

Literature Review of Forensic Psychiatry
As an Undergraduate Clinical Placement
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As partial fulfillment of Master of Nursing
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April 4, 2011

Abstract

This integrative literature review examines the nursing literature around the suitability of forensic psychiatry as a clinical placement for undergraduate nursing students with no previous clinical experience in psychiatric/mental health nursing. A search of the nursing literature using various databases, CINAHL, ERIC and Web of Science, that addressed the researcher's area of interest finds there to be a paucity of literature. Four of the five retrieved articles address the clinical placement of undergraduate BScN students in forensic psychiatry. The fifth article describes a collaborative partnership between a School of Nursing and a forensic Psychiatric Unit. Further research is suggested to evaluate the suitability of forensic psychiatry as a suitable place of learning about mental health/illness for undergraduate BScN students.

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Introduction

Statement of the Problem

Following World War II to the present time, there has been a shift in mental health care from psychiatric institutional care to local general hospitals, non-profit community agencies and psychiatrists (Goering, Wasylenki, & Durbin, 2000; Latimer, 2005). At best, care is fragmented leaving people living with mental illness vulnerable at various junctures (Latimer, 2005) and often admitted to corrections facilities. In fact, corrections facilities have been referred to as de-facto providers of mental health care (Davis, 2006).

The impact of the changes to the mental health system has a particular implication within the context of education for professional practitioners specifically that it reduces the availability of clinical placements in psychiatric/mental health nursing for undergraduate nursing students. Complicating the lack of placement opportunities is the fact that many students are often reluctant to request clinical placements in psychiatry/mental health (Arnold, Deans & Munday, 2004; Happell, 1999, 2000, 2001, 2009; Hoekstra, van Meijel & van der Hooft-Leemans, 2010; Ng et al., 2010). Yet clinical experience on inpatient psychiatric/mental health units is identified in the research literature as a major influence in changing student attitudes towards people living with mental illness (Happell, 2008; Mullen & Murray, 2002; Rushworth & Happell, 2000). The World Health Organization (WHO) states “evidence shows that exposure to appropriate curriculum content about mental health and supervised clinical practice in a relevant mental health area makes it more likely that student nurses will develop positive attitudes to mental health and to people with mental disorders” (WHO, 2007, p. 27).

Another set of issues affecting the mental health sector of health care is that the shortage of nurses predicted by government and by various nursing and health care organizations has led to struggles recruiting nurses and retaining those already in the system. Mental health settings share these same

struggles. In Ontario, mental health and addictions, community, and complex continuing care and rehabilitation have the highest vacancy rates for nursing (Ontario Hospital Association, 2007).

Lastly, the incidence of mental illness is predicted by WHO to increase at an alarming rate. By the year 2020, depression is “projected to reach 2nd place in the ranking of disability-adjusted life years (DALYs) calculated for all ages, both sexes” (WHO, 2010). All of these conditions place the mental health system and the people relying on the system at risk. With a lack of adequate funding and a lack of prepared nurses to care for and advocate for a system of care that is well funded and current, people living with mental illness will continue to be stigmatized and living in third world conditions.

Purpose of the Project-Questions Arising

This project examines the current research literature to identify gaps in nursing students' knowledge and to analyze those gaps in relation to the extent to which placements in corrections offer opportunities for students to meet their mental health nursing learning needs. Martin and Happell (2001) identify the value of student placements in forensic psychiatry provided the environment "does not reinforce the negative view that students tend to hold towards mental health nursing" (p.117). Holmes (2005) states "this complex professional nursing practice involves the coupling of two contradictory socio-professional mandates: to punish and to care" (p. 3). Is there literature that speaks to how it is students can be prepared to practice within the context of two such diametrically opposed systems in ways that facilitate learning?

It was assumed by the author, in advance of this project, that students could benefit from support to examine and question the place of intersection of the two dichotomous systems- health and corrections in which people living with mental illness are located. The process of moving people from one system to another – from the health care system to criminal justice; from facility to community and back again is also worth discussion. It is also about the intersection of nursing, corrections and the "inmate", "patient", "resident". How do students make sense of this intersection of systems and how do students fit into this shared space?

Contextualizing Purpose

Secure Treatment Unit (STU) as location

The Secure Treatment Unit (STU) of the St. Lawrence Valley Correctional and Treatment Centre is a 100-bed Schedule 1 facility for male offenders identified with serious mental illness serving provincial sentences in Ontario. The STU is operated as a partnership between the Ministry of Health & Long-Term Care (MHLTC) and the Ministry of Corrections (MC) with nursing staff providing care, programming and direct supervision of residents. Corrections staff maintains security of the institution including

continuous video observation of each of the four units, responding to crises situations on the floors as they arise. Offenders, who consent to a referral to the STU, are formally referred by the provincial jails within which they are incarcerated, to the STU. This is different from the psychiatric forensic system in which clients are court ordered for assessment or are found not criminally responsible (NCR) (Royal Ottawa Health Care Group).

It is within the context of the STU that the issue of student placements is located for the purposes of this project. This became an issue of concern when four third-year nursing students did a 96-hour placement at the STU in March 2010. For one student the experience was especially difficult. The student was accused by staff of sharing her telephone number with one of the residents. Although the student denied having shared her personal information, because of the difficult situation on the unit this accusation created, she was removed from the unit and completed her placement elsewhere.

This incident raised a number of questions for faculty and for the staff at the STU including management, corrections and nursing staff. Is this a placement suitable for undergraduate nursing students? Are there particular students who are more vulnerable in this setting? What can be learned about psychiatric nursing in this setting? How is it students will have experiences in psychiatric nursing if not forensic psychiatry? This is a small rural city in eastern Ontario with limited placement opportunities for students. The students in the program already travel to Ottawa for pediatric experience at the tertiary hospital for this area. This is an hour and a half drive each way. Can we ask them to do this drive for psychiatric/mental health nursing experience?

Location as Discipline

The intersection of forensic psychiatry and incarceration creates a space of contradictory expectations for nurses' practice. It is in this space or location that nurses are "constituted as both subjects and objects of power" (Holmes, 2005, p.5). Nurses continuously move between their caring role and the correction's role of custody in an attempt to stay within the limits or the dictates of the

institution in which their practice is located. Morrall (1999) contends “psychiatric nursing cooperates thoroughly in the enforcement of control in society” (p.120) either directly or indirectly. Morrall (1999) goes on to suggest that one need only observe the practice of the nurse on a locked forensic unit to see this element of nursing practice. A number of authors (Morrall, 1999; Gelnister, 1998) note that this practice of social control is surreptitious and insidious, often couched in the name of what is best for the patient and his/her treatment and plan for discharge to their community; treatment and plans which “make” the patient/inmate behave in ways that are more socially acceptable and less troublesome.

Nurses themselves are disciplined to be in particular ways with patients and with the health care/corrections system. Holmes (2005) identifies that nurses “have to show continuous deference to correctional guards in order to obtain their collaboration when dispensing routine psychiatric nursing care” (p.11).

Trends & Prevalence Rates

Health Canada (2006) estimates prevalence rates of mental illness/disorder in the Canadian population to be 4.5 to 5.5 percent of the population experiencing a mental disorder in a twelve month period. Internationally, mental illnesses accounted for 9.4% of the disability-adjusted life years (DALYs) in 2002 (Health Canada, 2006). “This is comparable to 9.9% for cardiovascular disease and almost twice as high as DALYs attributed to cancer (5.1%)” (Health Canada, 2006, p.38). Furthermore, the World Health Organization (WHO) estimates that by the year 2020, “depression is projected to reach 2nd place of the ranking of DALYs calculated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined” (WHO, 2010). One need only consider the aforementioned statistics and the global nursing shortage to realize that the question of who will care for people living with mental illness is of utmost significance. Luis and Gray, contributors to WHO’s Atlas: Nurses in Mental Health, 2007, note that nursing education is failing to prepare nurses to meet the needs of the population. The question of who will care for people living with mental illness is complicated by the lack of student interest in psychiatric/mental health nursing and by the practice of transinstitutionalization or the move of people living with mental illness from facility to community. This begs the question, where will “relevant mental health care” take place and who will provide that care?

The Senate Standing Committee on Social Affairs, Science and Technology (2006) suggests “to meet the increased demand for mental health services that are integrated and recovery oriented, an effective healthcare professional workforce is required” (as cited in Ng et al., 2010, p.102). The shortage of nurses, predicted by government and by various nursing and health care organizations, has led to struggles recruiting nurses and retaining those already in the system. Mental health settings share these same struggles. In Ontario, mental health and addictions, community, and complex continuing care and rehabilitation have the highest vacancy rates for nursing (Ontario Hospital Association, 2007). “The

inability to recruit nurses for mental health services is attributed to a lack of interest in the field and a dearth of incentives for mental health nursing. ... (A)nother reason is the lack of safety and security in the work environment and the stigma associated with mental disorders” (World Health Organization, 2007, p.9).

Locating “relevant mental health care”

According to Peternelj-Taylor (2008) the location of the caring for people living with mental illness is more and more in the corrections system. Peternelj-Taylor states “countless consumers of traditional mental health services increasingly find themselves seeking mental health care under the auspices of jail, prisons, and correctional facilities” (2008, p. 185). The closure of inpatient mental health beds and the move to community mental health without adequate funding for the development and implementation of a network of relevant care supports has led to more and more people living with mental illness admitted to jails or forensic psychiatric treatment units. As a result, the location of “relevant mental health care” is more and more located in jails and prisons or secure treatment units.

Background

Historical Context

Institutionalization, deinstitutionalization, transinstitutionalization

In an attempt to explain how it is that the system of care for those living with mental illness has come full circle, one needs to have a beginning understanding of institutionalization, deinstitutionalization and transinstitutionalization.

“Before the end of the eighteenth century, there was no such thing as psychiatry” (Shorter, 1997, p.1). In fact, surgery was really the only medical specialization at that time. This is not to say that mental illness/disease was not recognized but that it was more individual physicians or families who were concerned. Shorter writes that “human society has always known psychiatric illness, and has always had ways of coping with it” (p.1) whether it was by digging a hole in the floor and placing bars over the hole to contain the person suffering with mental disease or forcing the afflicted family member out of the family home to become a beggar or village idiot (Shorter, 1997). It was not uncommon for people living in villages and deemed to be affected by disorders of the mind to be chained in barns or to walls in their houses. These practices of containing the mentally ill were carried on in Europe and the American colonies (Shorter, 1997).

In the cities of England, at this same time, institutions did provide accommodation for the homeless, demented or psychotic. The accommodation, purely custodial, was located in hospices, jails and workhouses with no intention of providing therapy (Shorter, 1997). The French government did provide care in two established hospices for the sick, the criminal, the homeless, and the insane. “Both retrospectively, were known as scenes of horror, the inmates being regularly flogged, bound in chains, and subjected to stupefying hygienic conditions” (Shorter, 1997, p.6).

In the American colonies, the treatment of the mentally ill was similar; families were expected to care for family members who were afflicted. By the early 1800s, insane persons were locked in jails and kept

under horrific conditions (Slovenko, 2003). In 1841, Dorothea Dix, a Boston schoolteacher visited a jail where she became distressed by how it was that insane persons were being treated. Dorothea Dix became a strong advocate and reformer for having the mentally ill moved from jails to hospitals (Slovenko, 2003). As a result of her advocacy work, twenty states were persuaded to treat insanity as an illness (Slovenko, 2003, p.642). The development of the mental health system in Canada parallels that of the American system (Goering, Wasylenski, & Durbin, 2000). Shorter (1997) and Slovenko (2003) refer to this time as the “era of moral treatment”.

As a result of the reform movement, insane asylums were built outside of towns on large expanses of pastoral land that would provide fresh air and quiet for rest and recuperation. “Housing people in asylums in Canada began with humane intentions as a part of a progressive and reformist movement, which attempted to overcome neglect and suffering in the community, jails and poorhouses” (Davis, 2006, p.104).

Shorter (1997) articulates the controversy about asylums that arose in the early twentieth century:

The rise of the asylum is the story of good intentions gone bad. That the dreams of the early psychiatrists failed is unquestionable. By World War I, asylums had become vast warehouses for the chronically insane and demented. Yet whether the failure of the asylum lay in the nature of the enterprise itself is a controversy. Some argue that the asylum failed because it was overwhelmed by the ever-rising numbers of psychiatric patients in the nineteenth century. Others maintain that many people admitted to the asylum had no psychiatric illness and confined merely because they were social misfits and outcasts, inconvenient rather than ill. Through this historical debate, as through psychiatry itself, runs the cleft demarcating neuroscience from psychosocial understanding. The neuroscientific side of the story sees growing pathology; the psychosocial version sees a social universe increasingly intolerant of deviance..... at the end of the story, the asylum fails. (p.33)

One theory of deinstitutionalization is that following World War II, in the 1950s, with the introduction of psychopharmacology, the increase in overcrowding of psychiatric hospitals and the uproar over various “treatment” modalities such as induced insulin coma, psychosurgery and hydrotherapy, the move away from institutionalization to community mental health began (Davis, 2006; Slovenko, 2003). “The pharmaceutical industry quickly exploited the implications of the new compounds. Medication became the mainstay of treatment” (Slovenko, 2003, p.645).

Novella (2008) labels this thinking as “a mythical tale...a sort of sacred tale about past events which is used to justify social action in the present” (p. 306). Novella (2008) goes on to suggest that in fact, the coercive, controlling acts of the asylum continue in community but at a more concealed, less apparent level. It is suggested that as asylums were more often criticized as less than therapeutic spaces, the future of the profession of psychiatry was at risk. Coincidentally or not ... “psychiatrists have grown in number and presence and probably improved their image and social prestige as a consequence of the reform processes developed during the last decades” (Novella, 2008, p.308).

It must be said that the reasons for the move away from asylums, as locations of care for those living with mental illness, to community are multi-layered and deserve a comprehensive description rather than oversimplification.

Despite the fact that in the 1960s and 1970s, psychiatric facilities were at “their best since the early 1900s” (Slovenko, 2003, p. 647), the shift to community services and to psychiatric units in general hospitals moved forward. Policy makers and practitioners imagined that when living in community, the mentally ill would connect with their community physicians, would live in homes and would be welcomed into the community. During the 1970s it became evident that the imaginings and good intentions of government, the healthcare system and the patient advocacy movement were not successful. “...initial enthusiasm for deinstitutionalization dampened with the awareness that many discharged patients were living impoverished lives in the community, swelling the ranks of the homeless

and those in jails” (Goering et al., 2000, p.346). The funding spent on hospitalization did not follow patients to community. In Canada, provincial governments flowed more funds from hospital-based mental health services to community mental health, but the funds were inadequate in providing the care and supports needed for patients living in community. The system remains underfunded today (Davis, 2006; Goering et al., 2000). Goering et al. (2000) state “failure to achieve an ideal of community-focused mental health care is a result of insufficient resources” (p.349). With a system of care fragmented and under resourced, people living with mental illness “find themselves being bounced between courts, jails, and prisons- a process known as transinstitutionalization” (Peternejl-Taylor, 2008, p. 185).

“Critics have declared that the “deinstitutionalization of seriously mentally ill individuals has been the largest failed social experiment in twentieth century America” (Peternejl-Taylor, 2008, p. 185). The Honourable Michael Kirby, Chairperson of the Mental Health Commission of Canada in a speech given in Vancouver (2008) stated “The situation is even worse with respect to how we treat the mentally ill who have no place to live. They are growing in number and in cost to governments which are increasingly unable to afford to help them”.

Police are often the first responders to calls for assistance in community psychiatric emergencies (many of which involve the homeless mentally ill) and are therefore the point of entry to the systems of health care and/or correction’s treatment units for people living with mental illness. The criminal justice system, at both the federal and provincial levels, has become the de facto psychiatric facility providing care and containment of people living with serious mental illness (Davis, 2006). Davis (2006) references a number of Canadian studies that indicate the prevalence of serious, persistent mental illness is higher in jails and prisons than that of the general population. A report from Human Rights Watch (2003) as referenced in Davis (2006) found “American prisons now contain three times as many persons with mental disorders as do units in general and psychiatric hospitals” (p. 174). A recent report, *Under*

Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy' (2010), published by Corrections Canada, notes that there has been an increase of 71% in the number of "offenders admitted to federal jurisdiction with (sic) a mental health diagnosis" (p.13). The criminalization of mental illness has become the norm once again. "In the great world of 'they sayers,' they say that the more things change, the more things stay the same" (Peternelj-Taylor, 2008, p.185).

Psychiatric Nursing in Canada

In Canada there are two currently different models of psychiatric nursing practice and education. This split came about in the 1950s when psychiatrists attempted to take over responsibility for psychiatric nurse education through an apprenticeship model similar to that being offered in Ontario's hospitals for the insane (Tiplinski, 2004). This tug-of-war between psychiatry and nursing led to a split at the Manitoba-Ontario border with the four Western provinces adopting the model of Registered Psychiatric Nurses and the rest of the country maintaining a specialty within general nursing (Tiplinski, 2004).

In Ontario, the early asylums provided custodial care to patients housed in their facilities. In 1909, the government changed the focus of the asylum to care provision of the mentally "ill". The names of asylums were changed to hospitals for the insane and five schools of nursing were established in hospitals for the insane in Toronto, Kingston, Hamilton, London and Brockville to offer a standardized three year mental nurse training curriculum (Tiplinski, 2004). In an attempt to encourage better patient care and to provide a professional status for the nursing sisters, the Graduate Nurses' Association of Ontario (GNAO) mandated a lengthy affiliation with general hospital schools of nursing (Tiplinski, 2004). Despite resistance from the psychiatrists and the Superintendents of the Hospitals for the Insane, the GNAO persisted and in 1925, "a six-month affiliation for mental nurse students was instituted, and while the medical superintendents retained control of their schools, the affiliation was key in effecting the professional transition from mental to registered nurse in Ontario's institutions" (Tiplinski, 2004, p. 257). Tiplinski (2004) goes on to state

In 1930, again at the insistence of the RNAO leadership, general affiliations were increased to nine months and placed within the training program. And while some medical superintendents complained of “too much professionalism by the RNAO,” most were in agreement with the general affiliation for their students. (p. 257)

In 1921, Manitoba established two schools to train mental nurses. The schools were “institution-specific and developed according to the whims of their medical superintendents” (Tiplinski, 2004, p.259). Unlike the reaction of the GNAO in Ontario, the Manitoba Graduate Nurses Association (MGNA) reacted in the opposite way and lobbied for legislation that would make it more difficult for mental nurses to become registered nurses (Tiplinski, 2004).

Following World War II with an increase in the numbers of people admitted to mental hospitals and a shortage of nurses willing to work in mental hospitals due to poor wages and poor working conditions, RNAO had included mental nursing as part of mainstream nursing education. Because there was a lack of student placement opportunities at provincial hospitals, RNAO steered away from making mental health nursing a mandatory component of general nursing education. This provincial split continues to this day.

Forensic Psychiatric Nursing

Once considered an area of nursing that was less than desirable, forensic nursing has undergone significant transformation and is “attracting high-caliber quality professionals who are seeking the unique challenges the setting has to offer” (Shelton, 2009, p. 132). Kent-Wilkinson (2010) states that “forensic nursing is an emerging global nursing specialty, with subspecialties that focus on nursing practice at the clinical-legal interface of tending to victims and offenders, living or deceased” (p.425).

The larger specialty area of forensic nursing includes the following subspecialties: interpersonal violence including partner violence, sexual violence, elder abuse, child abuse and neglect; human trafficking; correctional nursing; forensic mental health; legal nurse consulting; emergency /trauma services; death

investigations; public health and safety; and mass disasters (International Association of Forensic Nurses). For the purposes of this project, I will focus on forensic psychiatry/mental health.

Forensic Psychiatric Nurses (FPN) focus their practice on patients identified most often as offenders having a diagnosed mental illness (Coram, 2006). (One might argue that offenders with mental illness incarcerated with offenders with no mental illness are often victims of crime within the facilities they are sentenced to for treatment). Kent-Wilkinson argues that the role of the FPN developed out of the demand for health care for offenders that was comparable to that of the general population (2010). This demand and the demand for the “advancement of humanity” are included in the mission, vision, and mandate of the International Association of Forensic Nurses (IAFN) and the Forensic Nurses’ Society of Canada (FNSC), an emerging interest group of Canadian Nurses Association (CNA). IAFN has membership on the councils of Amnesty International (AI), the United Nations (UN), Human Rights Watch, and Physicians for Human Rights (Kent-Wilkinson, 2010).

According to Holmes (2005), forensic psychiatric nursing in corrections is a “hybrid work environment” in that there “exists a certain paradox where nurses function as “peace officers” and “agents of care” (p. 3). It is this duality of criminal behavior and mental illness that can lead to practice dilemmas for the nurse.

Dilemmas associated with custody and caring have been identified in the literature as ethical dilemmas for nurses (Cashin & Potter, 2006; Kent-Wilkinson, 2010). Nurses may be exposed either first-hand or vicariously to violent and traumatic events; however the primary role of the forensic nurse is to assist and care for patients and to contribute to evidentiary collection (Cashin & Potter, 2006).

Role of the Forensic Psychiatric Nurse

Mason, Lovell and Coyle (2008, 2009) recently attempted to identify skills and competencies required by the FPN working in secure settings. Interestingly, the researchers concluded “there is some distance to go before we are at a stage where we can clearly delineate the skills and competencies of forensic

nursing practice” (2008, p.137). They did find however, that nurses are challenged in dealing with issues of violence and aggression and managing patients diagnosed with personality disorders (2008).

Lyons (2009) does identify the following as skills the FPN requires: interpersonal communication skills under onerous and difficult situations- communication with the incarcerated individual, with the police, courts, team members and other stakeholders; the ability to be self-reflective and to consider one’s own biases and emotional responses to what may be heinous crimes and behaviours; an awareness and comfort with one’s professional standards. Lyons (2009) goes on to identify the practical skills required as safety and security; assessment and management of risk for violence and aggression; knowledge of offending behavior and prison culture.

Methodological Approach

Whittemore (2005) states that literature reviews “present the state of the science, resolve conflicting reports of evidence, and have direct applicability to practice and policy” (p. 56). Integrative reviews “allow for the integration of diverse methodologies and has the potential to play a greater role in evidence-based practice for nursing” (Whittemore & Knafl, 2005, p.547).

An integrative review of the literature was used to explore the suitability of student nurse placements on forensic mental health units as places of learning about mental health nursing. Whittemore (2005) (as cited in Polit & Beck, 2008) refers to “an integrative review as a broad integration that can encompass theoretical or empirical literature- or both- and that uses a narrative approach to the integration of either qualitative or quantitative findings” (p. 665). The process of integration of quantitative and qualitative research literature “expands the understanding of a particular problem or topic in order to generate knowledge that will be useful to nurses” (Whittemore & Knafl, 2005 as cited in Norwood, 2010, p.131). Whittemore and Knafl (2005) describe a five-stage process used to “define concepts, to review theories, to review evidence, and to analyze methodological issues” (p. 547). This five-stage process described by Whittemore and Knafl (2005) was used in this literature review. The stages include: identification of a problem, literature search, data evaluation, data analysis and finally presentation of findings (Whittemore & Knafl, 2005).

A systematic integrative literature review is an appropriate methodology for this particular area of interest as it allows for synthesizing various studies “in order to more fully understand a phenomenon of concern” (Whittemore & Knafl, 2005, p. 547), being in this case, clinical placement of undergraduate nursing students in forensic psychiatry. The findings of the review will contribute to the learning needs and support of undergraduate nursing students placed in forensic psychiatry, and may secondarily contribute to attitudinal shifts in both practicing nurses and students.

Literature Search

Scope of Literature Review

Loiselle and Profetto-McGrath in Polit & Beck's Canadian Essentials of Nursing Research (2011), refer to Cooper's (1984) five search methods: "ancestry approach or footnote chasing, the decadency approach or searching forward in citation indexes, online searches, informal contacts such as research conferences, and the bibliographic databases" (p. 387).

For the purposes of this literature search, an online search of the literature using various databases- CINAHL, ERIC, and Web of Science, was done using key search terms: nursing student, attitudes, forensic psychiatric and/or mental health, student nurse placement, education. The reference lists of articles retrieved were also reviewed for further relevant literature. The ancestry approach was used with references from footnotes reviewed.

Inclusion/exclusion criteria included literature written in English and published in scholarly journals within the last 15 years. Literature directly related to student placements or education in the area of forensic mental health was included.

Of the five articles selected for this review, four of them were based on qualitative research. The fifth article was a description of a collaborative partnership between a School of Nursing and a Forensic Psychiatric Unit.

Data Evaluation and Data Analysis

Whittemore and Knafl (2005) identify that although "strategies for data analysis with integrative reviews are one of the least developed aspects of the process" (p.550), methods of data analysis used for mixed-method and qualitative research designs are applicable in integrative review data analysis. It is suggested in the literature that two or more individuals be involved in the coding of the studies used

for the integrative review (Loiselle & Profetto-McGrath, 2011; Whitemore & Knaf, 2005). For the purposes of this student project, this recommendation will not be followed.

The Primary Research Appraisal Tool developed by Paterson et al. (2001) as quoted in Loiselle & Profetto-McGrath (2011) was used to provide a systematic way to review and evaluate the studies. This tool covers such aspects as sampling, data gathering strategy, data analysis, researcher credentials, and researcher reflexivity. (Appendix A).

The next step is to extract data about the relevant study characteristics. This was done in table form using the following headings: substantive and theoretical underpinnings, methodology, findings, limitations, and critique. Citation and study participants were also included. (Appendix A).

There is a paucity of literature about clinical placements for undergraduate nursing students in forensic psychiatry and the preparation of students for these placements. Three articles described student placements in forensic psychiatry, one in Saskatchewan (1996), one in Victoria, Australia (2001), and the third was a report commissioned by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) (2001). The final two research articles were based on research done by Kent-Wilkinson in which she interviews nurse educators to gain an understanding of nursing education in North America in forensic nursing in general (2008, 2009).

Explicit data analysis methods specific to the integrative review are needed “to protect against bias and improve the accuracy of conclusions” (Whitemore & Knaf, 2005, p. 457). Data from primary sources were compared item-by-item and grouped together. The groupings were then further analyzed through the generation and naming of themes. There were five themes identified in the literature examined. The themes were:

- defining forensic nursing,
- the need for education of students in forensic mental health nursing,
- factors affecting student learning opportunities in forensic nursing,

- the dichotomy of custody and caring, and
- curricular suggestions.

Each of these themes is detailed below (Peternelj-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001; Kent-Wilkinson, 2008, 2009).

Perhaps the most significant finding though is related to the limited literature there actually is about student placements in forensic mental health settings. Inherent in this lack of literature may be an underlying assumption related to attitudes about people living with mental illness especially those who have committed crimes.

Defining Forensic Nursing

Forensic nursing in North America has been defined in various ways over the years and a number of concepts associated with knowledge of the specialty area of forensic nursing identified (Kent-Wilkinson, 2008, 2009). A working definition of forensic psychiatric/ mental health nursing is necessary if one is to develop education programs for those undergraduate and postgraduate nurses interested in this area of work. In particular, this project is interested in the definition of forensic psychiatric/mental health nursing and how it may be different from other areas of nursing especially psychiatric/mental health nursing. The literature reviewed for this project defined forensic/mental health nursing in similar ways and included the following:

- patients are cared for in a locked environment in which nurses are both caregivers and gatekeepers and in which nurses must balance care and custody of patients, and
- nurses intersect with the legal system and the health care system (Peternelj-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001; Kent-Wilkinson, 2008, 2009).

Need for Education of Student Nurses in Forensic Mental Health

Creating challenging and stimulating opportunities in mental health settings for student nurses in a therapeutic milieu is becoming challenging for nurse educators (Peternelj-Taylor & Johnson, 1996;

Storey & Dale, 2001; Martin & Happell, 2001). Often times students are not interested in placements in mental health nursing preferring to develop their technical “skills” while in school and upon graduation (Martin & Happell, 2001). The literature indicates that once students have theoretical and clinical experiences in psychiatry, their attitudes towards those living with mental illness are less negative, the students are less fearful, and they are more positive about the practice of mental health nursing (Peternelj-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001).

Each of the authors used in this project identify that appropriate locations of learning in traditional mental health settings are becoming scarcer (Peternelj-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001). This scarcity is due, in part, to the move to deinstitutionalization and the closure of hospital beds.

Factors Effecting Student Learning Opportunities in Forensic Placements

Peternelj-Taylor & Johnson (1996), Storey & Dale (2001), and Martin & Happell (2001) identify the characteristics of placements in forensic mental health that contribute to student learning. Not unlike other areas of clinical placement, the factors that influence the quality of forensic mental health student placements are staff attitudes and role modeling, the time spent in clinical and the availability of supportive clinical faculty. “Recognizing that education and practice are interactive processes directly affects (sic) the quality of clinical experiences” (Peternelj-Taylor & Johnson, 1996, p. 23).

Custody & Caring

The role of the nurse working in forensic mental health is one of providing care to clients in a secured environment. These two concepts are perceived by students to be diametrically opposed and to be incompatible. Peternejl-Taylor & Johnson (1996), in particular, suggest that in order to be therapeutic the nurse must recognize that the corrections system and the health care system are different and that therefore the roles of the nurses and the corrections staff are different. This may be a point of (un)ease for students. A space must be created and opportunity afforded the students to process and makes

some sense of the dichotomous roles of the two systems and how it is they intersect, compliment, and contradict each other. "Custody and caring can co-exist in the provision of therapy in a secure setting...and need not be seen as competing interests" (Peternejl-Taylor & Johnson, 1996, p. 25).

Curricular suggestions

The literature identifies limited educational opportunities available to undergraduate and graduate nurses in forensic mental health (Peternejl-Taylor & Johnson, 1996). Storey & Dale (2001) suggest that students are not prepared to work in secure environments and find this to be particularly so of students currently enrolled in undergraduate programs. Themes identified in the literature are the need for education in such areas as: core psychiatric/ mental health nursing courses, working as part of a team, therapeutic communication, boundaries and relationships, risk assessment, management of aggression and de-escalation techniques, least restraint policies and interventions, suicide awareness, legislation and charting, offending behaviours (Peternejl-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001).

The clinical component is critical to decreasing the stigma perceived by students towards forensic mental health nursing and the patients and to decrease student feelings of fear (Peternejl-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001). Identified in the literature is the importance of selecting students for clinical placements in forensic mental health who have good communication skills, are able to work as part of the team, and have good physical and psychological assessment skills (Kent-Wilkinson, 2009; Peternejl-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001). The authors go on to identify that students who are non-judgmental, professional, assertive, mature, and demonstrate integrity are suitable for these placements (Kent-Wilkinson, 2009; Peternejl-Taylor & Johnson, 1996; Storey & Dale, 2001; Martin & Happell, 2001).

In her book, *Trauma and Recovery: The Aftermath of Violence- From Domestic Violence to Political Trauma*, Judith Herman (1992) writes "about the impact of coming face-to-face with human

vulnerability and the capacity for evil in human nature...when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator” (as cited in Morrissette, 2004, p.536). Students may feel particularly vulnerable in this forensic corrections setting and may struggle with maintaining the therapeutic relationship.

Discussion

Although there is little research literature addressing baccalaureate student placement in forensic/corrections settings, Peternejl-Taylor & Johnson (1996) use a concrete example in their article *Custody & Caring: Clinical Placement of Student Nurses in a Forensic Setting*. Peternejl-Taylor & Johnson (1996) describe a clinical placement model used at the College of Nursing at the University of Saskatchewan in partnership with Corrections Canada Regional Psychiatric Centre- Prairies. The model description includes student selection, orientation, educational process, evaluation, clinical supervision, and significance to staff (Peternejl-Taylor & Johnson, 1996). I found the model to be rich in ideas and so adopted and adapted it for placement of students at the STU.

Student selection

Peternejl-Taylor & Johnson (1996) describe both personal and professional characteristics required of nurses working in corrections. These include stability, integrity, assertiveness, maturity and friendliness on a personal level and professionally, confidence, non-judgmental attitudes, ability to work independently, decisiveness and the ability to work in a secure environment (p. 26).

In placing students at the STU, similar attributes of students are required. Students are invited by members of the STU staff and management to attend an informal get acquainted meeting. The STU management team, including Corrections and Health, the clinical instructor and the students use the meeting as an opportunity to make decisions about the suitability of the STU as a clinical placement site. If, at this time, either the student or the faculty feel that the STU is not a good match for clinical placement, the student will be placed elsewhere. "Galindez (1990) notes that preparation for clinical experience in a prison setting must be carefully planned and implemented for the student to adjust quickly and receive the most from the learning experience" (as cited in Peternejl-Taylor & Johnson, 1996, p. 26). The students are given an overview of the STU which includes a description of the roles of various team members such as nurses and corrections staff. The expectations of the students are shared

by the clinical instructor and the STU team. Students tour the setting which is an important part of the decision-making for the student; all access to the STU and to the individual units is controlled by corrections and by the use of 'fobs'. For some this evokes a feeling of being locked in and can be quite disconcerting.

It should be noted that students are asked to express an interest in this placement prior to attending the get acquainted meeting. Those students identified by faculty as less mature and less self-assured or for whom there are concerns about professionalism or level of knowledge are dissuaded from the STU placement.

Orientation

Peternejl-Taylor & Johnson (1996) write "the mundane and the obvious cannot be taken for granted in the correctional setting. Information-sharing is vital to effective team functioning" (p.26) and I would add, to the safety of the students, staff and residents. Students placed at STU are provided with an extensive orientation provided by both corrections and nursing staff. The orientation includes the following:

- Corrections overview & role
- Emergency codes & procedures - fire, security & safety - demonstration of access codes, Personal Alert Locator (PAL) system, control room & camera monitoring system, locks & keys
- Boundary issues & therapeutic nurse (& student) /resident relationship
- Clinical file, admission procedures, assessment tools & documentation
- Tour of building & each unit
- Other related education opportunities - psychiatric assessment, discharge planning, therapeutic groups, roles of members of the interdisciplinary team, overview of mental illnesses, antisocial personality disorders, mental health status exam, community mental health partners

Education

The STU setting is ripe with learning experiences for the students. Not only do students establish therapeutic relationships with clients, they also develop valuable learning experiences with members of the therapeutic team- psychiatrists, psychologists, occupational therapists, social workers, addictions workers, First Nations workers, and recreational therapists. In no other previous setting have these

students been exposed to such a wide variety of team members. Students anecdotally have commented about observing “a real team at work” in the STU.

Professional boundaries are crucial to the safety and security of the client, student, staff and unit. “Recognizing that student nurses may have difficulty setting a professional tone for their interactions with clients, issues surrounding transference and countertransference are reinforced throughout the clinical rotation” (Peternejl-Taylor & Johnson, 1996, p. 27).

Students are introduced to the idea of gang culture and the implications of this culture for relationships between the inmates on the floors. The STU also provides students the opportunities to observe the impact of the social determinants of health - poverty, education, social connection, on the lives of the men admitted to the STU.

Evaluation

Student evaluations are done by both the student and the clinical instructor at mid-term and at the end of term. Students are also required to submit reflections following each weekly two-day experience. The reflections provide an opportunity for both student and faculty to engage in discussion about the placement experience. Post conference meetings with students and the faculty member take place at the end of each clinical day.

As well as the traditional clinical evaluation tool used in student placements, the STU unit managers and the clinical educator meet with students and their instructor at the end of the clinical placement. Because only two groups of students have been placed at the STU and because of the organization’s commitment to recruitment through educational opportunities, STU staff is very interested in student feedback.

Clinical supervision

According to Morrissette (2004) “Although students enter the psychiatric nursing profession with some theoretical knowledge and role-play experiences, they still report feeling frightened, overwhelmed

and /or emotionally traumatized by what they hear or observe” (p.534). Morrissette (2004) posits “it would be assumed that student mental health would be a priority supported by an established body of literature” (p.535). There is some literature that speaks to the issue of well-being for nurses working in psychiatric settings but the literature pertaining to the well-being of student nurses in psychiatric/mental health nursing is limited. “It is not a question of whether student nurse well-being will be affected but rather, to what degree” (Morrissette, 2004, p.537).

The role of the clinical faculty in mitigating some of the feelings students may experience is important and cannot be underestimated. The creation of space for thoughtful reflection for both student and instructor must be part of clinical supervision. “They [the students] need to realize that being vicariously influenced by patient problems is normal and is not indicative of personal deficiencies or pathology” (Morrissette, 2004, p. 538). This normalization of student experiences is of particular concern for students placed at the STU where clients may have committed sexual offences, child abuse, homicide, or other heinous crimes. It takes time and discussion for students to make sense of how it is that the person is neither their mental illness nor the crime that was committed.

Meaning

What is to be made of this literature review? Is the Secure Treatment Unit (STU) an appropriate placement for undergraduate BScN students? I am more conflicted about this now than I was when I first began this project. From conversations with students placed at the STU, there are opportunities for learning but from these same conversations, it is clear that particular students are better able to handle the setting as a place for learning, than others. Peternelj-Taylor & Johnson (1996) note that student experiences in a forensic setting are “similar to traditional experiences in psychiatric nursing, students learn to apply the nursing process to clinical experiences, but more importantly learn about themselves” (p. 28). Is this not the same for all clinical experiences?

Does placement of students requesting a mental health experience, in a corrections or forensic setting, perpetuate the myth of criminalization of people living with mental health issues? One way students learn about what it is to be a nurse is through clinical experiences. They are in a sense, constituted by the environment within which they have clinical experience and, in turn, come to constitute and make meaning of themselves as nurses through these various clinical locations and the people with whom they work, both staff and patients. According to Glenister, as cited in Tilley (1997), “student nurses learn and undertake actions, and hear and then espouse ideas through a process of assimilation” (p.44). It would follow then that student experiences such as coercion from a facility of incarceration to the presence of corrections officers (CO) who engage with patients requiring ‘special handling’, to the language of corrections/jailhouse, to the use of restraint be they ‘take-downs’, chemical restraint, six-point restraints or locked seclusion, expose students to an area of healthcare in which caring is difficult to discern. For the student never exposed to people living with mental illness, these can be powerful experiences, experiences that leave an indelible mark. More worrisome, though, is that these experiences may take on a sense of the mundane after a time.

Nursing literature identifies the role of the forensic nurse and the impact of that role on well-being (Cashin & Potter, 2006; Peternelj-Taylor, 2005; & Shelton, 2009). "Forensic nursing sub-specialties are some of the most controversial, challenging, and stressful roles nurses undertake" (Cashin & Potter, 2006, p. 191). Peternelj-Taylor (2005) identifies that the work of the forensic nurse takes place in "environments that are among the most controversial and stressful and that the patient populations are some of the most vulnerable and at-risk having lived lives of poverty, illiteracy, unemployment, homelessness and at-risk behaviours" (p.8).

How do students come to make sense of this environment? Martin & Happell (2001) write that students in a forensic nursing environment completed their placement feeling more positive about mental health nursing in general and forensic nursing in particular. I wonder though what this means? The authors go on to state: "In the context of an environment where the pressure to obtain sufficient mental health nursing placements of high quality, these results are pleasing" (Martin & Happell, 2001, p. 124). Is this what I am attempting to do in this project- justify finding high quality placements in mental health nursing? Are placements at the STU high quality? Is this actually more about my belief that students MUST have institutional based placements in psychiatric/mental health nursing at all costs? With deinstitutionalization and the closure of provincial hospitals previously housing people living with mental illness, is community not a suitable location for students to experience working with people affected by mental illness?

David Sines (1994), in his article, *The arrogance of power: a reflection on contemporary mental health nursing practice* writes that "there remains... a dependence on residential solutions for both the provision of care for clients and the education of nursing staff" (p. 895); this despite the decreasing availability of residential facilities. But that is another project.

As mentioned previously, the role of clinical faculty for students who do have experiences in settings like the STU, cannot be underestimated. As well as creating a space for opportunities for reflection and

making sense of the experience, clinical faculty need also to challenge students to consider what else may be happening in the setting beyond what they are observing.

What are the tensions created by the dichotomous nursing roles of caring and custody? How is it that not only the residents are governed and controlled by both corrections and the healthcare system to act in particular ways, but that nurses too are governed and controlled to be in this environment in particular ways? And what of power? As noted by Holmes (2005), “nurses are both subjects and objects of power” (p. 3). Holmes (2005) goes on to identify three types of power that nurses use: “coercion, discipline and therapy, because of their “hybrid” socio-professional status as peace officers and agents of care” (p. 8).

The STU is a complex setting. Is it a suitable place of learning for undergraduate nursing students? I remain uncertain. I am certain that with the predicted increase in numbers of people affected by mental illness, the move to community of people living with mental illness and the sometimes lack of supports in community, admissions to jail followed by possible admission to secure treatment units and forensic mental health, the justice system is increasingly becoming the de facto location of treatment for psychiatric/mental illness.

Do the experiences of students need to be in institutional settings or do opportunities for learning not exist in community? Perhaps the most significant learning for this student in completing this project has been letting go of my own tightly held beliefs about ways of acquiring knowledge and experience in mental health nursing- the deinstitutionalization of nursing student education. Much as I support and believe in deinstitutionalization with community support, I have not let go of the institutionalization of nursing education in particular in the area of mental health clinical placements.

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Appendix 1

Citation	Type of research	Study description
<p>Kent-Wilkinson, A.E. (2009). Forensic nursing education in North America: Social factors influencing educational development. <i>Journal of Forensic Nursing Science</i>, 5, 76-88.</p>	<p>Qualitative-interviews of forensic nurse educators to identify the broad area of forensic nursing & the lack of research in forensic nursing education.</p>	<p>Substantive & Theoretical Underpinnings: Using a constructivist approach, the author explored how social processes and the discourse around these processes impact upon the participant as do participant perspective & experience.</p> <p>Methodology: Interviews of forensic nurse educators who were involved in the development of early forensic nursing education in both Canada & the United States. A thematic analysis of the interview data was compared to the literature. The data was interpreted using constructivism</p> <p>Findings: Themes were organized under the following: organizational fostering factors; institutions of higher learning supportive factors; social, media, technology, economic, political, and sustainability factors; political factors/policies; historical factors. Forensic nursing education programs have been influenced by social factors and vice-versa. Education has changed attitudes; expended roles for nurses and created new roles; improved patient care.</p> <p>Limitations as identified by researcher: "Limited to forensic nursing education although forensic courses are offered by other forensic disciplines. Limited to North America which limits generalizability. Researcher's background in teaching forensic nursing".</p> <p>Kent-Wilkinson (2009)</p> <p>Critique: This study explored the larger specialty area of forensic nursing which provided an overview of the multiple social factors influencing forensic nursing education. It did not look at various areas of forensic nursing education which may have an impact on societal attitudes to the need for education in particular areas. For example, education in the area of caring for people who are victims of sexual violence may be more acceptable than education for nurses working with people living with forensic psychiatric issues.</p>
<p>Kent-Wilkinson, A. (2009).An exploratory study of forensic nursing education in North America: Constructed definitions of forensic nursing. <i>Journal of Forensic Nursing</i>, 5,</p>	<p>Qualitative- thematic analysis of data provided by 17 nurse educators who had developed forensic nursing education programs in North America (up to 2006).</p>	<p>Substantive & Theoretical Underpinnings: "Forensic nursing has developed over the past 10-15 years. Various concepts & definitions have been used to define & describe forensic nursing. There was a lack of consistency and understanding of the concepts needed to be included in education programs. The researcher undertook this study because of the lack of research to identify the constituent components of this specialized are of nursing practice/education.</p>

201-211.	<p>Purposive sampling.</p> <p>Semi-structured telephone interviews & e-mail questionnaires.</p>	<p>Methodology: Qualitative- purposive sampling: 17 forensic nurse educator participants. Interviews of forensic nurse educators who were involved in the development of early forensic nursing education in both Canada & the United States. A thematic analysis of the interview data was compared to the literature. The data was interpreted using "a thematic analysis from a constructivist worldview" (p.204).</p> <p>Findings: Nursing knowledge similar to nursing knowledge in general and that unique to forensic nursing was described under headings of "described knowledge, unique knowledge, differential knowledge, and dual knowledge" (p.204). "Unique knowledge is emerging as this specialty evolves" (p.210) .</p> <p>Limitations: As identified by the author, limited to forensic nursing in North America. Numerous questions around defining forensic nursing concepts remain indicating that one definition that includes all concepts may not be possible.</p> <p>Recommendations: Further research is needed to be able to define the concepts particular to forensic nursing.</p> <p>Kent-Wilkinson (2008)</p> <p>Critique: This article is similar to the above-reviewed one. The author attempts to define forensic nursing in order to define concepts which are of importance to education in forensic nursing.</p>
<p>Martin, T. & Happell, B. (2001). Undergraduate nursing students' views of mental health nursing in the forensic environment. <i>Australian and New Zealand Journal of Mental Health Nursing</i>, 10, 116-125.</p>	<p>Quantitative-pre & post placement questionnaires administered to students on first day of placement prior to orientation, to evaluate the suitability of forensic mental health placements. Suitability in terms of learning opportunities for mental health nursing & in enhancing student attitudes towards mental health nursing as a desirable place of practice.</p>	<p>Substantive & Theoretical Underpinnings: Mental health nursing is frequently not a placement of choice of undergraduate nursing students. A body of literature has found that suitable placements in psych/mental health have a positive impact on student attitudes. However with the decreasing number of suitable placements, forensic mental health was evaluated as to its learning opportunities for students and its impact on student attitudes to mental health nursing.</p> <p>Methodology: Evaluation of students' experiences of placements in forensic mental health was undertaken through the use of pre & post placement questionnaires. 34 questionnaires were returned- a return rate of 82.9%.</p> <p>Findings: The evaluation of the placements at the particular facility used in the study indicated that it was a 'suitable' site for undergraduate nursing placements. A comparison between pre & post placement questionnaires indicated that students' knowledge & understanding about the role of the nurse working in mental health did increase. Students' fears & anxieties identified in the pre-placement questionnaire had been significantly decreased following the placement. The students also identified that their learning would be helpful in other nursing settings. The authors did find that there was an increased interest in mental health nursing as a future career choice.</p>

		<p>Limitations as identified by researcher: Pre & post placement questionnaires were not the same. As a quality improvement project it was less rigorous than a formal research study.</p> <p>Recommendations: Placements continue in forensic mental health settings with students being assigned to a nurse buddy each shift to ensure that support & direction are in place; that the fears of students be acknowledged and discussed openly early in the placement; mini-tutorials be used.</p> <p>Martin & Happell (2001).</p> <p>Critique: The evaluation was done close to 10 years ago in a less formal way than a more formal rigorous study. The format for clinical placements is different than what is used here but the results would be transferable to a setting here.</p>
<p>Peternejl-Taylor, C. A. & Johnson, R. (1996). Custody and Caring: Clinical placement of student nurses in a forensic setting. <i>Perspectives in Psychiatric Care</i>, 32, 23-29.</p>	<p>Not a research article but rather a description of collaboration between a regional forensic psychiatric setting and University of Saskatchewan to provide a place of learning for nursing students.</p>	<p>Substantive & Theoretical Underpinnings: Author describes the collaboration between a Regional Psychiatric Centre and the University of Saskatchewan to provide teaching and research opportunities in the area of forensic psychiatric services.</p> <p>The nursing curriculum offered by the college offers core psychiatric mental health nursing courses which includes a 6-week placement component. Students may select other opportunities for further placements in mental health settings including forensic mental health.</p> <p>Process: 1. Students requesting placement are screened for "personal suitability" identified as good communication skills, assessment skills- both physical & psychological, able to work within a team. Personal attributes identified are professionalism, confidence, non-judgmental attitude, stability, integrity maturity (p.26).</p> <p>2. Introductory tour, orientation, educational opportunities reinforce the professional-nurse patient relationship and boundaries, learning around social determinants of health.</p> <p>3. Evaluation is both direct & indirect.</p> <p>4. Clinical supervision by faculty is on-site.</p> <p>Peternejl-Taylor & Johnson (1996).</p>
<p>Storey, L., & Dale, C. (2001). Pre- and post qualifying training for nurses in secure environments. In G. Landsberg & A. Smiley (Eds.), <i>Forensic Mental Health</i>:</p>	<p>Chapter written following publication of a report by the United Kingdom Central Council for Nursing Midwifery and Health Visiting. The report was based on a review of the</p>	<p>Substantive & Theoretical Underpinnings: Sense that since project 2000 introduced in 1989 in which nursing education was moved from schools to universities, there was an emphasis on theory rather than placement leading graduating nurses be left with reduced ability to develop skills. It was assumed that these students would require additional education in forensic psychiatric nursing.</p>

<p><i>Working with Offenders with Mental Illness</i>(pp.44-1-44-16). Kingston, N.J.: Civic Research Institute.</p>	<p>undergraduate and postgraduate education for nurses working in secure environments. The chapter represents the results of a survey of education providers, employers and more than 700 practitioners.</p>	<p>Methodology: Survey of education providers, employers and more than 700 practitioners to determine if there was appropriate preparation of nurses to work in secure environments.</p> <p>Findings: Findings indicated that there was a belief amongst registered nurses working in secure environments that preregistration fails to meet the needs of the service; too heavy an emphasis on adult mental health; students commonly lack practical skills in communication and interpersonal skills.</p> <p>Recommendations: Need to have multi agencies involvement in preparing students for this practice area. Nurses need to be in secure areas during their education in order to broaden their knowledge.</p> <p>Critique: Although this is a chapter in a book and limited details are provided about the research itself, it does provide some insight into the need for preparation. It is also rather dated research having been done in 1989.</p>
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