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## Practice in forensic psychiatry: A proposed interdisciplinary model

*Pratique en milieu de psychiatrie légale : proposition d'un modèle interdisciplinaire*

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### ABSTRACT

Although professional practice in forensic psychiatric settings is, in our opinion, extremely complex and requires the input of different disciplines, conceptual or theoretical models guiding such practice remain rare or poorly adapted. In this article, we propose an interdisciplinary model of practice to fill this gap. The objectives of this article are: to provide an overview of the literature review conducted; to report, as faithfully as possible, on our general method of consulting with employees practicing in a forensic psychiatric institution; and, finally, to propose an interdisciplinary practice model resulting from this general consultation within the organization.

**Keywords:** consultation, forensic psychiatry, inductive method, interdisciplinarity, practice model.

### RÉSUMÉ

Bien que la pratique en milieux psycho-légaux soit, à notre avis, extrêmement complexe, et qu'elle nécessite l'apport de différentes disciplines, les modèles conceptuels ou théoriques associés à cette pratique professionnelle demeurent rares ou mal adaptés. La proposition d'un modèle de pratique interdisciplinaire faisant l'objet de cet article constitue une tentative visant à corriger cette lacune. Les objectifs de cet article sont : de faire état des écrits scientifiques sur le sujet, de rapporter le plus fidèlement possible notre démarche de consultation générale auprès d'employés exerçant dans une institution psycho-légale et, enfin, de proposer un modèle de pratique interdisciplinaire résultant de cette consultation générale au sein de l'organisation.

**Mots clés :** consultation, démarche inductive, interdisciplinarité, modèle de pratique, psychiatrie légale.

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## INTRODUCTION

Healthcare practice in the forensic psychiatric setting is a “sub-specialty” of psychiatric care (American Nurses Association 1997). It has been recognized as such for several years now, and there has been an ever-growing interest in this new field of practice (Holmes 2002; Lynch 1993; Martin 2001; Martin et al. 2013). The specialty of forensic psychiatric care is situated at the intersection of criminology, law, criminal sociology, and psychiatry (Holmes, Murray, and Knack 2015; International Association of Forensic Nurses 1999). According to Mason and Mercer (1998) the emergence of forensic psychiatry within the vast field of psychiatry is relatively recent, but the continuing expansion of forensic psychiatry, together with the medicalization of criminality, is requiring from the professionals, who have made their career in this field, to take on roles related to both social control and to healthcare. This means that staff who work at the heart of the psychiatric and criminal systems are tied to a complex network of power relations in which they endorse particular roles that contribute to maintaining social order (Holmes and Jacob 2012). Care in forensic psychiatric settings is therefore shaped by its own particular dimensions, which go well beyond the usual definition of psychiatric care. Because forensic psychiatry maintains unavoidably close relationships (given the complexity of its objective and practice) with a whole set of academic disciplines, and in its capacity as a sub-specialty, the complex phenomena discussed in this article must be studied and understood using an eclectic approach that draws from various disciplines (International Association of Forensic Nurses 1999; Mason and Mercer 1998; Perron, Jacob, and Holmes 2015).

Therefore, although professional practice in forensic psychiatric settings is, in our opinion, extremely complex, and requires the input of various disciplines, the conceptual or theoretical models guiding this practice remain rare or poorly adapted. In this article, we propose an interdisciplinary model of practice that attempts to fill this gap. The objectives of this article are: to provide an overview of the literature review conducted; to report, as faithfully as possible, on our general method of consulting with employees practicing in a forensic psychiatric institution; and, finally, to propose an interdisciplinary practice model resulting from this general consultation within the organization.

## BACKGROUND

For over twenty years the institution recommended using the nursing model developed by Callista Roy (2009). This model was widely disseminated and taught to nursing staff, specialized educators, and security staff (also known as intervention officers). Tools were developed to support the use of this model, including the bimonthly progress note, the care plan, and the structured case study. The proposal for an integrated interdisciplinary practice model reflects the fact that

the institution is a highly specialized forensic psychiatric facility which has a supra-regional mission to care for people who have had dealings with the justice system and have mental health problems. Our objective was to develop a practice model that represents as closely as possible the best interdisciplinary practice in forensic psychiatric settings—the ultimate objective being to adopt this new model within the organization. With a view to revising its range of services, the institution was looking for a model of care that had an increased interdisciplinary focus and was better adapted to the (specific) clinical practice of forensic psychiatry. The directorate of nursing practice asked a team of researchers in nursing to propose an interdisciplinary practice model based on best practice and to do this in very close collaboration with nursing staff, specialized educators, and intervention officers (IOs).

## METHOD

### ■ Philosophies of care, literature review, and theoretical inspiration

The first step to developing the interprofessional model was to obtain an overview of philosophies of care in high-security hospitals in Australia, Canada, the USA, and Europe (primarily the United Kingdom). We then produced a literature review of the various practice models currently used in hospitals specializing in forensic psychiatry. The literature review was compiled using the CINAHL, PubMed/MEDLINE, PsycINFO, and Google Scholar databases. Several articles in English, published between 2000–15, were selected on the basis of containing the following key words: forensic nursing, nursing theories, models of care, forensic hospitals, and nursing care. The literature review identified seventy articles. These were studied in depth and thirty-two were chosen for inclusion. The thirty-two articles were summarized in order to pick out the relevant key aspects. The summaries were then analyzed in depth and only 28% (9/32) were retained as they matched the selection criteria exactly. Among other aspects, these articles outlined a precise theoretical perspective (as a basis for clinical practice) and the concepts associated with the theory were clearly defined.

Our literature review thus enabled us to identify nine theories as a basis for models of care practice. These models, which are used in some forensic psychiatric care settings, guided our preliminary model.

#### *Tidal Model*

The Tidal Model is a humanistic nursing recovery model developed by Barker (2000). It is based on the premise that the person suffering from mental illness has strengths, abilities, personal priorities, and a future (Jacob, Holmes, and Buus 2008). This nursing model, popular in forensic psychiatry environments, recognizes that the hospitalized patient has some challenges, but focuses primarily on the meaning that the patient gives to them. The patient is an expert on his/her own

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life and therefore the major contributor to his/her own recovery. This nursing perspective is centered on the phenomenological experience (lived experience) of the patient and on the role of nursing staff, which is to facilitate recovery and provide renewed hope (Barker 2000; Cook, Phillips, and Sadler 2005).

## *Integrated Practice Model*

This model was developed by Virginia Lynch, a pioneer of forensic psychiatry, and guides the role of nursing staff working in this setting (Lynch 2006). It has three main theoretical foundations: 1) the relevant fields of expertise (nursing science, criminal justice, and forensic science); 2) the healthcare system (victim and offender, healthcare and forensic nursing care; and 3) the social impact (social sanctions, human behavior, crime and violence) (Valentine 2014). In this model, patients are to be treated using an interdisciplinary and holistic approach (Lynch 2006).

## *Model of Nursing Interaction*

This model comprises six categories of interaction in forensic nursing care with the aim of establishing a relationship with the patient: creating and maintaining a relationship (one based on honesty, respect, and trust); encouraging and supporting interactions (helping patients to recognize their qualities and use their own resources); learning social skills (encouraging patients to engage in social activities and talk to others); guiding toward reality (helping patients to become aware of how they are and how they act); reflective interactions (perception of patients and their problems); and learning practical skills (encouraging patients to develop healthy living habits) (Rask 2001; Rask and Brunt 2007).

## *Healthy Living Program*

This model was developed in response to metabolic syndrome and the physical conditions that are likely to develop in people suffering from serious mental illness (Prebble et al. 2011). It includes programs related to health promotion activities such as weight loss, smoking cessation, and physical activity. It is a voluntary approach that not only improves physical health but also autonomy and recovery. For the program to work in an institution and be integrated into its organizational culture, it must be applied flexibly and systematically by the whole of the interdisciplinary team.

## *Hodges' Health Career Model*

This model has a politico-biopsychosocial structure aligned to current interdisciplinary practice (Hodges 1989), meaning that it is founded on a multidimensional critical approach, incorporating sociology and politics research, in order to understand the individual in context. It is based on four objectives: measuring achievements, providing holistic care, supporting reflexive practice, and reducing the gap between theory and practice (Doyle and Jones 2013). This model can be applied to various clinical situations in a forensic setting. When this model is used as a frame of reference, it places emphasis on the role of the care team, who must respond to the needs

of patients and prioritize their problems. It is also used as a guide to assess and provide help to patients with their physical, psychological, and social needs, as well as working with the legal system, in order to promote their recovery. The theoretical foundations draw on four sources of knowledge: interpersonal, scientific, sociological, and political (Doyle and Jones 2013).

## *Holistic Model*

This model is used in forensic care in assessment, healthcare, and psychotherapy for patients suffering from personality disorders (Byrt 2013). Holistic care encompasses physical (diet and exercise), cultural, and spiritual health, and the psychosocial needs of the patient. This model is based on problem solving, anger management, and decision making. Caring is a central concept in the holistic model and takes the form of an emotional, psychosocial, constant, and authentic care response (Hammer 2000). Caregivers must be there for patients, respect their situation, understand their experience, and show a desire to help.

## *Good Lives Model*

This model focuses on the crimes committed by offenders with mental health disorders, on their recovery, on promoting their personal goals, on reducing the risk of repeat offending, and on treating mental illness (Barnao, Robertson, and Ward 2010; Barnao and Ward 2015; Robertson, Barnao, and Ward 2011). The model favors an approach based on the strengths of the patient. It also implements mechanisms for change, meaning that behaviors judged to be maladaptive are replaced by appropriate behaviors when the patient is given skills, resources, and support by the nursing staff. This model puts the crime into context and focuses on the symptoms of mental illness, while conceptualizing both as maladaptive behaviors. This model offers a better understanding of the relationship between mental illness and crime with a view to creating an individualized care plan.

## *Risk-Need-Responsivity Model*

This model (Andrews and Bonta 2010), imported from the correctional environment, has been adapted to the forensic setting by adding the "mental illness" dimension. It was developed primarily to reduce the risk of repeat offending. Nursing interventions aim to identify and treat criminogenic factors. This model is based on three main principles: *the risk principle* (allocating the highest level of resources to the group that is most likely to commit an offense), *the need principle* (identifying the dynamic criminogenic risk factors and targeting them in treatment), and *the responsivity principle* (tailoring programs to the individual's personality: learning style, motivation, strengths, etc.) (Barnao, Robertson, and Ward 2010; Barnao and Ward 2015).

## *Recovery Model*

A popular model in mental health services, the *recovery model* is becoming increasingly popular in psychiatric care settings (Anthony 1993). This humanistic model is based on

the premise that any individual, including one suffering from a mental health disorder, can aspire to a rewarding future, take part in worthwhile and inspiring activities, enjoy self-determination, and finally, be able to live in an environment free from stigmatization and discrimination (Resnick, Rosenheck, and Lehman 2004). The distinctive feature of this model is that recovery is part of a process in which the person suffering from mental illness can continue to show symptoms while still being able to adapt to their (often chronic) condition and pursue their life goals (Jensen and Wadkins 2007).

This concludes the presentation of the theoretical perspectives that have informed our inductive method. This overview would be incomplete without reference to the work of Carper (1978) and Martin et al. (2013), which has also influenced the theoretical foundations of our method. The sources of knowledge (ways of knowing) identified by Carper apply in our view to all disciplines involved in caring for people in a forensic setting. The four ways of knowing identified by Carper (1978) are: 1) personal (understanding of self and others); 2) esthetics (the art of nursing); 3) ethics (the moral/ethical dimension of care; and finally; 4) empirics (the science of nursing).

The work by Martin et al. (2013) has identified sixteen standards of professional practice (Forensic Psychiatric Nursing Standards) in forensic psychiatry settings: 1) security, 2) legal framework, 3) ethical practices, 4) work in interdisciplinary teams, 5) the therapeutic relationship, 6) issues linked to the offense committed, 7) trauma, 8) risk management, 9) transition, 10) physical health, 11) substance abuse disorders, 12) families/caregivers, 13) health advocacy, 14) long-term care, 15) challenging behavior, and finally, 16) the fight against stigmatization and discrimination. These standards for professional nursing practice in a forensic psychiatric setting are defined in Table 1.

### **Preliminary model**

The next step in our method was to analyze the articles identified in the literature review in order to highlight the key concepts (codification) and then group them according to themes (thematization). Based on these themes, a preliminary model of interdisciplinary practice in forensic psychiatric settings was produced. To achieve this, the first three authors (DH, AP, & JDJ) carried out “codification and thematization” of the articles on an individual basis. They then discussed their respective results before agreeing on a “final” preliminary version. Soon after the preliminary model was conceived, based exclusively on the literature review, a meeting was held with the directorate of nursing care and multidisciplinary services. Following this meeting, the model was revised to incorporate the proposals made. This model was used to initiate discussions in the focus groups conducted with the staff (nurses, educators, and intervention officers). The preliminary model was not shared with the focus group participants. Only the member of the research team responsible for leading the focus groups was familiar with the preliminary model, which allowed him/her to stimulate

The forensic mental health nurse will:
1. Structure the treatment environment to integrate security with therapeutic goals.
2. Apply knowledge of the legal framework to service delivery and individual care.
3. Conduct forensic mental health nursing practice ethically.
4. Practice within an interdisciplinary team that may include criminal justice staff.
5. Establish, maintain, and terminate therapeutic relationships with forensic service patients using the nursing process.
6. Integrate assessment and management of offense issues into nursing care processes.
7. Assess for the impact of trauma and engage in strategies to minimise the effects of trauma.
8. Assess and manage risk potential of forensic service patients.
9. Manage the containment and transition process of forensic service patients.
10. Promote optimal physical health of forensic service patients.
11. Minimize potential harm from substance use by forensic service patients.
12. Practice respectfully with families/carers of forensic service patients.
13. Advocate for the mental health needs of forensic service patients in a prison or police custodial setting.
14. Support and encourage optimal functioning of forensic service patients in long-term care.
15. Demonstrate professional integrity in response to challenging behaviors.
16. Engage in strategies that minimize the experience of stigma and discrimination for forensic service patients.

**Table 1:  
Forensic Mental Health Nursing Standards  
(Martin et al. 2013, p. 174)**

discussions during the meetings while maintaining the inductive nature of the method. The proposed model, incorporating the elements taken from the focus groups (see below), was then presented during a public lecture at the hospital. We believe it is important to emphasize that the participants all confirmed that the final model reflected the discussions held by the focus groups.

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Dates	Nurses	Specialized educators	Intervention officers	Total
Day 1 (3 groups)	9	14	7	30
Day 2 (2 groups)	7	8	5	20
Day 3 (1 group)	3	2	3	8
Day 4 (2 groups)	8	8	2	18
<b>TOTAL</b>	<b>27</b>	<b>32</b>	<b>17</b>	<b>76</b>

**Table 2:**  
**Participants and job titles**

## Recruitment—focus groups

As the preliminary model was merely a basis for discussion, we felt that the contribution of the institution’s healthcare providers was vital if we were to produce a model that reflected daily clinical reality. Our recruitment strategy was highly effective and is evidence not only of the approach used but also of the interest that it created. To begin with, the director of nursing practice and multidisciplinary services presented the project at a special general meeting attended by the institution’s healthcare providers, specialized educators, and intervention officers (IOs). These employees were invited to volunteer to take part in discussion groups, which were held during the day and in the evenings in order to accommodate as many participants as possible. In collaboration with the human resources department, groups (n=8) were set up with the volunteer participants (n=76). It should be noted that nearly 80% of the healthcare providers who received the invitation agreed to join the eight focus groups, each made up of eight to twelve employees. All the groups contained representatives of the three professions (see Table 2).

The main aim of the focus groups was to discuss the daily practice of practitioners; that is, to provide an overview of current practice in the field and the interdisciplinary aspects that it requires. There was no discussion guide, but simply a general question: “Tell me about your professional practice here at the hospital.” All focus group discussions were recorded, transcribed, and analyzed by the first three authors (DH, AP, & JDJ) according to the principles of thematic analysis (Guest, MacQueen, and Namey 2012). The results of the analysis were incorporated into the preliminary model and the final design.

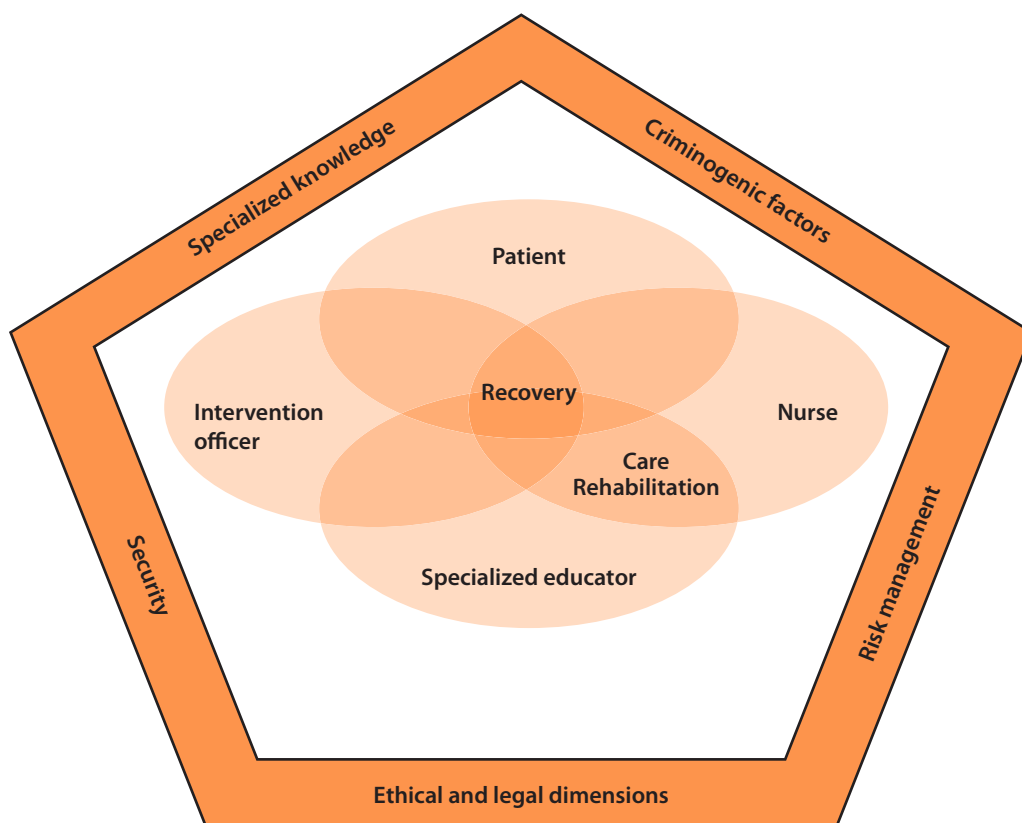
Healthcare providers were released from their clinical responsibilities so that they could take part in the focus groups, which lasted ninety minutes. A room was made available for the focus groups (discussions were digitally recorded and then transcribed). To encourage participation, meals were provided when the focus groups met during meal breaks. One focus

group was also formed to include all the unit managers (n=14). The final number of participants involved in this wide-ranging consultation was therefore ninety employees.

## RESULTS

Without making explicit reference to them, our proposed model draws on the central concepts of the metaparadigm of nursing as defined by Fawcett (1984) and later developed by Pepin, Ducharme, and Kerouac (2017), namely: environment, person, nursing, and health. Contrary to popular conceptual nursing models, our proposal puts the environment in which care is provided at the heart of nursing practice in forensic psychiatric settings. The environment is characterized by a particular security context that “controls” care delivery and risk management in a rigid way. Without this secure environment, care cannot be delivered. Next comes the concept of a person for whom strengths, qualities, aspirations, preferences, resources, and also weaknesses can be identified. The person receiving care partners with healthcare professionals, taking an active role (within his/her limitations) in his/her mental health recovery, with a view to safely returning to society (reintegration). We define nursing as the delivery of care and rehabilitation interventions with the ultimate objective of mental health recovery, the rehabilitation of the person and his/her successful reintegration into society. Nursing here is based on forensic psychiatric knowledge and empathetic attitudes that take a global, humanistic perspective, despite unavoidable security requirements. Finally, health is defined as the person’s capacity to take an active role in society according to his/her aspirations, strengths, and limitations.

Our inductive method was based therefore on various data sources: philosophies of care from numerous forensic psychiatric hospitals, the scientific literature (theoretical perspectives), and finally, focus groups made up of staff from the institution. The proposed model (see figure 1) includes



**Figure 1:**  
**Proposed interdisciplinary practice model in a forensic psychiatric setting**

the following key concepts: the forensic psychiatric context (including knowledge), actors, care, rehabilitation, and recovery.

## ■ Forensic psychiatric context

The participants that we met in the focus groups stressed the “special” nature of their working environment. Analysis of our empirical data and the literature review shows that the forensic psychiatric context comprises five fundamental dimensions: 1) specialist knowledge, 2) criminogenic factors, 3) risk management, 4) security, and finally 5) ethical and legal dimensions. These five dimensions, which underpin the forensic psychiatric context, shape the daily lives of nurses, educators, intervention officers, and patients.

The data we gathered show the need for staff to be well-versed in specialized knowledge related to the specialty of forensic psychiatry. This knowledge ranges from understanding diagnoses to aspects associated with patient status, and includes knowing the preferred interventions based on the clinical condition of patients. Criminogenic factors refer to all the elements that drove or drive the patient to commit an offense. These elements include situational, psychological, relational, sociological, and biological factors. Although criminogenic factors are part of specialized knowledge, we

believe it is important to place them in a separate category, in view of the particular environment under discussion here. Risk management includes the continuous assessment of risk factors and the steps taken to reduce the chances of an offense being committed (crime, violence against oneself or others, etc.). Security is a vital, unavoidable dimension of the forensic psychiatric context. Although the security aspects associated with the forensic psychiatric setting may inhibit the full expression of care as it is provided in “normal” hospital environments, all the participants consulted in the focus groups agreed that, without security, care is undeliverable (and unthinkable). This unanimous view is echoed in the scientific literature on the subject. Security can be divided into three categories (Kennedy 2007): environmental, relational, and procedural security. *Environmental security* includes architectural design, the institution’s perimeter, observation systems (camera, security booth), alarm systems (doors, windows, emergency signal for the institution perimeter), and preventive checks on care areas and activities. *Relational security* includes, quantitatively, the caregiver/patient ratio and the amount of time spent interacting with patients, and, qualitatively, knowing the patients, the quality of the support relationship in place, and of the therapeutic climate. This relationship obviously includes ongoing clinical observation, whether this is carried out by the nursing staff, educators, or intervention officers. Patients are also required

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to play a part in maintaining a secure environment. They will be expected to know and recognize the warning signs that an act of violence is about to be committed, whatever form it may take, and to act, by themselves or with the help of staff, to prevent their own security and the security of others from being endangered. *Procedural security* encompasses the policies and procedures necessary for sound risk management. This includes procedures affecting patients such as monitoring patients (movements, personal possessions, visitors, communication with the outside), as well as risk management procedures for employees (risk management procedures, emergency response plan, post-event and continuous quality improvement). As security concerns everyone, healthcare providers will be expected to adopt attitudes and behaviors designed to achieve safe practices while at the same time embedding these in an approach focused on patient recovery. The institution's administrative team is also responsible for supporting the development of safe attitudes and behaviors through initial and continuous training. In addition, we consider those with a "designated" responsibility for security, namely the intervention officers, to have a decisive role to play within care teams and through regular (teaching) interventions with the nursing and rehabilitation staff. Although security does concern everyone, intervention officers should act as role models in relation to safe behavior, while also respecting humanistic principles in care delivery. The fifth and final dimension of the forensic psychiatric context relates to legal and ethical dimensions. While staff must be kept informed of the legal status of patients in their care, they must also be informed of their duties and obligations towards patients. Patients who are hospitalized against their will (as is the case for most patients) have recognized rights that must be respected unless there are specific instructions to the contrary (such as a court order). In addition, staff working in a forensic psychiatric setting must comply fully with their code of professional ethics, even in a high-security care environment.

## Actors

The nursing staff, educators, and intervention officers are the employees involved in direct patient care. Our proposed interdisciplinary practice model involves four main participant groups: patients, nurses, educators, and intervention officers.

Patients play an active role in their care, recovery, and reintegration into society. Working closely with healthcare providers, they identify their challenges, their difficulties, and the means to achieve their goals. The patient is one of the central elements providing a focus for the members of the nursing staff. As far as possible, patients are responsible for their own health: they have their own resources, qualities, preferences, aspirations (life projects), and challenges to meet. Ensuring the involvement of the patient's family and friends is an important part of healthcare provision for the treatment team.

Nurses offer personalized nursing care, following a treatment plan that is developed with active participation from the patient.

The care provided takes into consideration the patient's strengths, aspirations, and challenges, which are identified in partnership with him/her. Nurses provide the resources that patients need to achieve their recovery goals. They work very closely with their colleagues (nurses, educators, and intervention officers) in order to achieve the goals of the treatment plan, all the while being constantly aware of the security dimension.

Educators are responsible for supporting the social rehabilitation of patients and, with this in mind, contribute when required to daily activities on the care units in addition to developing rehabilitation plans to deal with the problems hindering social adaptation. Ideally, these rehabilitation plans should target specific problems (understanding and drawing up a personal budget, improving communication skills, reflective activities, etc.) and be shared with other educators on other care units where hospitalized patients have similar problems. Educators are trained at a vocational college (post-secondary); few are trained at university. Community college training lasts three years and includes grounding in theory and clinical placements.

Intervention officers play a crucial role in the care team. Their role is to respond to the biopsychosocial needs of patients as well as carrying out security and surveillance for the care units. In particular, they observe patients' behaviors, which they communicate to the nurses and educators. They are responsible for security and deal with both its static and dynamic dimensions. As well as acting as role models, as discussed above, they are responsible for informing new members of staff about the importance of security while encouraging the development of security-conscious attitudes and behaviors. More specifically, they intervene in emergencies (physical assaults, etc.) and ensure the security of patients, staff, and the physical environment. They also accompany nursing staff and educators during activities that take place outside the care units. Finally, intervention officers prevent acts of violence and crisis situations by communicating effectively with all patients and reporting any changes in usual patient behaviors to the nursing staff or educators. Intervention officers have training in a variety of different fields (criminology, police studies, psychology, etc.). They do not have specialist training linked to their job title, but continuous training is offered by the hospital.

Any member of the team who comes into contact with patients should follow six principles, which can be summed up as follows: trust (trust in the potential of the patient); availability (service, openness, listening, collaboration with the patient); security (protection, precaution, calm, respect, patience); consideration (considering the patient's needs, taking time to meet the goals that have been set); empathy (listening, uncovering suffering, understanding another's point of view); and finally, consistency (being a role model, acting in accordance with one's values (Gendreau 2001).

All healthcare providers working in a forensic psychiatric setting should also be aware of the interdisciplinary tensions that arise

from working at the intersection of two types of institution— psychiatric hospital and prison—, at a point where their finalities intersect, overlap, and come into conflict. Previous and current research on this subject bears witness to the fact that the aims of care and of social control cannot be measured in the same way, which inevitably creates ideological tensions. Despite these tensions, interdisciplinary work must be implemented in order to ensure optimal care in a hybrid environment where security is a constraining but unavoidable element. Therefore, we emphasize the importance of distinguishing between the various roles of practitioners who work with patients. This clarification of roles must however take account of the fact that certain roles are carried out by more than one group of practitioners, which inevitably leads to overlap in some areas of practice.

## ■ Care

The care provided by nursing staff in a forensic psychiatric setting is based on the same principles as those that apply in general hospital settings. As such, it includes aspects concerning the therapeutic relationship, advocacy (defending patients' interests), assessing clinical condition and the level of danger to self and others, assessment of suicide risk, health promotion, illness prevention, and finally, risk management. It is important to note that patients suffering from serious physical conditions are transferred to institutions that specialize in physical care.

## ■ Rehabilitation

Rehabilitation refers to all therapeutic activities that are tailored to the needs of patients (physical activity, weight reduction, budgeting, cooking lessons, etc.). It also means organizing and fostering a therapeutic living environment by using patients' lived experience to improve their capacity to adapt and to help them to progress on their care pathway, while considering their life goals (intrinsic motivation).

## ■ Recovery

Recovery is, as we have described above, a clinical approach based on the patient's strengths, which aims to encourage them to reach their full potential. Using this approach, power to act is restored to the individual through a focus on the values of hope, respect, and autonomy (Anthony 1993). Here, recovery is understood as the result of care and rehabilitation activities that follow strict security principles.

## DISCUSSION

Forensic psychiatric care is a highly complex and specialized field situated at the intersection between many different issues (care, rehabilitation, security, mental health recovery, social reintegration), academic disciplines (health sciences,

criminology, criminal law, ethics), and professions (nurses, specialized educators, intervention officers, criminologists, psychologists, social workers, psychiatrists, doctors, etc.). The model proposed here aims to acknowledge this complexity, while putting forward a framework of professional practice in which all practitioners have their place and are able to draw on the knowledge and standards (professional and ethical) instilled during training, together with the knowledge acquired through their years of experience in the field. The model was developed and then approved by members of staff from the institution so that it would reflect the suggestions made in the focus groups and the daily reality of each individual's practice with patients and in teams.

It is clear therefore that the interdisciplinary dimension of the model is its key feature. However, one of the challenges of this exercise is reconciling the often-conflicting ideologies that arise from interdisciplinary modeling. As mentioned previously, care and security cultures in particular can come into conflict and make the roles of the various practitioners considerably more complicated (Dhaliwal and Hirst 2016). We must make it clear that the proposed model does not seek to ignore or to minimize this aspect but looks instead to draw on the expertise of all concerned, with complementarity as the guiding principle. The participants in the focus groups emphasized that security was an absolute prerequisite for care and rehabilitation, underlining the contribution of the former to the successful working of the latter. Nevertheless, we suggest that the reverse is also true: successful care and rehabilitation also contribute to the security role of the institution in the sense that appropriate treatment of physical, mental, and psychosocial needs reduces episodes of distress, decompensation, and acts of aggression performed by patients on themselves or others (Browne and Smith 2018; Heyvaert et al. 2012; O'Flynn et al. 2018; Sivak 2012; Wigglesworth and Farnworth 2016). It also helps, for example, bring stability to the units in which patients are hospitalized and to maintain the bonds (notably of trust) created between patients and members of staff (not to mention reducing the risk of occupational injuries and disability leave, and the subsequent disruption to interdisciplinary teams). Thus, while care, rehabilitation, and recovery are the cornerstones of the model, each of these areas is intersected by security issues, with a view to reciprocity rather than conflict. We believe that it is in fact this reciprocal nature that clearly marks out forensic psychiatric care as a distinct speciality.

The interdisciplinary dimension thus enables comprehensive care to be provided for the complex mental, physical, and psychosocial needs of the patient. All disciplines can make a clear contribution, for example through observing behaviors or by gathering comments from patients who are showing signs of distress or decompensation—activities that are not solely reserved for a particular group of caregivers. In the same way, the model is able to incorporate the development and delivery of activities, programs, or treatment plans that are developed in collaboration with the patient but also based on interdisciplinary

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discussions, relating for example to developing social skills, managing stress and emotions, weight loss, and hygiene. These all contribute to an operational reorganization of the social and health dimensions that are vital to the reintegration of patients. In the context of managing mental illness, such activities and programs allow us to make wider use of intervention tools other than psychopharmacology (Vacheret and Lafortune 2011). These short-, medium-, and long-term aims form part of a coherent and concerted approach making it possible to provide and maintain a stable, constant, and coordinated environment for patients during their hospitalization—an aspect seen to be essential with a view to recovery and social reintegration and the emphasis on objectives shared by the patient and the practitioners in the setting. These aims also make it possible to plan and coordinate links with the outside, working with practitioners in the community (e.g. hospitals, transitional services, etc.) in order to maintain a certain coherence in the approach developed with the patient. This aspect is routinely discussed in the scientific literature and was a recurring issue in all the focus groups.

## LIMITATIONS OF OUR METHOD

The limitations of our method mainly concern issues relating to the setting in which the process was undertaken. Although an international literature review was conducted, the practitioner feedback is specific to a particular, individual hospital setting. Therefore, it is important to stress that the model developed within the framework of our method will need to be modified and adapted to the contextual realities of other institutions.

## CONCLUSION

The aim of the study was to model a framework for interdisciplinary practice anchored in various sources of knowledge, namely the scientific, theoretical literature on the subject, and also in empirical data, in order to ensure coherence between the model and the lived experience of practitioners themselves. It is a model based on an “ideal” of interdisciplinary practice in which everyone, including the patient, contributes to the development and implementation of an integrated treatment plan that incorporates short-, medium-, and long-term objectives.

We believe that the proposed model can be transferred to a variety of environments responsible for treating people dealing with mental health disorders who have been involved with the justice system. The proposed model aims to be both prescriptive and flexible, to consider the specific nature of the environments in which it could be used or even differences in populations, the composition of teams, and cultures peculiar to different units within the same institution. We believe that this model offers a practical framework that can be applied by all practitioners working in a forensic psychiatric setting. It does

not create hierarchies within disciplines or professions, but instead draws on complementary expertise.

In our opinion the proposed model is innovative not only in its final “product”, but also in the original method that we used to develop it. By drawing not only upon established theoretical work and scientific studies, but also on the views of various groups of practitioners involved in forensic psychiatry on a daily basis, we believe that the proposed model is robust and incorporates all sources of knowledge relevant to its creation.

We should emphasize that, as with any interdisciplinary reflection, this model of practice requires appropriate resources to be available to support all the activities that are carried out as part of the work of a forensic psychiatric institution. In particular this means streamlining the administrative procedures for those who work closely with patients, assembling complete, integrated teams and allocating specific time to the care and psychosocial interventions that may require a more sustained commitment (Tenkanen et al. 2016). Allocating suitable resources would allow the model to be both implemented and maintained. Subsequent scientific studies could then be conducted to assess the contribution of this model to the work of practitioners, and to refine it further in order to maintain its suitability for both the needs of forensic psychiatric patients and those of the professionals who care for them.

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