly be measured on an ethical, physical or professional level. The state of knowledge about how ethical work is positioned in a system where ethics do not frame the way in which all staff are expected to function, is a topic for future inquiry.

To examine the elements that nurses identify as mitigating the context of their work in secure facilities exceeds the scope of this review, however could be a focus for future inquiry. It would be particularly interesting to explore administrative characteristics and practices affecting staff in secure facilities that may reinforce and encourage the use of *excessive* power (unnecessary) as opposed to *relative* (appropriate) power.

Recognizing where this literature review had taken me, I recalled that my original intention had been to explore the outcomes (the cost) for FMHNs working in secure

settings. I had some intuitive thoughts that a career in this type of nursing work affected the nurse in ways that would be of value to learn. I have now come full circle to a more informed awareness of the toll it must take on many nurses to spend a career navigating the ethical maelstrom of working as a forensic mental health nurse.

The personal attributes needed for this type of nursing work are described in the literature but fall short of providing any kind of clinical model to reflect how they are particularly therapeutic or different from those required by any other mental health nurse. Considered in the context of what has been learned from the literature, I question if these attributes, seen as valuable to the FMHN, are merely representative of the powerful discourses that shape the nurse as much as the patient. It may be that the nurse has assimilated attitudes, traits and behaviours in a defensive posture, in order to fit into the culture of the population (both staff and patients) in an environment where power and control are almost sacrosanct. This insight prompts inquiry about the true value of nursing traits, such as confrontation, which we learned is highly prevalent in the forensic environment, if they are not used for a therapeutic purpose. It also raises a disturbing concern that without a clearly articulated theoretical basis for FMHN practice, perpetuation of some nursing approaches may do more harm than good. This is especially true given the history many patients have with ineffective relationships or as victims of abuse themselves. Where do FMHNs turn to learn how to interact with a difficult and potentially violent patient group, different from those for whom other MHNs provide care?

There is a dearth of formalized education, foundational and ongoing, addressing the role of the FMHN and so it is unclear where the skills, attitudes and coping

mechanisms are learned, documented, or developed. Perhaps the high level of support in the literature for clinical supervision, and the establishment of a formal clinical coaching program will begin to address this issue. Without a solid educational grounding for forensic mental health nursing practice, there is a risk that the field will develop in a haphazard and confused fashion, and not in accordance with any standards specific to the practice demands. Even if there were specialized foundational knowledge for the FMH nursing perspective, there are insufficient and scattered educational systems to disseminate that knowledge at present.

In consideration of the nurse-patient relationship, so fundamental to all nursing practice, again different opinions exist. Some see the relationship between patient and FMHN as fundamentally different (Mason, Williams & Vivian-Byrne, 2002) from other nursing because of the nature of the detainment, the element of forced treatment, and the recognition that what patients say to nurses will be noted and used to make decisions about their placement and release.

More research is necessary to learn whether specialist status for FMHNs is appropriate and upon what basis it is supportable. Specific aspects of this nursing that require further exploration are fear and containing negative feelings of abjection (Jacob, Gagnon, Holmes, 2008), and coping with anxiety stemming from restraint and managing violent behaviours (Marangos-Frost & Wells, 2000). Niskala (1986) highlighted that “requiring particular attention is clarification of the forensic mental health nurse’s professional role - especially ethical and legal issues, role blur, and role conflicts” (p. 412).

It is not enough to have extensive experience in an area of nursing to be a specialist. A case for specialist status for FMH nursing requires recognition and codification of whatever is the extant body of knowledge specific to this nursing role. Ethical and political discussions acknowledging the tensions, as well as more research on defining what is truly nursing in this role, will help with theoretical development. Establishment of a theoretical basis for the practice would create a single conceptualization of forensic mental health nursing. Research targeting these outcomes could help to finally define the role, and highlight any distinctive features of FMH nursing such that the decision about specialist status could go forth. Perhaps the work of the IAFMHS special interest group in forensic mental health nursing will be disseminated more broadly to invoke dialogue and stimulate critical thinking.

Consequently, the literature reflects that the debate continues concerning whether or not there is a unique basis of knowledge or skill set that is applicable to this type of nursing work alone. Prolific authors of forensic mental health nursing work cannot agree. Burnard (1992), Burrow (1993b), Peternelj-Taylor and Johnson (1995) and Woods (2002) agree it is a specialist area. However, Mason and Mercer (1999), Whyte (2000) and Doyle (1998) disagree. At present, there is not a sufficiently cogent argument to end the debate about entitlement to specialist status for forensic mental health nursing, and so it will remain unacknowledged.

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Appendix A
 Synthesis of the Research – Samples

Burnard, P., Morrison, P., Phillips, C., (1999) Job satisfaction amongst nurses in an interim secure forensic unit in Wales <i>Australia & New Zealand Journal of Mental Health Nursing</i> , 8(1), 9-18.						
Study type	Setting	Subject	Study aim	Response Rate	Findings	Gaps/limits
The Index of Work Satisfaction Questionnaire, only one part was used in the present study to facilitate ease of use. Questionnaire format and contains 48 statements related was used. 1-Salary 1-Proffessional status 3-Interaction 4-Task requirements 5-Administration 6-Doctor 7-Autonomy	Small forensic unit offering assessment treatment, rehabilitation and after care for mentally disordered offenders.	given to all nursing staff in the unit at the time (n=48)	The aim of the study was to explore nurses' perceptions of job satisfaction. And to provide information that could be used as baseline data in the overall evaluation of the care provided in the unit.	n=40 83%	<ul style="list-style-type: none"> - major source of dissatisfaction is salary. - Felt strongly their job required specialist skills, (95% of the respondents). -Good satisfaction of effective teamwork. Interaction between team members is important to maintain clear lines of communication and consistency -Were less satisfied with issues, task requirements and administration. Paperwork and administrative work was too much -A significant number felt that nurse administrators should consult more and that a greater emphasis should be on patient issues. -High levels of satisfaction on doctor-nurse relationship and autonomy. 90% of nurses felt doctors understood and appreciated their role -Positive feedback about the levels of job satisfaction could be used to attract and retain nurses into this field Job satisfaction data could also be used to evaluate the effectiveness of organizational changes as services develop and expand. 	Interaction between members of different teams and between professional groupings, particularly, doctors and nurses, was generally rated as being of high quality. This may relate directly to the small size of the unit.

Caplan, C. A., (1993). Nursing Staff and Patient Perceptions of the Ward Atmosphere in a Maximum Security Forensic Hospital, <i>Archives of Psychiatric Nursing</i> , 7(1), 23-29.						
Study Type	Setting	Subject	Study aim	Response Rate	Findings	Gaps/limits
<p>The Ward Atmosphere Scale (WAS) was used to measure nursing staff and patient perceptions of the ward atmosphere.</p> <p>A separate questionnaire for demographic information was completed by nursing staff at the same time</p> <p>A questionnaire developed and designed to collect demographic data about patients was completed by the researcher through a review of the patients' medical records.</p>	<p>A maximum security forensic hospital located in a small city in the north-eastern United States.</p> <p>A maximum census of 65 patients located within four treatment units.</p>	<p>Nursing staff and patients on 4 wards of a maximum security hospital.</p>	<p>to describe nursing staff and patients' perceptions of the ward atmosphere in a maximum security forensic hospital.</p>	<p>(69%) n=70</p>	<p>Structure and compliance with the routine and behavioural standards were important to the differences in perception of the ward atmosphere.</p> <p>Pts perceived emphasis on compliance with routines, but felt that they did not understand the rules or staff expectations.</p> <p>Pts perceived an above-average amount of staff control, - enforcers of behaviour and regulations. Nursing staff perceived that they exerted only minimal control over patient behaviour.</p> <p>Nurses and Pts are affected by the potential for violence.</p> <p>Nurses believe they maintain a delicate balance between treatment and security.</p> <p>A majority of nurses indicated there are real physical dangers inherent in working here whereas other nurses believed the dangers as exaggerated.</p> <p>Indicated that forensic patients have unique characteristics that impact on the treatment environment and the provision of nursing care</p>	<p>Generalizability of this study is limited as it was done in only one maximum security hospital</p>

Evans, A., M., & Wells, D. (2001). Scope of Practice Issues in Forensic Nursing. <i>Journal of Psychosocial Nursing</i> 39(1), 38-45						
Study type	Setting	Subject	Study aim	Response Rate	Findings	Gaps/limits
Pilot Study research project had 2 parts: a survey and selected semi-structured interviews	Forensic settings comprised of:	Australia- via database of forensic nursing newsletter	Forensic nursing practice: locations, role definition, role boundaries	160 sent out (40 to each country)	<p>more than half of the respondents were not identified as forensic nurses by their position title, although only those assumed to be forensic nurses received a questionnaire. This raises questions about possible inherent difficulties when members of a group are not identified by their title. Also leads to questions about the visibility of forensic nurses because the absence of the word "forensic" in a position title fails to signal the specialty to the work environment.</p> <p>Approximately half of the respondents had no forensic-specific nursing qualifications- of concern because how forensic-specific knowledge and philosophy of practice are are communicated?</p> <p>There is significant role variation, across the Western world, in relation to how forensic nurses practice.</p> <p>Issues arising from the data include the visibility of forensic nurses, the client group, forensic-specific education, and role development.</p> <p>The invisibility of forensic nurses within the health care field, and even within the profession of nursing... is heightened when forensic nurses are unable to signal their specialty by having the word "forensic" in their position description/title</p>	It is likely the research sample was skewed in favour of forensic nurses with an interest in forensic nursing issues, or research because they are more likely to receive the Australian Forensic Nursing Newsletter, be a member of the IAFN, or be listed on the International Forensic Database.
	54% secure hospitals	New Zealand- via one forensic service as no register		58 were returned, a response rate of 36% n=58		
	11% prisons	UK- via international forensic database				
	16% morgue, university, self - employed.	USA- via membership directory IAFN				
	19% clinics, courts, emerg depts	North American: Internet bulletin board post: 6 USA and 1 Canadian				

Happell, B., Martin, T., & Pinikahana, J.(2003). Burnout and job satisfaction: A comparative study of psychiatric nurses from forensic and mainstream mental health service. *International Journal of Mental Health Nursing*, 12(4), 39-47.

Study type	Setting	Subject	Study aim	Response Rate	Findings	Gaps/limits
Packet contains: The Maslach Burnout Inventory The Job Satisfaction Scale of the Nurse Stress Index Satisfaction with Nursing Care and Work	Mental health service Melbourne AU	95 forensic psych nurses and 96 psych nurses	Compare forensic psychiatric nurses with psychiatric nurses in relation to burnout and job satisfaction	surveys to 95 forensic nurses (n= 51) and 96 psychiatric nurses (n= 78)	<p>More psych nurses suffer ‘higher’ burnout on the emotional exhaustion and depersonalization subscales when compared with forensic nurses who score lower</p> <p>Forensic psych nurses indicate greater satisfaction with their present level of involvement in decision-making at work and in the degree of support they receive in their job. Forensic nurses are less likely to consider finding another job within nursing. However, a higher proportion of forensic nurses considered finding an occupation other than nursing, compared with their colleagues from the mainstream service.</p> <p>Forensic nurses are more satisfied with their responsibility, and independence than psych nurses</p> <p>Forensic psych nurses showed a higher level of satisfaction with friendly atmosphere, co-operation and comfort at work, than the mainstream psychiatric nurses. Mainstream psychiatric nurses agreed that they had less knowledge about the disease and treatment, and needs and wishes of their patients than their forensic counterparts.</p> <p>Forensic nurses were less likely to consider that they have no right to be angry with patients..</p> <p>Overall, the forensic psychiatric nurses are ‘less’ burned out and ‘more’ satisfied , whereas the mainstreamed psychiatric nurses are ‘more’ burned out and ‘less’ satisfied with their profession, work environment, peer support and professional growth.</p>	<p>While the forensic sample represents a significant proportion of forensic psychiatric nurses in Victoria, the number of nurses from mainstream service constitutes a very small proportion of mainstream psychiatric nurses of Victoria.</p> <p>All employed with the one mental health service.</p>

Kirby, S.D, & Pollock, P.H. (1995). The relationship between a medium secure environment and occupational stress in forensic psychiatric nurses. <i>Journal of Advanced Nursing</i> 22(5). 862-867						
Study type	Setting	Subject	Study aim	Response rate	Findings	Gaps/limits
<p>demographic questionnaire and questionnaire to give impression of perceived workplace stressors (self harm, hostage) occupational stress indicator (Cooper et al, 1988</p> <p>- ward atmosphere scale (Moos, 1974) 100 true false questions assessing the social aspect of the wards by staff working on them.</p>	<p>Compared a high and med secure ward in northern England</p> <p><u>Ward A</u> high secure acute admission/ ICU high penal system referrals but also management issues from other psych hospitals</p> <p><u>Ward B</u> med secure – long stay /rehab either from Ward A or special hospitals</p>	<p>Levels of stress within the specialty of forensic psych nursing are mainly anecdotal and this study examines the possible relationship between an in-pt secure environment and stress for FPN.</p>	<p>Possible relationship between a secure environment and levels of occupational stress</p> <p>Hypothesis: occupational stress would be found at high levels throughout the sample - more on the high secure ward than the medium- & at higher levels than a normative group of mental health workers</p>	<p>80% return rate n=38</p>	<p>No significant differences between wards</p> <p>Max secure: anger and aggression are tolerated to a large extent as part of the treatment programmes but under strict supervision”</p> <p>Staffs have clearly defined personal methods of dealing with stress</p> <p>Staff rotation may represent a protective factor. Staff rotates between the wards q 18 mo difference in the wards security levels and regimes help diffuse boredom and apathy, help personal and professional experience..</p> <p>Max secure seen as therapeutic and members are committed dedicated and proactive with high degree of perceived control and satisfaction in the workplace.</p> <p>stress accepted as an intrinsic part of working within a forensic service and an appropriate coping technique is devised.</p> <p>Measure: sickness rates, aggressive incidents are associated with observed rise in occupational stress scores</p>	<p>No differentiation of sick time – long term from scattered days</p> <p>Mean years in facility 6 yrs</p>

Mason, R, Lovell, A, & Coyle, D. (2008). Forensic psychiatric nursing: skills and competencies: I role dimensions <i>Journal of Psychiatric and Mental Health Nursing</i> , 15(2), 118-130						
Study type	Setting	Subject	Study aim	Response rate	Findings	Gaps/limit
survey	Secure MH services Compared to a group from general mental health practice	Multi disciplinary staff – but focused on nurses	<p>identify skills and competencies of FPN</p> <p>Identify difference between FPN and non FPN and other disciplines?</p> <p>Perceived strengths and weaknesses in skills and competence</p> <p>What are required nursing skills and not required nursing skills?</p> <p>Establish the main benefits and barriers to FPN</p> <p>Main problems, skills to overcome the problems and skills to be developed</p>	<p>N=1172 (35%)</p> <p>3360 surveys sent</p>	<p>Forensic nurses main strength was life experience rated higher than clinical experience Empathy and clinical experience were others listed. This did not differ from non forensic nurses but all three differed from other disciplines responses</p> <p>main weaknesses forensic nurses put frustration at the top of the list ...in general terms, with aggressive patients, with management,, with psychiatrists, with ignorant staff and with lack of results</p> <p>Special nursing skills required by FN: Nursing PDs, listening skills, confidence, clinical knowledge, communication, non-judgemental attitude, empathy, patience,</p> <p>lack specific skills: assertiveness, confidence, conviction, decision-making capacity, direction empathy, enthusiasm evidence based experience further training knowledge motivation publications research respect from other disciplines, resources, specialty and time.</p> <p>Job satisfaction was listed as the main benefits to nurses, followed by patients progression</p> <p>Main barriers: bureaucracy(paperwork), lack of support from managers, management, medical power</p>	<p>A more structured and quantitative analysis would have given a clearer picture of the strength of each discrepancy found between each level of security.</p>

Rask, M., & Hallberg, I., Rahm. (2000). Forensic psychiatric nursing care- nurses apprehension of their responsibility and work content: a Swedish survey *Journal of Psychiatric and Mental Health Nursing* 7(2).163-177

Study Type	Setting	Subject	Study aim	Response rate	Findings	Gaps/limits
<p>Likert Scale questionnaire</p> <p>organization of care and nursing care:</p> <p>responsibility and content in nursing care:</p> <p>theoretical models of care and nursing care:</p> <p>clinical supervision for nursing staff and</p> <p>the nurses' job satisfaction.</p>	<p>Five forensic units with regional responsibility for providing care and treatment were chosen for this study.</p>	<p>Nursing care staff employed for more than 6 months, mostly IMNs ,RNs or RNs with advanced training in psychiatric care.</p>	<p>The aim of this study was to investigate nurses' views regarding the areas of responsibility and the content of nursing care. The aim was also to investigate differences concerning gender, training, and theories believed to guide nursing care in five Swedish forensic care units.</p>	<p>A total of 350 questionnaires were distributed and 246 responses were obtained (70% response rate).</p> <p>Four questionnaires were excluded because of high internal dropout (n=242).</p>	<p>2 most common areas of responsibility were 'activities related to patients A.D.L.'s and 'assessing, informing and educating patients and medical administration'. The least common were 'co-operating with social authorities' & 'educating patient's family and verbal interaction groups with family/patients.</p> <p>This study has shown forensic psychiatric nurses stated their responsibilities and work content as mainly consisting of actions relate to A.D.L.-activities, assessment, informing and educating patients and families as well as medical psychiatric actions. Practical work on the ward, regular verbal interactions and planning activities together with the patients were actions nurses stated as most frequent at the item level.</p> <p>Further research needed to investigate whether the aspects that dominate nursing care also coincide with what the patients see as beneficial for their recovery. It may also be useful to consider an increased focus on family involvement and a psycho-educational approach in forensic nursing care.</p>	<p>The findings do not show what is effective and high quality care from the patients' perspective or from the perspective of what type of nursing care is effective for the patients' rehabilitation.</p>

Appendix B:

Accreditation Standards
American Board of Nursing Specialties (2007)

CRITERIA

- Evidence of the professional and scientific status of the specialty exists.
- A body of scientific knowledge that is unique and distinct from that of basic nursing provides the theoretical underpinning for the specialty. A substantial portion of the knowledge base is not shared by other nursing specialties, although some of the components may be shared with related specialties.
- There is evidence of a societal need for nurses in the specialty and a pool of nurses who concentrate their practice in the specialty (50% or more of their work time, functions, or professional roles are spent in the specialty).
- A national or international organization with registered nurse members endorses or supports the specialty.
- The specialty has been defined, its core knowledge explicated, a scope of practice written, with the nursing component delineated, and standards for the specialty specified.
- The science, its set of elements, and the relationship of the elements to the whole of nursing science, is described.
 - The practice specialty's definition and/or standards describe how the following four essential elements of contemporary nursing practice as detailed in the American Nurses Association Social Policy Statement (ANA, 2000) are operationalized:
 - attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation;
 - integration of objective data with knowledge gained from an understanding of the patient or group's subjective experience;
 - application of scientific knowledge to the process of diagnosis and treatment; and, provision of a caring relationship that facilitates health and healing.
- If the specialty certification is available to other disciplines:
 - Role Delineation Studies (RDS)/job analysis data provide evidence that demonstrates the unique role of nurses from other disciplines practicing in the specialty.
 - Based on the RDS/job analysis, an examination, including but not necessarily limited to those unique nursing components, is administered to registered nurses.
 - the certification credential awarded to nurses is a nursing credential; the nursing credential is awarded only to registered nurses.

Appendix C

Competencies and skills required by nurses working in forensic areas.

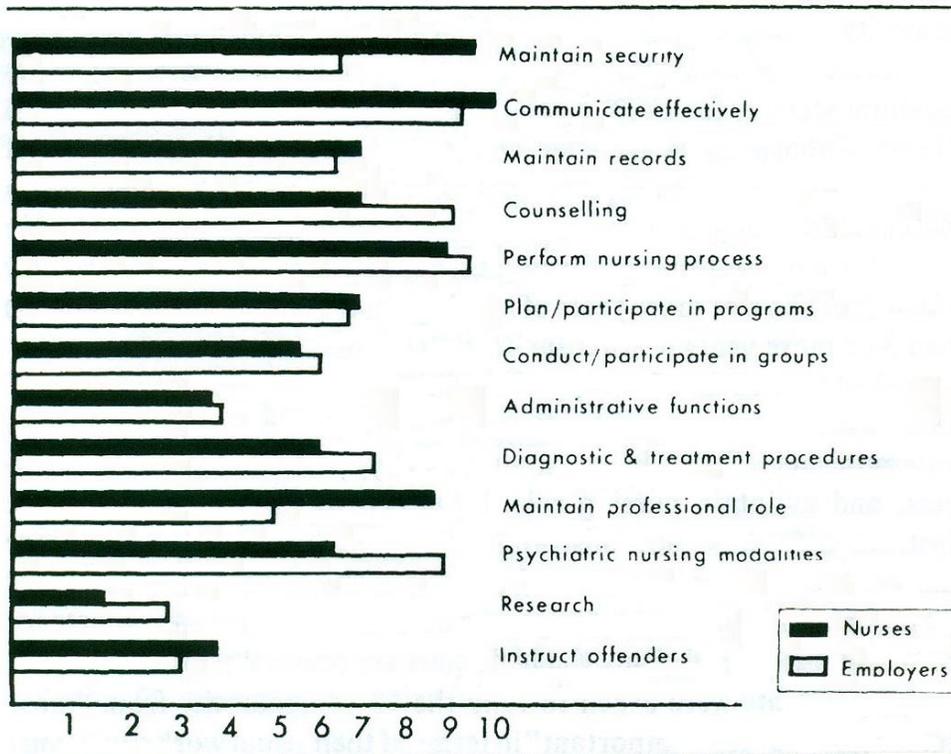


Figure 1: Mean weighting for each of the 13 competencies.

Niskala, H. (1986). Competencies and skills required by nurses working in forensic areas. *Western Journal of Nursing Research*, 8(4), p 405.

Appendix: D
Forensic Education in Canada

1. FORENSIC STUDIES PROGRAM, Mount Royal University- Calgary Alberta certificate program in forensic mental health nursing
2. FORENSIC HEALTH STUDIES CERTIFICATE PROGRAM, Seneca College, Toronto.
3. FORENSIC PROGRAM, British Columbia Institute of Technology (BCIT) course in Forensic health sciences Technology not nursing specific
4. MASTER OF NURSING WITH FORENSIC SPECIALTY, College of Nursing, University of Saskatchewan
 - Nursing 815 - Grad Advanced – forensic mental health nursing
 - Nursing 486 - Post Registration...Forensic nursing in secure environments