Experiences and Perceptions of Nursing Staff Working With Long-Stay Patients in a High Secure Psychiatric Hospital Setting

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Background and Objective: Forensic psychiatric nursing is a demanding nursing specialty that deals with a highly complex group of patients who are detained in restrictive environments, often for lengthy periods. There is little information about the daily experiences of these nurses. This study sought to explore the roles and relationships of forensic psychiatric nurses with long-stay patients in a high secure hospital in England.

Method and Analysis: The study obtained data via three focus groups, and thematic analysis was carried out using NVIVO 10 software.

Results: Five prominent themes emerged: First, nurses elaborated on their roles with patients and the kinds of interactions they had with them. The next two themes explored the reasons why some patients are long-stay patients and the challenges nurses face while working with this group. The fourth theme was the impact of external support, such as the patient’s families, on length of stay. The final theme covered the changes that the nurses observed in these patients and in themselves over time.

Conclusion: It was noticeable that those interviewed were committed professionals, eager to provide an optimistic and hopeful environment for the patients to help them progress through “the system”. The study presents a number of pertinent issues regarding long-stay patients that provide a basis for further research and to inform policy, educational reforms, and clinical practice.

KEY WORDS: forensic nursing; high secure care; long-stay patients

Forensic psychiatric nursing is a small yet growing nursing specialty that practices in both secure settings and in the community. In the United Kingdom, this includes forensic psychiatric units at three different levels of security—low, medium, and high. These units cater to individuals who experience a mental disorder and have committed an, often serious, offense or are otherwise deemed to present a risk to others. In the United Kingdom, the first high secure hospital, Broadmoor Hospital, opened in 1863—since then, forensic psychiatric nursing has evolved to keep abreast to meet the needs of forensic patients and to contribute and influence scientific research and development of relevant policies (Woods, 2004).

Mental health nursing generally is both complex and demanding and is composed of different components of care, including supervising, assessing, forming therapeutic relationships, administering medication, and maintaining a rehabilitative and social atmosphere on the wards (Rask & Hallberg, 2000). According to Harrison, Hauch, and Hoffman (2014), the profession is chosen by people who are ardently seeking to make a difference in someone’s life and are looking for opportunities that are centered on the patient. Because of the long contact time and being
the closest to patients—compared with other mental health professionals—forensic nurses are the professional group that is most involved in caring interactions with patients (Caplan, 1993; Mason, 2002).

Forensic psychiatric nursing differs significantly from general psychiatric nursing for a number of reasons (Mason, Lovell, & Coyle, 2008). First, forensic psychiatric nurses face a dual obligation as a custodian and as a carer, and according to some authors, this is the single most important factor that differentiates forensic psychiatric nursing from other psychiatric nursing specialties (Peternelj-Taylor, 1999). Second, the patient group forensic psychiatric nurses work with is highly complex with most displaying both a mental disorder and a history of mostly serious—offending (Caplan, 1993; Robertson, Barnao, & Ward, 2011). Most of these patients experience chronic psychotic disorders and often have a history of substance abuse and trauma (McKenna, 1996).

An additional challenge in working with patients in secure forensic settings is their often very long stay in the institution. According to the Sainsbury Centre for Mental Health (2009), 18% of the population were in forensic services for 10–20 years, whereas another 6% were in forensic services for 20–30 years (Rutherford & Duggan, 2008). This has been described as potentially being longer than necessary impacting negatively on individual quality of life. According to Vollm et al. (2016), such long-stay patients have complex needs and pathways are mainly characterized by previous admissions to secure care, self-harm, significant offending histories, and high rates of violent incidents and seclusion within institutions. On the basis of this, it can be said that experiences and challenges in caring for this group of patients may be different to those who do not stay for prolonged periods; however, there is no current research that has investigated this.

This study explores these challenges to understand the nurses’ experiences while caring for this complex group. The study is related to a larger, multicenter study funded by the National Institute for Health Research, “Characteristics and Needs of Long-Stay Patients in High and Medium Secure Forensic Psychiatric Care: Implications for Service Organisation.” This national project aimed to identify the prevalence of “long stay” in forensic settings (defined in the study as a length of stay of more than 5 years in medium secure care or more than 10 years in high secure care), the characteristics of this patient group, and the views of various stakeholders on the service provision for these patients (Vollm et al., 2016). The study reported herein explored the perceptions and experiences of nursing staff caring for long-stay forensic psychiatric patients in a high secure hospital, with a particular focus on nurse–patient relationships, patient characteristics, and the care pathways.

Method
Research Design
A qualitative research design, using focus groups, was adopted. A focus group approach was chosen as it elicits a natural interaction through which descriptive and in-depth data can be obtained from multiple interactions at the same time (Forrester, 2010, p. 61). Focus groups consisted of semistructured questions aimed to initiate a dialogue between participants, and they were encouraged to share examples from their daily experiences. It should be noted that, although an individual interview leads to the obtainment of information that is uncontaminated by others’ experiences and perceptions, the focus group approach was adopted to allow the participants to reflect and discuss their counter experiences and to observe the dynamics of the nursing staff that could help understand their lives in the wards better (Calcraft, 2005). Focus groups were recorded using an audio recorder and transcribed in verbatim. One of the focus groups was conducted by author S. M. (a research assistant with a background in psychology), and two focus groups were conducted by author S. D. (at the time, a Master’s student in mental health research, again with a background in psychology).

Participants
The study was advertised via email to nursing staff at the Rampton High Secure Forensic Psychiatric Hospital located in Nottinghamshire, United Kingdom. Considering the aim of the study, eligibility to participate was dependent on having worked at the hospital for at least 5 years. This was considered to be a long enough time by the research team to be able to share insightful experiences of caring for this patient group. No other exclusion criterion was applied. Ten participants were recruited and divided into three focus groups (with five, three, and two participants). The uneven numbers across the groups was because of scheduling issues and last minute cancellation because of other work demands. Participant details can be found in Table 1.

Focus Group Schedule
Focus groups were hosted at the Mike Harris Centre at Rampton Hospital, which is located outside the locked area, to provide more comfort and confidentiality to participants. Participants were given an information sheet stating the aims of the study before the focus group. This included the definition employed in the main study of “long-stay” described as those patients who have stayed in a high secure hospital for more than 10 years. A focus group schedule was composed of three main sections with corresponding questions: background, relationship, and service provision. The background section aimed to initiate a rapport by asking the nurses how long they had been...
employed at Rampton Hospital and about their interest and understanding of long-stay patients (e.g., questions related to their role with long-stay patients, patient characteristics, the care that the patients receive, external supports). The relationship section aimed to explore their understanding of “therapeutic relationships” and the unique differences or concerns when interacting with long-stay patients (e.g., questions related to any apprehensions of concerns, the uniqueness of caring for long-stay patients vs. shorter-stay patients, observed changes in therapeutic relationships over the years). The service provision section was more concerned about service improvement and international service comparison (e.g., questions related to differences in care when caring for long-stay patients, drawbacks regarding the care that is available, suggestions for improving care).

Data Analysis
A thematic analysis approach (Braun & Clarke, 2006) was employed to the data using NVIVO 10 software. An inductive approach was adopted to avoid restraints and preconceptions in the interpretation of data as it is concerned with generating a new theory, rather than a deductive approach that aims to test an existing theory (Thomas, 2006). Repeated readings by authors S. D. and S. M. allowed initial codes to be identified. The relationship between codes was then refined, and codes were rejected or collapsed into broader themes and subthemes. At each point of analysis, the codes were reviewed by the authors for any biases or misrepresentations and to ensure that they captured the inquiry of the study and other experiences that were articulated during the focus group sessions.

Ethical Considerations
Ethics approval was obtained from the Research and Development Department of Nottinghamshire Healthcare NHS Trust. Potential participants were provided with a participant information sheet a minimum of 24 hours before a focus group session took place, aiding informed voluntary consent, which was obtained in written format. Participants were informed that they could withdraw at any point, which would result in their data being destroyed. Information from the sessions was kept confidential, and pseudonyms were applied to the focus group transcripts. All data was stored on a password-protected database to which only the researchers had access.

### Results and Discussion

Through the completion of a thematic analysis, five major themes that captured the experiences and perceptions of forensic nurses working with long-stay patients at the high secure hospital were identified. These were best captured under the following: (a) role of nurses, (b) reasons for long stay, (c) challenges faced with long-stay patients, (d) external support, and (e) changes over time. The themes and subthemes are summarized in Table 2.

### Role of Nurses

There was a strong emphasis on the therapeutic aspect of the role beyond that of maintaining a positive atmosphere on the wards by all participants. Regardless of the number of years a patient might have spent in hospital, maintaining hope and fostering a safe and rehabilitative environment were seen as the essence of a nurse’s role. In addition, effective communication was also found to be important for helping patients establish stability and develop trust that would in turn help them look forward to transitioning out of a high secure hospital. Nurses felt that forming such therapeutic relationships with the patients

| TABLE 1. Participant Details |
|------------------------------|
| **Focus group 1** | **Focus group 2** | **Focus group 3** |
| Gender          | 4 women          | 3 women          | 2 men          |
| P1: 10          | P6: 31           | P9: 34           |
| P2: 19          | P7: 14           | P10: 15          |
| P3: 9           | P8: 13           |                 |
| P4: 9           |                 |                 |
| P5: 12          |                 |                 |
| Role in the hospital | Staff nurse (P1, P2, P3, P4) | Ward managers | Team leaders |
| Duration of focus group | 1 hour 25 minutes | 1 hour 10 minutes | 1 hour 15 minutes |
| Timing of focus group | a.m.             | a.m.             | a.m.             |
| Total participants | 5                | 3                | 2                |

(Pn = participant number.)
TABLE 2. Themes and Subthemes

| Theme                      | Subthemes                        |
|----------------------------|----------------------------------|
| Role of nurses             | Maintaining hope                 |
|                            | Therapeutic relationship          |
|                            | “Worth it”                        |
| Reasons for long stay      | Institution feels like home       |
|                            | Anxiety and sabotage              |
| Challenges faced with      | Uncertainties about care pathways |
| long-stay patients         | Blurring of boundaries            |
|                            | Importance of team                |
| External support           | Positive support                  |
|                            | Negative support                  |
| Changes over time          | In nurses:                        |
|                            | Know the patients                 |
|                            | Complacency                       |
|                            | In patients:                      |
|                            | Feelings toward nurses            |
|                            | Progress                          |

and being positive role models to them were fulfilling experiences.

Certainly with personality disordered patients, issues with relationships are paramount really, so therapeutic relationships are a way to try and explore that and work together. It should be a safe relationship. I feel that that is the number one part of my job. I don’t think it’s something like “oh now I am going to have a therapeutic relationship with that patient,” it is something you have going on all the time. (P3)

A therapeutic relationship for me personally is being a role model. I, speaking for myself, I need to be a very positive role model for that person. At the same time I need to understand that if they become very hostile to me I don’t take that personally. It’s difficult at times not to take it personally but it’s seeing beyond that; what was happening at the time for that individual person, what going on in their life at that particular time. And there needs to be more staff being positive role models. (P10)

Responses from participants in this study therefore focused mainly on the positive aspects of their role, emphasizing therapeutic over custodial aspects. It has been reported consistently that patients in secure forensic settings have experienced abusive or unstable relationships in the past (Timmerman & Emmelkamp, 2001). The nurses in our study appeared to be aware of such histories and recognized the importance of providing a safe and stable environment. They referred to the role of simple interactions—playing games or chatting with the patients while serving food—as the first steps in building trusting and therapeutic relationships.

The development of such relationships has been found to be one of the most important roles in forensic nursing (Peternelj-Taylor, 1998) through which patients are able to develop trust and respect for nurses. Such therapeutic relationships are crucial to help move the patient forward and have a facilitating effect on treatment (Olsson, Strand, Kristiansen, Sjöling, & Asplund, 2013). Notably, despite concentrating on long-stay patients in their contributions, the nurses in our study clearly seemed to have “moving on” as the ultimate goal of their endeavors and emphasized the importance of hope. They emphasized that they remained both optimistic and hopeful even when they were unsure of the patient’s care pathway or they knew it would be difficult for the patient to move out of the hospital. Hope has often been found to have a positive influence on patients and to enable them to keep a positive outlook on the future (Kylmä & Vehviläinen-Julkunen, 1997).

Notwithstanding the challenges, nurses felt that their job was very rewarding, and this is consistent with previous research that found forensic nurses to experience less stress and have more satisfaction in their job compared with nurses in other psychiatric settings (Happell, Martin, & Pinikahana, 2003).

Reasons for Long Stay

The focus groups raised several key perceptions of nurses regarding why a patient becomes a long-stay patient. All the nurses felt that there were patients who had become very comfortable in an environment where they are cared for and felt safe. As such, the patients began to view the hospital as their home and the staff as their closest relations. The development of such feelings was attributed to their often unstable backgrounds. Patients often experience a lot of anxiety before any transition and may behave in ways that jeopardize their chances of transitioning out of the hospital. This could be through denying their offense or using violence as a strategy to sabotage their chances of moving on.

And I think for a lot of the patients here this is probably the best home they’ve ever had, because they’ve come from quite dysfunctional backgrounds, they’ve been from pillar to post in care homes. They’ve been abused as children and I think, you know, here, they feel safe, they feel contained, they know where they stand and they do build really good relationships with the staff on the ward. (P8)
I think a very common feature in the very long term patients, or the patients I have worked with the longest in my current place is the sabotage when they are starting to move on. Quite often, they would openly admit that they are terrified to move on, so they would do something to deliberately set themselves back and create an incident rather than working through those anxieties. (P3)

For many long-stay patients, who have spent a large part of their lives in various institutions, the only close relationships they have are with the staff members, and these relationships are often the most secure relationships they have ever experienced. This finding is supported by studies that suggest that forensic patients form constructive relationships of which they have had very little experience in the past (Caplan, 1993; Mason, 2002). Although the development of positive relationships with staff is essential, overattachment can be negative for the patient’s progress. With the inability to trust easily as well as a lack of coping strategies to end close relationships, patients typically feel very anxious about leaving the hospital and thereby sabotage their chances of transfer and increase their length of stay. Such incidents of relapse as well as high levels of anxiety during transition or before transition have been reported in previous studies (Centre for Mental Health, 2011). Notably, transfers out of secure care or to less secure settings can be very complex and challenging because of the lengthy processes of referral, assessment, and so forth, adding to the anxiety it provokes in patients. Given the importance of stable therapeutic relationships, it has been suggested that such transfers should be staggered and the new team of nurses should attempt building rapport before the actual move takes place (Kennedy, 2002).

Challenges in Working With Long-Stay Patients

For patients who have been in the forensic system for over 10 years, nurses found it difficult to keep them motivated to persevere in their treatment and engage in new interventions. Often, the nurses experienced challenges regarding how to effectively discuss the future with their patients when the nurses themselves were uncertain about the care pathways.

I’ve got one at the moment who is doing therapy and he throws in, “yeah I know this, I’ve done this with so and so.” It is so hard to start off from that point. You think “oh God this person has done all this work, how do I do something different?” (P3)

The patient I am working with at the minute has been institutionalised for 15 years and has a relatively settled period so he has in his mind that he is going to transition out now, and I have to tell him that no you have not finished your initial treatment and you probably have another one after that…actually it’s about shaping expectation and being realistic while keeping them on the good positive track. (P5)

Another challenge reported was related to boundary maintenance—an issue felt to be more important in long-stay patients compared with those who move on quicker. A supportive team and supervision was felt to be required as often there were concerns about the blurring of professional boundaries in the relationships, particularly with long-stay patients. Teamwork and support were felt to be of critical importance to avoid burnout and fatigue. Because of their challenging work, the nurses felt that, in overwhelming situations, stepping back and seeking their team’s assistance to be very helpful.

There is a level of familiarity with these patients and it is important that the team is around to keep an eye around on what’s happening. Sometimes it is natural to slip the boundary, so a team can support you to stay on track and make sure the relationship stays professional. A strong team will be able to do that. And they have the ability to be concerned about things like, what you did there, or why you did your session overrun by 20 minutes, why did you give that patient extra time? (P2)

They are not fragile physically, they are violent offenders, but mentally they are very fragile and they can’t take much…there is no self-esteem. Building on all those things is wearing on the nurse. It is tiring and hard, people do suffer burnout, but that passes and you get through it with the right support and you then go on to help somebody else. (P1)

This issue of professional boundary maintenance between the forensic nurse and the patient group is described as “one of the most important competencies required by psychiatric mental health nurses” (Peternelj-Taylor & Yonge, 2003, p. 55). Sharing one’s frustrations and problems with a colleague has been found to assist with monitoring the behavior of the nurse as well as act as a support system to counter feelings of burnout (Rushton, Armstrong, & McEnhill, 1996; Sheets, 2001). Such approaches are especially important to monitor blurring of professional boundaries with the patients (Baron, 2001).
Others have reported feelings of burnout and fatigue in forensic services, which could lead to dissociation with the forensic patients (Coffey, 1999; Dhondea, 1995). The importance of team working has also been emphasized, and a strong team has been associated with job satisfaction and the alleviation of work pressures felt in nurses (Kramer & Schmalenberg, 1991; Lu, While, & Barriball, 2005). Competent clinical supervision has been found to reduce feelings of detachment, depersonalization, and burnout in forensic nurses indicating the need for an effective supervisory team for the nursing staff (Edwards et al., 2006). However, the training that is required for the nurses to attain this has not been identified.

### External Support

A prevalent theme in caring for long-stay patients, was the importance of external support, mainly through families. The nurses shared a two-sided notion of how families and friends in the community can potentially impact the progress of patients. In some cases, external support can positively affect the patients by providing them a reason to progress through the system and move back into the community.

They’ve got something to move towards haven’t they? Reason to move out. (P4)

I’ve got no stats…but from personal experience; they seem to move through quicker having that support, that communication, knowing that they have something to go out…Knowing that they’ve got that support or link to the external world. (P5)

On the other hand, some nurses felt that families may not understand the patient’s needs, and might not want them to move on. In some cases, the families could be afraid of the patient and prefer that the patient to remain in the forensic system.

I think some families often want to give the patients some kind of support, phone calls or writing letters, things like that, but as far as going one step further, and being the sort of carer outside, that’s a different, it depends on individuals obviously, but for some families, that is too much for them really. (P1)

I feel sad from a patient’s point of view. But when I put myself in a family’s shoes, if they have been repeatedly assaulted by the person, when they were in the community, in extreme cases that person might have killed another family member; it is understandable when they are anxious or not supportive of the person moving on. (P5)

There is thus far very sparse literature on the positive and negative influences of external support on the progress of forensic patients. Whereas some evidence indicates that knowing someone in the community can motivate the patient to progress through the system (Castro, Cockerton, & Birke, 2002; Shah, Waldron, Boast, Coid, & Ullrich, 2011), the impact of negative family attitudes toward a patient moving on has not been reported elsewhere.

### Changes Over Time

#### Changes Observed in the Nurses

Nurses shared the view that, over the years, they understood and got to know the patients and their needs better. They were able to attend to nonverbal behaviors more accurately and thus form healthy relationships.

An example of a good relationship is when you look at the patient and you know that the patient is not feeling right that day, or that something is on their mind, you don’t have to ask them, you know it; you can talk to them about it. (P4)

Nurses also felt that the trust they developed through knowing the patients better could lead to some degree of complacency. This could make it difficult to identify changes occurring in the patient’s behavior.

You do become slightly more complacent with long-stay patients just for knowing them and their nuances, how they are and their triggers and their tell tale signs if something is not right. Whereas my guard would be slightly high with somebody who has been in the hospital less or whom I don’t know too well. It only takes something to happen to be reminded of where you are and who you are working with and anything can happen at any time regardless of how well you know somebody. (P5)

These reflections on the changes they felt in themselves indicate again the importance of reflective practice (Paget, 2001), teamwork (Kramer, Schmalenberg, & Hafner, 1989; Lu et al., 2005), and supervision (Peternelj-Taylor & Yonge, 2003).

#### Changes Observed in the Patients

Nurses commented on the potential development of strong feelings, including feelings of love directed to the nurses by the patients. Some patients may also develop sexual feelings that can be hard for them to express because of...
fears of the negative consequences for expressing such emotions. The staff in our focus groups, however, were able to normalize the development of such strong attachments.

I think loving other people is a human need and I think the people here haven’t had very much opportunity to express those feelings towards someone. It is natural then to feel like that to a staff. (P2)

We’ve had sexual experiences as well...that is a patient having sexual feelings towards a staff just to be clear. A few years ago the reaction would have been “oh we have to get the staff off the ward.” Now it is like “let’s get it into perspective. They have been in custody for 6 years, it is a 23 year old male, let’s make sure everyone is safe. Let us not ostracise.” (P5)

The development of romantic feelings toward staff in secure settings has been described elsewhere (Quinn, Happell, & Welch, 2013; Ruane & Hayter, 2008). A sexual relationship with the patient is often seen as a grave misconduct by the nursing staff, and patients can be exploited during their stay at the psychiatric hospital (Gutheil & Gabbard, 1993; Sheets, 2001). It was encouraging to see that staff handled such situations with sensitivity thereby ensuring that the patients felt comfortable in talking about this aspect of their experience.

Nurses felt that the patients would also start disclosing more personal information over the years, particular as they began to feel safe, while continuing to build relationships with nurses. Such disclosures helped them to not only engage in therapy but also be perceived as improving their relations with other patients.

And again, some patients are making disclosures about things here that they’ve never spoken to anybody about…. Disclosure of the patients whilst they have been here starts when they start to feel safer and build relationships; they start to say what happened that they might not have said in their lives. So you can see how difficult it is for them. (P1)

Long-stay patients were described as more mellow and relaxed over time, and some of the nurses felt that some of the patients eventually began to accept their diagnoses and recognized the benefits of the therapy sessions. There was also a risk though that they might be overlooked because of their more settled behavior compared with that of more newly admitted, potentially volatile patients.

In terms of this patient group, they are dead easy to miss. If they are settled in long term, it is hard to get them motivated people. They might have already done loads of stuff, you know, then you’ve got time pressures, they just sit in the corner. (P3)

Limitations of the Study
This study explored, through the use of focus groups, the experiences of nurses in caring for long-stay patients in a high secure forensic psychiatric setting. The main limitation of the study relates to the small sample size of the groups, which was below the recommended number of four to eight participants (Kitzinger, 1995). Although we made every effort to achieve these numbers, this proved challenging because of the nature of the work of the target group and the need for nurses to respond to emergencies at short notice. Our target population is therefore similar in some respect to “hard-to-reach” populations for whom small recruitment numbers are to be expected (McClelland & Newell, 2008). The generalizability of the study is low as the perceptions of the nursing staff have been obtained from one high secure psychiatric hospital in England only. We recognize that our findings will therefore have to be interpreted cautiously; replication of this study in other high secure psychiatric hospitals will provide a more comprehensive view of the perceptions of long-stay patients by forensic nurses.

Implications for Clinical Forensic Nursing Practice
In terms of the clinical implications of our research, the importance of stable therapeutic relationships between patients and nurses is paramount, and the potential disruption of this stability when patients are transferred is worth noting. Problems arising because of transitions should be further researched in both high and medium secure forensic care units to inform political reforms that allow for smoother transitions of long-stay patients. The significance of teamwork and reflective practice cannot be overestimated; one might speculate that the positive experiences reported in our study and the ability of nurses to adapt an attitude that facilitates hope for one of the most marginalized groups in society were partly facilitated by the relatively high nurse–patient staffing levels found in a high secure hospital. At the same time, such reflective practices and maintenance of professional boundaries can advise the advancement of education and training for forensic nurses. Further research should investigate the blurring of professional boundaries that can potentially influence the risk assessment and management of long-stay patients.
Conclusions

The experiences of forensic psychiatric nurses have been researched before (Caplan, 1993; Harrison et al., 2014; Kramer et al., 1989; Lu et al., 2005; Mason, 2002; Peternelj-Taylor, 1998, 1999); however, previous research has not attended to long-stay patients. It might be expected that the challenges faced by this group of professionals serving one of the most challenging patient groups would be amplified when considering long-stay offender patients. It is therefore encouraging that we observed very positive attitudes and experiences in the focus group participants as they discussed caring for long-stay forensic patients. A number of themes will be of relevance to service developments for this patient group while others provide recommendations for future research to develop training and education for forensic nurses. Future research should explore the themes identified here in other forensic settings. Another theme that warrants further exploration is the role (both positive and negative) that families and friends play in the recovery of forensic patients.

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