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ORIGINAL ARTICLE

Exploring adaptations to the clinical reasoning cycle for forensic mental health nursing: A qualitative enquiry

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ABSTRACT: *Forensic mental health nurses (FMHN) provide care to address the needs of people who have mental illnesses across a range of diverse settings. The Clinical Reasoning Cycle (CRC) has been identified as a potential framework to assist FMHNs; however, adaptations were required to reflect the unique nature of the clinical setting. This study aimed to explore adaptations made to determine suitability prior to implementation in practice. Nominal Group Technique was used to explore suggested adaptations determined from a previous study and reach a consensus on the changes. Fourteen senior nurses from a state-wide Forensic mental Health (FMH) service participated. A consensus was reached for two proposed changes. Data were analysed using thematic analysis. Three main themes were interpreted from the data; FMH adaptations are warranted, the focus of the CRC, and who owns the cycle? Nurses in this study considered the need to include offence and risk issues due to the impact these factors have on the therapeutic relationship and cognitive bias; however, they also identified the need to focus on recovery-oriented care while engaging in clinical reasoning. Nurses in this study also expressed some reluctance for nursing to 'own' the model, due to concern that ownership may cause division among the team or result in inconsistency in care. However, some participant's suggested the CRC with adaptations assisted FMH nurses to articulate their specialist skills and knowledge to others and highlight the nursing contribution to care. Further work is needed to finalize adaptations with a focus on engaging the consumer carer workforce and interdisciplinary team.*

KEY WORDS: *clinical judgement, consumer, forensic psychiatric nursing, nominal group technique, professional identity.*

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INTRODUCTION

Forensic mental health nursing (FMHN) is a term used to identify nurses who work in criminal justice and FMH settings and who have Specialist skills (Maguire & McKenna 2021). Nurses working in these areas experience a range of clinical challenges related to practicing in settings that can be custodial (such as police custodial settings and prison). There are also security requirements and restrictions, and where conflict with the ethical principles of mental health nursing can occur. Consumers can also present with a range of trauma experiences, risk factors, offence-related issues and challenging behaviours (Martin *et al*. 2012).

To assist FMHNs in the delivery of care, frameworks can be used to guide practice and influence positive collaborative work with consumers while also encouraging sound clinical judgement, clinical-reasoning, and reflective practice (Maguire *et al*. 2022a, b). One framework that has been identified as potentially suitable for FMH nurses, is the Clinical Reasoning Cycle (CRC) (Maguire *et al*. 2022a). The CRC is a methodical framework designed to guide nursing practice to have a positive influence on consumer care (Levett-Jones 2018). However, while the CRC may potentially be suitable for FMHN, there have been no studies investigating its utility in these settings. The CRC tends to also use language and prompts that concentrate on general health management, reflecting its origins, this highlights the need for adaptations for use in FMH nursing (Maguire *et al*. 2022a,b,c).

BACKGROUND

Nursing practice requires decision-making about consumer care and often relies on the capability of nurses to provide care in fast changing, challenging environments that require a range of cognitive skills and the application of sound clinical knowledge. Clinical-reasoning is a process that assists clinical decision-making and can be particularly valuable when employed in circumstances that may be unpredictable, evolving, or uncommon. Applying effective clinical-reasoning results in accurate and informed clinical-judgements and decisions (Levett-Jones 2018) which promotes the best consumer outcomes. The CRC is a process that can guide clinical-reasoning, and is comprised of eight steps (Fig. 1) (Levett-Jones *et al*. 2010). The CRC also contains select cues to prompt person-centred care and engage in evidence-based practice (Theobald & Ramsbotham 2019).

FMH nurses are required to make decisions which are complex in nature, often in dynamic settings. In these settings, a greater proportion of consumers tend to engage in aggression in comparison with consumers in civil mental health settings (Bowers *et al*. 2011; Dickens *et al*. 2013). There may also be the presence of challenging behaviours (although not frequent, situations may involve siege/hostage type/protest situations), as well as offence paralleling behaviour (a behavioural sequence that includes actions, beliefs, goals and behavioural scripts, similar to behavioural sequences involved in previous criminal acts see Daffern *et al*. 2007). The presence of prisoner culture (established code that guides behaviours, beliefs, and interactions of prisoners which can remain when the person transfers) can occur in these settings (Maguire *et al*. 2022c; Maguire *et al*. 2012; Martin 2010; Martin *et al*. 2012; Mitchell *et al*. 2021). Further challenges in FMH nursing can include additional legislation related to offending behaviour and risks posed by individuals, where decisions can often be determined by courts and other external authorities rather than the treating team (Maguire *et al*. 2022c). Correctional services may also hold authority over care-decisions when a consumer is in prison, including placement management within the prison (Corrections Victoria 2019). Furthermore, many consumers and their families and carers will be subject to discrimination and stigma, where decisions about their leave from the hospital and transition into the community can be met with concern from the public, and negative coverage by the media (Martin *et al*. 2012; Skipworth *et al*. 2019).

While there is a range of complexities related to the environment and needs of consumers, there is also a range of factors related to inherent tensions in the therapeutic relationship that can influence nurse's clinical-reasoning in FMH care. The therapeutic relationship is fundamental and one of the most important skills required by FMHNs (MacInnes *et al*. 2014). However, there can be a strain on the therapeutic relationship in FMH where security requirements are often grounded in distrust. The legal status of consumers challenges the notion of voluntarism in treatment, and previous negative life experiences of consumers can result in attitudes that may be suspicious or hostile towards others, including nurses (Feerick *et al*. 2021; Maguire *et al*. 2022c). FMHN are also members of society, where the predominant stance is disapproval of criminal and violent behaviour (Marshall & Adams 2018; Martin *et al*. 2012), which adds further complexity to the environment.

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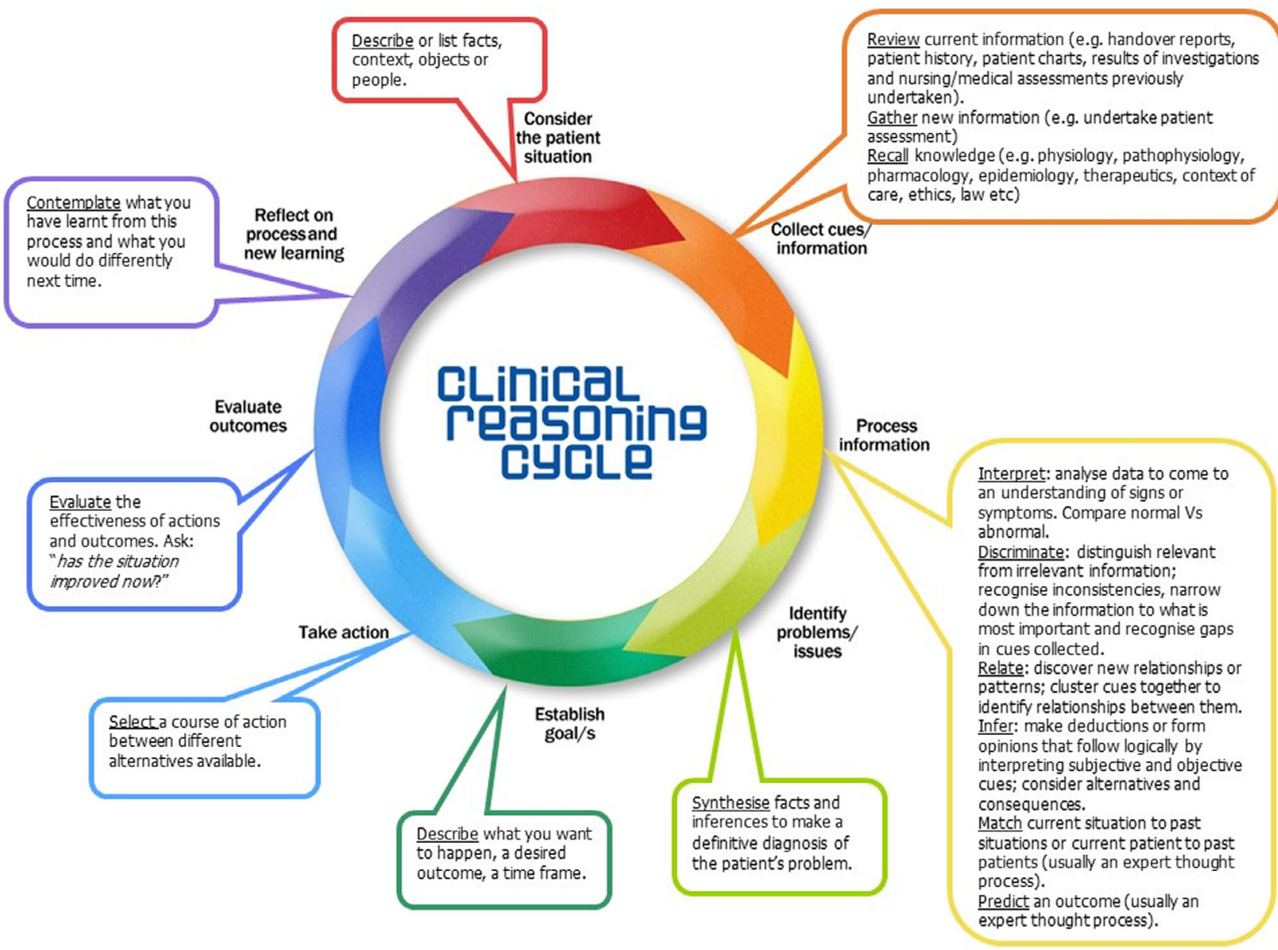

FIG. 1 The clinical reasoning cycle (Levett-Jones *et al*. 2010).

The CRC offers a person-centred framework to guide nursing care and encourage clinical-reasoning and reflection; however, in its current form, it is general health centric. The CRC does however align with several of the domains of recovery-oriented care such as collaborative partnerships and meaningful engagement, holistic and personalized care as well as the involvement of family, carers and significant others (Lim *et al*. 2019; McKenna *et al*. 2016; Simpson & Penney 2018). Additionally, consumers have reported that when the recovery-oriented focus is high, the quality of care and therapeutic relationships is rated highly (Coffey *et al*. 2019).

A recent study investigating the Nursing Process and the CRC in FMH identified the CRC as suitable for a state-wide FMH service; however, the nurses in this study suggested that adaptations would be necessary to enhance utility (see Maguire *et al*. 2022a,b,c). Following on from the previous study, permission was given by the developer of CRC to make changes based on the recommendations made by the nurses in the previous study (experienced FMH from across the service). Against this background, the aim of this study was to further explore the CRC and make adaptations made to ensure the model is aligned to support evidence-based FMHN practice.

METHODS

To explore the adaptations suggested by the nurses from the previous study, a Nominal Group Technique (NGT) was used to seek feedback and reach consensus about adaptations. The NGT offers a structured approach to facilitate the development of ideas in relation to problems and/or solutions, which are then discussed and voted on in a group (McMillan *et al*. 2014). Some advantages of the NGT include the ability for all group members to have input, allowing for equal

opportunity to contribute and generate ideas, limiting domination by others during group processes, and assisting in the identification of areas of concern (Boddy 2012). A traditional NGT generally consists of four-steps (1) silent generation of ideas, (2) round robin, where participant share their ideas, (3) clarification and (4) voting privately and then assessing the group views (Foth *et al*. 2016). For this study the NGT was modified to divide the group into two, for stages 1–2, with both groups merging for stages 3–4. Separating the groups for the first two-stages allows for greater ease of facilitation and gathering of ideas, due to the smaller group size.

The groups were facilitated by TM, LG, MO and GW who are all nurse researchers with extensive qualitative experience. Prior to the day, participants were sent a document outlining the CRC, the original CRC framework (Fig. 1), the adapted CRC version with highlights of the changes, and a vignette to assist with consideration of utility of the CRC. The vignette was developed by experienced FMH nurses who have worked across various settings including nursing education, in-patient and the prisons. The participants were asked to read the documents before attending the NGT. Prior to the commencement of the NGT, participants were given a short presentation on the CRC and adaptations. The adaptations (see Table 1) were derived from feedback gathered in a previous study where nurses suggested changes to the CRC they thought would enhance utility in a FMH setting.

When the groups were split, each participant was asked to read through the vignette, while using the CRC to come to an understanding of the consumer's situation and needs. The purpose of the vignette was to provide context and create a scenario participant's could work through while using the CRC as a prompt, to elicit their impression of using the CRC as a guide in the FMH setting. The group composition was pre-determined to ensure there were nurses from prison and inpatient settings in each of the smaller groups to capture views for each setting. One of the authors was the Director of Nursing and to ensure she was not involved in the facilitation she took field notes and assisted with the collection of documents. In the small groups, the generation of ideas and round robins were conducted, before the larger group re-formed for clarification and voting. An additional discussion transpired in relation to further adaptation for the CRC in the FMH setting. The total time of the NGT was two-hours.

Setting

This study was conducted at the Victorian Institute of Forensic Mental Health (Forensicare), located in Victoria, Australia. Forensicare is the leading provider of FMH services across Victoria, Australia and provides recovery focused programs to people who have a serious mental illnesses. Services are delivered across three directorates through a secure inpatient service (136 beds) at the Thomas Embling Hospital, mental health services in prisons throughout Victoria, and a community FMH service that provides programmes predominantly for people who have a serious mental illness and have offended or considered to be at high-risk of offending. Forensicare has around 500 nurses (registered and enrolled nurses).

TABLE 1 *Adaptations to the CRC presented to participants*

	Original model	Adaptations
Adaptation one	Clinical Reasoning Cycle in the middle	Consumer carer and their families and supporters in the middle of the CRC
Adaptation two	Text box titled 'describe': Describe what you want to happen, a desired outcome, a time frame	Text box titled 'describe': Describe: what does the consumer want to happen
Adaptation three	Patient is used throughout the cycle	Patient changed to consumer
Adaptation four	Title: Clinical Reasoning Cycle	Title: Clinical Reasoning Cycle-Forensic Mental Health Nursing
Adaptation five	Text box titled 'Review': Current information (e.g. handover, reports patient history, patient charts, results of investigations and nursing/medical assessments previously undertaken). Text box title 'Recall': Knowledge (e.g. physiology, pathophysiology, pharmacology, epidemiology, therapeutics, context of care, ethics, law etc.)	Test box title 'Review': Current information (e.g. handover reports, consumer history including index offence and risk assessments). Text box title 'Recall': Knowledge (e.g. pharmacology, epidemiology, context of care, legislation, ethics etc.)

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Participants and recruitment

Purposive sampling was used for this study with the criteria for inclusion requiring nurses of grade five and above (see Table 2 for a description of nursing grades). This inclusion criterion was determined based on nurses needing to have an advanced understanding of FMHN practice including nursing frameworks, assessment, decision-making and addressing ethical issues. Nurses who are grade five and above hold a range of positions from resourcing and managing the service after hours (including attending incidents and approving emergency leave), they are educated and authorized to function autonomously in advanced and extended direct care clinical roles (nurse practitioners), as well as being involved in policy and strategy roles.

An email was sent to eligible nurses detailing the study. The nurses were requested to indicate their interest to participate by responding to the email invitation. Consent was attained via paper-based or electronic consent forms, where participating nurses returned signed consent forms by email or handed a signed paper copy to the researchers. A total of 14 nurses participated, $n = 6$ from the prisons, $n = 5$ from the inpatient setting and $n = 3$ from across the service (roles that cover all directorates). There were $n = 8$ RPN5 nurses, $n = 3$ RPN6 nurses and $n = 3$ RPN7 nurses who participated.

Data collection

Written and verbal data were collected via the NGT. Groups were facilitated using the question guide which asked participant's to reflect on the vignette, what was helpful when using the CRC, what was not helpful, and a series of questions on each of the CRC adaptions made (see Table 2). All aspects (large and small groups) of the NGT were audio-recorded and professionally transcribed. All notes written during the silent generation of ideas were also collected, participant responses to each question were written on individual post-it notes which were then adhered to a large piece of paper with the corresponding question written at the top. Post-it notes were also transcribed for data analysis.

TABLE 2 *Nursing grades description*

Grade	Position
RPN1	Graduate Nurse
RPN2	Staff Nurse
RPN3	Associate Nurse Unit Manager
RPN4	Clinical Nurse Educator
RPN5	Nurse Unit Manager Clinical Nurse Consultant Nurse Practitioner Candidate Clinical Administration
RPN6	Nurse Practitioner Senior Mental Health Nurse
RPN7	Director of Nursing Operations Manager

RPN, Registered Psychiatric Nurse.

Data analysis

The data were analysed using the proposed six-stage approach from Braun and Clarke (2019). These phases were as follows, phase one: familiarization of the data, were TM listened to the recordings several times and checked the recordings against the transcripts for accuracy, while also creating notes. All post-it notes were then transcribed by TM. The second phase occurred when TM, LG and GW independently developed codes by identifying similar statements and allocating suitable codes. Phase three involved TM and LG searching for themes by creating thematic maps on a word document. The fourth phase involved a review of early themes by the research team which resulted in further analysis and refinement. Following the team review, the transcripts were revisited by TM to ensure the coding supported the themes, and important data were reflected in the themes. The final phase was the writing of this paper.

Rigour

During the phases of the study rigour was established by employing a study design that was reflexive and systematic in nature. The participants were recruited as they were considered the most appropriate to address the research questions. The study was designed and conducted by experienced nurse researchers and included experienced FMHN (TM and JR). The review of transcripts against the audio-recording ensured accuracy, and this was also enhanced by the collection of written notes generated in stages 1–2 of the NGT. The analysis and theming of the data were done in collaboration, and the use of quotes demonstrates the themes. To ensure accurate reporting the Consolidated criteria for Reporting Qualitative research (COREQ; Tong *et al*. 2007) checklist was used.

Ethical considerations

Approval to conduct this study was granted from the Swinburne University of Technology (Project ID:

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6171). Approval for access to Forensicare and to include Forensicare nurses in this study was granted by the Forensicare Operational Research Committee. Ethical requirements were met by the researchers. Confidentiality was maintained by de-identifying data and assigning participant numbers. To distinguish verbal responses from written responses, the letter 'N' has been used to code nurses in the NGT, and the letter 'G' the group number (either one or two) was used to code written responses generated in the silent rounds.

RESULTS

Three themes were interpreted from the data related to the presented adaptations to the CRC as well as a list of recommendations for further adaptations and considerations for the CRC. Before presenting the themes, it is worth providing the results of the voting for the adaptations (see Table 3). There were only two adaptations where consensus (>70%) was reached by the group, and these were yes to adaptation two and no to adaptation five. Both were changes suggested in the recall and review box (Fig. 1). It is important to highlight that although consensus was only reached for two adaptations, there was general agreement among the group that consensus was not reached because more changes were deemed necessary. It should also be noted that one person had to leave the group during the voting section due to other commitments (see Table 4).

The three themes were: (i) forensic mental health adaptations are warranted, (ii) The focus of the Clinical Reasoning Cycle and (iii) who owns the cycle?

TABLE 3 *Votes for each adaptation*

Adaptations	(n = 14)[†]
Adaptation 1	
Yes	8
No	5
Adaptation 2	
Yes	11
No	3
Adaptation 3	
Yes	7
No	6
Adaptation 4	
Yes	8
No	5
Adaptation 5	
Yes	3
No	11

[†]One participant left due to work commitments during part of the voting process.

Theme one: Forensic mental health adaptations are warranted

The first theme relates to the participant's perceived need to ensure the CRC is contextually appropriate to gain a holistic understanding of the consumer and their situation. Participants in particular considered three factors essential for inclusion: offence and risk issues, the impact of bias, and stakeholder influence. Including prompts about the offence and legal status were viewed as helpful in developing an understanding of the consumer's needs in whatever setting they may be in.

> The standout was in the describing context (including offence history). This for me, aligned with formulation G2

> The changes are applicable to custodial environment, much more appropriate to mental health nursing, useful and relevant to the setting G1

> The changes made to the review section is more specific to mental health in forensic care G1

In addition, inclusion of FMH specific factors was seen as way of articulating FMHN skills and knowledge "the people who are wanting our care should be getting it from people with specialized, expertise and knowledge. And this shows that we are, and we have got skills and we're scientific in our approach" *N9*.

Identifying the possible influence of individual or team bias was seen as important by the participants, due to the potential for biases to impact consumer care and clinical-reasoning. Participants suggested that at times even just seeing the movement sheet (sheet that details incoming prisoners), can start thought processes that may then influence care and clinical-reasoning.

> Sometimes it can just come on off the movement sheet. You open the movement sheet and go, "Oh, crap. They're back" N6

As a result, participants were keen to see prompts contained early in the cycle in order to prevent the influence of preconceived-ideas and bias.

TABLE 4 *Recommendations for further changes*

Include more prompts in the review/recall section
Include more prompts to catch bias
Include consumer and team goals
Include trauma history, gender, cultural, diversity needs
Include stakeholder impact
Ethical issues rather than ethics

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We have the biases of the clinician, we need to be aware of them because our management, our treatment plan will depend on that N14

If you start thinking about here, you haven't caught yourself early enough. Where do you catch it? You need to actively catch yourself. It can even be when you're gathering information because if you've looked at them on the incoming sheet and you are already like, "Well I already know what I'm expecting. I have not even thought to gather all the information because I assumed I knew it already…we want to acknowledge that is a risk" N3

That's where things the biases come in. Am I only looking at what's in front of me? Do I know that I've seen this guy 20 times before and am I, think, using those preconceived ideas? N5

The influence of bias was also identified as being related to the type of offence as opposed to already knowing the person.

I think it can even come in right at the beginning (the influence of bias), in consider the patient situation. Because when you're reading the vignette, if you look at the fact that it was a highly publicized case in the media, straight away, you have that bias and often with these cases, people have already made comments about it, the media, everyone. (N4)

Participants also highlighted the impact stakeholder influence can have, where there can be pressure exerted to make certain decisions, which may be a departure from what the clinician deems suitable or appropriate.

We have to provide the best possible care and put that person at the center of it, regardless of how that person might end up there or whatever other externalities are influencing it. Particularly in FMH, there's a lot of external forces that sometimes can be at odds with what we might think is best clinically N2

Different settings have a different input. The hospital, I would say don't have as much input from stakeholders as what the prisons do. With our team, we have a lot of pressure from at times to accept people who are not appropriate to be accepted, but that pressure and bias from all the stakeholders can be quite challenging as well because they reflect that onto you N7

Participants also indicated it was important not to lose sight of physical health issues, where the adaptations had resulted in less prompts regarding physical health care in order to incorporate FMH specific factors.

Physical results could also be useful. Delirium, physical history is important. This needs a prompt so it's not forgotten G1

They are only examples, but removing the pathology and physiology may be still important in the info to collect, include ethics G1

Physical history is important. This needs a prompt so it's not forgotten G2

In addition to the factors they wanted to include and retain, there was also a sense that some of the language in the original CRC mode needed adapting to ensure it is relatable to FMHN. For example, one participant stated they were unsure what was meant by the term ethics contained in the review section, while they were familiar with the term ethics, FMHN are possibly more focused on the concept of ethical dilemmas and problems.

Theme two: The focus of the clinical reasoning cycle

This theme reflects the debate among the group regarding risk and recovery-oriented care and where the consumer and the nurse's clinical-reasoning need to be located in the cycle. There are inherent risks in FMH settings, and there can be a tendency to focus on risk, possibly at the expense of recovery-oriented care. This point was emphasized by one participant's comment where they noted while looking at the adaptations "we haven't talked about the whole person. It's very FMH risk focused, isn't it?" (N9). There was also the acknowledgement that at times the consumer and clinicians' goals may not align, "it doesn't address when the clinician identified needs, don't match consumer identified needs, wants" G1. Furthermore, developing recovery goals can prove difficult in some environments, where the establishment of goals was suggested to be "not always achievable in correctional settings" G1 and where "restrictive environments make it difficult to achieve a positive way to get new treatment needs and recovery goals" G1.

Working through issues related to risk and recovery was also seen by the participants as a skill learned over time, and one that novice nurses, in particular, will need to develop.

What advanced clinicians do as well, they intuitively know when it's the right time to be including family, carers and consumers in that process as well… we are drawing on because of expertise N9

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> A novice may jump straight into including families and make contact, but there might be an IVO (Intervention Order). And a novice may not think about things like-…Do I know that the consumer murdered the father, so it's about making sure that wherever we put carers and families and supporters in here, it's done in a way that is respectful and considered and safe N11

There was also acknowledgment that information gathered using the CRC could also be used to prompt discussion with consumers about perhaps why they may not be meeting their goals.

> We can then use assessment information we've gathered about their offending, their illness and their response to managing all of these things, to help them understand the reason they're not perhaps achieving some their goals because of other things N9

Disagreement among participants existed as to where the consumer should be included in the cycle. Adaptation one resulted in the text in the middle of the CRC being changed to the consumer their families/carers/supporters. There was a sense that having the consumer in the centre of the framework "aligned with the new model of care" (G1) and "sends a good message" (G1). However, it was noted having the consumer in the centre of the cycle did not necessarily result in nurses including the consumer while using the cycle to work through the vignette, "we have placed the person and their close support at the centre, but I've not included them in the assessment" G2. There was some discussion among participants about "the clinical reasoning cycle staying in the middle and then there would be a loop around to the outside of the whole cycle that would have the consumer carer, family and supporters" N14. One participant also stated "I'd prefer to keep clinical-reasoning in the centre, it keeps accountability on the nurse and avoids not having to include the rationale for decisions" (N6).

While participants were supportive of a focus on the consumer, they considered having them in the centre rather than CRC "deflected from the clinical-reasoning which is important on the clinician… we need to highlight, especially those who have been in practice for a long time, we do have cognitive biases that we're not aware of. And that bias does impact our formulation, our treatment plan that could have potential consequences on the patient" N14. It would seem removing the CRC from the centre had the unintended impact of removing the focus on reasoning when the participants were working through the vignette.

Theme three: Who owns the cycle?

This theme relates to the uncertainty expressed by participants related to having the word nurse in the title, with some participants keen to see nurse included "I like it, but I feel it should be swapped around. I feel it should be forensic mental health nursing-Clinical Reasoning Cycle" G1. Whereas others expressed concerns about use of nurse in the title. This was conveyed as a desire to be collaborative and inclusive of other disciplines for example "I think the nursing is like not really accommodating other disciplines, like the doctors and allied health" N14. There was also apprehension that if the cycle was seen as a nurse-only tool this may cause division among the interprofessional team or result in inconsistencies in the delivery of care. Questions were raised as to whether nurses can only influence nursing practice, as demonstrated in the following quote, "Do we have the authority or have the power to influence of the direction or the thinking of other disciplines" (N9).

This issue also raised discussion that other disciplines have specific tools, which lead to questioning as to why nurses should nurses not have their own tool and own the cycle "this is a tool which can be use by a skilled forensic mental health clinician. We as nurse leaders in this organization can say, this is what we want the nurses to do in this" N2.

There were also a range of recommendations made to enhance the CRC which were elicited from group discussion and the post-it notes detailed in table four. Participants were keen to see changes made and then further consultation to occur with the Lived Experience Team and the other disciplines.

DISCUSSION

Consumers of forensic mental health services have an expectation of good-quality care when accessing treatment (Shields *et al*. 2019). Forensic mental health nurses make up a large proportion of health professionals delivering such care. It is therefore important that care delivered by forensic mental health nurses is in line with contemporary evidence-based practice. The CRC provides a process for clinical decision-making in care delivery.

This is the first study exploring a range of potential adaptations to the CRC to assist forensic mental health nurses. Participants were engaged in a NGT to enable application of the adapted CRC, using a vignette, to explore individual and group perceptions of the

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proposed adaptations. Participants reached consensus on two adaptations (one change accepted and one change rejected), and while consensus was only achieved on two of five adaptations, the NGT generated careful examination of the utility of the CRC in the FMH setting and fruitful discussion regarding suitable adaptations to enhance use for FHMN.

This study highlights the importance of contextualizing frameworks to ensure their utility. It has been identified that the complex working environment of the FMHN has often resulted in criticism due to a reluctance in addressing the offending needs of consumers, which can result in fragmented care (Howells *et al.* 2004; Martin 2008). Care may be ineffective when nurses focus on the offence and allow their feelings and values to dominate their clinical perspective. Similarly unhelpful is when offending behaviour is not considered a concern, and offending behaviour is ignored resulting in significant parts of the consumer's needs not being addressed. The offending may be overlooked when it is considered morally and personally distressing (Hammarström *et al.* 2019; Jacob *et al.* 2009), and exposure to threats, violence and challenging behaviour can also result in professional dissonance (Hammarström *et al.* 2019). To assist in addressing complex and FMH specific-issues, the inclusion of offence and risk issues in the CRC became paramount. However, this must be balanced with careful attention to the provision of recovery-oriented care in partnership with consumers and family/carers supporters (Maguire & McKenna 2021).

As identified by participants, while using the vignette to work through the CRC there was a tendency to focus on risk, often related to the consumers offending behaviour. In order to manage complex situations and behaviours, nurses may resort to using controlling and restrictive interventions (Barr *et al.* 2019), and this may place a strain on the therapeutic relationship (Green *et al.* 2018). The need to balance any restrictions placed on consumers with recovery-oriented care, while also fostering consumer involvement and a therapeutic milieu has been highlighted in the literature (Marklund *et al.* 2020; Nyman *et al.* 2020; O'Donahoo & Simmonds 2016). When the therapeutic relationship is no longer the focus of FMHN practice, there is the potential for a custodial culture to develop (Feerick *et al.* 2021; Maguire *et al.* 2012). To counter against this occurring, FMHNs need to demonstrate self-awareness, maintain professional boundaries, and understand and manage the impact of transference and countertransference, requiring nurses to reflect on their practice to ensure care is holistic, recovery-oriented and person-centered (Martin *et al.* 2012; Nyman *et al.* 2020; Pettman *et al.* 2020). The adapted CRC may assist nurses with this process.

Retaining clinical-reasoning at the centre of the cycle was seen to be important in terms of accountability and in highlighting the complexities of clinical-reasoning. Interestingly, having the consumer in the middle of the CRC did not result in a focus on recovery-oriented care, while this was the intent, participants were of the opinion there needed to be more prompts throughout the CRC to consider the consumer, and prompts to consider when it is safe for all to include families/carers/supporters. It was also noted during the NGT that more prompts were needed to "actively catch yourself" to prevent the influence of cognitive bias. Nyman *et al.* (2020) suggest a strategy that may assist in preserving the therapeutic alliance, which could include consideration of protective factors in treatment planning to promote recovery-oriented practice. Prompts related to consideration of risk and recovery-oriented care in the CRC could also provide a healthy focus for clinical supervision and reflective practice to encourage examination of these issues when they arise, as well as assisting novice nurses in navigating in what can be a complex area of practice (Marklund *et al.* 2020).

The theme 'who owns the cycle' illustrates the disparity among the group in relation to nurses owning the CRC. Issues related to professional identify in mental health have been observed, where a lack of communication about mental health nursing as a profession to a broader audience has been identified as a contributing factor (Hercelinskyj *et al.* 2014). Issues related to professional identity in FMH may also be amplified as nurses working in this setting may struggle to work through what is described by Aiyegbusi (2009, p. 30) as "intense emotional phenomena that tend to arise out of interpersonal relationships with patients and colleagues". In addition, working in settings such as prisons may also contribute to professional isolation and potential for enculturation to criminal justice values as well as issues related to professional identity, as nurses may have to undertake activities that seem to go against their professional role (Martin *et al.* 2012). Furthermore, some literature suggests nurses are overlooked as autonomous care-providers due to an inaccurate image depicting them as caring and trusted, yet lacking influence and autonomy due to their subservient roles to medical staff (Godsey *et al.* 2020). As suggested by one participant, the inclusion of nurse in the title, offered a way for

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nurses to own a framework and articulate their practice to consumers and other disciplines. Martin (2008) stated that if FMHN wished to attain formal recognition as a specialty area of nursing, then their distinct knowledge and skills need to be identified. The CRC in addition to FMHN Standards of Practice and competencies may contribute to outlining the knowledge and skills needed, giving FMHN' direction and ownership of their unique contribution to consumer care within the interdisciplinary team.

Limitations

This study took place within one FMH service in Victoria, Australia which may limit the generalization of this study to other settings. While the study called for the inclusion of senior nurses, their views may not necessarily illustrate the views of all senior nurses across Forensicare. One of the participants had to leave to attend to other matters, so was not present for all of the voting. As participants recruited for this study held senior roles with attached responsibilities, and while not ideal, the absence at the time of voting by the participants reflects issues associated with real-world research in clinical settings where attending to clinical matters will override participation in research at times. While this study only included senior nurses, the next phase will involve the consumer/carer workforce, nurses from grades one to six and allied health to seek feedback about the adaptations. A key strength of this study was the involvement of nurses from across the service who have a range of advanced skills and knowledge in FMHN, as well as the inclusion of nurses who are directly involved with consumer care. Limitations as they relate to use of the NGT include issues around measuring consensus, which in this study was set at above 70%, and issues related to what characterizes an expert, where we considered nurses grade five and above to be expert.

CONCLUSIONS

Participants were engaged in a NGT to work through local adaptation to the CRC for FMH, vote on the proposed changes, and contribute towards discussion about further changes required. The responses from participants highlighted inherent practice challenges in the FMH setting, while also emphasizing the need to seek feedback prior to making changes, as any change can result in unintended consequences, which may then impact negatively on practice. While there is a strong desire and commitment to the provision of recovery-oriented care in FMHN, achieving this must be made with careful consideration to offence and risk issues, along with consideration of individual and group biases and reflection on practice. Further adaptations to the CRC are necessary to emphasize recovery-oriented and clinical-reasoning.

RELEVANCE FOR CLINICAL PRACTICE

Using an appropriate framework to guide care, clinical-reasoning and decision-making has the potential to impact treatment outcomes for consumers families/cares and supporters. The introduction of the CRC with adaptations for the FMH setting may offer a shift from custodial practice, in its place providing a holistic recovery-oriented framework that prompts reflection on the critical issues inherent in FMH settings. Nurses in this study identified further adaptions and further work is required to finalize the CRC for this setting. The engagement from the nurses signals a willingness to address the issues in a collaborative manner to enhance practice for all. A commitment to recovery-oriented practice also needs to be promoted at a local and organizational level, as well as at a professional level. Furthermore, the CRC may offer a way for FMHNs to enhance their professional identity by articulating the necessary skills and knowledge required in this unique area of nursing practice.

ETHICAL APPROVAL

Approval to conduct this study was granted from the Swinburne University of Technology (Project ID: 6171). Approval for access to Forensicare and to include Forensicare nurses in this study was granted by the Forensicare Operational Research Committee. Ethical requirements were met by the researchers.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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