

An exploration of the role of the court liaison nurse within the
New Zealand criminal courts

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ABSTRACT

This thesis explores and describes the role of the mental health nurse in criminal courts in New Zealand. Nursing practice in criminal courts has not previously been examined in the New Zealand context. The court liaison nurse (CLN) is the sole health practitioner in a setting involving a high level of public and media scrutiny. It was therefore surmised that nursing in a setting at the juncture of two conflicting cultures, justice and health, would generate considerable tensions for the nurse. Naturalistic qualitative descriptive research design and mixed methods were used to gather rich information about this discrete cohort of CLNs and their nursing practice. A survey-questionnaire was sent to all nurses practicing in the role. In-depth interviews were then conducted with six CLNs who also completed a two week audit of their day-to-day practice.

The findings reveal that despite their seniority and wealth of experience, their work and educational experiences had not prepared the nurses for practice that was immersed in a legal setting. CLNs encountered multiple challenges to maintaining their nursing values and focus. Significantly, they had to adjust their professional language to realise effective communication. CLNs experienced alienation because of the novel practice setting, a lack of understanding about the role and the absence of a structure for professional support. They felt as if they did not belong in either the legal or health setting. There was a pervasive sense of a group of nurses who felt undervalued by their colleagues, epitomising the isolated nature of the role. As a result, CLNs are a disparate group who would benefit from a supportive national CLN forum.

CLNs encountered many complications on a daily basis in the course of brokering court liaison and court diversion. Disparities were uncovered in relation to resourcing and some practices. Two aspects of their practice were particularly troubling for CLNs. They reported that obtaining consent in the court setting and the exchange of health and offending information was problematic. These aspects were complicated by the public nature of the court and the involvement of multiple agencies. Importantly, the research highlights the need for expert and dedicated professional support for the CLNs both at the coalface and in an ongoing capacity.

CLNs have attained advanced and additional knowledge and skills regarding the interplay between the mental health and justice systems. Their level of expertise is

currently not recognised. A way forward to embed this nursing practice for the future is suggested through development of a framework for practice including standards and competencies for practice, an educational pathway and a professional support structure. Consideration could then be given to specialty practice areas or an expanded Registered Nurse (RN) scope.

These nurses perform a crucial role in working with people with mental health concerns in courts and advocating for health interventions for the person. CLNs have a vast amount of valuable knowledge regarding the intersection of mental health and justice systems. It is hoped that bringing together the CLNs' experiences and knowledge into the public arena of mental health nursing will stimulate and motivate others to continue the drive for acknowledgement, continuity and ongoing evolution of this important and necessary nursing role.

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TABLE OF CONTENTS

Abstract	ii
Acknowledgements	iv
Table of contents	vi
Table of figures	xiv
Table of legislation.....	xv
Table of tables	xvi
Attestation of authorship	xvii
Chapter One: Introducing the thesis.....	1
A note on terminology and focus	2
Court liaison nursing	3
Researcher positioning and rationale for the research.....	4
Thesis structure.....	6
Chapter Two: Review of the literature.....	8
Introduction	8
The literature search	8
Section One: Background to development of services for people with mental illness involved with criminal justice services	9
Evolution of a growing population of people with mental health concerns in justice populations.....	10
Contemporary responses to the needs of mentally unwell people at the front end of the interface with the law	11
Court diversion and court liaison.....	11
Point of arrest and police diversion schemes.....	15
Referral pathways to and from court diversion and court liaison schemes	16
Responding to an increasing population of people with mental health concerns interfacing with the law in New Zealand	17
Recovery in Forensic mental health services.....	18
Evolution of mental health nurses in criminal courts in New Zealand.....	19
Scholarship surrounding mental health nursing within court and prison settings ...	20
Section two: Progression of forensic mental health nursing	26
Key concepts drawn from forensic mental health nursing scholarship.....	29
Educational preparation for forensic mental health nursing.....	29
Standards and competencies	31
Forensic mental health nursing and role ambiguity.....	32
Consent and information sharing in a multiagency context	34
Lack of professional support	34
Cultural awareness in the criminal justice sector	35

Recognition – a sense of being under-valued.....	36
Summary	36
Research aims.....	37
Chapter Three: Methodology	38
Introduction	38
Research question and aims	38
Theoretical perspective - constructivism and naturalistic inquiry.....	39
The ontological dimension	40
The epistemological dimension	42
The methodological dimension.....	44
Research design.....	44
Qualitative descriptive methodology.....	44
Mixed methods	46
Participant sampling and recruitment.....	48
Survey questionnaire	48
In-depth interviews and audit	49
Tools.....	49
Survey questionnaire	49
Development of the survey questionnaire.....	50
Piloting/pre-testing the survey questionnaire.....	51
Survey questionnaire - structure and content.....	52
In-depth interviews (semi-structured).....	53
Development of draft interview questions	54
Interview process	55
Audit	56
Development of the audit tools/key/instruction sheet.....	56
Data collection set 1	57
Data collection set 2	57
Instruction sheet and key.....	57
Data analysis and data re-presentation	58
Quantitative analysis.....	58
Re-presentation of quantitative data	58
Qualitative analysis.....	58
Re-presentation of qualitative data	60
Data quality and design credibility.....	61
Researcher values	63
Research supervision	63
Research presentation	64
Ethical implications and consent.....	64

Seeking informed consent and maintaining confidentiality	66
Cultural consultation	67
Summary	68
Chapter Four: Findings survey questionnaire	69
Introduction	69
Response rate.....	69
Findings	69
Section One: Demographic and role details regarding nurses.....	69
Demographic characteristics of sample	70
Qualifications	71
Role details	71
Work profile	71
Working conditions at court/access to resources	74
Section Two: Orientation, education and training requirements.....	74
Orientation to the CLN role	75
Alienation-educational preparation required.....	75
Extended support.....	76
Professionalism in the legal system	77
The ideal.....	78
Education and training pathways.....	78
Theme One - Defining parameters to the role.....	79
Court liaison service and CLN role – functions and responsibilities.....	79
Liaison, and systems and roles of others.....	80
Theme Two: Education - legislation and law	81
Theme Three: Possibilities for a post-graduate pathway	82
Theme Four: The need for a national forum	82
Support	82
Peer support.....	82
Organisational support	83
National educational workshops	83
National guidelines/templates	83
Section Three: Supervision and opportunities for dialogue about practice.....	84
Clinical supervision	84
Improving quality and availability of professional clinical supervision.....	85
Barriers to engaging in regular clinical supervision.....	86
Other opportunities to reflect on and discuss practice	86
Routine	87
Less frequent but desirable.....	87
Collegial/informal/opportunistic	88

Section Four: Inter-professional collaboration, court diversion and nursing practice tensions	88
Inter-professional collaboration	88
Court diversion and court liaison	91
Understandings of court diversion	91
Advocacy and enabling	92
Bridging between systems	93
Brokering court diversion	93
Working within the relationships	94
Resilience	94
Knowledge and resources in the wider mental health services	95
Nursing practice tensions	96
Issues in the practice setting	96
Cultural and ethical matters	97
Cultural concerns	97
Ethical concerns	97
Attitudes	98
Confidentiality, privacy and information sharing	98
Role conflict	99
Final thoughts	99
Enjoyed most	99
Autonomous practice and variety	99
Court mental health interface	100
Making a difference – nursing advocacy liaison and education	100
Enjoyed least and CLN recommendations for the future	101
Vulnerabilities related to isolation, autonomy and pressure	101
Organisational inclusion, support and acknowledgement	102
National standards, consistency in delivery of role and support systems	103
Education and training opportunities	104
Recognition of specialist nature of mental health nursing in courts	104
Summary	105
Chapter Five: Findings in-depth interviews	107
Introduction	107
Theme One - Wealth of experience	107
Summary	109
Theme Two - No normal day	109
Setting the scene	109
Prioritising the immediate	110
The centrality of the assessment	111

The value of the written word.....	112
Exercising discretion to divert.....	112
Interweaving the liaison role.....	113
Summary.....	116
Theme Three – Part of but not part of.....	117
Unfamiliarity.....	117
Outside the usual.....	119
Modification of language.....	120
Disconnect.....	121
Solitary practice.....	122
Work ethic.....	124
Ethics.....	124
Tension between the aims of the two systems-justice and health.....	124
Court as the client.....	125
The dilemma of informed consent.....	126
Disclosure.....	128
“I don’t know if it’s just us”.....	129
Providing reports to the court.....	130
“Wading through the mud”: outlining the requirements for professional clinical supervision and support.....	132
Organisational processes.....	133
Resources.....	133
Presence.....	134
Changes in systems and services.....	134
Barriers to negotiating appropriate outcomes for people seen at court.....	135
Knowledge barriers.....	135
Reciprocal collaboration.....	136
Overcoming problematic attitudes.....	136
Professional requirements.....	138
Summary.....	139
Theme Four – Added layers.....	140
Wisdom and professionalism.....	140
Knowledge of legislation and medico legal environment.....	142
Expert resource regarding mental health issues for court and justice agencies	143
Expert resource for mental health professionals regarding the mental health legal interface.....	143
Diverse assessment skills.....	144
Fitness to plead.....	145
Collaborative practices.....	146

Consult liaison.....	146
Balancing and negotiating.....	147
Familiarity	147
Summary	148
Theme Five - Requirements for practice and recognition	149
Education	149
Professional supervision and support	150
Clinical supervision.....	151
Support	151
Access to forensic consultant expertise and support from court.....	152
“Commonality of experience”: National consistency.....	153
Recognition.....	155
Evolving role	155
Summary	156
Chapter Six: Findings of the audit	158
Introduction	158
Referral information	159
Characteristics of individuals	161
Gender and age	162
Ethnicity.....	162
Offence details	164
CLN interventions, activities and processes.....	166
Assessment interviews.....	166
DAO.....	166
Liaison	166
Advice provided to court	167
Outcome from contact with CLN	167
Time	167
Other CLN activities and interventions.....	167
Summary	168
Chapter Seven: Discussion.....	169
Introduction	169
Court liaison nursing	169
The overarching themes	172
Theme One - Wealth of experience	173
Theme Two – “No normal day”	174
Theme Three – Complications encountered by nurses practicing in courts.....	176
Bridging disciplinary boundaries	176
Ethical concerns	178

Balancing the demands of therapy and public safety	178
Role conflict	179
Complications in the relationship – consent, information sharing and ethical guidance	180
Organisational processes	183
Barriers to negotiating care and appropriate outcomes for people seen at court	185
Theme Four – Requirements for sustaining and maintaining practice	188
Educational preparation required	188
Education regarding cultural and disability factors	190
Professional support structures	192
National consistency	194
Theme Five - Extraordinary practices	195
Assessment expertise	198
Collaborative practices	198
Theme Six - Recognition	199
A possible way forward	201
Credentialing	202
Advanced practice roles	202
Framework: standards and competencies for practice	203
Specialist opportunities	204
Summary	206
Chapter Eight: Conclusion	208
Introduction	208
Summary of the findings - CLNs since the early 1990s in New Zealand	209
Future research directions	211
Limitations of the thesis	212
Contribution of thesis	213
Final reflections	214
References	218
Appendices	237
Appendix A: Ethics documents	237
MREC	237
AUT	239
Locality agreements	240
Southern DHB lead	240
Waitemata DHB	241
Waitemata DHB confidentiality agreement	242
Canterbury DHB	243

Capital & Coast CDHB	244
Appendix B: Letters	245
NZFPAG	245
FMHS managers	247
Survey cover letter	249
Survey reminder letter	250
In-depth interviews and audit cover letter	251
In-depth interviews and audit reminder letter	252
Appendix C: Participation information sheets and consent form.....	253
Survey participant information sheet	253
In-depth interviews and audit participant information sheet	255
In-depth interviews and audit consent form	258
Appendix D: Data collection tools	260
Survey questionnaire	260
Guide to interview	274
Data collection instruction sheet and key	277
Audit data collection set one.....	279
Audit data collection set two	282
Appendix E: Confidentiality agreements	285
Confidentiality agreement - AUT administrator.....	285
Confidentiality agreement - Transcriber.....	287
Confidentiality agreement - Typist.....	288
Appendix F: Psychological support	289
Psychological support - AUT Student Services.....	289
Appendix G: Screening assessments and the Criminal Procedure (Mentally Impaired Person) Act 2003	290
s. 38 – Criminal Procedure (Mentally Impaired Persons) Act 2003.....	290
38 Power of court to require assessment report	290
Screening assessments	290

TABLE OF FIGURES

Figure 1: Frequency of CLN contact with other agencies	89
Figure 2: Quality of the contact with other agencies	90
Figure 3: Demonstrates the relevant fields and potentially conflicting ideologies that the court liaison nurse role interacts with. The shaded areas demonstrate the unique dimensions that through their interactions have contributed to the development of the CLN role. The person the CLN assesses sits within the overlap of the three dimensions.	180
Figure 4: Simply demonstrates the layers of knowledge and specialist experience that contribute to the knowledge and expertise required in CLN practice.....	197

TABLE OF LEGISLATION

NEW ZEALAND

Children, Young Persons, and Their Families Act 1989: 81,167

Criminal Procedure (Mentally Impaired Persons) Act 2003: 81,111,
119,135,142,143,144,145,160,161,166,167,171,195,212,274,278,290,291

Health and Disability Commissioner Code of Health and Disability Services Consumers
Rights 1996: 184

Health Information Privacy Code 1994: 34,181

Health Practitioners Competence Assurance Act 2003: 138

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:
25,81,119,135,160,195,274,278

Mental Health (Compulsory Assessment and Treatment) Act 1992:
52,71,81,111,113,115,160,170,181,189,194,274,278

New Zealand Public Health and Disability Act 2000: 48

Privacy Act 1993: 34

AUSTRALIA

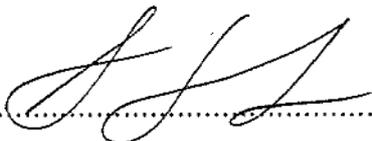
Mental Health Act 1996 (WA): 13,170

TABLE OF TABLES

Table 1: <i>Socio-demographics of participants in the survey</i>	70
Table 2: <i>Highest qualification of participants in survey</i>	71
Table 3: <i>Work profile of participants in the survey</i>	72
Table 4: <i>Rating the importance of liaison and diversion functions</i>	91
Table 5: <i>Issues in the practice setting</i>	96
Table 6: <i>Referral sources to CLNs</i>	159
Table 7: <i>Primary reason for referral to CLN</i>	160
Table 8: <i>Stage in court process when referral was made</i>	161
Table 9: <i>Demographic characteristics of people referred to CLN</i>	161
Table 10: <i>Mental health information regarding people referred to CLN</i>	163
Table 11: <i>Offence categories</i>	165

ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor any material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed .. 

Date 10/11/2014

Chapter One: Introducing the thesis

Forensic mental health nurses weave their way through a maze of personal, social and political dimensions regarding crime and mental illness to broker fitting outcomes for the mentally unwell person. As one may imagine, navigating this maze leads to internal ethical conflict for the nurses.

The court liaison nurse (CLN) plays an integral role in the pathway of the mentally ill person in the New Zealand criminal justice system. Not only is this role carried out in an area of mental health care that attracts significant public and political attention (Chaplow, 2007), but the nursing practice is shaped in important ways by the setting. As the sole health professional in the setting, the nurse is practicing in isolation from health systems, structures and collegial supports. Within this environment, these factors have been identified as having implications in terms of decision making, ethical issues and role related tensions (Turnbull & Beese, 2000; McKenna & Seaton, 2007). Evans (2007), a forensic psychiatrist, suggested other health professionals practicing in that setting would experience similar ethical tensions as the forensic psychiatrist. Therefore the potential for the nurse to experience role conflict is a very real feature of practice. These tensions are born out of the competing demands for the nurse to provide advice to the court and to work in a therapeutic manner with the mentally impaired person. Such challenges and paradoxical practice circumstances, inherent in forensic mental health nursing practice, have been highlighted in the literature (Holmes, 2001).

From its formal beginnings in the 1990s, mental health nurses have stepped in and developed the CLN role in New Zealand. There were approximately forty one nurses providing mental health nursing expertise to the criminal courts in New Zealand at the time of this study. The number of CLNs is small compared to the total number of registered nurses whose main practice area is mental health, $n = 4092$ (NCNZ, 2012), in New Zealand.

Through the use of three data sources, this thesis explores and analyses the court liaison nurse role in the New Zealand criminal courts. The aim is to describe the nursing knowledge embedded in clinical practice through focusing on four main questions:

1. What are their nursing backgrounds and professional experience?
2. What are their daily professional activities?
3. What ethical tensions do they experience and how do they manage them?

4. What are their education, training, supervision and support needs and should there be a specific framework or model for their practice?

This introductory chapter explains the researcher's position and research rationale. The chapter concludes with an outline of the thesis structure.

A note on terminology and focus

Reference is made throughout the thesis to the person the nurse assesses and has contact with in the course of the CLN role. Given that typically people receiving health care are referred to as patients (Collins, 1993) it is important to clarify the terminology used at the outset. It could be argued that the person who has contact with the nurse in the court setting is not a "patient" in the traditional sense. The person may or may not have a mental disorder, mental illness, intellectual disability or other relevant condition. They may not be seeking health care but instead be referred to the CLN by others. CLNs use a variety of terms to describe the person they had contact with at court, e.g. person, patient, client, consumer, service user, person with experience of mental illness, person with learning disability, mentally disordered offender, and offender. Likewise, many terms are used in the domestic and international literature. Travelbee's (1971) interpretation of the meaning of "patient" from a nursing perspective is useful. Travelbee contends that people in need of assistance should be viewed as individual human beings rather than as patients. She suggests "patient" is an unhelpful stereotypical label useful only for communication purposes.

Terminology has important implications. According to Peternelj-Taylor (2004) and other critics (Swinton & Boyd, 2000), nurses in forensic settings commonly depersonalise the people they work with through language used. Peternelj-Taylor (2004) suggested that how the forensic psychiatric nurse "views" the patient is an important ethical concern. Positioning the patient as the "other" in forensic settings implies a negative form of engagement as opposed to a therapeutic orientation to care (Peternelj-Taylor, 2004). Therefore, to reflect that the person the nurse has contact with may not be a patient in the true meaning of the word, the words "person", "individual", and "people" are applied in the thesis. This also avoids using language that may associate negative connotations both for the nurse and their practice, and for the person.

The focus of this research is the nursing practice of the CLNs in the study. Undoubtedly, the context has a considerable influence on the possibilities and

limitations of the work of nursing and the ability to meet the needs of the mentally unwell person. Therefore, attention to the landscape or context in which the nursing takes place, and the multitude of relationships, is of vital importance if the nursing practice is to be made clear. It is hoped that this research will contribute in a positive manner to the wider body of knowledge regarding the interface between the criminal justice and the mental health systems and the outcomes for the person with mental impairment. The term mental impairment includes mental disorder and intellectual disability.

Although it is the writer's preference to refer to health services for people experiencing mental health concerns using the term "mental health", the terms "psychiatric" and "mental health" are both used in the thesis. "Mental health" reflects the true multi-disciplinary nature of the mental health professionals who provide the services to mentally unwell persons (Sullivan & Mullen, 2006). When relevant, the term "psychiatric" is used to be congruent with the scholarship the thesis draws on.

Court liaison nursing

Mental health nurses began practicing in courts as part of the response to the high prevalence of mental illness amongst justice populations internationally. An assortment of schemes and specific courts were instigated internationally with the aim of ensuring appropriate outcomes for the people with mental health concerns in justice populations (Shaw, Creed, Price, Huxley & Tomenson, 1999; James, 2006). Two main types of schemes emerged: liaison and diversion schemes (James, 2006). Court diversion is defined as "a policy of transferring the mentally ill away from the criminal justice system and into psychiatric care" (James, 2006, p. 529). Court liaison includes court diversion as well as linking, brokering and liaising with a variety of agencies and services in the community (James, 1999). Mental health nurses in courts assist with assessment and the early identification of mental illness, facilitate referral to appropriate services, and provide advice to courts. The literature regarding the extent and purpose of these schemes and the role of the mental health nurse within these is examined in Chapter Two.

Researcher positioning and rationale for the research

My background as a registered nurse included practicing in community, court, prison and inpatient forensic mental health settings for over thirteen years. The experience of practicing as a CLN inspired me to commence this doctorate. The four underpinning research questions were shaped by several assumptions I had about the CLN role.

Firstly, I considered it a stimulating and challenging autonomous role for nurses, which needs to be treasured and developed. Secondly, there was inadequate clinical and educational support available for nurses in this role. Finally, along with other CLNs, I believed the distinct scope of practice needed to be articulate and recognised.

I was influenced by a justice liaison (court and prison liaison) nurses' conference when I was a novice court liaison nurse. An excellent presentation by a forensic psychiatrist outlining the role of the CLN led me to question why nurses were not the ones defining and speaking about their own role. In addition, I was motivated by the scholarship of Buresh and Gordon (2000) concerning the importance of nurses valuing what they do and speaking in their own voices about their nursing practice and making nursing practice visible. Nursing information about the delivery of health care was considered missing in many public and political forums. Buresh and Gordon (2000) entreated nurses to consider the impact their information could have on aspects such as resource allocation and education budgets across the health spectrum. I thought the CLNs' knowledge regarding this interface could be invaluable to service planners and funders.

Likewise, Gage and Hornblow (2007) identified that historically, nurses were not expected to talk about the distinctive features of their roles that make a difference to the health of the people they cared for. Also, nurses did not require this of themselves. Gage and Hornblow (2007) also implored nurses to embrace opportunities that arise out of a continually changing health sector to re-examine professional roles, culture and demonstrate leadership. These challenges posed to nurses struck a chord with me at the time. My own practice experiences led me to believe this was a nursing role that was poorly understood and CLNs themselves needed to make this role visible and heard. Therefore, I anticipated that the relatively new status and novelty of the CLN role in New Zealand would provide a unique opportunity to advance the principle that nurses should define their own roles.

Similarly, Crowe's 1997 article encouraging nurses to critically analyse their practice and the context in which it occurred provided thought provoking background. Crowe

(1997) argued that nurses must come from an informed position which implies that in order to do so, collaboration and knowledge is required. Accordingly, Crowe (1997) stated that education should be self-determined rather than determined by service providers or others. The lack of tailored education for court liaison nurses and the “learn on the job” attitude seemed unsafe and unnecessary to me even in my novice status at the time.

I found the CLN role provided autonomy. The opportunity to develop working relationships with professionals from other disciplines, albeit very different kinds of relationships compared to those with fellow health professionals, was appreciated. Mental health nurses infrequently receive positive feedback or the sense that one is making a difference, particularly in an overworked, over stretched health system. Therefore feedback from the judiciary at the time, and the sense of being valued with recognition as a credible expert practitioner was affirming.

However, despite feeling valued and able to contribute in a positive manner in the court setting for people with mental health difficulties, nurses were not prepared in undergraduate education for practice in a legal environment. Nor was there any specific training pathway for nurses to practice in this role, let alone in forensic mental health nursing overall. In New Zealand, there was no precedent for nursing practice in the criminal courts. Consequently, there were no formal documented parameters. Court liaison nurses had to “learn by the seat of their pants”.

Both my colleagues and I found obtaining adequate support and professional clinical supervision with nursing colleagues was problematic due to the lack of understanding of the unusual practice setting. The court was a foreign environment for nurses. As Seaton stated, “Before becoming a court liaison nurse, I had never entered the courts....” (McKenna & Seaton, 2007, p.460). I spent many hours agonising over issues such as informed consent and sharing health information in the court. From discussions with colleagues, it was apparent there were regional variations in how the court liaison service was being delivered. This observation was supported by McKenna and Seaton (2007), who also expressed that there was no published assessment of the effectiveness of the service. There was a scarcity of information and clarity regarding the role in New Zealand.

Another important consideration in this research was to make visible the CLNs role in working with mentally unwell people in the court setting. Historically, according to

Chaplow (2007), advocacy for offenders with mental health problems has not been a priority. He suggested this may be because of the mentally unwell offender's initial presentation and high risk behaviour to others (Chaplow, 2007). Accordingly, the research sought information regarding the people referred to CLNs, and whether the CLN was able to facilitate suitable outcomes for the mentally unwell person within the criminal justice system.

Best practice and outcomes for consumers is founded on a knowledgeable and supported workforce. For that reason, increased knowledge regarding the support and education CLNs require will result in delivering better services to the people who use the service. This study will contribute to the fundamental body of knowledge that underpins mental health nursing practice. It will explore and articulate the nurses' knowledge about their own role and educational needs. Furthermore, it is hoped the research will enrich international scholarship and practice regarding forensic mental health nursing.

On the basis of my experiences and those of my colleagues, I decided to commence this study to illuminate the role and give voice to CLNs through a description of the joys and frustrations of CLN practice. It was important to initiate research that explored and recognised the particular knowledge required to practice in this unique environment.

Thesis structure

Chapter Two examines the scholarship regarding mental health and nursing services to the courts. The chapter provides a synthesis of current scholarship/knowledge regarding forensic mental health nursing roles, relevant professional challenges and their relevance to the court liaison nurse. Chapter Three provides justification for the choice of qualitative descriptive methodology and an outline of the mixed method research design. The research design, incorporating data collection methods of survey, in-depth interviews and an audit of daily practice, was chosen to elicit rich findings regarding the innovative role of the mental health nurse in the criminal courts in New Zealand. The research findings are presented in the next chapters. Chapter Four addresses the survey findings. The in-depth interview findings are portrayed in Chapter Five. Chapter Six addresses the audit findings. Chapter Seven analyses the key themes and highlights the contribution of this study to the body of CLN knowledge while offering recommendations for practice. The thesis concludes in Chapter Eight with an

explanation of the limitations of the research. Implications for nursing practice and policy are discussed and future areas for research suggested.

Chapter Two: Review of the literature

Introduction

This chapter critically examines scholarship surrounding nursing practice in the criminal courts. Review of the literature assisted with developing and refining the topic. The literature review is organised into two main sections. To provide context to CLN practice, it commences with a review of the background to forensic mental health services and the growth in numbers of people with mental health concerns in justice populations. Examination and comparison of the differing types of schemes set up to meet the needs of the mentally unwell person in criminal justice systems follows. The scholarship surrounding the mental health nurse's position in criminal courts with reference to prison nurses who also practice out of the usual frame of reference for a health professional is then considered. Section Two of the review focuses on nursing practice. Because CLNs are situated within forensic mental health services in New Zealand, the historical development of forensic mental health nursing is reviewed. Due to the paucity of scholarship regarding court liaison nursing, forensic mental health nursing literature was examined with the aim of identifying key concepts that may be relevant to the CLN role. Tensions and challenges identified in the literature for forensic mental health nurses provided a starting point for the research to review court liaison nursing practice. Finally an overview of the research focus, questions and aims is presented.

The literature search

The initial electronic search using the terms 'justice liaison nurse' and 'court liaison nurse' on CINAHL and OVID from January 1999 to June 2009 identified three articles. The literature was not directly relevant to the thesis. Therefore, the search was widened to incorporate forensic mental health nursing using the following databases: EPSCO, CINAHL, MEDLINE, PROQUEST and OVID. A process of auto alerts was set up to capture literature as it came through. As the study advanced, search terminology was updated to expand knowledge of the topic with a number of search terms utilised to access forensic mental health nursing and other relevant literature. These terms included: forensic mental health nurse, psychiatric nurse, court diversion, criminal justice system and mental health service, special patient status, criminal procedure mentally impaired persons act, criminal procedure mentally impaired persons act and

nursing, forensic mental health service, forensic psychiatry, forensic nursing, and specialist nursing. Influential New Zealand documents and other published works were hand searched to provide contextual information.

Section One: Background to development of services for people with mental illness involved with criminal justice services

In order to understand contemporary nursing within a forensic setting, the review commences with a brief overview of the origin of services for mentally ill people. Possible reasons for the growing population of people with mental health concerns within justice populations are then explored.

Historically provision of services for mentally ill persons arose out of societal responses to protect others from them rather than a need for care (Jacob, Holmes & Buus, 2008). Scholars agree that development of mental health services in New Zealand stem from the British system (Brunton, 1996; Coleborne & MacKinnon, 2006). By the mid 1860s there was a network of asylums and institutions throughout New Zealand (Coleborne & MacKinnon 2006). The asylum served as the means by which segregation of the mentally unwell from society was made possible (Jacob, et al, 2008).

Further segregation of the mentally unwell population occurred. In the United Kingdom, the creation of legislation in the 1800s to separate the “dangerous” from the “ordinary mad” to ensure public safety took place (Mason & Chandley, 1990, p.668). Similarly, in New Zealand, segregation of “lunatic prisoners” and “criminal lunatics” occurred through the 1846 Lunatics Ordinance in New Zealand for the “dangerously insane”, and the “committal process was both a legal and a medical one” (Colborne & MacKinnon, 2006 p. 372). The opening of Broadmoor asylum in the United Kingdom in 1863 provided special and secure accommodation for various classes of the criminal lunatic detained under the Criminal Lunatics Act (Brunton, 1996; Mercer, Mason & Richman, 2001; Kettles & Woods, 2006). Other western countries and New Zealand followed the United Kingdom with the introduction of separate facilities for the criminally insane (Brunton, 1996). These facilities served the dual purposes of therapy and control (O’Brien, 2001). New Zealand’s first national maximum secure facility was developed as a special division of a ward at Seacliff Hospital and it was constructed to provide “absolutely secure quarters and supervision for specific individuals who were found criminally insane” in 1914 (Brunton, 1996, p.37).

Focused forensic mental health services developed in the late 20th century. These services attempted to establish a new ethos of care as a result of significant inquiries, notably the Glancy and the Butler Reports in the United Kingdom (Mason, King and Dulson, 2009) and the Mason Report in New Zealand (Mason, Ryan & Bennett, 1988).

Evolution of a growing population of people with mental health concerns in justice populations

Consideration is now given to understanding changes in the landscape of the people with mental health concerns who may interact with criminal justice systems. Of relevance to the current configuration of mental health services, significant socio-political changes in the mid 20th century influenced the genesis of mental health services to the courts (Mason et al, 1988; Chaplow, 2007) and subsequently the court liaison nurse role. From the 1950s through to the 1990s intense de-institutionalisation was common in Western countries generating considerable change in the way health services were provided for the mentally unwell (Scull, 1985; Coleborne & MacKinnon, 2006; Brunton, 2005). With closure of large psychiatric institutions, the aim was that people were cared for in the community.

As a result of this philosophical change, gaps in service provision were created, particularly for people with mental illness who presented with a high level of risk and those who were imprisoned (Mason et al, 1988). De-institutionalisation is considered a factor associated with the high numbers of people with mental disorder in the prison population (Lamb & Weinberger, 1998; Choe, Teplin, & Abram, 2008). Commentators have observed prisons appear to have become the new revolving door for the group of people who bounce between justice and mental health (Brinded & Evans, 2007; Morrissey, Meyer, & Cuddeback, 2007). This trend became referred to as “criminalising mental disorder” (Teplin, 1984; White & Whiteford, 2006). In seeking an explanation for this trend, authors across two decades have suggested there is no doubt that the lack of mental health resources available in the community was a factor in the elevated numbers of mentally ill people arrested and low detection rates of mental illness among detained persons (Abram & Teplin, 1991; Birmingham, Mason, & Grubin, 1996; Brooke, Taylor, Gunn & Maden, 1996; Baksheev, Thomas & Ogloff, 2010).

It is of concern that, not only are there increasing prison musters worldwide (Walmsley, 2011), but mental illness research has found that rates of major mental illnesses such as schizophrenia and depression are between three and five times higher in offender

populations compared with those expected in the general community (Brinded, Simpson, Laidlaw, Fairley, Malcolm, 2001; Ogloff, Davis, Rivers & Ross, 2007). Fazel and Seewald (2012) confirm the high levels of psychiatric morbidity consistently reported in prisoners from many countries over four decades. This suggests the trend of criminalising mental disorder (Teplin, 1984) is not being reversed. This trend involves implications for not only court liaison nurses and mental health services, but for wider health services in the provision of health care to people with mental health concerns in justice populations.

The prison statistics are just one part of the information about offenders with mental health problems who present with complex needs in the criminal justice system. Clearly, mentally impaired persons are present at all points of the justice system from first contact with police through to disposal (Ogloff et al, 2007). Of interest to the thesis is that according to Baksheev et al (2010), while the needs of the “captive population” are well researched and understood, the needs of people at time of arrest and whilst in police custody is not well researched. The responses to the increasing numbers of people in criminal justice populations are now considered.

Contemporary responses to the needs of mentally unwell people at the front end of the interface with the law

Differing approaches to the care and disposal of the mentally disordered offender have developed internationally (Salize, Lepping & Dressing, 2005), reflecting the differing cultures, values and belief systems of each society. Examples include court diversion and court liaison schemes developed in England and Wales, Australia, New Zealand and the United States (James, 2006), and specific problem solving courts such as mental health courts in the United States (Steadman, Redlich, Griffin, Petrila, & Monahan, 2005; Seltzer, 2005), and point of arrest schemes in police stations in England (Riordan, Wix, Kenney-Herbert, & Humphries, 2000; James, 2000) and New Zealand (Paulin & Creswell, 2010). There are significant differences in how court diversion schemes and services operate internationally (Parsonage, 2009). The following section provides a brief examination and comparison of the main features of these approaches.

Court diversion and court liaison

To understand the CLN role, the review will now examine the historical and international development of two forms of mental health intervention in the criminal justice system: court diversion and court liaison schemes. Initiatives were premised on

the principle that mentally ill people who offend have the same right of access to mental health assessment and treatment as that of non-offenders (Birmingham, Wilson & Adshead, 2006). As McKenna states “There is a strong legal and moral argument for the right of ‘offenders with mental health problems’ to equivalency to the same degree of mental health service provision as the general population” (2011, p.76). Equivalency is an ethical principle of justice, especially justice for the vulnerable in terms of access to resources (Birmingham et al, 2006). Equivalence of care as a concept emerged in New Zealand following the recommendations in the Mason Report (Mason et al, 1988) and formed the ideological underpinning for the delivery of mental health care to the mentally unwell person in justice settings (Brinded & Evans, 2007).

Court diversion is defined as “a policy of transferring the mentally ill away from the criminal justice system and into psychiatric care” (James, 2006, p. 529). This may be contrasted with diversion programmes which “initially increase contact with the criminal justice system through supervision and treatment but which are aimed at reducing contact with the criminal justice system over time” (Richardson & McSherry, 2010). Court diversion in New Zealand is a separate process to the Police Adult diversion scheme. The Police Adult Diversion Scheme “allows for some offenders who have been charged to be dealt with in an 'out of court' way. If the offender completes agreed conditions, the prosecutor can seek to have the charge withdrawn and a conviction will not be recorded” (New Zealand Government, 2013).

Court diversion schemes originated in the United States as early as 1914 and in England and Wales from 1989 (James, 2006). Comparing services developed for differing historical causes, with diverse legal, funding and geographical circumstances is problematic. The thesis will focus on two schemes - court diversion and court liaison as they have the most similarity with the New Zealand situation. The aim of court diversion and liaison schemes is to meet both mental health and criminal justice goals (McKenna & Seaton, 2007). The two schemes have some distinct characteristics but overlap in some respects.

Liaison schemes developed in England and Wales where there was a low referral rate, run by nurses who linked cases to local psychiatric services (James, 2006). In contrast, the diversion schemes developed where there was a greater need to admit people directly to hospital from court (James, 2006). The latter were considered a practical alternative when a person with mental health problems came to the attention of the

criminal justice system, given the problems involved in providing mental health treatment once the person was in prison (Sly, Sharples, Lewin & Bench, 2009).

In the Australian situation, federal political structure and geographical expanse has meant that each State and Territory has its own health care system, mental health laws and criminal legislation (Brett, Carroll, Green, Mals, Beswick, Rodriguez, Dunlop and Gagliardi, 2007). Consequently, diverse service models have developed in response to the needs of the mentally unwell people which take into account the unique needs of each State and Territory (Brett et al, (2007). Some Australian territories have developed Forensic Mental Health Services that are integrated with main stream mental health services while others provide a parallel service (Brett et al, 2007). The idea that the “hybrid system” has developed along a continuum of parallel and integrated services which are responsive to the needs of the population is seen as positive (Brett at al 2007).

All States except South Australia provided a court liaison service (Brett et al, 2007). The Western Australian mental health court liaison service is described following a review against criteria suggested by James, 1999 (Brett, 2010). The court liaison service covers the whole state, with daily input to the main court in Perth, covering other courts once a week or as needed. Remote and regional courts are covered by teleconferencing (Brett, 2010). The clinicians were described as senior nurses who are authorised to perform assessments and make referrals under the Western Australian Mental Health Act (Brett, 2010).

The nurses at court carry out a semi-structured interview, covering basic areas of a mental health assessment recorded on a standardised form (Brett, 2010). The aim is to ensure that the key aspects of an interview are incorporated but also enables to nurses to use their clinical judgement to record other relevant issues (Brett, 2010). However, while providing a useful description of Western Australia’s mental health court liaison service the focus was examination of outcomes and considering the service against criteria described in the literature. For the purposes of this research there was negligible attention to the nurse’s role.

In contrast, New Zealand has a National Framework (MoH, 2001) to guide service delivery and one funding stream (Brinded, 2000). However, McKenna and Seaton (2007) noted there are some regional variations in how court liaison services are structured and delivered in New Zealand.

In summary court diversion provides the opportunity for further mental health assessment and may result in either inpatient or community treatment or no additional follow up from health services. Court diversion can occur at any stage of the court process but usually takes place before conviction (Greenberg & Nielson, 2002). Court diversion does not mean the criminal process stops but enables the mental state of the offender to be taken into account by the court (Greenberg & Nielson, 2002).

Court liaison includes court diversion as well as linking, brokering and liaising with a variety of agencies and services in the community (James, 1999). Court liaison services are targeted at the early identification of individuals with mental illness appearing before the court who require mental health and other services: conducting assessment and providing timely advice to the court about a person's mental illness; and diverting offenders where appropriate (Sharples, Lewin, Hinton, Sly, Coles, Johnson and Carr (2003).

A forum is established that enables liaison to occur between legal and mental health professionals (Brinded, Malcolm, Fairley, & Doyle, 1996). In doing so, the court liaison service ensures the mental health needs of offenders who may not be facing a custodial sentence are met. Importantly, the idea of the broader framework of court liaison is that it does not replicate existing general mental health services (Greenberg & Nielson, 2003). This integrated model of court liaison provides a vital role and link in working alongside general mental health services. Brinded et al (1996) observed that the New Zealand court liaison service combines the advantages of both diversion and liaison concepts.

Evaluation of court diversion and court liaison schemes in England and Wales highlighted important problems regarding the structure of the services (NARCO, 2005; James, 2006). Areas identified as causing schemes to fold included inadequate national coordination and consistency in approach, not enough psychiatry input, barriers to admission and a lack of beds. The development of a nationally coordinated approach to these services was therefore put forward as a solution (NARCO, 2005, James, 2006). Later evaluation of all court division and court liaison schemes in England found that, although the schemes carry out their core function well, "their organisational embedding was often poor and their sustainability questionable" (Pakes & Winstone, 2010, p.873).

Point of arrest and police diversion schemes

Several studies have found that the prevalence of mental illness in police custody is disproportionately higher than in the prison population (Ogloff, Warren, Tye, Blaher & Thomas, 2011). Given the prevalence of mental illness in prison populations is significantly higher than in the general population (Fazel & Seewald, 2012), this information is concerning. Research by Baksheev et al (2010) of a sample of police cell detainees in Victoria Australia found the rates of mental illness to be two to twenty six times higher than in the general population. For this vulnerable population, health care needs are unmet (Baksheev et al, 2010). This is concerning as the need for better screening and education of parties involved was identified as early as 1995 in the United States by Steadman, Morris, and Dennis. The ability to carry out adequate and consistent means of screening for mental illness in police populations remains an issue highlighted by many authors for example; in England, (Riordan et al, 2000), and Australia, (Baksheev et al, 2010; Ogloff et al, 2011). To ensure identification and intervention for people with mental health concerns occurs in a timely manner, standardised screening tools, evaluation of services, joint education and working models using interagency collaboration are required (Pakes & Winstone, 2010; Ogloff et al, 2011).

In response to the prevalence of mental illness among the police custody population, point of arrest schemes have been implemented. Diversion at point of arrest is suggested as the preferable option to offer early intervention or flag the need for assessment at court (Riordan et al, 2000; James, 2000). Mental health nurses in New Zealand have been involved in recent joint innovations by justice, health and police systems to address the mental health and substance dependence needs of those who come into contact with police (Paulin & Carswell, 2010). Similar schemes have been established in England (James, 2000; Parsonage, 2009) and Australia (Saunders, 2000) with mental health nurses working with police.

Evaluation of the New Zealand “watch house” pilot found that mental health nurses in police watch houses along with nurses in crisis teams are influential in assisting with diverting the person involved in minor offending to appropriate health services at the point of arrest (Paulin & Carswell, 2010). Examination of these schemes reinforces the importance of having trained mental health nurses working in police stations alongside police providing screening assessments, liaison, referral for the mentally unwell person

and education for the police (Fry, O’Riordan & Geanellos, 2002; Paulin & Carswell, 2010).

The two schemes (court diversion and court liaison explained in the sub section titled Court diversion and court liaison (p.11) may be further contrasted with police station schemes. Police station schemes have a more preventive aspect to the service with early identification of mental illness and referral to health services (James, 2000). Offending is also likely to be less serious than those referred to court diversion and liaison schemes and interventions at that time may prevent more serious offending (James, 2000). Diversion at point of arrest is more cost effective (Parsonage, 2009). Although, as Parsonage (2009) points out, data collection is patchy and there is a need for robust evaluation of diversion schemes. The police watch house nurses can play a vital role in liaising with the CLN for those mentally unwell people who are not able to be diverted from police custody. This system may provide another link in ensuring mentally unwell people are identified at the earliest possible point and referred for assessment and treatment.

Referral pathways to and from court diversion and court liaison schemes

It has been found that the effectiveness of the court diversion and court liaison schemes and the CLNs is dependent upon the robustness of the corresponding referral system (Pakes & Winstone, 2010). Critique has been made of the ability of players involved in the criminal justice system to detect mental illness in defendants in courts and refer for screening. This issue of inconsistencies in referral for screening and assessment features across courts internationally for example in England (Parsonage, 2009; Pakes & Winstone, 2010), and police schemes: in England (James, 2000; Parsonage, 2009) and Australia (Ogloff et al, 2007). Relying on perceptions of non-health professionals to identify defendants with potential mental disorder is not satisfactory (Pakes & Winstone, 2010). It follows that recommendations for training of the relevant non-health professions have been suggested to assist them to identify whether a person may be mentally unwell and therefore require referral for assessment (Ogloff et al, 2007; Pakes & Winstone, 2010; Hean, Heaslip, Warr & Staddon, 2011).

The implication from these studies is that people with mental impairment in the court populations may not be identified and therefore their health needs not assessed nor are

they diverted to health services. This information emphasises the importance of having mental health nurses in place and accessible to courts.

Critique of the success of the schemes found success was reliant on the openness of mental health services to accept people referred from court nurses (Turnbull & Beese, 2000; Mullen & Ogloff 2009; Parsonage, 2009). Additionally, the effectiveness of court diversion and court liaison schemes has been found to be reliant on adequate resources to refer the person onto (James & Harlow, 2000; Parsonage, 2009). In line with this, recent research in England has found access to secure beds from court schemes in particular is difficult (Pakes & Winstone, 2010).

Additionally, research emphasises the ad hoc development of court diversion and court liaison schemes has meant reliance on individuals to develop services and functional relationships with the wider agencies (NARCO, 2005; Pakes & Winstone, 2010). The research suggests this way of working is not ideal and recommends service level interagency agreements are required (Parsonage, 2009; Baksheev et al, 2010; Pakes & Winstone, 2010). Conclusions from the research suggest the need for robust interagency protocols that do not rely exclusively on individuals. Furthermore, Parsonage (2009) argues for an “all-stages diversion” service functioning at all stages of the criminal justice system from arrest through to sentencing. This way of thinking and integrated approach may assist with breaking down the barriers relating to obtaining mental health care for people in justice populations and assist with continuity of care.

The literature evaluating court diversion and court liaison schemes does not include the nurses’ perspective and contribution. The review will now consider the New Zealand response to people with mental health issues involved with the criminal justice system and the subsequent creation of a role for the mental health nurse within the courts.

Responding to an increasing population of people with mental health concerns interfacing with the law in New Zealand

Traditionally, in the New Zealand situation, satisfactory health services were not available to mentally unwell persons who had contact with law enforcement services (Chaplow, 2007). In the late 1980s, following a succession of significant incidents involving high numbers of prison suicides and an assault in the community by an ex-psychiatric patient, the Government established a committee of inquiry. It resulted in the Report on Procedures Used in Certain Psychiatric Hospitals in Relation to

Admission, Discharge or Release on Leave of Certain Classes of Patients (The Mason Report) (Mason et al, 1988). The Mason Report followed a number of concerns and reports relating to mental health services in New Zealand (Mason et al, 1988).

A series of recommendations regarding mental health service delivery in New Zealand came out of the Mason Report. They were aimed at addressing the deficit in mental health service provision (Mason et al, 1988). Most significantly, the responsibility for meeting the mental health needs of mentally ill offenders (or alleged offenders) sitting with the health sector was made clear in this report (Mason et al, 1988). Subsequently, in the 1990s, comprehensive regionalised forensic mental health services were established (MoH, 2001). This framework for service provision ensured that wherever the mentally unwell person was within the criminal justice system, access to mental health care is available (Mason et al, 1988). Regional forensic mental health services were established to provide varying levels of care within a range of settings, from secure inpatient services to outreach in courts, prisons and follow-up in the community (MoH, 2001). These specialist forensic mental health services comprise the full range of mental health professionals one would expect in a modern mental health service (Mullen & Ogloff, 2009). Despite seeming a contradiction forensic mental health services promote overarching principles of the recovery paradigm (Simpson & Penney, 2011).

Recovery in Forensic mental health services

Recovery was defined for New Zealand mental health services as:

[h]appening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses but it does mean that people can live well in spite of them (Mental Health Commission, 1998).

Although the overarching philosophy of recovery is applicable in forensic mental health care, there are constraints and particular challenges for both patient and staff (Simpson & Penney, 2011). Restrictions on personal freedom and independence, obligations for legal accountability on the part of professionals and the patient and adherence to treatment appear to be in opposition to concepts of the recovery process (Simpson & Penney, 2011). As a way of reconciling the recovery paradigm with forensic mental health care Simpson and Penney (2011) suggested rather than viewing security and treatment as oppositional goals they should be viewed as requirements of one another.

“Recovery demands that we think carefully about how we deliver care, in a spirit of partnership, respect and involvement even when being coercive” (Simpson & Penney, p.304, 2011).

Problematically, CLNs are not in a standard nursing therapeutic role. They are even further removed from the forensic mental health patients referred to by Simpson and Penney: that is those patients “found unfit to stand trial, not criminally responsible, or with a forensic hospital as the final disposition after criminal offending” (p. 301, 2011). CLNs are likely to be engaged with these patients at the front end of the criminal process or with people who may never become a forensic patient. It is surmised the CLNs ability to be therapeutic may be constrained by the role and the environmental context in meeting requirements for the court.

Evolution of mental health nurses in criminal courts in New Zealand

This section follows the development of the mental health nurses’ role in the courts in New Zealand. The authors of the Mason Report recognised the success of an informal court liaison service that had evolved in 1987 in Auckland (Mason et al, 1988). This court liaison service commenced on the background of difficulties securing psychiatric admission from court for people who presented as high risk. Senior psychiatric nurses initially provided the court liaison service to the Otahuhu District Court in South Auckland with Kingseat Hospital (Peters & Wade, 1996; Mason et al, 1988). Although a formal evaluation was not undertaken, the service to the Courts in South Auckland was described as efficient, effective and time saving (Mason et al, 1988). The judges reported that they had implicit faith in the nurses’ recommendations (Mason et al, 1988). It was acknowledged that nurses were able to provide a rapid service to the courts through expert nursing assessment (Mason et al, 1988). The Mason Report (1988) therefore recommended the establishment of court liaison services attached to the Regional Forensic Mental Health Services. Subsequently, court liaison services and the court liaison nurse role were formally implemented in the early 1990s (MoH, 2001).

The court liaison model of service provision implemented in New Zealand followed a model from the United Kingdom (McKenna & Seaton, 2007). It aimed to identify individuals in the court system with mental illness who should be followed up within the mental health system (MoH, 2001). An underpinning principle was that the health system took responsibility for mentally unwell offenders (Chaplow, 2007). Whether the

health professional at court conducting the assessments and liaison sits within general mental health services or forensic mental health services is worthy of consideration given the broad expanse of liaison and brokering required of the nurse at court (Mullen & Ogloff, 2009). Turnbull and Beese (2000) identified that nurses sat within a variety of forensic and general mental health services. There is an argument for court liaison services being part of mainstream mental health services backed up by forensic mental health specialists especially in rural and suburban areas (Mullen & Ogloff, 2009). Ideally, according to Mullen and Ogloff (2009) the local mental health professionals should be familiar with the patient group thus eliminating barriers to forensic court liaison staff seeking follow up and/or admission.

The emphasis for forensic services within the New Zealand courts is to provide triage and advice (MoH, 2001). There are two key aspects to this forensic mental health service: the court liaison nursing role (which involves assessment, triage and engagement with treatment services), and formal court reporting (from psychiatrists and psychologists) (Chaplow, 2007). Forensic mental health clinicians, including CLNs, provide expert assessment and advice to the court regarding an array of matters such as illness, disability, triage, and disposition (Chaplow, 2007). Nurses, psychiatrists and psychologists must be qualified and prepared to give expert opinions, and liaise between numerous health and social agencies (Chaplow, 2007). CLNs are the clinicians who provide “on the spot” mental health expertise in the New Zealand court system. CLNs provide the link between the many agencies and services who may be involved in the pathway of the mentally unwell person who has come to the attention of the courts.

Scholarship surrounding mental health nursing within court and prison settings

Review of the international research revealed that court diversion and court liaison schemes were focused on the characteristics of the person referred to the service, service evaluation and outcomes, for example, in England (Parsonage, 2009; Pakes & Winstone, 2010) and in Australia (Sly et al, 2009; Brett, 2010). Despite spanning international services, the findings of the evaluation research were remarkably similar as referred to in the section regarding court and police schemes. Turnbull & Beese (2000) provide the only piece of research examining the role of the mental health nurse in United Kingdom magistrate courts indicating minimal comprehension regarding the nursing practice at this juncture. They found nurses unprepared to practice in the setting who as a result experienced disquiet regarding expectations of the role.

Little is known about the role of nurses in criminal courts. There is some research on prison nursing roles and a care manager role. That research documents some difficulties expressed by nurses who practice in unconventional roles, in particular the unique ethical experiences of the prison nurses (Walsh, 2009) and care managers (Prebble, Diesfeld, Frey, Sutton, Honey, Vickery & McKenna, 2012) is considered. Five sources of scholarship were unearthed that referred to the CLN role in New Zealand.

Peters and Wade (1996) provided a description of the Auckland liaison services to the court and reported on the findings from a retrospective review of referrals to the service and outcome data over a two year period. In terms of the CLN role, they suggested that because judges actioned the nurses' recommendations, judges found their reports useful. This was supported by a survey of the Auckland judges to determine quality of the service; they rated the services provided by the CLNs highly. However, other than briefly describing the functions of the nurse within the service, and helpfully pointing out that it was more cost effective to have nurses in courts rather than psychiatrists, the study did not discuss nursing practice.

An audit of contacts with a court liaison service following the first year of establishment was undertaken in Wellington New Zealand (Brinded et al, 1996). The resulting report outlined that an experienced health professional, who is usually a registered psychiatric nurse, was present throughout court sitting times (Brinded et al, 1996). With respect to the CLN role, it was reported the courts found the service positive because it provided early intervention and appropriate outcomes for persons with mental disorder (Brinded et al, 1996). The audit identified that training for all relevant parties regarding mental illness was essential (Brinded et al, 1996). Similarly Shaw et al (1999) and James and Harlow (2000) in England, and Peters, O'Hagan and Hallwright (2000) in New Zealand, and Ogloff et al (2007) in Australia identified the need for education regarding identifying mental state concerns for relevant parties.

Barnes (1997) profiled criminal defendants who enter the mental health system and become psychiatrically hospitalised via the court liaison service in one regional forensic service in New Zealand. Whilst not directly researching the role of the court liaison nurse, Barnes (1997) acknowledged the useful detailed information collected by the court liaison nurse at the time of his or her screening assessment. The study emphasised that the court liaison service fulfilled an extremely valuable function at the interface of the criminal justice and mental health systems in New Zealand through identification

and screening of defendants (Barnes, 1997). A recommendation was made for the standardisation of the information collected and the classification procedures court liaison services used throughout New Zealand with the aim of improving comparisons between regions (Barnes, Hudson & Roberts, 2000). There is no evidence this recommendation was actioned.

Peters et al (2000) briefly examined the role of the nurse at the intersection of the criminal justice and the mental health service in New Zealand in 1999. It was part of a wider evaluation of the interplay between courts and the mental health system for the Department for Courts. Qualitative methodology was applied to ascertain the perspective of 95 stakeholders including consumers, court liaison nurses, judges, court staff, lawyers and other relevant representatives from bodies such as the Mental Health Commission and support groups (Peters et al, 2000). Feedback regarding the court liaison nurse role was positive. However, attention to that role was minimal. Contextual factors have altered significantly in the thirteen years since the study, including: reformed legislation and greater dispositional options for the mentally disordered offender (Brookbanks, 2006) and greater numbers of prosecutions (Ministry of Justice, 2008). It is at this ever increasingly complex intersection that the CLN practices.

Smith (2004) expressed the ethical dilemmas he faced as a CLN. He provided insights into the impact of what being a nurse in the criminal court meant. Smith considered the ethical responsibilities of the nurse in caring for the mentally disordered offender and the CLN role. He commented on the significance of the principle of patient autonomy. As a CLN, he encountered a number of challenges and tensions resulting from an unusual autonomous role in the criminal justice system and a nursing practice that was bounded by the discipline of law.

Smith (2004) reported that his inadequate knowledge of the legal setting resulted in his lack of professional confidence. Sometimes Smith encountered negative treatment and attitudes from others in the setting. Also he experienced challenges with the therapeutic relationship. Remaining focused on his role as a nurse and not being distracted by legal processes was challenging.

Smith (2004) referred to the fast paced, pressured setting and highlighted the stress involved with assessing risk, providing advice and risk management. He identified that he had a strong advocacy dimension to his practice because he attempted to address the mental health needs of people in court.

Smith (2004) also described being adaptable and confident in his skills. Furthermore, he reported he needed well developed communication skills and a sound knowledge of criminal law. He was sensitive to the effects of trauma on people and the loss of dignity for a client in cells. All the above impacted on his confidence and ability to function as a nurse in the setting. Finally, Smith referred to the importance of becoming accepted in that environment. These factors have congruency with Seaton's (McKenna & Seaton, 2007) experiences and the findings in the Turnbull and Beese (2000) study.

Turnbull and Beese (2000) presented findings from exploratory research into the experience of six mental health nurses in court diversion schemes operating in magistrates' courts in England. Against a background of deinstitutionalisation and lack of knowledge about this new nursing role, they examined how the nurses coped. They explored the impact on nurses practicing in a role for which there was no existing model and where they were required to establish themselves in a ritual-bound environment complicated by competing professionals and protocols.

Key findings from the qualitative descriptive research included that the experienced mental health nurses articulated that their education to date had not prepared them adequately for this role (Turnbull & Beese, 2000). The nurses experienced reality shock as a result of lack of preparation, differences in language, use of negative stigmatising terminology, isolation and resistance. Another issue for the nurses was how health information was disclosed in open court. These experiences combined to bring into question the nurses' professional identity as mental health nurses, implying that role conflict resulted from practising in a role without clearly defined parameters. Finally, the research emphasised that competencies needed to practice in criminal courts had not previously been identified as part of the nurses' skills base. Turnbull and Beese (2000) recommended the role of the nurse had to be redefined in the context of relationships with the professionals involved in the criminal justice system.

Likewise, literature regarding prison nursing roles recognises nurses are practicing within an institution that does not share a health based ideology (Walsh, 2009).

Corrections systems are grounded in ideals related to the maintenance of a fair and just society (Department of Corrections, 2012). They aim to achieve this through a vision of improving public safety through compliance with sentencing, reduction of re-offending, and rehabilitation (Department of Corrections, 2012). Nursing was founded on the moral principle of caring and the belief that nurses have an obligation to do good

(NZNO, 2010). It is generally accepted that nursing ideology encompasses caring, holism and patient-centred care (Taylor, 1997; Hammer, 2000). Essentially “caring” means things matter to people (Benner & Wrubel, 1989). It is posited that nursing based in caring can positively affect the outcomes of illness (Benner & Wrubel, 1989). To “care” enables people to discern problems, creates meaning and gives direction and motivation for solutions (Benner & Wrubel, 1989). To achieve patient centred care, interpersonal processes involving nurse-patient interactions and two way communication based on a relationship between the nurse and the patient are used (Carper, 1978).

Given the differences encountered in the corrections environment, the prisoner patient, the culture of the prison and the differing underpinning ideologies, it is understandable that prison nurses may experience emotional or moral conflict (Walsh, 2009). Walsh (2009) studied “emotional labour” in prison nurses in England and Wales. Not only did the nurses experience conflict due to the factors mentioned above, they also experienced internal conflict resulting from dialogue with themselves over what they should do versus what they wanted to do (Walsh, 2009). Nursing inherently works against the values of the system in which they are practicing in corrections settings (Gadow, 2003). The potential is for nurses to become caught in a contradiction between their best intentions to fulfil their profession’s moral values while concurrently meeting the aims of both the external and the employing organisation.

Gadow (2003) explored the unique ethical dimensions in relation to correctional nursing in the United States of America. Although from another country, the principles she examined are applicable to the New Zealand nursing situation. Gadow (2003) makes an analogy that correctional nursing brings ethical dimensions into sharp focus like a prism brings colours into sharp focus. “As a prism, it differentiates competing philosophies of punishment and their implications for practice” (Gadow, 2003, p.167). Thus, colliding philosophies may contribute to the internal conflict experienced by nurses practising in forensic mental health and legal environments (Walsh, 2009).

Gadow (2003) suggested that the examination of those philosophical differences is vital for an autonomous profession. She suggested that it is only nurses in these settings who consistently practice within both dimensions of care and custody. Accordingly, only nurses can speak to the relationship between care and punishment, because only nurses are asked to practice both. Whilst Gadow (2003) is focused on ethical dilemmas in

prison nursing, other practitioners in aligned fields such as the health and disability sector may have similar experiences. Research in New Zealand has found care managers under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CCR)Act 2003) experienced tension and contradiction while providing compulsory care and rehabilitation (Prebble et al, 2012). Thus CLNs may share experiences of ethical unease with prison nurses and care managers.

In contextualising this study, the first section of the review has looked back over the last twenty years to critique and synthesise the scholarship. This provides a comprehensive overview of the context of the CLN role. The review largely focused on research regarding the intersection of the mentally unwell person within the justice system and scholarship surrounding the role of the mental health nurse in courts.

The review positions the CLN within forensic mental health services within New Zealand. Internationally, not all mental health nurses in courts sit within forensic mental health services (Turnbull & Beese, 2000). Given the still novel status of the role and the ongoing development of court schemes, where the nurses' position best fits within services will become clear over time as more evaluative research is conducted. Court schemes run by nurses from general mental health services with back up from forensic mental health specialists may provide a useful practice model (Mullen & Ogloff, 2009).

A significant outcome of the review is that there is scant attention paid in the scholarship to the nurses' perspective regarding court liaison and court diversion schemes. Consequently there is no description or analysis of nursing practice or research based knowledge of this legal mental health interface from a nursing perspective other than the Turnbull and Beese (2000) study.

In the New Zealand context, the CLN role is mentioned in three studies where the focus was on psychiatry and the role of forensic mental health services in their interface with the justice system (Peters & Wade, 1996; Brinded et al, 1996; Peters et al, 2000). The CLN role features in Barnes' (1997) research and Smith's (2004) paper. However, vital information from the CLN practicing at the coal face has not been the focus of this literature. Information such as the nurses' perceptions regarding this interface, details regarding referrals to CLNs and where the CLNs saw gaps in the service have not been canvassed. There has been minimal evaluation of the court liaison nurse role or the services delivered to the courts in New Zealand (McKenna & Seaton, 2007).

Examination of literature related to prison nursing revealed nurses practicing in justice settings may experience emotional labour. Emotional labour was generated by the uncertainty created by differing ethical underpinnings and cultures. This experience may be pertinent to the CLN who also practices in a setting where differing ideologies meet. There was clearly a gap both in knowledge regarding court liaison nursing practice in New Zealand and a lack of consultation with CLNs regarding this interface. The gap in knowledge provided the impetus for this research.

The following section reviews the scholarship in relation to forensic mental health nursing.

Section two: Progression of forensic mental health nursing

This section of the review focuses on the history of forensic mental health nursing. Minimal scholarship exists regarding the history of forensic mental health nursing in New Zealand, therefore literature from the United Kingdom, Australia, Canada, Sweden and North America was drawn on. Key concepts highlighted in forensic mental health nursing are briefly examined: education, standards and competencies, role ambiguity, consent and information sharing, and professional support. Consideration is then given to cultural factors in light of the demographics of the New Zealand population and the unique obligations the health sector has under the Treaty of Waitangi (MoH, 2008). Issues for forensic mental health nurses regarding recognition and valuing conclude the section.

It is important to acknowledge that the values, theories and attitudes from which forensic mental health nursing has evolved come from mental health or psychiatric nursing, accounts of which go back to the 18th and 19th centuries (Kettles & Woods, 2006). The beginnings of a specialised field of practice in forensic psychiatry were born from the alliance between psychiatry and criminology (Jacob et al, 2008). As a result of the commission of Broadmoor Hospital as the first high-secure mental health facility, “special hospital” forensic mental health nursing began (Bowring-Lossock, 2006). The first official role for nurses working with people with mental illness who had offended was created.

Unfortunately, little is known about early forensic mental health nursing practice (Evans & Wells, 2001). Nursing practice is conspicuously absent in the literature regarding early psychiatric care (O’Brien, 2001). Formal documentation surrounding forensic

mental health or forensic psychiatric nursing did not appear until the early 1990s (Bowring-Lossock, 2006). Likewise, according to Prebble (2007), accounts of New Zealand psychiatric nursing prior to the 1980s were minimal. CLNs are rarely mentioned nor do they feature as part of research endeavours even though they are often the health professionals at the coalface of court schemes.

There are several possible explanations for the lack of nursing scholarship regarding early forensic mental health nursing. Burrow (1998) suggests the Official Secrets Act in the United Kingdom as a probable reason for the lack of documented evidence about nursing in special hospitals. All staff working in special hospitals in the United Kingdom were subject to the Official Secrets Act until 1989 (Burrow, 1998). In line with this, three phases of the development of the forensic mental health nursing role were offered by Dale, Woods and Thompson (2001). The first was an “inert” stage (1963-1985); whereby the nursing occurred mostly in the large high security hospitals that were very separate from wider society. The second stage was the “awakening” period (1985-1995); new services were being developed with nurses keen to describe their experiences. The final stage from the mid 1990s to the present was considered an “empirical” stage. Funded research and doctoral degrees provided evidence about practice, with greater scrutiny of services’ adherence to evidence-based practice and clinical governance.

Another explanation for the lack of scholarship regarding mental health nursing refers to the location of nurses in the hierarchy of the institutions and the organisational culture. According to Campion, Coleborne and Prebble (2012) “medical superintendents were at the top of the institutional hierarchy, while nurses and attendants occupied a considerably lower rank, especially during the early years when the position entailed little training” (p.35). O’Brien (2001) concurs, arguing that in the New Zealand context “the dominance of medical understandings of mental distress, and the working-class status of asylum attendants” is an explanation for the absence of a “systematic theoretical account of attendants’ practices” (p. 129). Similarly, in the United Kingdom context in 19th century asylum nursing, nurses were viewed as an adjunct to the dominant medical profession. They were not encouraged or taught to question practices and provide opinions (Cheung & Nolan, 1994). Therefore, it is not surprising that developing nursing roles such as those in forensic mental health nursing continued a tradition of silence and of not valuing nurses’ work.

A pattern of inadequate resourcing for mental health services repeatedly led to staff coping with overcrowding and staff shortages (Grant, 2001; Prebble, 2007). These factors may have contributed to the developing nursing practice not being recorded. In addition, those practicing in mental health services at the time were viewed as less expert than healthcare professionals practicing in other health areas (Grant, 2001). Mental health staff experienced stigma (Prebble, 2007), generating feelings of being second rate health professionals (Grant, 2001). As a consequence, analysis and development of their professional roles was hindered.

Similarly, Chaloner and Kinsella (1999) in the United Kingdom suggested that the reluctance of nurses to discuss their practice and examine their role may have been a result of the scrutiny and public concern the area of practice attracts when something goes wrong.

Nolan (1993) described the development of the mental health nurse in the United Kingdom. Notwithstanding the lack of early mental health nursing scholarship, mental health nursing had its genesis in the “attendants” employed in the large asylums in the 18th and 19th centuries (Nolan, 1993). The original attendants were artisans undertaking any task from shoe repairs to supervising meals (Nolan, 1993). With widespread social reform occurring in the late 19th century, it was recognised that training for attendants would be beneficial. With the passing of the 1870 Education Act, formal training for attendants was underway in the United Kingdom (Nolan, 1993).

In the New Zealand situation, an example of the role of attendants and nurses at Tokanui Hospital in the early 1900s provided by Campion et al (2012) refers to working “at the coalface of patient care and were responsible for implementing the treatment regimes outlined by their medically qualified superiors” (p.35). There was some informal on-site training for attendants in the late 1890s (Papps & Kilpatrick, 2001). However, formal training for nurses in mental health did not commence until 1905 (Papps & Kilpatrick, 2001). Although qualified and recognised, Mental Deficiency Nurses were not registered under the Nurses Registration Act 1901. With the advent of the Nurses and Midwives Act 1944, training programmes for psychiatric nurses came under the jurisdiction of the Nurses and Midwives Board (Papps & Kilpatrick, 2001). By the mid 1900s in New Zealand, trained psychiatric nurses were providing “day to day, hour to hour care, assisting doctors with treatment, dispensing drugs, calming and

comforting patients, administering punishment, and protecting the outside world by preventing escape” (Frew as cited in Grant, 2001, p.236).

The historical gap in knowledge regarding forensic mental health nursing is reflected in the on-going lack of recognition regarding present-day forensic mental health nursing roles (Evans & Wells, 2001). However, despite its silent beginnings, forensic mental health nursing has continued to progress since its inception in the mid 1800s. In the 21st century, specialist forensic nursing practice settings are diverse (Lyons, 2009). Many sub-specialties have developed in forensic nursing where nurses practice at the clinical-legal interface, working with victims and offenders (Lyons, 2009; Kent-Wilkinson, 2010). Reflecting a maturing forensic nursing discipline, Lyons (2009) argued that it is not the location where the nurse works with the patient that defines the relationship as forensic, but the purpose of the interaction. Peternelj-Taylor and Hufft capture the essence of nursing in this field:

[t]he integration of mental health nursing philosophy and practice within a socio-political context that includes the criminal justice system to provide comprehensive care to individual clients, their families and their communities (cited in Peternelj-Taylor, 1999, p.9).

Key concepts drawn from forensic mental health nursing scholarship

The focus of this thesis is the forensic mental health nursing sub speciality – court liaison nursing. There is a very small amount of literature specifically regarding the CLN role. Forensic mental health scholarship has been included in the review because forensic mental health nursing involves a range of legal dimensions like the CLN role. It was surmised that New Zealand CLNs may experience similar challenges and contradictions as forensic mental health nurses.

Educational preparation for forensic mental health nursing

International scholarship acknowledges that nurses have innovatively embraced and developed new roles in forensic settings. This has occurred in the United Kingdom (Chaloner, 2000; Mercer et al, 2001; Bowring-Lossock 2006) in Canada (Peternelj-Taylor, 2008) in New Zealand (McKenna & Poole, 2001; McKenna, 2011) and in the United States of America (Lyons, 2009; Kent-Wilkinson, 2010).

Forensic mental health nursing has grown to encompass practice settings across a range of environments. These include inpatient mental health units of varying security levels,

correctional facilities, police cells, court rooms, court cells, prison cells, and peoples' homes (Lyons, 2009). It is acknowledged that nurses practicing in forensic mental health settings have a very demanding role to fulfil, in difficult circumstances, which are carried out with a high degree of commitment (Collins, 2000). Internationally, forensic mental health nursing has been described as changing and developing at a fast pace (Brennan, 2006; Walker, Langton & Thomson, 2011). Many forensic nursing roles have evolved before educational and theoretical development has occurred (Kent-Wilkinson, 2011). As mentioned earlier, mental health nurses have been creative in stepping into previously uncharted areas to ensure people have access to mental health nursing care. There is now a growing body of research literature illuminating forensic mental health nursing roles and in particular identifying educational and support needs (Kent-Wilkinson, 2011).

Early authors identified that basic nursing training does not prepare nurses for work in forensic settings (Niskala, 1986; Whyte, 2000). This was supported by later authors and international research in the United Kingdom (Mason & Carton, 2002; Mason, Coyle & Lovell, 2008a; Mason, Lovell & Coyle, 2008b; Bowring Lossock, 2006) and in Australia (Evans & Wells, 2001; Baxter, 2002), and Sweden (Rask & Aberg, 2002). Additionally, there is consensus within the literature that there are minimal post-graduate educational opportunities for nurses practising in forensic mental health arenas (Kent-Wilkinson, 2011).

Turnbull & Beese (2000) emphasised a gap in education for nurses within court settings. They described their "initial pervasive impression from interview transcripts was of people who had been placed in a post without preparation or briefing on how the criminal justice operated, and without any reference point for guidance" (p.293).

Although some recent development of specific forensic mental health education has occurred internationally, gaps remain for forensic mental health *nurses*. The School of Forensic Mental Health in Scotland (SoFMH) was established in 2007. They provide education for all members of the multi disciplinary team. Some modules are discipline specific, e.g. targeted to psychiatry, however, there were no modules in the SoFMH prospectus that appeared to be presented from or for a nursing perspective. A paper is available in Saskatchewan University (UoS, n.d.) Canada titled forensic nursing in secure environments (NURS 486.3). In contrast, there is no specific course of study for the court diversion and liaison work in England (Pakes & Winstone 2010).

Discipline specific education for nurses in *forensic* mental health settings is not available in New Zealand. Forensic mental health nursing education continues to be “submerged in generic post-graduate forensic psychiatry papers or advanced nursing papers” (McKenna & Poole, 2001, p.20). The Mason Report identified the need for specialist training in forensic psychiatry (Mason et al, 1988). Subsequently, the national Framework for Forensic Mental Health Services (MoH, 2001) developed following the recommendations in the Mason Report (1988) identified the need to review the training and education needs for all staff working in forensic services. McKenna (2010) reiterated the importance of a national focus to forensic mental health education. He emphasised that “The ability to respond to complex and evolving demands on existing services requires a knowledge [sic] and skilled workforce committed to evidence based and values based practice.....” (McKenna, 2010, p.1). This is an area that remains unresolved, particularly for nursing. Despite McKenna and Poole highlighting “the lack of educational opportunity, the lack of a research base to guide practice, and the lack of a distinct professional voice to carry the development of the speciality forward” (2001, p. 20) over 10 years ago, this situation has not changed in New Zealand.

Prior to this study, the level of education and/or training of the current New Zealand court liaison nurses and national educational options were not documented. There is no specific court liaison nursing education or specific forensic mental health nursing education available in New Zealand.

Standards and competencies

Whilst there has been progress in recent years towards defining forensic mental health nursing standards and core competencies, international incongruence and a lack of recognition for this specialist nursing practice remains a core issue. Standards, skill sets and competencies for forensic mental health nurses continue to be debated in the literature. According to Peternej-Taylor (2010):

Professional standards are authoritative statements, which reflect the current state of knowledge and understanding of a discipline and articulate the profession’s values and priorities. These standards describe the responsibilities for which its practitioners are accountable, in order to promote safe, competent, and ethical care (p.55).

Standards of practice and competencies for forensic mental health nurses have been developed in one state in Australia by senior nurses at the Victorian Institute of Forensic Mental Health Care (Forensicare, 2012). The standards are in addition to core generic

mental health nursing skills and competencies. These standards have commenced from a position that forensic nursing is underpinned by mental health nursing.

Research was undertaken in the United Kingdom to identify core competencies of forensic mental health nursing by Mason et al (2008a); Mason et al, (2008b). Following an extensive study, the authors concluded there was still some distance to go before skills and competencies of forensic psychiatric nurses could be delineated (Mason et al, 2008b). Their findings were congruent with other findings that there is a need for ongoing research regarding defining the forensic mental health nursing roles in Australia (Martin, 2001; Martin & Street, 2003), Canada (Holmes, 2005), and the United Kingdom (Bowring-Lossock, 2006). In line with these findings, Turnbull and Beese (2000) reported that the competencies nurses needed to function in the court environment were not part of the nurses' skill base coming into the role.

In 2008, Peternelj-Taylor critiqued the development of nursing roles working with mentally ill people in the justice setting. She suggested there are many questions yet to answer, such as what the best models for service delivery are, and "what knowledge and skills are required to provide competent and ethical nursing care" (p. 186).

To inform the thesis, key factors from forensic mental health nursing literature regarding role tensions and role ambiguity were reviewed.

Forensic mental health nursing and role ambiguity

The therapeutic relationship is central to the practice of mental health nurses (O'Brien, 2001; Mason et al, 2009). Interpersonal processes as articulated by Peplau (1992) are considered to be the foundation of mental health nursing practice. The ability to establish a therapeutic relationship is described as one of the critical competencies that a forensic mental health nurse should have (Peternelj-Taylor, 1998). However, some authors suggest that attention to the therapeutic relationship in forensic mental health nursing has not been adequate (Martin, 2001). The nature of the relationship effects every aspect of the nursing process and the ability to provide therapeutic nursing care (Peternelj-Taylor, 1998). Other influences such as the socio-political context of the settings mould the nature of the relationship (Crowe, 1997).

Forensic mental health nurses provide security and safety at the same time as therapeutic nursing care. Therefore, it is not surprising that challenges exist for the nurse with maintaining a therapeutic orientation to their nursing practice. The

dichotomy for forensic nurses in managing security and safety concerns versus caring and the impact this has on the therapeutic relationship was originally raised in the literature by Burrow (1993). Later authors have continued to examine this challenging aspect of forensic mental health nursing practice (Schafer & Peternelj-Taylor, 2003; Martin & Street, 2003; Holmes, 2005; Fisher, 2007).

The duality arising from providing care while at the same time enforcing detention leads to role ambiguity for nurses (Holmes, 2005). Similarly, Brennan (2006) used the term “role conflict” to describe the role ambiguity that forensic mental health nurses experience with the therapeutic relationship and controlling aspects of their role. To comprehend this complex area of nursing, Jacob, Gagnon and Holmes (2009) argued that development of theoretical (conceptual) analyses, and engaging in ethical discussions is vital for forensic mental health nursing. Of particular relevance to this thesis, Smith (2004) highlighted concerns regarding the mental health nursing concept of the therapeutic relationship for nurses practicing in courts. Smith (2004) referred to the nature of the law and the environment as an unsympathetic environment and harsh for the person with mental health concerns. He suggested the nurse needed to be aware of this and understand the stressors the person was facing. He considered this then had an impact on the nurses’ ability to carry out the therapeutic aspects of their role. Smith (2004) also noted the nurse could encounter multiple pressures from police and lawyers which impacted on their ability to advocate for the persons health needs to be met and hence the ability to be therapeutic. Similarly Turnbull and Beese (2000) found the reality shock the nurses experienced and the entire context of the setting brought into question the nurses’ professional identity and practice as mental health nurses.

One of the significant tensions for forensic mental health nurses relates to the role of the nurse in security and safety coupled with carrying out risk assessment and management. Risk assessment and management are key skills for forensic mental health nurses (Woods, 2002; Lyons 2009; Bowring-Lossock, 2006). Both Seaton (McKenna & Seaton, 2007) and Smith (2004) emphasised that risk assessment was particularly significant for the court liaison nurse as a sole health professional in the justice environment. Risk assessment was a stressful aspect of the role. It was surmised this stress may stem from the duality of the role and balancing the dimensions of safety and care within the court setting. The CLN practices within a setting with multiple agencies and professionals. Whether these factors have significance and impact on the CLNs is unknown at this time.

Consent and information sharing in a multiagency context

Increasingly, nurses are practicing in less traditional settings. They work closely alongside other disciplines, police and corrections, and in court settings. The nature of the information the nurse handles in these settings therefore has another element to it compared to usual nursing roles. For example, McKenna and Poole (2001) observed that nurses in these settings “are likely to handle evidence, or be party to information, which may have a bearing on ensuing legal proceedings” (p.18). Health providers have legal obligations regarding consent and information sharing in accordance with the Privacy Act (1993) and the Health Information Privacy Code (Privacy Commissioner, 1994).

This new area of practice for nurses involving the crossover of health and offending information requires some thought and consideration. The following three studies identified work was needed in this area of practice. Turnbull and Beese (2000) suggested this is an area crucial for investigation. The 2004 Survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales recommended that all schemes should have a policy on information sharing (NARCO, 2005). More recently, Pakes and Winstone (2010) undertook an audit of all known assessment, liaison and diversion schemes in England. They explicitly recommended mandatory training in “the legal context of information exchange” and development of a “shared understanding of confidentiality” (Pakes & Winstone, 2010, p.880). It was not known how nurses manage consent and information exchange in the context of nursing in the court setting with multiple agencies in New Zealand.

Lack of professional support

Certain types of support are identified as crucial in forensic mental health nursing. Several practice areas were identified in the literature as posing significant challenges for nurses and other health professionals practicing in forensic settings. For example, they include: emotional responses, role parameters, and the ability to remain true to a health ethos.

Emotional responses evoked in the nurse as a result of the person’s offending behaviour and/or personality traits was identified as a potential ethical concern for forensic mental health nurses (Woods, 2002; Jacob et al, 2009), and in prison nursing (Walsh, 2009). Similarly, Birmingham et al (2006) identified that prison doctors may experience strong

reactions due to the nature of the patients' offences which in turn may affect doctors' responses. Emphasising the need for clear ethical frameworks and professional supports, Mullen (2000) referred to the potential for forensic psychiatrists to be influenced by overwhelming pressures within the setting. Maintaining a therapeutic health focus is imperative (Mullen, 2000). Implications can be drawn from this and applied to the CLN role which is similarly situated within the court setting. Therefore clear role parameters are crucial. When the ability to be therapeutic is compromised, the caring health ethos is potentially diminished (Peternelj-Taylor, 2004; Jacob et al, 2009; Aiyegbusi, 2009).

Across a decade of forensic mental health nursing scholarship, there was extensive acknowledgement of the need for professional support and guidance, such as professional clinical supervision (Rask & Levander, 2002; Handsley & Stocks 2009) and adequate management support (Aiyegbusi, 2009). There has been recent recognition and support for professional supervision in New Zealand for mental health nurses through Te Pou (2009). However, access to professional supervision has been variable (McKenna, Thom, Howard & Williams, 2010). A system for recording and evaluating effectiveness of professional supervision was lacking (McKenna et al, 2010) and therefore it was not known whether professional supervision met the needs of court liaison nurses.

Cultural awareness in the criminal justice sector

Ethnic populations including indigenous Maori and those of Pacific Island descent feature in greater numbers in forensic mental health and corrections populations than other ethnicities (Tapsell, 2007). Controlling for population, Maori are apprehended for committing at least three times the number of offences as New Zealand Europeans (Department of Corrections, 2009). According to Oakley, Browne, Wells & Scott, (2006) access to healthcare for Maori and Pacific people with mental health problems is low. Of concern is the fact that both Pacific people and Maori are less likely to have had access to services than other ethnic groups (Oakley et al, 2006).

In New Zealand, the Mason Report (1988) clearly delineated the need to develop mental health services that provided high quality, culturally acceptable care and effectively engaged Maori (Tapsell, 2007). A recent response to the needs of Maori with mental illness in the criminal justice system is the Kaupapa Maori forensic service in the Waikato. This "One Service Two Providers" model was developed in 2010 (PUAWAI,

2011). Kaupapa Maori teams provide treatment services to clients within a Maori cultural context (PUAWAI, 2011).

Of concern is that, according to Durie (2011), one of the most urgent challenges in Maori health is to build capability for early intervention. The CLNs are ideally placed to ensure Maori with mental health concerns within the court setting are able to access appropriate services. However it is not known at this time whether Maori are referred appropriately to CLNs.

Recognition – a sense of being under-valued

A sense of feeling undervalued as nurses is present within the literature regarding forensic mental health nursing (Bowring-Lossock, 2006). Historically, forensic mental health nursing was invisible (Evans & Wells, 2001) and seen as low status. Similarly, forensic psychiatry as a whole was undervalued (Mullen, Briggs, Dalton, & Burt, 2000). Forensic mental health nursing has not received the same attention or appreciation as other areas of nursing realise (Gillespie & Flowers, 2009). The ongoing dialogue in the literature regarding defining forensic mental health nursing and competencies and seeking recognition reflects this. A parallel debate exists within psychiatry regarding whether forensic psychiatry is a specialty area or one aspect of general adult psychiatry (Arboleda-Flores, 2006; Hodgins, 2009; Mullen & Ogloff, 2009).

Despite initial debate regarding whether forensic mental health nursing was a specialty area of nursing, latterly it is viewed as a distinct discipline and has been described as an emerging global nursing specialty (Kent-Wilkinson, 2010).

Summary

The literature review provided contextual information regarding the development of nursing roles in forensic mental health nursing contexts. A significant outcome of the review finds that there has not been any research undertaken regarding the court liaison nursing role in New Zealand from the perspective of the nurse and nursing practice. One study undertaken in the United Kingdom (Turnbull & Beese, 2000) provides useful insights into the role of community psychiatric nurses in magistrates' courts. It was identified that specific knowledge is required to practice in this role beyond the requirements of the mental health nurse (Turnbull & Beese, 2000). Internationally, there is also a gap regarding the nursing perspective at this juncture.

The literature provides us with a little understanding of some of the challenges evidenced in forensic mental health nursing. However, again, the New Zealand forensic mental health nursing perspective is absent. Key concerns were highlighted regarding managing sharing of health information and consent in the context of the court. The dilemma forensic mental health nurses face with respect to therapeutic relationships and the potential for role ambiguity are introduced. The importance of role preparation, education and access to professional supervision were raised. Historical lack of recognition and consideration of forensic nursing roles is touched on. Importantly in the New Zealand context the impact of cultural influences on nursing practice and mental health services is recognised. The review identified a lack of scholarship and examination of mental health nursing in courts. The lack of scholarly work identified in this area justified the importance of the research topic.

Research aims

Three main concerns underpin this study. Firstly, the court liaison nursing was novel and was not a well researched area of nursing practice both nationally and internationally. Secondly, there was not a specific education or training pathway for nurses practicing in forensic mental health settings or in the CLN position in New Zealand. Thirdly, guidance in terms of an organised system of professional support and supervision and standards or a framework for practice was absent.

The overall aim of the study was to explore, describe and constructively analyse contemporary nursing practice at the criminal justice mental health interface in New Zealand. Progression of the court liaison nurse role requires in-depth analysis of its current status and activity.

The research questions are initially addressed through describing CLNs professional nursing background, training, education, and experience. The thesis then describes the daily nursing practice and professional relationships. The study reveals tensions and the complexities that affect CLNs nursing practice. CLNs expressed how they managed these tensions. Analysis of the practice allowed in-depth understanding of the challenges and facilitators to CLN practice including the CLNs requirements for education, training and professional support. The findings will inform the body of nursing knowledge both nationally and internationally.

Chapter Three: Methodology

Introduction

The methods applied for the initial inquiry into this area enabled broad exploration of the nursing practice. Exploratory research seeks to respond to questions such as, “What is the full nature of the phenomenon? What is really going on here? What is the process by which the phenomenon evolves or is experienced?” (Polit & Beck, 2001, p.18). This thesis is an exploratory study. The explorative and descriptive approach enabled through qualitative descriptive methodology as described by Sandelowski (2000a, 2000b) best facilitated illumination of the CLN role.

Sandelowski suggests that “Qualitative descriptive study is the method of choice when straight description of phenomena is desired” (2000b, p. 334). Qualitative descriptive methodology utilises a mixture of sampling and data collection tools and re-presentation techniques to guide the research (Sandelowski, 2000b). Accordingly, this thesis incorporates those features through the use of a qualitative descriptive methodology. To capture broad understanding of the CLN role, mixed methods including survey, in-depth interviews, and an audit sought answers to the “who, what and where of events or experiences” (Sandelowski, 2000b, p.338) of the participant CLNs.

Qualitative descriptive designs draw from tenets of naturalistic inquiry which is embedded in the constructivist paradigm (Lincoln & Guba, 1985). According to Guba and Lincoln (Lincoln & Guba 1985; Guba 1990), constructivism aims to carry out research in natural settings by examining the variety of constructions that people have within their social world. As a consequence, the research strategy was designed to reflect the nursing practice as much as was possible through the eyes of the CLNs and the social world of nursing practice in the criminal justice system. This chapter outlines the underpinning assumptions of naturalistic inquiry and the qualitative descriptive methodology framework. Then it describes the research methods and processes that were used to obtain and analyse data regarding the CLNs’ practice.

Research question and aims

The overarching aim of the research is to describe “What is the role of the mental health nurse in the New Zealand criminal courts?” The nursing knowledge embedded in clinical practice is explored through focusing on four main questions. The answers will

seek to understand and make visible contemporary nursing practice at the criminal justice mental health interface in New Zealand.

The following questions were developed regarding the court liaison nurse (CLN) role.

1. What is the nursing background and professional experience of CLNs?
2. What are the daily professional activities of CLNs?
3. What ethical tensions are experienced by CLNs and how are they managed?
4. What are the education, training, supervision and support needs of CLNs and should there be a specific framework or model for their practice?

Theoretical perspective - constructivism and naturalistic inquiry

The word “paradigm” is a term that has generated confusion in the literature (Weaver & Olson 2006; Guba, 1990). Therefore, it is helpful to consider what is meant by this term at the outset. Guba defines paradigm as a “basic set of beliefs that guides action, whether of the everyday garden variety or action taken in connection with disciplined enquiry” (1990, p.17). The paradigm provides a framework for the researcher and assists with making order out of chaos (Grant & Giddings, 2002). The beliefs encompassed in the underpinning paradigm specify and permeate every act associated with the inquiry. To ensure the research remains true to the worldview embodied in the paradigm, reflection on all aspects of the inquiry process must occur (Lincoln, 1990). Adherence to the particular beliefs, values and assumptions of the underpinning paradigm was important in this study to ensure congruency from the beginning of the study through to data analysis and re-presentation of the information generated in the research.

In considering the qualitative paradigm, Munhall describes that philosophical underpinnings for qualitative research methods reflect the “beliefs, values and assumptions about the nature of human beings, the nature of the environment and the interaction between the two” (2007, p. 99). Therefore, in broad terms, qualitative research approaches are described as inductive compared to deductive quantitative paradigms.

Qualitative descriptive methodologies utilise specific methods of discovering and reporting the truth of these discoveries (Munhall, 2007). Lincoln and Guba (1985) proposed naturalistic inquiry as an alternative constructivist methodology to challenge the analytical/empiricist thought of the positivistic paradigm. This was deemed as being necessary because the evolution of human beings involves capacity for interpretation and the ability to construct reality. As a consequence, the study of the human world should be conducted differently to that of the natural or physical world (Guba, 1990). Human perception cannot be deemed conclusively “real”, as it is “made up” and shaped by the individual’s interaction with society and culture (Patton, 2002). Therefore, within the context of naturalistic inquiry, the world and reality are seen as human constructs that cannot be considered and appreciated in isolation from their context (Patton, 2002; Lincoln & Guba, 1985).

From the constructivist perspective, reality is understood as being constructed in the mind of individuals. People understand and experience their world differently according to their perceptions, expectations, values, culture, and relationships. To ensure clarity as a researcher in relation to my position in the research, and understanding my values and beliefs, engaging in and understanding ontological, epistemological and methodological dimensions became important in order to remain true to the underpinning beliefs of the chosen paradigm.

Viewing and understanding of the world through a constructivist lens becomes clear when the relevant dimensions are expanded. Lincoln and Guba (1985) use the term “axiom”. For the purpose of this research, the term “dimension” is more accessible. The three dimensions, ontology, epistemology and methodology, are explored next, providing clarification as to how this basic set of beliefs has guided the research that explored the role of the CLN.

The ontological dimension

This section explores the meaning of ontology and how that manifests in the constructivist paradigm. Crotty neatly defines ontology as “the study of being” (1998, p.10). Ontology deals with the nature of existence and the structure of reality. It provides a particular way of viewing and understanding the world (Crotty, 1998). Ontology adds the “what is” view while epistemology adds “what it means to know” to the theoretical perspective (Crotty, 1998).

If the concept of reality in constructivism is considered we find that within a naturalistic inquiry, reality is a social phenomenon and therefore multiple constructions of reality exist (Denzin & Lincoln, 2000). This implies acceptance that there are many and varied ways of knowing, sets of meaning and separate realities (Crotty, 1988). It follows that constructivist researchers believe that social reality exists as individuals experience it and as it has meaning for them. Taking this notion a step further, relativism provides recognition that one individual's understanding of the world may be quite different from another individual's (Crotty, 1998). Accordingly, within research with a relativist ontology there will always be many different interpretations of the topic being explored. The acceptance of the idea that there will be differing interpretations of the phenomena and experiences under study by the individual CLNs and of the interpretation of the data by the researcher was of significance in this research. The portrayal of the differing perspectives and interpretations the CLNs brought to the study was enabled through this ontological position.

In line with this ontological stance, seeking generalisations is not considered meaningful when studying human behaviour. Generalisations are defined as "assertions of enduring value that are context-free" (Lincoln & Guba, 1985, p.110) and timeless. Generalising the findings of research is one of the aims of the research carried out in a scientific realm. Qualitative researchers dispute the view that generalisations are possible due to the fact that the research is undertaken by human beings and inextricably linked to a particular context (Miller & Crabtree, 1999a; Lincoln & Guba, 1985). The uniqueness of the settings being studied is valued instead. I do not claim that the views of the CLNs I studied or their statements have universal application. Rather, as a qualitative researcher, this research was not designed with a view to the findings regarding this unique nursing role being able to be generalised to other nursing contexts.

Similarly, it follows that the concept of causality is rejected because a process of "mutual simultaneous shaping" (Lincoln & Guba, 1985, p.37) is occurring. It is believed that all things must influence each other and it becomes impossible to separate causes and effects into specific boxes of linear trajectories. This constructivist orientation to research differs markedly from traditional modes of inquiry where a single or a minimum number of correct viewpoints is sought. The concept of causality does not fit with the ontological position of constructivism because it is not possible to find a singular, verifiable truth because there are multiple, socially-constructed realities (Patton, 2002). For these reasons, a study of the CLN role that was based in a

quantitative paradigm in the first instance was deemed inappropriate. The methodological framework in a constructivist inquiry believes that many different outcomes could be produced by the same cause, and “explanations are at best ‘here-and-now’ accounts that represent a ‘photographic slice of life’ ” (Lincoln & Guba, 1985, p.155).

The ontological position effects how the findings of the research become apparent and are analysed. Lincoln and Guba refer to truth emerging as a “composite picture of how people think” (1985, p.80). The researcher cannot discard divergent or conflicting constructions of reality while trying to pull together a level of understanding (Lincoln & Guba, 1985). It follows that a holistic approach that seeks to include each person’s experiences and the context in which they occurred is considered and incorporated into the emerging construction(s) in this mode of research (Appleton & King, 2002). Therefore, the goal was to give voice to the CLNs and promote their views and perspectives of the CLN role.

The epistemological dimension

This section considers where constructivism sits epistemologically. Epistemology adds understanding about how we know what we know. The epistemological beliefs underpinning constructivism influence qualitative descriptive methodology. Epistemology is concerned with the manner of how we study the world and how knowledge of the world is obtained (Patton, 2002). Therefore the questions that epistemology poses are important in orienting the research approach, the underlying assumptions, and how the research outcomes are presented (Crotty, 1998).

Knowledge generation, meaning, understandings, what we know, and study findings are “the creation of the process of interaction” (Guba 1990, p.27) between the researcher and the study participants in a constructivist approach. Therefore, ontology and epistemology are interwoven and it becomes impossible to consider one without the other (Guba, 1990). The constructivist position epistemologically in relation to what is known, what can be known and how we know, is the belief that people construct meanings about the world through interactive experiences with others.

To achieve an interactive approach, cooperation of the participants was essential. Consequently, the research design incorporated appropriate elements to ensure cooperation between the researcher and the participants. Epistemology was important

because knowledge was generated through interaction on several levels. For example, interactions existed between the researcher with CLNs and the researcher with the CLNs information in accordance with Lincoln and Guba's flow of Naturalistic Inquiry (1985).

Recognition of values is important due to the subjective nature of this dynamic interactive approach and the place of values in the research. Values are seen as essential in knowledge creation in the constructivist paradigm. Values are "the moral principles or accepted standards of a person or group" (Collins, 1993, p.1310). Constructivist inquirers argue that facts are both "value-laden" and "theory laden" (Guba & Lincoln 1989, p.105). Lincoln and Guba (1985) propose four ways in which values influence constructivist inquiry. From the outset, the researcher's own beliefs and values will influence the choice of topic. The paradigm chosen to guide the research has a value position and assumptions. The methodological paradigm has underpinning values that guide the research. Finally, the cultural values embedded in the study context will be recognised. Values in the study setting will influence the research.

Therefore, the impact of values and the role they play in the research are encapsulated in the choice of methodology and the research design. The "mutual shaping" referred to by Lincoln and Guba (1985) is influenced by both the researcher's and participants' own value systems. This means the researcher must accept that the participants' beliefs and values may be very different from the researcher's own. As researcher, being cognisant of the values I brought to this study was particularly important because of my background as a CLN. For this reason, robust reflective processes were integrated within the research design. These are outlined in the section titled "Researcher values" (p.63).

One critique of this approach is the emphasis on the individual view rather than the impact of society as a whole (Pawson & Tilley, 1997). However, this critique fails to understand that constructivism does recognise the complex interplay that helps to form, develop and alter an individual's constructions of any phenomena (Lincoln & Guba, 2000). The constructivist position acknowledges that "multiple knowledges" can exist together, and that it is possible that a range of views may emerge during a naturalistic inquiry (Guba & Lincoln, 1994, p.113). This position generates challenges for the researcher in practical terms to represent the individual's perceptions as well as the common and divergent themes. However, for this research, there was a fundamental

starting point in that both the researcher and participants had common ground as registered nurses and CLNs. The research identified common themes during data analysis whilst at the same time divergent or disparate views were also incorporated.

In summary, research is an interactive process. Reality is understood to be a social construct. Knowledge is assumed to be shaped by history and social circumstances over time (Denzin & Lincoln, 2000). Although my position was that of researcher, I was not detached from the research context or the participants. The assumption was that my relationship with the research and the participants was interactively linked and that my values as a researcher and a nurse had some bearing on the research.

The methodological dimension

The methodology refers to “the strategy, plan of action, process, or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty, 1998, p.3). In other words, the methodology provides the framework and rules relating to the choice of methods.

Research design

Qualitative descriptive methodology

Qualitative descriptive methodology as outlined by Sandelowski (2000a, 2000b) was deemed the appropriate methodology to appreciate the CLN role. The qualitative descriptive methodology was underpinned by naturalistic inquiry and constructivism. Rich description of the nursing practice was required. This approach allowed the nurses’ perspective to be heard and themes to emerge from the data and permitted the use of several methods. The methods were a survey questionnaire, in-depth interviews and then an audit. This enabled a holistic view of the realities and meanings of the role of the CLN to be captured. The aim of a naturalist inquiry is to understand people’s constructed meaning of truth and reality. These underpinning assumptions meant that the nurses’ voice was given precedence in the research.

Of particular relevance for this research, qualitative descriptive designs provide an existing framework for practice based research, which is particularly appropriate for nursing and policy development (Sandelowski, 2000b). This methodology is described as a particularly useful approach for nursing practitioners who are considering entering their clinical area of expertise as researchers. The underpinning naturalistic inquiry paradigm, used in this study, enables the depiction of multiple constructed realities or

worldviews to bring people's understanding together. The court liaison nurses' realities are multiple, constructed, interactive and inseparable in the realms of health, education and the criminal justice system. The choice of research topic and methodology was influenced by my past experience and working with CLNs, as well as a strong desire to make visible the paradigm of nursing in the criminal justice system.

Several key features of a naturalistic inquiry were relevant. Firstly, as mentioned above, the relationship between the researcher, the research, and the participant is important on several levels. In a naturalistic inquiry, the researcher is not seen as a neutral spectator in the research (Lincoln & Guba, 1985). As such, researchers are recognised as bringing a responsive approach to the research and data through the use of effective interpersonal skills (Miller & Crabtree, 1999a). In a distinct move from the positivist paradigm, the principle of "the human as instrument" incorporates the development phase of the research, encouraging the researcher to discuss topics or issues prior to his or her investigation with fellow practitioners (Lincoln & Guba, 1985). Carrying out this process assists with refining the inquirer's thinking before contemplating access to the field (Lincoln & Guba, 1985). This feature of the study design enabled the researcher to take account of the CLNs' opinions and ideas prior to commencing the study.

Similarly, the adaptable and responsive position of the researcher continues throughout the research in the implementation and analysis stages. Data collection procedures can be adapted where necessary through the use of creative and intuitive processes. Interaction continues with the process of data analysis when the researcher seeks convergent and divergent viewpoints and explanations for any discrepancies.

Incorporated in the concept of "human researchers as instruments" is recognition and valuing of the "tacit" knowledge the researcher brings to the methodology (Lincoln & Guba, 1985). The researcher had experience as a CLN. Insights from that experience were useful in designing the study. Familiarity with the CLN role, CLNs and services also assisted with gaining access to the participants and engagement during the interviews.

The appreciation and treatment of the data is another significant characteristic of a naturalistic inquiry. Understandably, texts based on interviews and observations are described as being attained through reciprocal processes taking into account the unique contexts and being influenced and bounded by the values of all involved (Lincoln & Guba, 1985). For that reason, this research took the position that multiple meanings and

some degree of interpretation are always involved in the analysis of a text. Sandelowski and Barroso (2002) suggested that because the data are “constructed entities” they cannot be separated from findings. Here, the so called raw data of qualitative research (e.g., the interview transcript and the field notes) are not pre-given, but rather are already interpretive products. As Wolcott observed “Everything has the potential to be data, but nothing *becomes* data without the intervention of a researcher who takes note – often makes note – of some things to the exclusion of others” (1994, pp. 4-5). The findings are considered a result of the intertwining of the process of the research and the final product in which the researcher is an implicit part.

In this research evidence of the intertwining processes can be found in the researcher’s experience as a CLN, dialogue with CLNs prior to commencing the research, member checking of transcripts and themes and incorporation of CLNs’ suggestions regarding the design of the audit instrument. The ability for ongoing analysis enabled the researcher to interact with the data to “oil the wheels” (Appleton & King 1997) of thought and facilitated consideration of diverse interpretations. Similarly, the purposive sampling strategy used in qualitative descriptive designs (Sandelowski, 2000b, Patton, 2002) and the ability to work with the participants to construct an understanding of the key issues assisted with formulating the researcher’s ideas about the progression of the study.

Qualitative descriptive research methodology design meets the aim of providing a description without embellishment, in language that would make the research useful in practice for the nurses (Sandelowski, 2000b). This incorporated the use of robust data collection techniques, the documentation of research procedures including details of methodology, and the data analysis procedures. In line with this approach, purposive sampling and inductive data analysis were chosen. The details of the mixed methods follow.

Mixed methods

Mixed method designs use quantitative and qualitative methods within a single project (Tashakkori & Teddlie, 2003). The use of mixed methods allows the researcher to approach the phenomenon being studied from different angles to allow a more complete understanding of the topic than could be gained from using a single method (Giddings & Grant, 2007). Traditionally, qualitative and quantitative approaches have been associated with discrete paradigms.

The quantitative paradigm is associated with the dominant empirical positivist “scientific method” and the qualitative paradigm with the “human science” focus concerned with the social world from which meaning is derived (Haase & Myers, 1988; Dzurec & Abraham, 1993). A common aim of both qualitative and quantitative research is in reaching for understanding of the world we live in. Demonstrating lack of understanding of the orientation of an approach or blurring of paradigms is a major critique of using mixed methods (Giddings & Grant, 2007). However, as Sandelowski (2000b) and others (Dzurec & Abraham, 1993; Giddings, 2006) suggest, in mixed method research this need not be the case.

In support of using mixed methods, Dzurec and Abraham (1993) refer to inquiry being about understanding and explanation. In order to achieve this, integration of qualitative and quantitative methods can be used. So instead of viewing the use of mixed methods as mergers or combinations of world views or paradigms, qualitative descriptive methodology involves the explicit framing of the inquiry in two or more world views which are distinct from each other (Sandelowski, 2000a). “Because techniques are not linked to either paradigms or methods, combinations at the technique level permit innovative uses of a range of techniques for a variety of purposes” (Sandelowski, 2000a, p.248). Accordingly, the overall research design sits within the constructivist paradigm, but the techniques used to gather data employ quantitative and qualitative techniques.

The aim was to discover the “who, what, and where of events, of experiences, or their basic nature and shape” (Sandelowski, 2000b, p.338). To that end, three methods were employed: postal survey questionnaire, in-depth interviews, and an audit. Data collection occurred in a sequential manner. One aspect of the study led into and informed the next. Data gathered in the survey was used to develop phase two and three of the study. In this way each method mutually enriched each subsequent method and provided a depth of understanding that would not have been possible using one method. Individual semi-structured in-depth interviews then further explored key themes to come from the survey and the nurses’ perspectives of the role. This method ensured the fleshing out with rich data regarding the main issues that came out of the survey. The final method, an audit, was designed to capture the CLNs day-to-day activities, thereby constructing a comprehensive picture of this nursing role.

Participant sampling and recruitment

Two sampling strategies were employed in the research. For the first phase, the survey, the aim was to survey the entire target population. Purposive sampling strategy was used in phase 2 and 3. The objective of purposive sampling is to identify information rich cases for in depth examination (Patton, 2002). The purposive sampling strategy assisted with ensuring that participants were typical of the population or particularly knowledgeable about the subject (Polit & Beck, 2008) and would be representative of the group.

Survey questionnaire

All nurses who were practicing in the court liaison role in New Zealand whether full time, part time, relieving or providing cover, were invited to participate in phase one of the research. Inclusion of as many of the court liaison nurses as possible maximised the scope and variety of information.

Despite the initial intention to include all New Zealand CLNs, Hauora Waikato (an independent Kaupapa Maori forensic mental health service provider) did not authorise participation by their CLNs. Hauora Waikato is a unique service in New Zealand providing a range of forensic mental health services for parts of the Waikato and wider Midland region (PUAWAI, 2011). The contributions and perspective of the Hauora Waikato CLNs would have been invaluable, bringing a much needed cultural perspective to the research. Subsequently, only the CLNs in New Zealand practicing within District Health Board (DHB) forensic mental health services were invited to participate in the postal self administered questionnaire. DHBs are organisations established by the New Zealand Public Health and Disability Act 2000. Public funding is provided to DHBs from the Ministry of Health on behalf of the Crown. DHBs are responsible for ensuring the provision of health and disability services to populations within a defined geographical area (District Health Boards, n.d.). The DHB CLNs formed a target population of potentially 41 nurses covering court liaison in New Zealand.

There was no comprehensive mailing list available of all CLNs in New Zealand or other expedient means of directly contacting them at that time. Therefore, to ensure all DHB CLNs had the opportunity to participate in the survey, information packs regarding the study were mailed to DHB court liaison managers or team leaders for distribution. The

information packs included: Letter to Manager (Appendix B), Cover Letter Survey (Appendix B), Survey Participant Information Sheet (Appendix C), and Survey questionnaire (Appendix D). To maximise returns, a reminder letter (Appendix B) and extra information packs were sent out to the DHB Managers three weeks following the first letter.

Several CLNs contacted the researcher because they wished to participate but had not been able to complete the survey questionnaire within the original time frame.

Following discussion with the supervisors, these CLNs were invited to complete the survey up until the interviews commenced.

In-depth interviews and audit

Six potential participants were invited by the researcher to take part in phase 2 (in-depth interview) and phase 3 (audit). The aim was to explore common and unique manifestations of the role and any regional variations or idiosyncrasies (Sandelowski 2000b). The purposeful maximum variation sample (Sandelowski, 1995) included participants from three areas in the North and South Islands, contributing diversity of experience and location (from cities and rural regions).

To ameliorate understandable reluctance on the part of nurses to devote precious patient care time to completing audit-like activities, the same six nurses were invited to take part in phases 2 and 3. The rationale was that nurses who were fully cognizant of the research aims and very much part of the research would be more willing to complete phase 3, the two week audit. The six nurses also had the opportunity to have input into the design of the audit tool. Details regarding phase 2 and 3 were then emailed and posted to the participants. Participants were offered the choice of a CD or book voucher as a small compensation for giving their time and as a thank you for taking part in the research (refer to Appendix B for letter inviting participants to take place in the in-depth interviews and the reminder letter).

Tools

Survey questionnaire

Several definitions exist as to what constitutes a survey. The definition proposed by Hox, de Leeuw, & Dillman (2008) suggest a survey is “a research strategy in which quantitative information is systematically collected from a relatively large sample taken from a population” (p.2). A broader view of the survey can be found in descriptive

exploratory survey studies (Elliott & Hayes, 2003). These authors suggest this type of design is used to obtain accurate information about the characteristics of a specific phenomenon, or rate of a phenomenon's occurrence, especially when little is understood about the phenomenon within the positivist paradigm (Elliot & Hayes, 2003). Tolich and Davidson (2003) suggest "surveys provide a 'snapshot' of a group's attitudes, values or behaviour at one point in time" (p.133). In this research, survey questionnaires were used to obtain baseline information, demographic facts and data about nursing practice in the criminal courts, the nurses' opinions on specific issues and how they felt about the role (Polit & Beck, 2008).

Gathering detailed descriptions of the existing nursing practice served a twofold purpose. Firstly, it articulated the nursing practice and identified key topics for the following phases of the research. Secondly, it provided a foundational knowledge for the future of this nursing role.

Development of the survey questionnaire

The literature review did not reveal a replicable tool or previous research directly applicable to the New Zealand context. Therefore, the survey questionnaire was developed by the researcher. Relevant guides were consulted regarding structure, layout, content, language, pre-testing and piloting, and optimising the return rate (Tolich & Davidson, 2003, de Leeuw, Hox & Dillman, 2008).

Incorporating the CLNs thoughts and the researcher's experiential knowledge is fitting in a research design underpinned by naturalistic inquiry (Lincoln & Guba, 1985). Therefore, consultation with CLNs currently practising within the role took place to ascertain pertinent and topical issues for the survey. It was not known whether any of the CLNs who were consulted in the development phase participated in the survey questionnaire due to the anonymous nature of the survey questionnaire. Relevant themes elicited from the literature review informed the survey questionnaire design. The questionnaire incorporated the researcher's experiential knowledge, observations from practice and the key themes articulated by Seaton (McKenna & Seaton, 2007) and Smith (2004).

Development of the content and structure of the survey schedule was also informed with tools forwarded by scholars who conducted research into the consult liaison nurse role in Australia (Sharrock & Happell, 2002). This study also drew on the format used by

Turnbull and Beese (2000) to explore the nature and quality of working relationships between the community mental health nurses and others in Magistrates courts in one area in England.

Attention was paid to the structure of the survey questionnaire. The use of language was reviewed to ensure it was as jargon free and user friendly as possible (Tolich & Davidson, 2003). Questions were kept simple with one question asked at a time to avoid confusion, non-responses and/or incomplete answers (Tolich & Davidson, 2003). Each section consisted of both close-ended and open-ended questions to tease the information out and encourage participation by giving the nurses an opportunity to relay practice details, and challenges to practice.

Piloting/pre-testing the survey questionnaire

Piloting allows for refinement of the data collection tool and generally increases quality and validity (Campanelli, 2008). Pre-testing assists the researcher to clarify whether the tool is clearly worded and will provide the data required to answer the research question. Piloting also facilitates checking that major biases are eliminated (Campanelli, 2008). Attention to the potential for biases was a significant consideration for the researcher given lack of experience in the research role and ongoing involvement with CLNs. One of the supervisors with extensive knowledge in forensic mental health nursing provided rigorous feedback and challenged the researcher's rationales for including questions or asking them in a particular manner. This ensured as much as was practicable that any personal biases on the part of the researcher did not colour the questions.

Usually the pilot is performed by a small sample of the target population, with those undertaking the pilot having the necessary knowledge and skills to complete and evaluate the questionnaire reliably (Burns & Grove, 2001). The survey questionnaire was piloted on two occasions: firstly, with a nurse who had practised in a consult liaison nurse role in a general hospital (a role with some similarities to the CLN role) and secondly, with a nurse who had previously practiced in the court liaison nurse role. The nurses who pre-tested the survey were asked to read the Participant Information Sheet and complete the survey considering the following:

1. Whether the terminology was easy to follow and applicable
2. How difficult or complex they found the survey overall

3. How complicated they found individual questions
4. If the aims of the research as described to the participants conveyed what the researcher hoped they did
5. How long it took to complete and whether there was enough space to write answers (Tolich & Davidson, 2003, p.142)

The feedback clarified how some questions could be improved.

Survey questionnaire - structure and content

The self administered postal questionnaire was organised into four sections. The four sections included: demographic/background information; preparation for the role; education and training; and supervision and support. Turnbull and Beese (2000) identified that success in the CLN post was very much dependent on collaboration with other agencies. Participants also documented the importance of building lines of communication, establishing trust, credibility, and mutual respect (Turnbull & Beese, 2000). To gain an understanding of the relevance of these working relationships in the New Zealand CLN context, the quality and frequency of the relationships was explored in section 4 of the survey questionnaire.

A mixture of open-ended and close-ended questions and ratings were employed. The final survey had 58 questions (Appendix D). Forty one of the questions were structured as close-ended questions which simplified the participants' response and ease of data analysis for the researcher. The close-ended questions varied in format from fixed response questions (e.g. 1, 2, & 3), lists of items which participants ranked, ordered or rated (e.g. 43, 44, & 45), questions that enabled multiple responses (e.g. 14, 23, & 50), and open-ended questions (e.g. 25, 27, & 52). Open-ended questions can result in diverse data fitting with the aims of the research (Polit, Beck, & Hungler, 2001). Open-ended questions also enabled the generation of issues arising in practice that the researcher may not have been aware of or thought to canvas in the research (Polit et al, 2001). Open-ended questions allowed as much information as possible to inform phase 2 and 3 of the research.

Because of the dearth of information available regarding this cohort of nurses, Section 1 sought to obtain baseline demographic information, including details about longevity as a nurse and length on time in the CLN role. Role specific information was sought regarding hours per week practiced in the role, other roles performed for the forensic mental health service, whether the nurse was a Duly Authorised Officer (DAO) under the Mental Health (Compulsory Assessment and Treatment) Act 1992, whether the

CLN had a job/role/position description, courts regularly covered, and sites visited. The final part of Section 1 focused on the availability of resources for the nurse at court.

Section 2 (items 18-29) elicited detailed information regarding nursing qualifications, and background education. Experiences regarding the nurses' orientation to the role were explored with ample opportunity for detailed responses in open-ended questions. The nurses were asked to provide opinions regarding educational/training pathways for CLNs and to outline their perception of what that pathway should look like.

Because of the isolated nature of the CLN practice environment and the small numbers of CLNs and therefore minimal opportunities for the reciprocal supportive collegial relationship that is possible in health settings, the survey explored professional supervision opportunities, supports available, and opportunities to communicate with CLN peers.

Section 3 (items 30-42) focused on clinical supervision and support. Opportunities for discussion and reflection on practice were explored. Three questions focussed on whether the nurses discussed practice with CLNs outside of their regions, and the nature of contact with CLNs; whether contact occurred through a formal process or informally. This section concluded with space for the CLNs to outline any final thoughts regarding clinical supervision and support.

Section 4 (items 43-58) explored areas of tension and specific challenges. Topics canvassed included relationships, diversion and liaison, ethical and cultural challenges, and specific practice related tensions such as informed consent, information sharing, and dual roles.

Capturing the nurses' thoughts and ideas was important to inform recommendations regarding the CLN role and future role development. Therefore, the final questions asked CLNs to elaborate on the most and least enjoyed aspects of the role. Space was provided for any further comments if the participants wished. The researcher was mindful this was an opportunity for CLNs to discuss or contribute to dialogue about their role.

In-depth interviews (semi-structured)

The aim of this phase of the research was to explore beyond background demographic information, role description and working conditions. The goal included exploration of

intricate details surrounding individual experiences, the thought processes, feelings, and beliefs relating to practicing as a nurse in the criminal justice system.

Semi-structured interviews were chosen in preference to structured interviews. Data collection by semi-structured interviews allows participants to be asked questions within a flexible framework (Patton, 2002). Interview questions in semi-structured interviews are guided by a list of particular topics to be covered rather than a list of set questions (Miller & Crabtree, 1999). The idea behind this was that this group of senior nurses' who practice autonomously would be able to talk freely on all the topics, describe the challenges, describe what works well and provide critiques of the role and systems. This way of researching also acknowledged that they were the experts in this role and their opinions were valuable.

Development of draft interview questions

A list of key topics and prompt questions for the interview guide was initially compiled after review of the literature. Firstly, the literature revealed that little was known about nursing practice in criminal justice settings. Therefore, the wider forensic mental health nursing literature was reviewed. This revealed common themes including lack of specific education and training, the need for professional supervision and support for forensic mental health nurses, and tensions and contradictions that arise for health professionals due to the nature of the non-health based environments and the potential for the health professional to experience role conflict. Therefore, the interview guide included the following broad topic sections with further prompts under each section: background education and training; functions of the role; relationships; areas of conflict and challenges to the nursing role; framework or model for practice (Appendix D).

Following preliminary analysis of the survey questionnaire the following topics were expanded upon during the interviews: orientation; training pathway; national templates/guidelines; management support and recognition of the complexity of the role and specialty status (Appendix D). In the survey, overwhelmingly CLNs reported they enjoyed the autonomy and the role's increased responsibility. Therefore, the interview invited participants to describe what the role meant to them and how they managed the complexity and responsibility.

Interview process

Miller and Crabtree describe the interview as “a research gathering approach that seeks to create a listening space where meaning is constructed through an inter-exchange/co-creation of verbal viewpoints” (1999b, p.89). To make the most of this approach, two hours were allowed for the interviews. These took place in the participant’s own health setting at a negotiated time. Refreshments were offered by the researcher. However, due to time and flight schedules this proved challenging to facilitate with all participants. This was discussed with the participants and it did not appear to present a concern for any of them. On the contrary, the participants were extremely welcoming, generously provided refreshments and expressed happiness to be taking part in the research.

Being a registered nurse with many years of experience in interviewing people did not preclude undertaking specific preparation prior to conducting the interviews. Approaches to the interviews and processes were initially reflected upon and discussed with the cultural advisor, and then a supervisor both before and after interviews. Guides to carrying out interviews were perused (Miller & Crabtree, 1999b; Davidson & Tolich, 2003; Smythe & Giddings, 2007) with the aim of ensuring a genuine and respectful relationship developed during the interview to facilitate depth and richness of data.

The notion of “researcher as instrument” is one of the underpinning principles of naturalistic inquiry (Lincoln & Guba, 1985). This implies the researcher is sensitive and responsive to the intricacies of the inquiry process. As researcher, I had to be cognizant of all the skill levels, expertise and experience they brought as individuals to the CLN role. I had to be able to be responsive, follow cues or leads, explore issues and topics as they arose and appeared relevant to the purpose of the study. This fine-tuning process was undertaken as each interview took place. Following each interview, notes were made of any contextual or other general impressions of the interview, and possible changes to the interview guide. The cues or leads provided by the participant guided me regarding the next interview. This process extended to phase 3 as elaborated below.

The progression of the interviews was very much as Smyth describes: “People don’t speak or think in a linear fashion” (Smyth & Giddings, 2007, p.49). The initial approach in the interview was to start with broad open-ended questions such as “Tell me about how you came to be in this role” or “Talk me through your day” with the intention of then progressing through the interview guide. However, from the first

interview all that was required was to ask the initial question, and then dialogue flowed in torrents. The interview guide was subsequently used as a checklist whereby topics were ticked off as the CLNs covered them. The guide was then referred to at the end of the interviews if specific topic areas had not been covered by the CLNs. My role as inquirer was to listen and perhaps prompt or clarify at times (Smythe & Giddings, 2007).

An independent Transcriber typed the transcripts from the audiotapes. Once typed, the transcripts were returned to the participants to check and provide further comment if they wished. The researcher did ask some clarifying questions at this stage.

Audit

The final phase of the study commenced following the in-depth interviews. The aim of this phase was to capture day to day activities carried out by the CLNs over a two week period. Discussion with CLNs gave the impression that routine DHB statistical data collecting processes did not depict the enormity of this role. Especially notable was the liaison aspect and the inability to record the multitude of valuable ‘corridor conversations’ the CLN experiences every day. The involvement of the nurse in brokering the appropriate outcomes (such as diversion to mental health services, or linking people in with other health and support services) was not widely known and understood.

The aim was to collect data regarding the type of each activity and the time spent on each activity, separating out clinical and non direct clinical activities. This goal was balanced with the need to ensure this phase of the research was not too onerous for the participants.

Development of the audit tools/key/instruction sheet

To assist with engagement in the audit and refinement of the data collection tools, instruction sheet and key, this phase of the research was discussed with each participant at the conclusion of the in-depth interviews. Feedback was sought regarding the format of the data collection tools and the suggested time frame required to complete the audit. Consensus was reached with participants that they were able to complete the data collection tool in any manner that suited them, by hand or online. The participants suggested reducing the data collection period from 4 to 2 weeks. The participants suggested they choose a suitable two week period that would best reflect their usual

practice. This was to take into account unusual events for example public holidays, court rosters and other reasons that the court may be closed and the nurse not able to capture their usual practice on court list days. The participants' feedback was incorporated in the design. The process of discussion between researcher and participants assisted with consistency in the information recorded for the audit.

Data collection set 1

This data collection tool recorded details regarding each individual approach made to the CLN over the two week audit period. It aimed to capture every approach and discussion the nurse had whether or not that resulted in an assessment. Microsoft Word was used to design an audit template for the CLNs to record every interaction they had with potential clients in relation to court matters. Details relating to the referral were gathered such as: court, referrer, reason for referral, demographic details of person assessed, whether they were a known client of mental health service, diagnosis if known, type of offending, stage in legal process, whether referral was for advice only, details regarding the interview, liaison and consultation details, DAO role, interactions with the court, outcomes from legal process and CLN contact, DHB statistics, other activities, and estimation of total time spent on each referral or contact.

Data collection set 2

Data collection set 2 recorded details regarding any other non-direct patient related activities the CLN considered relevant to the CLN role and not recorded in the data set 1. Examples of these activities included: providing education to others, travel time (if more than 30 minutes to travel to court), research (e.g. reading legislation and judgements), seeking expert opinions, obtaining advice and contacting other court liaison nurses.

Instruction sheet and key

An instruction sheet accompanied the two data collection tools. The participants were sent the forms electronically and were able to choose whether they filled them out online or by hand.

A key to using the audit forms streamlined the recording process for the nurses. However they were able to use whatever terminology suited them in capturing day to

day activities (see Appendix D for the Data Collection Instruction Sheet and Key; Data Collection Set 1; Data Collection Set 2).

Following the consultation process, the participants were emailed the data collection tools, instruction sheet and key.

Data analysis and data re-presentation

The Statistical Package for Social Sciences, version 19 (SPSSTM) was used to generate the descriptive statistical analysis. Thematic content analysis which is fitting in qualitative descriptive methodologies (Sandelowski, 2000b) was employed to analyse qualitative data into themes.

Quantitative analysis

Data were entered into the SPSSTM, version v19 programme. (IBMTM SPSSTM, 2010). SPSS is particularly suited to the analysis of quantitative research to facilitate the processing of large quantities of data and calculation of statistical measures. The quantitative data was primarily nominal and ordinal, therefore non-parametric descriptive statistics including the mean, median and mode along with measures of variation, range, and standard deviation, tallies, frequencies and percentages were calculated. Guidance and assistance was sought from one of the supervisors and an expert in SPSS from AUT University. Each question was initially analysed individually. Then a process of data reduction, organisation and interpretation was necessary to complete the analysis, as explained by Davidson & Tolich (2003). Hence some of the findings from the analysis of each section of the survey have been summarised and grouped together as is fitting for a qualitative descriptive study (Sandelowski, 2000b). This process was undertaken in consultation with the supervisors.

Re-presentation of quantitative data

Simple descriptive statistics were used to describe the results. Data was presented as text summary or represented in table and graph form to allow for a visual perspective of the data and easy interpretation.

Qualitative analysis

The thesis has already established that findings are viewed as “constructions” or “meanings” which are created through the inquiry process (Lincoln & Guba, 1985).

This means that any construction which emerges from a qualitative inquiry may be seen as unique, for a particular set of circumstances may never occur again in exactly the same way.

Qualitative content analysis was deemed the most appropriate data analysis strategy to find patterns or themes in the data (Morgan, 1993; Hsieh & Shannon, 2005; Sandelowski, 2000b). Qualitative content analysis is described as “reflexive and interactive as the researchers continuously modify their interpretation of data to accommodate new data and new insights about those data” (Sandelowski, 2000b, p.338). This approach of analysis is oriented toward summarising the informational content of that data (Sandelowski, 2000b). Content analysis involves reading the material and “using a consistent set of codes to designate data segments that contain similar material” (Morgan, 1993, p.114). The codes are derived from the data and can be modified as the careful reading and re-reading of the data that takes place during the course of the study (Morgan, 1993; Sandelowski, 2000b). The coded sections are then categorised, further analysed and interpreted into patterns or themes (Morgan, 1993).

The following process was followed with the qualitative data. The data was transcribed verbatim from the interviews (by the Transcriber) and survey questionnaires (by the researcher) onto Microsoft Word. The transcripts were read and tapes listened to repeatedly by the researcher. Then initial codes using different colours per code were derived firstly by the researcher and then one of the supervisors. These were brought together and discussed between the research and supervisor and consensus was reached. As Morgan (1993) describes, the codes were derived from the data and through careful re-reading of the data, they were modified. This process enriches the analysis because the researcher gains insight about the phenomenon.

Patterns in the categories were then interpreted asking *why* and *how* the patterns came about and summarising and grouping (or interpreting) the patterns into themes (Morgan, 1993). “Theme” or “pattern” can imply a variety of meanings, including a recurring event (or frequency of occurrence) and a unifying element, essence, or motif (or singular thread or link) (Sandelowski and Barroso, 2002). The research sought patterns and ideas that described current practice, would inform future practice, challenges to practice and identified areas (of practice) for further exploration.

It is recognised that knowing about a phenomenon includes understanding the context to give meaning to the phenomenon and that all description requires perception

(Sandelowski, 2000b). Accordingly, the choice of what to describe and the process of describing involves transformation or interpretation (Sandelowski, 2000b). Maxwell describes interpretive accounts as “grounded in the language of the people studied and rely as much as possible on their own words and concepts” (1992, p.289). Interpretation occurs through the researcher’s familiarity with the data. Constantly returning to the original data sources develops the researcher’s intuitive grasp of its meaning, which finally matures into an interpretation of the multiple realities that exist.

Once themes were derived, the methodological expertise of one the supervisors was used to ensure that the themes reflected the data, thereby providing interpretive validity. However a caveat applies here and the researcher acknowledges that the “expert” can only validate what was presented to them (Sandelowski, 1998; Maxwell, 1992). The repetitive analysis process occurred until consensus was achieved and a report representative of the information provided by the CLNs was produced. The interview participants indicated that the analysis of the data organised into themes was reflective of the content of the interviews. This lends confidence to the applicability of the findings. Interpretive validity of the findings was also demonstrated by having the themes and findings approved by the participants as suggested by Lincoln and Guba, (1985).

Re-presentation of qualitative data

Careful attention was paid to ensure that choices about what was emphasised in the research fit the research purpose and methods (Sandelowski, 1998). Sandelowski recommends that the format for data presentation uses “a straight descriptive summary of the informational contents of the data organised in a way that best fits the data” (2000b, p. 338). Therefore, the themes were arranged in a straight forward manner from the most prevalent to least prevalent theme. Findings from the three data collection methods were integrated descriptively in the analysis as suggested by Creswell (2003).

A fundamental belief of the researcher was that this research would be useful and relevant to CLNs in everyday practice. Therefore, one of the aims of qualitative descriptive studies, being to ensure the reader hears the participant’s voice with minimal voice-overs by the researcher, was particularly applicable (Sandelowski, 2000b). The research provided a conduit for the CLNs perspectives with the nurses’ descriptions and voice having precedence in the analysis and representation of data. Attention was paid to ensuring the CLNs views were accurately captured. Hence, employing the nurses’

own words in the form of quotes to describe practice was essential. Sharing the final writing of the research with the participants occurred, not so much to establish approval but to provide a means to reflect on the experience of the research for the participants and their nursing.

Data quality and design credibility

“Rigour” is a term associated with traditional research paradigms and ways of thinking (Tobin & Begley, 2004). Rigour is described as “the means by which we demonstrate integrity and competence, a way of demonstrating the legitimacy of the research process” (Tobin & Begley, 2004, p, 390). The overall thrust of this research is qualitative therefore the overall integrity of the research will be judged by mechanisms applicable to a study undertaken in the qualitative paradigm. Therefore several steps inherent in qualitative descriptive methodology were applied throughout the research to demonstrate credibility. Assessing the “goodness” of the research is not just about judging the process but is the about quality of the actions and understanding stemming from the research (Lincoln, 1990). Two sets of criteria were developed for assessing quality in constructivist inquires: trustworthiness (Guba & Lincoln, 1989) and authenticity (Lincoln & Guba, 1985). Sandelowski suggests that through descriptive and interpretive validity we can demonstrate the research is true to it aims (2000b). Evidence of the strategies used to ensure validity, integrity and credibility of the research is provided below.

The aim of the research was to present a truthful and accurate account of the nurse’s perspectives (Sandelowski, 2000b). Most importantly, to represent in a straight forward manner what the nurses considered to be the crucial aspects of their role, knowledge and needs. To achieve this end, Koch and Harrington (1998) refer to the necessity of ongoing conversation between the inquirer, the nurses and the research to reach agreement. Sandelowski (2000b) contributes that although it is unlikely that all the data within the inquiry will be reported on, what is described should represent a consensual view of the data. This is known as descriptive validity, a valid description of events that most people (including researcher and participants) observing the same event would agree is accurate (Maxwell, 1992). It must also be recognised that all decisions involve choice and inevitably interpretation on the part of the researcher (Sandelowski, 2000b). Interpretive validity takes descriptive validity to another level and refers to the valid

description of the *meaning* participants found from the events or circumstances they are describing that those participants would agree is accurate (Maxwell, 1992).

Planning was an essential component in enhancing credibility of the research. The sequential nature of the research was designed to enhance credibility in initially eliciting key themes in the survey and building on these in the next two phases. The processes of seeking verification were established prior to the study and adhered to. The checking and verification processes in place, returning of transcripts to participants to check their transcripts, and monitoring of feedback were part of systems involved in maintaining a research audit trail.

Patton (2002) refers to triangulation methods as a means of reducing systematic bias and distortion during data analyses phases, thereby ensuring credibility. This research used triangulation in terms of member checking (triangulation by review by inquiry participants), independent analysis (triangulation with multiple analysts) and data from one phase of the research not only informing the next phase but also confirming data (methods triangulation).

Two phases of the research involved quantitative elements. Therefore rigour in respect to these elements was reviewed using internal validity and reliability as the key issues integral to rigour of quantitative research (LoBiondo-Wood & Haber, 2006).

Verification strategies with respect to the tools were employed by seeking advice and assistance from experts in the relevant areas. The process of piloting and checking the data collection tools can be found under the section headed “Piloting/pre-testing the survey questionnaire” (p.51) and “Development of the audit tools/key/instruction sheet” (p.56).

Internal validity is the degree to which a study reflects or assesses the specific concept that is under measurement, and can be assessed in terms of internal and external validity (LoBiondo-Wood & Haber, 2006). Internal validity is considered met when the design of the study is congruent with the aims of the research. The survey questionnaire was designed to capture a broad understanding of this cohort of nurses and the functions of their role. This was congruent with the aims of the research. The data collection instruments used in phase 3 further developed the aims of the study by recording in detail the functions and daily nursing practice. Therefore the tools met criteria for internal validity.

External validity refers to the extent with which the results of the study are generalisable or transferable (Polit et al, 2001). External validity is not applicable to this research. The research was positioned in an overall framework of a naturalistic inquiry; therefore generalisability of the study of this unique nursing role was never the intention.

Auditability is a concept used in qualitative research to support dependability or reliability (the quantitative equivalent.) Auditability refers to the circumstances by which one researcher can follow the analysis pattern of another (Lincoln & Guba, 1985). This means another researcher should be able to arrive at similar conclusions using the available documents and raw data. In other words an audit trail was laid down (Polit et al, 2001). All aspects of the research were described in the methodology section and all tools are listed in Appendix D.

Researcher values

Findings in qualitative studies are partly composed of the knowledge, beliefs, and influences of the researcher (Sandelowski & Barroso, 2002). Therefore acknowledgement of the researcher's values, based on personal and professional experience, is central to ensuring self awareness of prior opinions and biases. It was stated at the outset that the researcher practised in the court liaison nurse role from 2002 to 2008 and continues to have a professional interest in the court liaison nurse role.

The underpinning assumptions for qualitative descriptive methodology fit with the researcher's views regarding reality in that the researcher believes in multiple experientially based constructed realities. It was central to the researcher's values that the clinical skills of the nurses were acknowledged and valued in this study. It is not possible to eliminate bias but a reflexive process ensured transparency. Reflexivity is described by Munhall as the "process by which researchers recognise that they are an integral part of the research process and vice versa" (2007, p. 318). Reflective processes were established to ensure a thorough approach to the research. These included: research supervision and research presentation.

Research supervision

The supervisory role was crucial in ensuring the research process was systematic, logical, and that an adequate audit trail was congruent with the methodology. A process of regular reflexive supervision took place to assist with transparency. For example, one supervisor with clinical expertise in forensic mental health and research questioned my

motivation for certain aspects of the study at times, guided me back to the literature, and encouraged me to provide justification for my thinking to reduce bias. The researcher applied the expertise of other supervisors with methodological expertise and extensive knowledge of the law/mental health interface. Many pre-existing notions I had were constructively challenged. In addition to the supervisors' expertise, the participants' expertise contributed considerably to the reflexive process.

Field notes were kept regarding interviews and discussed with supervisors during debriefing post interviews. Reflective notes were kept by the researcher throughout the study and discussed with supervisors.

Research presentation

In addition to regular individual supervision sessions, a yearly presentation of progress with fellow DHSc candidates and their supervisors provided a safe but challenging forum to discuss work and defend the research design.

Presentation of the research to groups familiar with the context (nursing colleagues and CLNs) allowed for reviewing and checking the credibility of the research, as well as critical examination of the researcher's analysis.

Ethical implications and consent

Ethical considerations relevant to this study incorporated truthful representation of the findings made throughout the research process. Prior to commencing the research, ethical approval for the research was received from the Multi-region Ethics Committee (MEC) on 30th of September 2010. Criteria were met for minimal risk expedited review as described in the Ethical Guidelines for Observational Studies 11.13 (Ministry of Health, 2006). AUT University Ethics Committee granted ethical approval. This required the ethical dimensions relating to informed consent and confidentiality to be considered in relation to all the data collection methods.

The following steps took place associated with seeking ethical approval and support to carry out the research:

- 1) Informal discussion occurred with people in key positions such as the Nurse Director of the Southern District Health Board (SDHB) to assess the level of support for the research prior to gaining formal ethical approval.

- 2) Support was sought from the New Zealand Forensic Psychiatry Advisory Group (NZFPAG) which consists of forensic mental health service Directors and Managers.
- 3) As the lead District Health Board (DHB), ethical approval processes were completed with the Southern District Health Board. Refer to Appendix A for locality approval.
- 4) Local agreements were negotiated with each DHB and Regional Forensic Mental Health Service for approval to carry out the research. This involved approval to approach managers of their Forensic Mental Health Services and hence court liaison nurses. The process involved contacting the relevant research centre within six DHBs (Waitemata, Central, Capital and Coast, Canterbury, and Southern). Each DHB had its own criteria and processes regarding obtaining a local agreement to contact and carry out research with their staff. Refer to Appendix A for locality approval. The Managers or Team Leaders of all the Regional Forensic Mental Health Court Liaison Services were contacted by the researcher to ascertain how many surveys to send to each region. The aim was to include all nurses who cover the CLN role in each region.

It was recognised that participating in the research and disclosing potentially difficult and ethically problematic practice scenarios may result in participants experiencing distress. Therefore the availability of a counsellor was arranged with AUT Health and Wellbeing Services should this be required. Refer to the Participant Information sheets (Appendix C), Consent forms (Appendix C) and AUT Health and Wellbeing letter (Appendix F).

During the development of the proposal, consideration was given to having an identified process to follow if a participant disclosed unsafe nursing practice. Following rigorous discussion with the supervisors it was decided that the participants were experienced nurses who were practicing autonomously and that it was highly unlikely that this scenario would ensue. However, to protect both the participants and the researcher this was discussed at the start of each in-depth interview. Participants were informed that if any concerning nursing practice was disclosed, the researcher would be obligated to discuss the concerns with the participant and if the matter could not be resolved the researcher would discuss the concerns with the supervisors for further advice. Issues such as uncovering unsafe or illegal nursing practice did not arise during the data collection phase and there was no need at any stage to follow through with this plan.

Seeking informed consent and maintaining confidentiality

Obtaining informed consent implies a process has been undertaken in which participants have received information and understood the research, and are able to refuse or consent voluntarily to participate in the research (Polit et al, 2001). Full explanation of the study was provided in Information sheets (Appendix C). Return of the completed survey questionnaire implied consent (Appendix D). Written consent was obtained from the in-depth interview and data collection activity participants (Appendix C). The survey questionnaires collected no identifying details and were therefore anonymous. Once the completed survey questionnaire was returned by the participant to the AUT Administrator, withdrawal of the information provided was not possible. Withdrawal from participating in the in-depth interviews was possible up until the interview had been conducted. Withdrawal from the audit was not possible once the completed data collection tool was returned to the researcher.

All steps possible were taken throughout the study design and implementation to ensure the anonymity, privacy and confidentiality of participants. Details of the voluntary and confidential nature of the research were outlined to the potential participants in the information sheet and consent forms. These details were reiterated at the commencement of each in-depth interview. All six participants indicated they understood this issue and the steps the researcher would take in the final presentation to maintain confidentiality and anonymity as much as possible. The final report was returned to the participants for reviewing and checking.

Maintaining anonymity and confidentiality in a small group that practiced in a public forum presented particular challenges. In addition to employing pseudonyms, some detail such as descriptions of work settings, timeframes and details of specific incidents from the practice stories, were altered to ensure the CLN involved could not be identified. It was particularly important to the integrity of the research that the participants felt confident their responses would be kept private and confidential and their anonymity would be protected as far as possible.

Participants have the right to expect that any information they share during the study will be kept in the strictest confidence (Polit et al, 2001). Only the researcher had access to the raw data (survey questionnaires, interview transcripts and data collection activity and database with individual names). The supervisors only had access to data relayed electronically with the researcher. Raw data was kept in a locked drawer in the

researcher's office at the Southern District Health Board in Otago whilst being used. Once the raw data from the Survey and Audit was entered on to a database and the interview transcripts transcribed, the original surveys and interview tapes were returned to the AUT University administrator to be stored in a locked cabinet for six years. At the end of the six year period the raw data has to be destroyed. Only the researcher, the supervisors and AUT Administrator had access to the raw data held in a locked cabinet at AUT University.

Confidentiality agreements were signed by the AUT Administrative assistant who received the anonymous survey questionnaire at the AUT Akoranga Campus and the Transcriber for the interviews (Appendix E). The research focus was on nursing practice, therefore no identifying information regarding the person being referred to the court liaison nurse was collected at any stage of the research.

Cultural consultation

As with any healthcare practice and/or research in New Zealand there is a commitment to the Principles of the Treaty of Waitangi. Any research with people requires thoughtful consideration of the ethical and cultural implications of the study (Davidson & Tolich, 2003). Therefore, obtaining cultural advice was one of the key components of this research. Consultation occurred with a cultural advisor regarding ethical and cultural implications for Maori of all stages of the research from development of the proposal, developing the research tools, interview protocol, and analysis.

Prior to commencing the research discussion was held regarding how to approach the Kaupapa Maori court liaison service. Therefore developing a relationship with the manager of that service to facilitate participation of the court liaison nurses in the research was commenced. The researcher consulted with the Manager of the Kaupapa Maori court liaison service prior to the commencement of data gathering.

Furthermore the Clinical Director of that service was the Chairman of the NZFPAG. Approval and support for the research had been sought and given by the NZFPAG. Therefore the Clinical Director was aware of the research. Ultimately the Kaupapa Maori court liaison service did not consent or participate.

The discussion with the cultural advisor during interpretation of the data generated meaningful insights and reflection for the research. For example the cultural advisor

generated valuable discussion with the researcher regarding over representation of Maori in the criminal justice system and the likely demographics of the CLN group. The reasons for highlighting this became clear when the statistics regarding people appearing in the criminal justice system and demographics of the nursing population were reviewed. Controlling for population, Māori are apprehended for committing at least three times the number of offences as Europeans (Department of Corrections, 2009). Thus, cultural competence is fundamental to CLN practice, and more broadly, knowledge and implementation of the principles of the Treaty are fundamental to nursing practice in New Zealand. Consequently, the research explored issues pertaining to access to relevant cultural assessment. The cultural advisor encouraged the researcher to think more widely and consider whether any recommendations could be made from the research in relation to education needs for CLNs with respect to cultural matters.

Summary

This chapter explained the qualitative descriptive methodology and the philosophical position of the research, aided by the appendices. The course of action taken to obtaining ethical approval was outlined. How the research addressed credibility was established.

Comprehensive background information regarding this cohort of nurses was obtained through the use of a qualitative descriptive methodology and mixed method research design. The research design also enabled broad description about the nursing practice and teasing out of the complications these nurses face.

Chapter Four: Findings survey questionnaire

Introduction

This chapter provides the findings from the survey questionnaire. The mixed method research design was constructed to capture both specific demographic and practice details, as well as the perspectives of the participants. To meet this end, the survey questionnaire incorporated both qualitative and quantitative aspects. The rationale for the methodology and research design is outlined in detail in Chapter Three.

The 58 item survey questionnaire consisted of four sections. Section One elicited demographic information to describe the profile of this group of nurses and details regarding practicalities of the role. Section Two recorded details relating to preparation for the role, education and training. Section Three explored supervision and support. Section Four examined working relationships and specific challenges to practice.

To assist with analysis the returned individual questionnaires were numbered. The number of the individual questionnaire is included in brackets at the end of participant's quotes.

Response rate

Of the forty one (N = 41) survey questionnaires sent out, twenty eight (68%) were returned with confirmation of practice in the court liaison nurse role in New Zealand. Considering average response rates for mail surveys range between 58-61% (de Leeuw et al, 2007), the response rate was satisfactory.

Findings

Section One: Demographic and role details regarding nurses

Details about gender, ethnicity, age, length of time as a CLN and qualifications were elicited. Information pertaining to the CLN role, such as courts and list days covered, and other nursing roles covered were revealed. Finally resources available to the nurse were explored.

Demographic characteristics of sample

Table 1: *Socio-demographics of participants in the survey*

Socio-demographic variable	Number of responses (N = 28)	Percentage
Gender		
Male	13	46
Female	15	54
Ethnicity		
NZ European	20	71
Maori	4	14
Indian	1	4
Pakeha and Maori	1	4
British	2	7
Age in years		
30 or below	2	7
31-40	5	18
41-50	5	18
51-60	9	32
61+	7	25

The gender mix was relatively equal (see Table 1). Over three quarters of nurses identified as being of European or British ethnicities. Eighteen percent of nurses identified with Maori ethnicity (see Table 1). This figure is approximately representative of Maori in the general population according to Statistics New Zealand's data regarding demographic trends (2012). Maori comprise approximately 16% of the total population (Statistics New Zealand, 2012). In terms of ethnicity statistics, the 18% NZ Maori ethnicity for court liaison nurses is double the 7% NZ Maori ethnicity statistic for all nurses in New Zealand, but in line with the 16% of nurses who practice in community mental health who identify as NZ Maori (NCNZ, 2012).

This group of nurses fit with the profile of community mental health nurses according to NCNZ statistics (2012) with an exception regarding age. The participants ranged in age from twenty seven to sixty four years. The average age of the participants was fifty five years. 57% of those responding to the survey are fifty-one years of age or over (see Table 1). This number is greater than the 41% of all nurses in NZ who were aged fifty years or older (NCNZ, 2012).

Qualifications

Of the N = 28 participants nineteen (68 %) CLNs indicated they have completed post-graduate study (see Table 2). Of that nineteen, (n = 11; 40 %) completed study specific to forensic mental health. Apart from a focus on forensic mental health the academic emphasis of the remaining (n = 8) 28% was on trauma, and service delivery to a specialist child and adolescent population.

NCNZ statistics for post registration qualifications indicate that 66% of community mental health nurses and 46% of all practicing RNs have a post registration qualification (NCNZ, 2012). 68% of the CLNs had a post registration qualification. When that data is compared to the above NCNZ (2012) statistics, the level of commitment to post-graduate education by CLNs is heartening. The data suggests the CLNs are a highly educated group.

Table 2: *Highest qualification of participants in survey*

Highest qualification variable	Number of responses (N = 28)	Percentage
No higher education	8	28
Post-graduate Certificate	7	25
Post-graduate Diploma	9	32
Masters	3	11
No response	1	4

Role details

Work profile

All of the participants (N = 28) confirmed they have a role/job/position description. Twenty-one nurses (75%) advised they were Duly Authorised Officers (DAO) for the purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). DAOs are health professionals who have been designated and authorised by a Director of Area Mental Health Service (DAMHS) to perform certain functions and use certain powers under the MHA. This is a statutory appointment. There is an expectation that DAOs will have relevant training and experience in order to contribute to the assessment and treatment of people with mental health problems (Ministry of Health, 2012). McKenna & O'Brien (2013) noted practicing as a DAO to be a complex and

demanding role. This involves balancing the “need for treatment, the assurance of public and personal safety and the protection of service users’ human rights” (McKenna & O’Brien, 2013, p.198).

Table 3: *Work profile of participants in the survey*

Variable	Number of responses (N = 28)	Percentage
Length of time in CLN role		
< 1 yr	4	14
1-5 yrs	10	36
6 – 10 yrs	7	25
11- 15 yrs	5	18
16-20 yrs	2	7
Type of court worked in		
District court only	12	42
Youth court only	1	4
High court only	1	4
District/youth/high courts	3	10
District/youth courts	1	4
District/youth/high/family courts	1	4
District/high courts	9	32

The profile indicates the participants were an experienced group of nurses practicing from five to forty two years as registered nurses (mean 22, SD = +/-10.8) with one to eleven years as CLNs (mean 6.9, SD = +/- 5.1). Fifteen years was the average number of years experience as a registered nurse prior to becoming a CLN. A number of the nurses had considerable longevity in the CLN role (see Table 3). Across twenty eight participants there was 194 years’ collective experience as CLNs and 615 years’ experiences as RNs.

In order to elicit details relating to the extent of the CLN role, the nurses were asked to provide information regarding types of courts and list days covered, hours worked in the CLN role, and other health sites visited in the course of carrying out the CLN role. CLNs provide regular cover to District Courts on “list days”. A list day in court involves defendants’ first appearance in a summary jurisdiction court. List days are referred to as either the "list court", "first call court", "police court", or "arrest and bail court" (Searle, Slater, Knaggs, November, & Clark, 2004).

In terms of the type of courts the CLNs worked in, half worked in a single type of court whether that be the District Court, Youth Court or the High Court (see Table 3). The other half worked in a combination of these court systems. Working between Youth, District, and High Courts requires the nurses to have a wide range of knowledge regarding specific legislation and assessment skills when working with people across the age spectrum from youth to adulthood.

CLN cover provided to courts on list days ranged from one list day per four weeks to twenty-eight list days per four weeks. The average number of list days covered was sixteen (SD = +/- 7.869). Three participants did not respond. Nurses who practice across multiple roles and courts help explain the range of list days covered by individual nurses. For example, some nurses were employed in prison liaison and psychiatric district nursing roles and either provided cover for the CLN role or were employed to work a set number of hours in both roles. One nurse solely covers Youth Court for four list days per four weeks.

In terms of the range of the nursing practice, a minority of the participants (n = 9; 32%) indicated they practice solely as court liaison nurses. The majority (n = 18; 64 %) also cover other nursing positions. Five nurses (18%) practiced less than twenty hours per week in the CLN role, employed firstly as either forensic prison liaison nurses or forensic psychiatric district nurses. Forensic prison liaison (n = 15; 54%) and forensic psychiatric district/community nurse roles (n = 9; 32%) were the most common other roles carried out by the CLN. The other positions covered included: forensic inpatient staff nurse, after-hours crisis, assessors in police cells, and community mental health and liaison.

These dual roles help to explain the weekly hours worked by nurses in the CLN role. The participants in the study worked on average 33.37 hours (SD = +/-13.3) per week in the court liaison nurse role. Two nurses (7%) indicated they routinely worked over 40 hours per week, 42 and 45 hours respectively.

The nurses identified which sites they visited over a four week period from a list of five sites. The sites included: forensic mental health service; community mental health teams; police station; other hospitals; inpatient units at different locations. Twenty-six (93 %) of the nurses indicated they visit at least one "other site" over a four week period. Twenty-one (75%) of the nurses visit multiple sites over a four week period.

Working conditions at court/access to resources

In order to function effectively, efficiently and professionally, CLNs must have access to resources and tools. CLNs were asked to identify whether they had an interview room available to use at court, whether they had a computer to use at court, and if they did, whether they were able to access health records and information from the DHB whilst at court.

Most importantly, it is imperative that individuals' privacy is maintained during health assessments. To do so requires access to a room to conduct assessments. Timely access to clinical information to inform assessments and subsequent recommendations provided to the court is also required.

Therefore, the impact of working conditions and access to resources were explored. The survey found the working conditions the CLNs experienced varied. Only half (n = 14; 50%) of the nurses had access to all of what are considered reasonable tools and working conditions to carry out their role, namely: an office or dedicated working space at court, a room to interview people in privacy, and access to a computer and health records with their respective District Health Boards while at court. Two CLNs (7%) did not have access to any of these. Of particular concern, 40% (n = 11) of the nurses did not have access to a computer at court. Many implications stem from the lack of resources.

A key part of the CLN role is to provide timely, accurate and professionally presented advice to the court. The absence of immediate online access to DHB clinical information systems delays obtaining information and timely reporting to the court. Not being able to type reports has implications in presenting information to the court in a professional manner. Advantages can also be found in relation to effective use of time through electronic systems rather than presenting handwritten reports to the court, both on the spot at court and later in copying and filing documentation for DHB requirements.

Section Two: Orientation, education and training requirements

This section outlines the key features regarding preparation to practice in the CLN role. Following on from this, access to relevant ongoing education is detailed. The data was

grouped into the following two main categories: orientation, and education and training pathway, with subcategories.

Orientation to the CLN role

Only half (n = 14; 50%) of the CLNs in this study indicated their orientation to the role was adequate. Disturbingly a further two (7 %) indicated this question was not applicable because they did not receive any orientation to the role. Five (18 %) CLNs indicated they had an adequate to excellent orientation. However, when asked to comment on what additional training would have been helpful in their induction, twenty one (75 %) of CLNs provided detailed suggestions regarding necessary content of an orientation. These responses were analysed into the following four categories: alienation-educational preparation required, extended support, professionalism in legal system, and the ideal.

Alienation-educational preparation required

The data expressed there was an absence of preparation and this either explicitly or implicitly linked to CLNs sense of alienation. The primary issue identified regarding orientation was for education relating to the legal system. Explicitly, the nurses recommended prior induction to law, in particular education regarding relevant legislation, what the terminology means and its application.

CLNs described the legal setting as a discrete foreign terrain. They highlighted there was a need for guidance and formal training regarding legal processes and court protocols. The fact that the practice setting was a very distinct environment was emphasised through the CLNs comments about not understanding the terminology, for example “*charges laid indictably (or not)*” (24). References were made to obtaining insights about court protocols which indicates another level of understanding required to be able to navigate their way around in that context.

Indicative of the lack of orientation and the ability to pass knowledge from outgoing to incoming CLN, many CLNs noted they required to be informed of basic details such as how to contact other services and who to speak to within the services.

Two nurses who routinely practice in other forensic nursing roles but “fill in” for CLNs touched on the sense of “difference” and “alienation” compared with their usual nursing role. They reported on their knowledge deficits regarding legislation and legal

processes. *“I work mostly as a prison liaison nurse and simply cover the court liaison nurse when he is on annual leave. The court system is hard to get my head around! But court gets easier each time”* (3).

These examples capture the pervasive work ethos of CLNs who “just get on with it and do the job”. Perhaps this explains the success nurses have had in crafting a role without formal support and training. This CLN relieved in the courts while his or her colleague was on leave. *“I feel inadequate to the court/legal process. I have the Act etc to follow, it is just a matter of getting on with it and learning about all the legal jargon”* (7). Not only did the nurses suggest “induction” and a “working knowledge” was required, the need for “formal training” was consistently emphasised with respect to the legislation and court procedures. A sense of disconnection experienced through inadequate role preparation was evident and expressed explicitly.

Extended support

Following on from recognition that the CLN role required particular knowledge were recommendations regarding length of the orientation and longevity of the support *“The best training would be to have a court liaison nurse with experience working beside the person being inducted into the role”* (21). The ability to provide more support and guidance through “shadowing” by an experienced CLN for a longer period of time than a routine orientation was deemed necessary. CLNs suggested a more structured four-week orientation rather than two weeks was preferable.

CLN practice is so far removed from the usual nursing practice situation that the many and varied scenarios the CLN will need to navigate their way through are not likely to occur during a two week orientation. It is generally accepted practice that for experienced nurses a two week orientation is adequate in inpatient settings or community mental health teams, because there is the on-going ability to draw on colleagues around them. *“The ideal would be to buddy with an experienced CLN for a good period of time – maybe a month or so”* (14). The CLNs suggested this length of time was necessary because it was unlikely the different situations they would need assistance with will occur within two weeks. Relevant clinical support is imperative for CLNs to have confidence in their assessment and role and in delivering their recommendations in that setting.

Not all courts function in the same manner; there are environmental and operational differences between High, District and Youth Courts. Access to cell blocks, interview rooms, phones, court staff, and knowledge of court protocol is dependent on individual court processes. As referred to by this CLN, *“To cover three courts I was orientated for two weeks. Had not visited two of the courts I was expected to cover”* (16). Therefore, the potential is for a negative impact on efficiency, if the orientation is not thorough and the CLN has not been introduced to the relevant staff and processes.

Most CLNs do not have experienced CLN colleagues around them with whom to discuss practice with. The CLNs expressed the need for senior CLNs to transfer knowledge to novice CLNs. They draw attention to the need for the orientation and support to involve both an educative component regarding the justice system and legislation, and guidance on the floor with practical clinical support on a daily basis. The CLN may be intimidated if not accustomed to the formal court environment.

A longer period of orientation would create a base level of knowledge to develop the speciality area of practice. Ultimately, this would benefit people with mental health concerns in the justice system.

Professionalism in the legal system

Well developed communication skills are fundamental to nursing, but are absolutely crucial in this environment. CLNs are not prepared for the role and the foreignness of the setting, as evidenced by comments such as needing guidance regarding being able to stand and speak confidently. Additionally, they are expected to write professional reports to the courts. CLNs clearly articulated the need for education around communicating both in writing and verbally in the court environment, and learning court etiquette.

Similarly, in support of the strangeness of the setting, CLNs suggested the orientation should include *“Things to avoid”* (10) and *“How to cope with cranky judges and/or legal egos”* (10). The CLNs specified that to be able to work within the environment and successfully traverse the mental health/legal interface requires better understanding of justice processes and the law pertaining to mental health issues.

CLNs identified writing a report for the court requires particular consideration in relation to the court situation. They suggest this entails a knowledge of legal processes and pathways, when to comment and when not to comment, patient rights and informed

consent, for example *“So not just writing a professionally presented ‘business formatted’ letter but thinking about what is appropriate to share within that context...”* (16). There is a particular skill and knowledge required in providing information in an open public forum to the court. Mental health nurses are used to practicing in a health context where the sharing of information is clearly governed by their individual DHB policies, and overarching privacy legislation.

These comments are suggestive of a radically different experience to previous mental health nursing contexts. This dilemma is encapsulated in the following participant comment: *“Ways to convey information verbally for legal professionals that separates the ‘care’ component from the court component”* (10). Information exchange within the court setting was explored further during the in-depth interviews. The CLNs expressed a desire to present as professionals but found they were ill equipped to do so from their existing knowledge base and their CLN orientation. Hence the expressions of feeling alienated and undervalued can be understood with this background.

The ideal

Finally, while the CLNs were asked to comment on what would have been helpful in their orientation, comments were also provided by five (18%), of the CLNs who indicated that their orientation was adequate to excellent. The successful common elements included extensive support with an experienced CLN, clinical supervision and mentoring from a CLN, six month secondment to CLN role with CLN and, ultimately, a comprehensive orientation:

Orientation to and introduction to – community mental health service, structure and services provided, managers/charge nurses of [the] forensic inpatient units, role expectations of court liaison. Formal explanation by court of expected protocol/boundaries with Judiciary and all court network (6).

Interestingly, these five CLNs had a background of previous forensic nursing experience. This may be relevant in terms of a pre-requisite for the CLN role. They also indicated specific post-graduate education incorporating forensic psychiatry and the law papers was crucial.

Education and training pathways

Data regarding the nurses’ opinions about the desirability of role specific educational or training pathway and communication with the wider CLN group follows. Twenty-three (82%), of the CLNs agreed there should be a formal specialised education/training

pathway to practice in the court liaison nurse role. There was one (4%) no response and four (14%) of the CLNs did not think there needed to be an educational or training pathway for the role.

The strong perception throughout the study was that CLNs' understanding of the role and the environment came through the day-to-day exposure and seeking out information themselves. CLNs were not satisfied with this situation. The following statement typifies the pervasive sense of discontent: "*The lack of educational opportunities is disappointing and may ultimately be a reason I move on*" (18). Participants reported that opportunities for ongoing professional development were limited for CLNs, and that education should not cease after orientation. On the other hand, the four participants who were happy with the status quo were focussed on performance and did not envision any benefits from an educational pathway.

A much mooted idea that a solid background in mental health nursing, as well as knowledge of mental disorders and legislation was required prior to commencing in the CLN role was evident. "*The hope is that nurses work in inpatient areas after registration that will expose them to good clinical learning before being appointed to senior clinician posts such as court liaison*" (10).

Four main themes emerged regarding education and training. The responses echo the data regarding a comprehensive orientation but with more elaboration, description and detail. Suggestions for a formal educational pathway range from a requirement for three years post registration experience before commencing in a CLN role, to a post-graduate pathway that included a post-graduate certificate and perhaps work towards a Masters Degree or nurse practitioner scope of practice.

Theme One - Defining parameters to the role

The nurses plainly convey that there need to be parameters outlining the CLN role with appropriate education and training implemented. Within this theme, the nurses' proposals were collated into the two sub groups: court liaison service and CLN role - functions and responsibilities: and liaison, systems and roles of others

Court liaison service and CLN role – functions and responsibilities

Role expectations and definitions for court liaison nursing are required. The potential for role confusion was expressed. This is indicative of the need for a framework and

standards for practice to provide guidance for the CLNs. A need for clear outlines of the role of the court liaison service and CLN role within forensic mental health and general mental health services was expressed.

Specific aspects of CLN functions were suggested as requiring formal education for practice, such as mental health, intellectual disability and risk assessment, conducting interviews, DAO role and communicating in the courtroom (both report writing and verbal).

The need for guidance regarding the role of the nurse in this setting was revealed:

“Primary aspects and expectations of the role within court along with potential conflicts of focus (as a nurse)” (6). The complexity of the nurse’s practice was apparent as this statement exemplifies: *“‘The Big Picture’ (What and why you are at court). ‘The small picture’ (WHO to help and why - when to intervene and when NOT to)”* (15).

Understanding of the wider socio-political context and discerning where the boundaries of the CLN role may lie are currently learnt on the job.

Liaison, and systems and roles of others

The need to understand the wider liaison aspect to the role and links to external services, stakeholders and agencies featured strongly. The participants outlined services and organisations they required understanding of and relationships with including: community corrections, prisons and prison nurses, lawyers, court staff, Child Youth and Family Service, youth aid, victim advisors, regional intellectual disability care agency (RIDCA), mental health services and forensic mental health services.

Furthermore, actual knowledge of the purpose of the role of others was stressed: *“As this is a specialised area, training should be available for a training pathway to become familiar with legislation, court, prison, police, probation services and systems”* (12).

Collaborative inter-professional and inter-agency relationships were explored in part four of the survey questionnaire.

Similarly to the suggestions for orientation the importance of understanding how systems work was emphasised for example, *“Court procedures from bench to bail room”* (5). Working with external agencies and services required an understanding such that flexibility in their thinking and approach was needed.

Significantly many CLNs expressed having a clear understanding of forensic mental health services and the interplay with wider mental health services was deemed necessary, for example, “*understanding dividing lines of responsibility between forensic psychiatry services and general mental health services*” (6).

Theme Two: Education - legislation and law

It was overwhelmingly clear that there is a necessity for education regarding legislation and law. This emphasises the intense learning undertaken by the CLNs and the requirement for this knowledge to translate into competent practice. However, there is a shift here from orientation to legislation and from becoming familiar with terminology to the need for in-depth understanding of intended principles of the acts and understanding of the actual practice of the acts. As one person reported, “*Comprehensive training in legislation and precedents and relevant judicial decisions is essential*” (15). Furthermore, there were suggestions that the nurses’ knowledge base should be extended through education encompassing criminology, law and mental health law.

Multiple participants listed legislation and specific parts of acts and sections they required education in, for example; Criminal Procedure (Mentally Impaired Persons) Act (CP(MIP)Act 2003), Mental Health (Compulsory Assessment and Treatment) Act (MHA), Summary Proceedings Act, Criminal Justice Act, Intellectual Disability (Compulsory Care and Rehabilitation) Act (ID(CCR)Act 2003), Children, Young Persons, and their Families Act, Bail Act, and Sentencing Act, and relevant amendments.

The CLN involvement with the client does not necessarily end after the initial assessment and provision of advice to the court. CLNs continue to follow cases through the court process often acting as a link between the parties and health services. Often CLNs are asked to explain what is happening at court, even by lawyers. Therefore, the CLNs’ articulate in-depth training regarding legislation pathways was necessary. The CLNs reported that they need to be able to be competent and confident.

Finally, incorporating feedback from the core people/organisation concerned should form part of any professional development education programme as suggested: “*Feedback from lawyers and judges and CLIENTS*” (15).

Theme Three: Possibilities for a post-graduate pathway

CLNs drew attention to the idea that a post-graduate pathway could lead to motivation to complete a Masters pathway with a forensic mental health nursing focus.

Furthermore, a pathway to nurse practitioner featured as a possibility:

Ultimately a pathway to nurse practitioner would be appropriate with adequate post-graduate academic and clinical mastery. This would highlight the expertise required for the role and therefore hopefully be recognised as a clinical specialist position. This would allow the consideration for court reports to be completed by nurse practitioners and will showcase nursing knowledge as a respected profession (27).

CLNs proposed there should be identified requirements to practice in the CLN position such as more than three years experience as a RN. A small number recommended CLN education was incorporated in post-graduate courses. However, they also pointed out there is a risk that the CLN role specific education becomes lost in generic courses.

Theme Four: The need for a national forum

The CLNs were unanimous in articulating the need for, and benefits of, a national forum for CLNs. This statement portrays the isolated position in which most of the CLNs practice and hence a reason why inter-region and national contact should be facilitated: *“I am not sure what the answer is; I would like to know what other regions do”* (9). Their responses have been grouped into two main categories: support, and national educational workshops.

Support

Peer support

Overwhelmingly, all of the CLNs (N = 28; 100%) indicated that a formalised means of communicating as a group of nurses to discuss nursing practice issues in the court liaison role would be useful. Twenty six (93%) indicated that all of the following aspects of a peer support group would assist them: educational opportunities; information sharing; peer support.

The nature of the contact with CLNs outside of their own region was explored. The research sought to ascertain whether CLNs communicated with other CLNs inside or outside of their region. Fourteen (50%) of the CLNs indicated they discussed practice with CLNs outside of their region. Of those the majority (n = 10; 36%) indicated this

was an informal arrangement, for example, on a “need to” basis for specific issues. The most common reasons for seeking out contact with CLNs outside of their own region involved the passing on of information regarding immediate practice situations.

For a small number of CLNs, regular prearranged contact with other CLNs occurred for the purposes of clinical supervision and peer support. This is discussed in Section Three.

Organisational support

Not being able to allocate the time needed featured frequently in relation to peer support, education and training and clinical supervision. This was coupled with a sense of not feeling supported to do so by management and senior nursing colleagues for example, “*Managerial understanding of the role, pressure and depth of knowledge that is required*” (2). It was suggested that the dynamics of the role were not understood hence leading to feelings of being undervalued.

National educational workshops

The need for annual CLN specific educational workshops and conferences featured strongly in the responses. Other suggestions included: teleconferences, blackboard, and email forum for communication. The important message was that it was considered regular contact with other CLNs would be useful. The CLNs highlighted the value of dialogue with peers to discuss practice scenarios, and ethical issues. They called for continued mentorship and several reiterated that routine meetings with other court liaison nurses, “*would be a GREAT help*” (7). Participants described the many benefits of the historic national CLN fora, which no longer occur due to fiscal constraints.

National guidelines/templates

The development of national templates, guidelines and standards for CLN practice was a common recommendation. One participant suggested standards could be “*endorsed by NZNO and NZCMHN*” (27). Ideally, standards would be implemented and corresponding “*Training/workshops would be advantageous for the beginning practitioner in the role...//... with ongoing training*” (28).

Annual or more frequent CLN national fora would focus on practice competencies such as, “*How to achieve Nursing Council requirements in an environment where we don’t*

get a lot of opportunities to attend study days” (26). Difficulties CLNs experienced with meeting formal professional development requirements surfaced during the in-depth interviews. These are discussed further in the next chapter. Furthermore, it was suggested that if CLNs had a consistent standard of practice this may be useful when visiting judges attend their court.

Finally, the value of getting together as a group of CLNs to deliberate about practice is encapsulated in this statement: *“I think people often get caught up in the complexities and miss what we are actually there for, which could compromise people’s care from forensic services” (26). This CLN’s comment emphasises the potential for the nursing to become diluted within the justice setting.*

Section Three: Supervision and opportunities for dialogue about practice

This section explored access to and barriers to clinical supervision, and other opportunities utilised to reflect on and discuss practice.

Clinical supervision

CLNs are often the sole health professional in the court, with limited ability to contact colleagues for advice and restricted timeframes within which to work. The CLN needs to get to know a diverse range of professionals and understand their ways of working. To achieve this they have to establish collaborative relationships with them.

Significantly, there are limited opportunities for CLNs to contact and discuss scenarios with colleagues who are familiar with the context while they are at court. These factors emphasise the need for access to regular robust clinical supervision.

Twenty-one (75%) of the participants were engaged in receiving clinical supervision. Eight (29%) of those nurses engaged in clinical supervision indicated that it did not meet their needs as a court liaison nurse. Seventeen (61%), CLNs provide clinical supervision, however only nine (32%), of those nurses provide clinical supervision to court liaison nurses.

Despite twenty-one (75%), of the CLNs being engaged in clinical supervision fourteen (50%), of the CLNs provided insights as to how access to and quality of clinical supervision could be improved. Two overarching themes emerged in response to being

asked how clinical supervision could be improved, and barriers to receiving clinical supervision.

Improving quality and availability of professional clinical supervision

CLNs reported the importance of the supervisor having experiential knowledge of the CLN role. A requirement for a clinical supervisor to have clinical credibility in the field and understanding of the complexities that come with CLN nursing was strongly articulated. *“Supervisor would ideally have previously worked or is working in the court liaison role for at least one year. At the very least a good knowledge of the court process, legislation and complexities of working in court environment”* (27).

The next most prevalent expression was that regular clinical supervision should be available to all court liaison nurses: *“CLNs should receive regular clinical supervision. Autonomous role, often don’t get the opportunity to discuss practice/concerns with colleagues. If don’t set formal times practice could become unsafe”* (26). This comment emphasises the importance of opportunities to reflect on the role of the nurse within the court setting.

CLNs suggested that engaging in and providing clinical supervision should be compulsory: *“Become supervisor role 12 months as a CLN”* (22). Therefore, using CLNs from other DHBs as clinical supervisors would assist with availability of clinical supervisors. Other suggestions included considering formal facilitated group supervision, and provision of more training in clinical supervision.

Finally, the potential of technology to overcome access barriers to clinical supervision and meeting as a group was put forward. It was suggested that this may provide the means to enhance opportunities to engage in supervision with persons who understand the intricacies of the role. Technology could be used through the use of teleconference or videoconference facilities. This appears to be working successfully for one participant who found peer supervision through telephone was the most beneficial element for them in terms of support. Although, as one CLN shared, *“Video conferencing and telephone conferencing hasn’t proven effective in breaching the gap. Most regional nurses observe timetable clashes”* (10). If technology is used for the CLNs as a group, there may need to be a nominated facilitator.

Barriers to engaging in regular clinical supervision

Time, availability of clinical supervisors and geographical issues were noted as the major barriers to engaging in clinical supervision. Commonly, the CLNs expressed not having the time to devote to clinical supervision.

Finding a clinical supervisor from a small group of nurses with the required clinical credibility was an issue: *“Difficult to access supervision that I feel has clinical credibility”* (15). Of concern was commentary related to clinical supervision not being available or offered.

The geographical spread of forensic mental health services in New Zealand and the resulting physical barriers to accessing face to face clinical supervision featured: *“We are rural. It would be great to have someone available LOCAL. It makes it a long day to travel just for supervision”* (7). This statement epitomises the challenges and frustrations experienced regarding supervision.

Many CLNs described utilising informal opportunities to discuss practice with each other in lieu of formal clinical supervision: *“Informal supervision via other nurses in [XX] region when required, other local nurse and myself discuss issues on an informal when required basis”* (15). However, informal arrangements were not adequate with CLNs attempting to find a clinical supervisor. One CLN noted, *“I have thought about seeking out a supervisor and paying for this service”* (7).

Other opportunities to reflect on and discuss practice

Due to the isolated nature of the CLN role and the many and varied scenarios they encounter, the CLNs were asked about opportunities available within their own service to reflect on and discuss practice. Fifteen CLNs (54%) indicated there were adequate opportunities within their own service for discussion and reflection on practice, with thirteen nurses (46%) indicating there were not. When asked to elaborate on these opportunities, twenty two (79%) CLNs provided comprehensive data as to what these opportunities were. Six (21%) responded that this was not applicable to them. The data overwhelmingly accents the importance of discussing practice with knowledgeable practitioners. The following categories became apparent: routine, less frequent but desirable, informal/opportunistic/collegial.

Routine

CLNs emphasised they need to be able to discuss their practice with clinicians familiar with the area: *“Being a highly specialised area of nursing, there are situations that are unique to this role and supervisors from other disciplines do not understand the details and stressors of the job”* (5). Therefore it is not surprising CLNs reported they required more contact with the forensic psychiatrists as a resource to assist with practice issues. The notion of having a *“designated psychiatrist team member”* (20) available to discuss practice issues was also raised during the in-depth interviews. If CLNs cannot obtain the expertise they require within their own discipline, utilising the expertise of other disciplines, in particular the forensic consultants, appears a sensible approach. Other avenues included discussing practice with clinical nurse specialists and other senior staff who had a background in forensic mental health nursing.

Routine *multidisciplinary team meetings* were listed as the most common forum for discussing practice. Daily and weekly handovers and various regular meetings were indicated as the other most common fora to generate useful dialogue.

Less frequent but desirable

Only five (18%) CLNs referred to yearly forensic team meetings, study and training days as opportunities for discussion on practice, for example, *“We are a regional team and our management ensures that all court liaison nurses have an opportunity to meet at least 2x per year”* (21). However, while such days are valuable, they may not meet the ongoing day to day needs of CLNs to be able to discuss practice.

The following excerpt details the sense of isolation the CLN experiences without suitable clinical and managerial support:

We have not had a regional meeting for several years. In my particular area we are a small team and I often do not feel supported or able to safely reflect or call upon some members for advice/support. The knowledge of the legislation and court process for some members is inadequate ...//... there is no support from management to ensure it happens. I frequently do not have any cover at the courts when I am on leave (even planned) (27).

The lack of management support lead to the CLN feeling undervalued.

Collegial/informal/opportunistic

Initiating informal collegial discussions with CLN colleagues within their own team and from other forensic teams was outlined as useful to discuss issues and take advice. However, these opportunities were often referred to as inconsistent and, although beneficial were not meeting an ongoing need for the CLNs. They relayed making the most of the moment: *“Of the professional support opportunities available, the most meaningful happens over lunch break”* (10).

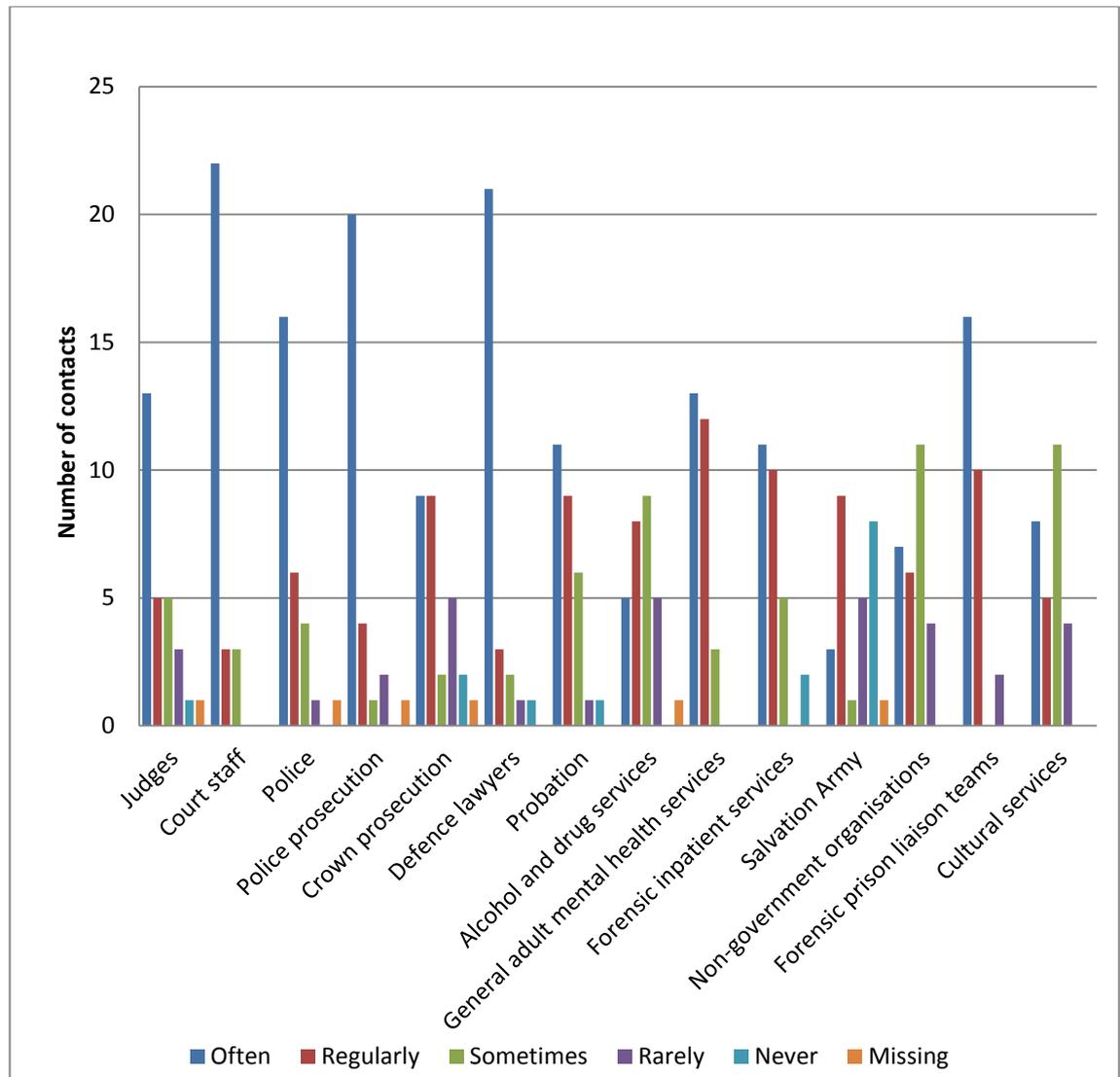
Section Four: Inter-professional collaboration, court diversion and nursing practice tensions

In order to gain understanding of difficulties CLNs face in carrying out the role the quality of and frequency of the contacts with other professions was explored. The CLNs understanding of court diversion and ability to facilitate effective outcomes for the person with mental health concerns is considered. Finally, complexities the CLNs may have encountered arising from the practice setting are outlined.

Inter-professional collaboration

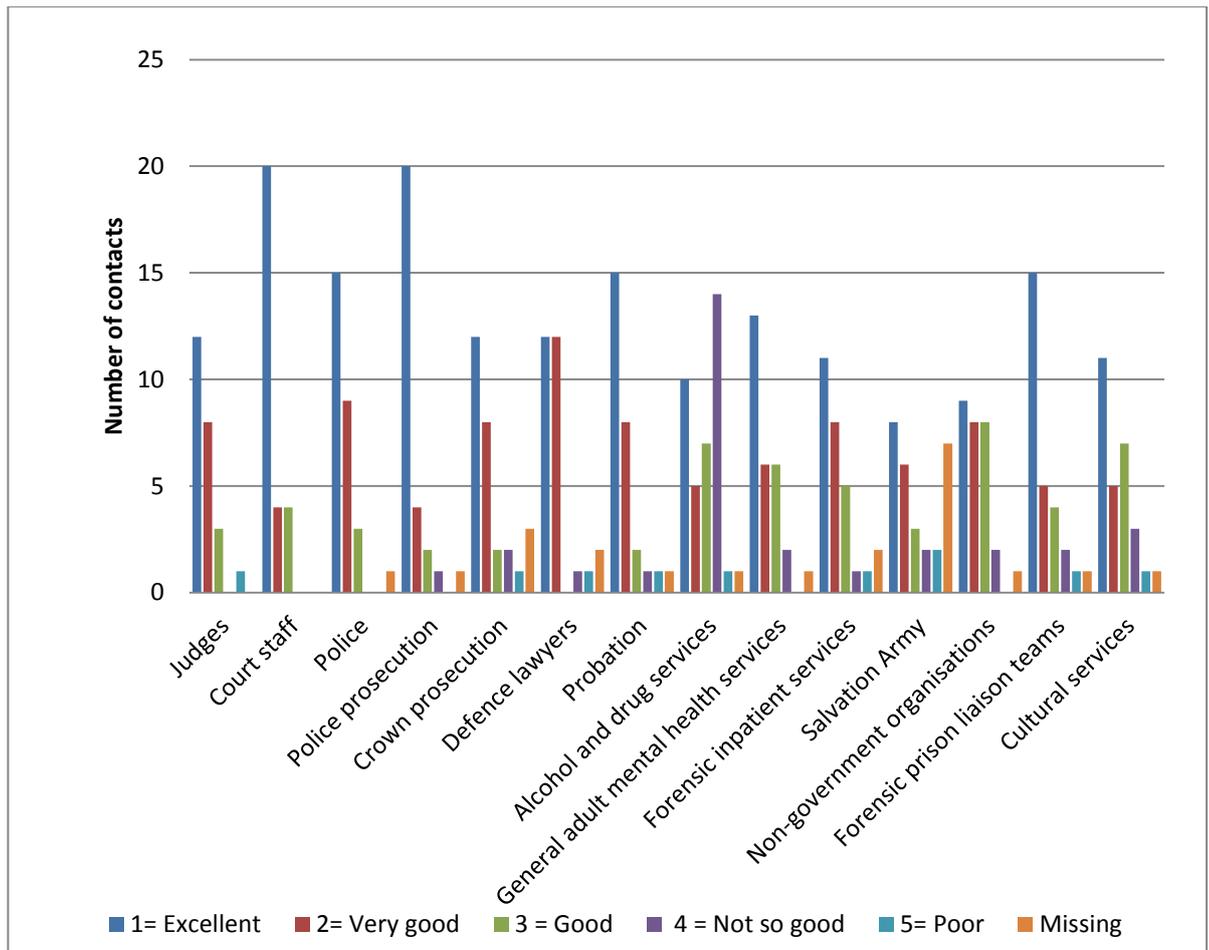
The complexities involved in facilitating health interventions in the court setting require not only interprofessional collaboration (Bethea, Holland & Reddick, 2014) as identified by Turnbull & Beese (2000) but more extensive interagency collaboration. In contrast to interprofessional collaboration whereby health professionals from various disciplines collaborate to achieve quality patient care (Hoffman, Rosenfield, Gilbert & Oandasan, 2008) interagency collaboration involves the sharing of information between agencies to achieve specified outcomes (Germundsson & Danermark, 2012). Interagency collaboration relies on a number of factors for success such as clear expectations of individuals, groups, and organisations and clear demarcation of roles (Germundsson & Danermark, 2012). Success within interagency collaboration relies on a common viewpoint or aims (Germundsson & Danermark, 2012). The success of the nurses in magistrates' courts in England required establishing communication, trust, credibility, and mutual respect (Turnbull & Beese, 2000). To ascertain the extent of and quality of the interprofessional and interagency relationships In the New Zealand context, the nurses were asked to rate the frequency of contact on a scale from Often to Never with specified professions/professionals and agencies and then the quality of the contact on a scale from 1 = Excellent to 5 =Poor.

Figure 1: Frequency of CLN contact with other agencies



CLNs had the most contact with court staff (n =22; 77%), defence lawyers (n =21; 75%), police prosecution (n =20; 71%), police (n =16; 57%), forensic prison liaison teams (n = 16; 57%), judges (n =13; 46%) and general adult mental health services (n = 13; 46%). Least contact occurred with the Salvation Army (n=3; 11%). Refer to Graph 1.

Figure 2: Quality of the contact with other agencies



However, when the data for the quality of the contact is reviewed, the figures level out (Refer to Graph 2). Quality of the contact was rated “excellent” equally between court staff and police prosecution (n=20; 71%), each. Forensic prison liaison teams, probation and police were rated “excellent” by fifteen (54%). General adult mental health service contact was rated as “excellent” by thirteen (46%). Defence lawyers, crown prosecution, judges twelve (43%) rate as “excellent”. The quality of the contact with alcohol and drug services and cultural services was only rated “excellent” by ten (36%) and eleven (39%) respectively.

The surprising results were the ratings regarding frequency of contact with alcohol and drug services and cultural services. Only five (18%) of the CLNs rated the frequency of contact with alcohol and drug services as ‘often’. Of concern was that quality of contact with alcohol and drug services was rated as “not so good” by fourteen (50%) of the CLNs. Frequency of contact with cultural services was rated “often” by eight (29%) and more surprisingly four (14%) rated frequency of contact as “rarely”. Given the numbers of people going through the criminal justice system with alcohol and drug misuse and

the identified high numbers of Maori in the criminal justice system (Statistics NZ, 2009), the contact frequency and quality data related to alcohol and drug and cultural services warrants attention.

Court diversion and court liaison

Data regarding the functions of court diversion and court liaison was gathered. CLNs rated how important they considered the liaison and diversion functions of the CLN role on a 5 point Likert scale. The ratings were vital (5), very important (4), sometimes important (3), rarely important (2), and not important (1). Unexpectedly twenty one (75%) CLNs rated the liaison aspect of the role as vital compared to seven (25%) rating diversion as vital. In contrast, eight (29%) rated diversion as very important, with only three (11%) rating liaison very important, and four (14%) sometimes important.

Table 4: *Rating the importance of liaison and diversion functions*

Variable	Number of responses (N=28)	Percentage
Diversion		
Vital	7	25
Very important	8	29
Sometimes important	4	14
Rarely important	0	0
Not important	0	0
No response	7	25
Missing	2	7
Liaison		
Vital	21	75
Very important	3	11
Sometimes important	0	0
Rarely important	0	0
Not important	0	0
No response	4	14

Understandings of court diversion

Twenty five (89%) of the nurses provided their understanding of the diversion aspect of the CLN role. Three (11%) did not respond. These explanations of court diversion and

court liaison neatly illustrate the role of the mental health nurse in the court setting: *“The two roles dovetail each other as we are advocates for the correct pathway of the mentally disordered offender”* (2); *“Mental health issues that impact on those before the courts are highlighted with potential for diversion for treatment”* (18). The understandings of court diversion provided by the CLNs were in accordance with the literature. As outlined in Chapter Two court diversion provides the opportunity for further mental health assessment and may result in either inpatient or community treatment or no additional follow up from health services. Court liaison includes court diversion as well as linking, brokering and liaising with a variety of agencies and services in the community (James, 1999).

Of concern, there was some confusion evident in six (21%) of the responses. Two (7%) of the participants stated they were respectively, unsure, and did not know what was meant by court diversion. Four (14%) of the participants confused the role of the CLN in diverting people to mental health services with ‘police diversion’. One participant helpfully suggested *“Diversion needs to be defined”* (24).

The following two themes were derived from the CLNs understandings of court diversion: advocacy and enabling, and interpreter.

Advocacy and enabling

A strong sense of advocacy came through in descriptions of court diversion and the CLNs role: *“Ensuring that people with mental health disadvantage are advocated for in courts as appropriate”* (6). The CLN assists with channelling people with mental health problems into appropriate mental health services instead of going into custody where possible. CLNs recognised court diversion had a part to play in reducing stigma as these two comments reflect: *“Diverting a person out of the court system reduces the stigma associated with any mental illness”* (21). Furthermore, participants described their part in assisting people with mental illness to avoid being unnecessarily criminalised as a result of being mentally unwell at the time of the offending. *“It may assist with mental health act disposition which is an assistance to that client rather than punitive”* (16).

Importantly, the CLNs emphasised their role in early intervention for people with mental health difficulties in the criminal justice system. In particular, for those people who are *“lost to follow-up or first presentation who present at court ...//... (16)*

CLNs described the importance of knowing the possible pathways to pursue for the potentially mentally unwell person: *“Diversion from prosecution, diversion from inappropriate use of the legislation, diversion of clients to appropriate care/treatment, or even diversion from mental health services when it is contraindicated ...//... it is all vital”* (27). This comment also emphasises that the role of the CLN in protecting health resources plays an important part. Furthermore, the importance of maintaining a ‘CLN presence’ in court is accentuated: *“Making sure you are there to ensure appropriate pathways for our clients is vital”* (27).

Bridging between systems

Central to the advocacy and enabling qualities of the CLN practice is the comprehensive understanding of how mental health matters and the criminal court interact. The CLN acts as an “interpreter” of both systems for those involved, for example, *“Engaging with others to give understanding of mental health issues”* (9). Similarly, CLNs explain aspects of the legal system for people with mental health concerns, their caregivers and health provider. As in the participant’s example CLNs are available to assist with the understanding of mental health concerns for professionals in the justice system. The CLNs position in three professional domains; health, legal and social services enables them to bridge the three systems to interpret and clarify concerns related to mental health issues.

Brokering court diversion

Twenty two (78%) of the CLNs responded noting specific barriers or facilitators to being able to carry out the diversion aspect of the role. Six (22%) did not provide a response. The responses are grouped into three sub-themes. Ignorance and negative attitudes of professionals involved in the legal system and knowledge and resource deficits in the wider mental health system were described as barriers. The CLNs outlined collaborative relationships, credibility, and education as key factors to overcoming resistance to alternative pathways for people with mental impairment. The relationship the CLN developed with key persons and agencies within the criminal justice system was commonly considered the most important factor in facilitating court diversion to health services.

Working within the relationships

Repeatedly, the quality of the relationship the CLN was able to establish with prosecution staff was noted as significant in negotiating court diversion. Furthermore, the CLN establishing credibility and mutual respect developing between the players within the setting, has a significant impact on the ability to carry out the role:

“Credibility - the credibility / of the service/ representatives have with any of the court service participants will define whether there are barriers or facilitators” (6). CLNs discussed working hard to gain respect and credibility in the setting.

CLNs provided ongoing education to create a common understanding to overcome ignorance about the CLN role and mental illness: *“Education of Police, ongoing, relevant and necessary”* (15). Although the sense of frustration regarding the need for education and the reception they received at times came through: *“I am trying to offer regular education sessions to address this”* (14). Topics for which education was provided included: court diversion, services and facilities available, mental health conditions, and communication.

Resilience

CLNs demonstrated resilience in brokering court diversion. They frequently encountered resistance to the role they were required to execute, referring to a lack of cooperation and willingness from community mental health teams to seek solutions. The CLNs suggest the level of ignorance or understanding by others involved dictated whether these served as a barrier or facilitator for diversion.

They also found lack of understanding of mental illness and cognitive impairment and the relevant legislation amongst lawyers. Furthermore, they encountered reluctance to consider alternative options on the part of police and prosecution as a barrier to court diversion. Some suggested this rigidity stemmed from attitudes about mental illness: *“General attitudes by court officials that “they” (mental health consumers) are using their illness as a defence to allay criminal charges”* (18). Obtaining suitable outcomes often relied on individuals within the system: *“Some prosecutors are easy to deal with as are some judges. Some are staunch in creating a paper trail and expect a conviction and demand court reports despite logic and common sense”* (27).

CLNs described having to be persistent and consistent in seeking beneficial outcomes for people: *“I have learnt not all is in our control and liaison by consistently giving the*

same message, being realistic and having sound rationale when liaison allows diversion to be considered at every opportunity. They see me coming” (27).

Knowledge and resources in the wider mental health services

Many participants reported that general mental health services did not understand the CLN role. This often meant health information the CLN required regarding the person who was appearing in court was not readily available. Furthermore when the purpose of the CLN role was not understood CLNs encountered barriers and delays to obtaining appropriate outcomes for people. CLNs felt their expertise was not taken into account by crisis and emergency teams. A long standing mis-conception regarding the role of forensic mental health services stood in the way of facilitating appropriate outcomes at times for example, “*General mental health services, perception of what is and what is not ‘forensic’*” (2). Several CLNs expressed that when people who were inpatients in mental health services were charged, this generated unease for them.

A key barrier related to a perceived lack of resources such as availability of beds impedes the CLN facilitating the appropriate pathway. Again, the reluctance on the part of services to engage and be creative regarding health needs of people was disappointing and frustrating for CLNs. This communicates a lack of understanding of the role of the CLN and the court liaison service and the vulnerability of the person who is mentally unwell in the criminal justice system.

On a positive note, CLNs appeared prepared to work with teams to address issues related to communication and familiarisation with the CLN role: “*it requires ongoing work with inpatient unit*” (26). Participants suggested they had initiated strategies to remedy this, such as conducting regular in-service education with mental health services.

Nursing practice tensions

Issues in the practice setting

A number of areas were identified from the literature as possibly generating ethical quandaries for the CLN. These are listed in Table 5. These categories requested yes or no responses. Of note, over half (57%), of the CLNs identified concerns with sharing information and confidentiality in the court setting. Surprisingly, only ten (36%), of the CLNs indicated concerns regarding informed consent. The notion of obtaining consent in the court setting, and challenges encountered with information sharing and documentation featured strongly in the in-depth interviews. Whilst only seven (25%) indicated concern with the client-nurse relationship, eighteen (64%), had concerns with the duality involved with justice and health.

Table 5: *Issues in the practice setting*

Variable	Number of responses N=28			
	<i>Yes</i>	<i>Percentage</i>	<i>No</i>	<i>Percentage</i>
Information sharing	16	57	12	43
Confidentiality	16	57	12	43
Informed consent	10	36	18	64
Documentation	6	21	22	79
Client-nurse relationship	7	25	21	75
Dual role criminal justice system/health	18	64	10	36

Cultural and ethical matters

Twelve (43%) of the CLNs indicated they had experienced cultural or ethical issues that caused them concern. Fifteen (54 %) indicated they did not experience cultural or ethical concerns. There was one (3%) no response. However, when asked to elaborate on cultural or ethical concerns, twenty seven (96%) of the CLNs provided an example of a cultural or ethical issue they had experienced in practice. While there is overlap between cultural and ethical concerns, for the purpose of this study, these examples have been grouped into separate categories.

Cultural concerns

The main cultural concerns were around cultural input and the difficulties CLNs faced during communication with mental health cultural services, for example, “*Little communication with [cultural liaison] even after several attempts*” (5). Others experienced delays obtaining specific cultural assessments resulting in adjournments until the cultural assessment could be arranged.

Conversely, when specifically asked about access to cultural input, twenty three (82%) indicated they are able to access Maori or other cultural workers if required at court. Only five (18%) CLNs responded they did not have access to cultural input at court.

Concerns were expressed that working with the Whanau/family of people with mental health concerns was challenging in the court setting for example, “*Whanau/family members not allowed in cells at Court when you are assessing people*” (23). This is indicative of the focus of the court setting in comparison to the health setting where a more holistic approach is encouraged.

Nineteen (68%) of the CLNs indicated they use Maori models or frameworks in their practice relating to situation involving Maori. The research did not ask the CLNs to elaborate further on use of Maori models or frameworks in practice.

Ethical concerns

Three broad issues emerge with respect to ethical concerns: attitudes, confidentiality, privacy and information sharing, and role conflict.

Attitudes

CLNs listed examples of the attitudes of others regarding people with mental health concerns in the justice system as an ethical concern for the CLNs. The attitudes of others in the criminal justice system towards people with mental illness were discussed earlier. Similarly, CLNs reported that people working in the criminal justice system sometimes lack awareness of mental health concerns, for example, *“Police treatment of the mentally unwell whilst in custody, attitude of lawyers to mentally unwell clients and their knowledge of mental health”* (13). Further demonstration of a lack of awareness and knowledge of the types of impairment people may be experiencing is evident in this example: *“A judge yelling at a known client of Intellectual Disability Service (functioning at a 7yr old)”* (27). While ignorance of impairment in itself is not an ethical issue, the resulting position it places the CLN in raises ethical concerns for the CLN. Situations such as this may place CLNs in a potentially compromising position. The CLN has to decide how to manage the situation and what approach is least likely to further inflame the situation for the person. They would most likely be required to calm and deescalate an upset, bewildered client and family, and support people as well as supporting health professionals. While at the same time, the CLN has to remain professional and carry out the role of providing impartial advice and recommendations to the court.

Confidentiality, privacy and information sharing

CLNs raised ethical issues regarding the sharing of information, such as *“disclosure of information to families and some non-government organisations”* (24). Maintaining confidentiality and privacy were clearly a concern for the CLNs in open court, for example, *“there is a problem with some judges who openly discuss some people’s mental health issues in court, even when I’ve provided a written memo to try and avoid that”* (14). Similarly, maintaining privacy while conducting interviews in court cells was problematic. The CLN practice is conducted in a public forum.

The isolated nature and vulnerability of the CLN role was portrayed as captured by this statement: *“Most requests are of a verbal nature and there is no way to verify the request from lawyers, police etc”* (17). There is no paper trail of referrals made to the CLN because most are made verbally. Therefore, there is nothing to support that a request for assessment or information was made.

Role conflict

CLNs touched on the conflict they experienced when their assessments contributed to the person losing their liberty:

Ethical issues often arise in this role. An example: when bail is opposed because the person is believed to be a risk to themselves. The court asks for assessment and they are assessed as a risk to themselves, therefore remanded in custody. It often feels like my involvement has influenced their incarceration - query doing harm to the person (26).

Final thoughts

Finally the CLNs provided comprehensive opinions regarding the most, and least, enjoyable aspects of the role and what they would like to see changed. The most enjoyable aspect of the role was overwhelmingly noted specifically as “autonomy” by twenty-six (93%), of the CLNs. Twenty four (86%), provided information about what they enjoyed least about the role. Twenty five nurses (89%), provided suggestions regarding what they would like to see changed about the CLN role.

Enjoyed most

Autonomous practice and variety

Concepts of independence, increased accountability and decision making were described as features of autonomous practice contributing to making this the most valued aspect of the role:

Working independently with associated heightened accountability is very satisfying - particularly when I get things right. The challenge, autonomy and unpredictability of situations/individuals and balancing an interaction with several individuals each with a different focus (6).

CLNs found the greater accountability stimulating and affirming of their skills as nurses. They explicitly referred to the nature of professional nursing accountabilities being extensive compared to a normal mental health nursing role: “*Being accountable for my professional functions/role outside of employer/employee relationship*” (10).

Along with accountability sits responsibility. The CLNs were very aware of the increased responsibility, but considered it an enjoyable challenge and took ownership of this: “*The autonomy and responsibility, decision making is a great part of the role. I have developed the role in the [xx] region and made it my own*” (11).

CLNs appreciated the variety of the practice, from the people referred to them, the professionals at court, as well as the diverse range of scenarios they encountered. CLNs described the role with unmistakable passion for nursing practice in this setting, referring to being mentally stimulated and challenged: *“I enjoy my role very much. I still have a passion for the field of work I am currently in”* (2); *“I ADORE my job 100%!!!”* (11). CLNs referred to enjoying having to think quickly on their feet. This description encapsulates characteristics of the nursing, the variety and the tempo: *“I enjoy the fast paced environment, the need to do quick accurate assessments and implementing interventions as required”* (26).

Court mental health interface

CLNs traverse a distinct practice setting. Despite spending their entire time navigating between two systems, it was evident that the CLNs enjoyed this unique practice setting: *“The challenges of melding law and mental health to assist both with appropriate outcomes”* (9). They acknowledged this was not the usual nursing environment and worked within it. There was a sense the CLNs relished working with professionals who were not from health disciplines: *“Working with other occupational groups, the change in environment”* (15). They found working as the only health professional in a non-health environment exciting and stimulating.

A sense of being valued in that setting was articulated as *“respect from Court Officers that include the Judges”* (22). They also indicated they gained respect from other stakeholders such as police and lawyers.

Making a difference – nursing advocacy liaison and education

A strong flavour of advocacy for the people they worked with and their families came through: *“Gaining access to the mental health service for clients and their families for the first time”* (23). Being able to contribute positively in peoples’ lives was rewarding as this CLN relays: *“Working with the people and families and assisting with the process to allow people to move on and get the treatment required to get on with their lives”* (27).

The liaison aspect of the role is significant and is further emphasised as an enjoyable and challenging aspect of the role. Engaging with a range of services, for example, *“after assessment, liaison is at the core of this role and I enjoy that”* (24). The variety of contact with a range of different services and individuals was valued, *“I love*

networking with other stakeholders - it makes a change from just other mental health services” (11). The liaison function incorporated sharing nursing knowledge and education, of “being able to provide and impart a wide range of information within and about a very specialised arena” (6). Finally, the CLNs expressed that they enjoyed showcasing nursing through their practice in the courts.

Enjoyed least and CLN recommendations for the future

The key areas of concern were vulnerabilities arising from the isolation, organisational inclusion and support, national standards, education and recognition. These echo the data from the body of the survey.

Vulnerabilities related to isolation, autonomy and pressure

Vulnerabilities exist within the inter-professional and interagency environment. This was at times incredibly stressful work. In their solitary position, CLNs reported they were at risk of being mis-represented, manipulated, and exposed to unprofessional attitudes directed towards them: *“having to be aware of being manipulated by others (mostly lawyers)” (13). Furthermore, they were cognizant of people’s rights and expressed concern when they were not consulted, as this example relays: “Lawyers who push ‘has mental health issues’ in the court, but have not discussed the same with me” (20).*

CLNs described being exposed to explicit verbal abuse in the courtroom from judges and others, for example:

Dealing with some judges (I have been yelled at) ...//... Lack of professional respect by some judges and some other team members from other health professions and sometimes the public (both in court and in the paper,) dressing down what can happen when a judge is upset at mental health services and you are the person representing them (27).

The CLN refers to the “paper” meaning newspaper. A perspective of the nurse’s work had been reported publicly with no consultation with the nurse. Another CLN reported they had been referenced in the newspaper with no consultation, rendering them vulnerable. These examples demonstrated the public nature of the role and the vulnerability the CLN can be practicing under. It is concerning that CLNs are not accorded professional respect at times, and it is difficult for them when frustrations regarding the wider mental health service are directed at them. This treatment at court, where the CLN undertakes a very complex role, adds to the sense of not being valued.

Time was a significant issue in managing the workloads on their own and providing a competent service to the court: *“Sometimes I do not have enough time to complete my assessment and needing to rush the client to answer questions for me (which I dislike) when the court registrar is telling me to hurry up”* (23).

The concern is that CLNs felt there was nowhere for them to take these matters to be considered or addressed. CLNs felt they were not able to complete thorough assessments due to the courts’ time constraints. There was no consideration anywhere as to whether this was appropriate for nurses to be conducting assessments under this duress. Furthermore, some CLNs had multiple courts to cover which intensified the pressures.

On the other hand, a few nurses experienced the opposite to the CLN practice in the fast paced larger courts. Those in smaller courts received fewer referrals and, as a consequence, when not working with the legislation on a continuous basis: *“it does make it difficult ‘grasping’ the pathways. Days can be boring and difficult to take other work as you have to ‘keep an ear out’ with what’s going on”* (14).

Organisational inclusion, support and acknowledgement

Feelings of being unsupported and undervalued and that those in management and nursing leadership positions did not comprehend the complexities of the role were apparent. There was a keen sense of disappointment in the lack of support from managers and recognition of the level of responsibility the CLNs have. CLNs recommended that greater support was required from management in the future: *“Showing an interest in what we do so they can provide adequate support. We as a team only hear from management when something goes wrong”* (16).

Similarly, the lack of understanding of the court liaison service and CLN role by the wider mental health service has already been noted as a barrier to obtaining appropriate admission for people in the courts:

Relationships between other parties i.e. community mental health services and management, by them having an understanding of 'what we do in' court liaison. Very few are aware of how to use the service effectively. Despite us educating teams via presentations there still seems to be some uncertainty. Communication is the ultimate for court liaison. To function effectively we are only as effective as the information we receive (16).

That example demonstrates the extent of the lack of understanding of the purpose of the CLN role and services working in silos.

CLNs articulated being caught in conflict between services as to who is responsible for responding to the needs of the person, for example: *“Conflict with the crisis team regarding responsibility for recent arrests”* (24). Despite these issues the CLNs continued to advocate for the needs of the person with whom they were working.

There was a lack of knowledge by their managers about the role of court liaison services. Emphasising the need for dedicated CLNs they described managers not understanding the need for competent CLN presence in court on list days and being available to respond when called by the court. CLNs relayed being tied up with caseload crises and community caseload management and not able to respond to the court: *“Lack of support (managerial/collegial/other professions) with community case management”* (24). CLNs faced particular administrative challenges when at court such as not having access to computers whilst at court.

Many CLNs reported that they were excluded from organisational decision making, for example: *“Management change of process at a higher level between agencies without consultation with the coal face workers as to what works and what does not”* (2). Decisions were made about the CLN role without consultation with CLNs. This exclusion was compounded through lack of communication within their own teams. The CLN is the person representing the wider mental health service in court but is not aware of service changes/decisions.

Finally, as the front person at court, CLNs were the ones who were confronted by the court when formal court reports were not completed on time. They accepted this was their role, but suggested communication between the report writers and CLNs needed to improve.

National standards, consistency in delivery of role and support systems

Significantly, CLNs repeatedly recommended that national standards and documentation were required. National standards would ensure all working in the area would have sound knowledge of court processes and legislation and would also assist with defining the parameters of the role and with role clarity for the CLNs.

Indicative of the isolation, and lack of support and guidance, were the significant concerns expressed regarding differing interpretation and inconsistency in application of the Criminal Procedure (Mentally Impaired Persons) Act 2003 by individual judges: *“Also it is very difficult dealing with different judge’s interpretation of the legislation and what seems to be a very inconsistent approach”* (14). CLNs were not clear whether drawing attention to inconsistencies in these matters was part of their role. Parameters of the CLN role around legislation are unclear; most of the time they are consulted by the court and their advice followed, while in some courts they are ignored. CLNs are not formally trained in working with legislation, nor do they have an official role regarding this.

Greater liaison and contact with each other was suggested to facilitate consistency. A common suggestion was for a national body for CLNs to be established. Other ideas to promote consistency in practice and provide support included holding compulsory regional meetings and annual conference/forums for CLNs.

Education and training opportunities

Once again, the need for role specific education featured strongly as an absolute necessity for the CLNs. Lack of access to ongoing education and an education/training pathway raised significant concerns in relation to retention of skilled staff, for example, *“The lack of educational opportunities is disappointing and may ultimately be a reason I move on”* (18). There are serious implications in relation to workforce planning in regard to CLNs.

Recognition of specialist nature of mental health nursing in courts

Woven throughout the data were references to “specialist” and “expert” in relation to court liaison nursing. The position was described as independent clinical practice in an advanced practitioner role using new and different knowledge. Clearly, the CLNs considered this a role that required highly developed skills at an expert level. Furthermore, the level of skills, complexity, knowledge and the scope of the CLN practice is currently not recognised by colleagues. In consideration of the future of court liaison nursing the majority suggested that recognition of the level of expertise in the role would assist with ensuring there is a future CLN workforce. CLN is not a sought after position and this could be addressed through acknowledging the work that

is already undertaken by CLNs, professional recognition as a specialist position and with appropriate remuneration.

Summary

The four sections of the survey provided information regarding demographic details of the nurses and role particulars, preparation for the role, education and training, supervision and supports, inter-professional collaboration and specific challenges to practice.

The data found the CLNs are a mature group of nurses who have extensive mental health nursing experience prior to commencing in the CLN role. CLNs practice across a variety of courts which has implications in terms of the extent of knowledge required. 75% of CLNs were DAOs. Over half of the CLNs were required to cover other roles within their team on a routine basis. CLNs perform work across multiple sites and a range of courts. The data revealed significant variation in working conditions and resource allocation to enable CLNs to provide competent and timely advice to the courts. This highlights discrepancies across New Zealand in providing a nationally consistent mental health service to the courts.

Overall there was poor role preparation and orientation. Access to relevant post-graduate or ongoing educational opportunities were limited and not supported. The data revealed specific education is required to practice in the CLN role and to maintain competency. Detailed information was provided by the CLNs regarding optimum orientation and education. The sense of alienation indicated the importance of robust, tailored education. The majority of the CLNs agreed that a CLN specific education pathway leading to a post-graduate qualification is required.

Developing national consistency in the delivery of the role featured throughout the data. CLNs expressed isolation and their thirst for knowledge. National guidelines, templates and clinical practice standards were deemed necessary, along with national peer group forums to discuss and reflect on practice.

The uniqueness of the practice setting requires gaining access to professional supervision and support. Barriers to clinical supervision included time, availability of suitable supervisors, and geographic isolation. Informal opportunities to reflect and discuss practice were often utilised. Only half the CLNs reported they had access to opportunities within their own services to adequately reflect on and discuss practice.

Difficulties existed for the CLN obtaining collegial support and advice while still at court. CLNs expressed dissatisfaction with the level of their managers' understanding of the complexity of the role. These issues raise significant concerns for CLNs who are practicing in a complex setting that is cut off in many respects from their health colleagues. The CLNs reported that these issues require urgent attention.

The extent that the CLN was involved in communication with other professionals, services and organisations was revealed. Greatest contact occurred with court staff, prosecutors and defence lawyers. The quality of the contact was rated the highest with the court staff and prosecutors. Of concern was the low rate of contact with alcohol and other drug services and cultural services and the quality of those contacts.

The importance of the functions of court diversion and liaison are detailed along with some of the significant barriers the CLNs faced when brokering court diversion. These ranged from negative attitudes about people with mental health difficulties, resistance from wider mental health services, shortfalls in inpatient beds, and deficits in knowledge of the aims of the court liaison service.

Multiple tensions stemming from the unique practice setting were identified by the CLNs. Tensions relating to cultural and ethical matters were articulated, highlighting the differing priorities of justice and health. Key issues related to the CLNs ability to be able to communicate with family/whanau, attitudes and stigma, confidentiality, information sharing, documentation, and role conflict.

The data from the survey informed the guide to the in-depth interviews, particularly in relation to orientation, professional clinical supervision, support and resources, recognition, and access to training and education. The amount of information provided by the participants in relation to the preceding topics was phenomenal and therefore warranted further exploration.

Despite the challenges the CLNs outlined, it was heartening to read the many comments relating to enthusiasm for the role and appreciating the autonomy, responsibility and opportunities for garnering new knowledge the position afforded. The CLNs provided detailed data regarding the role with comprehensive recommendations for what was required to ensure the nursing practice is consistent, and remains safe and competent. The following chapter presents the findings from the in-depth interviews which build on the findings from the survey.

Chapter Five: Findings in-depth interviews

Introduction

This chapter illuminates the perspectives which emerged from the second phase of the research. This involved in-depth interviews with six CLNs from across New Zealand. Five overarching themes are discussed under the headings '*wealth of experience*', '*no normal day*', '*part of but not part of*', '*added layers*' '*requirements for practice, and recognition*'. The themes are further grouped into sub-themes that seek to portray the participants' nursing practice. The themes are illustrated with excerpts from the transcribed interviews.

The first theme very simply introduces and describes who these nurses are. This interview data enriches the total picture of how the nurses' qualifications and experiences influence the CLN role. The second theme focuses on the daily professional activities of the CLNs. Exploration of issues CLNs face, including ethical tensions, are in theme three. The fourth theme reveals the extension of knowledge and expertise the CLNs have acquired to practice in the role. Theme five presents the debates regarding the scope of court liaison nursing practice, education and training needs, professional supervision and support needs, and the need for acknowledgement of this extended scope of practice.

To bring clarity of meaning to the excerpts, some formatting of the transcribed data was necessary. The use of jargon or repeated words has been removed from the excerpts. The use of ... //... indicates one or more sentences have been edited. The occasional word was changed or added, to protect anonymity or clarification; these words are enclosed in square brackets. Names of places have been replaced with "xx". Pseudonyms have been used for the participants.

Theme One - Wealth of experience

This theme integrates the nursing backgrounds and the professional experiences of the six registered nurses out of the total of 41 who practice as CLNs. Six CLNs were purposefully chosen from across New Zealand to enable a range of nursing and CLN practice experience and environmental diversities to be captured. Insights emerge as to who they are as nurses and the wealth, and immense depth, of experience these nurses had prior to commencing the CLN role.

Although the length of time practicing as CLNs ranged from three to eighteen years, their work experiences prior to commencing the CLN role were extensive. Their experiences included nursing in Maori mental health and forensic mental health across rehabilitation and acute settings, a position as a nursing tutor at a School of Nursing, staff nurse, charge nurse, co-coordinator, and clinical nurse specialist in forensic mental health services before moving into the CLN role.

One CLN's opinion that considerable depth of nursing knowledge was required to practice as a CLN concurred with the others. It was suggested that extensive nursing experience coupled with post-graduate education provided a solid platform to have the confidence to practice as a CLN. Others had work experiences that, while outside of nursing, informed their development as nurses. For example, another CLN commenced their working life in education, followed by many years in acute mental health nursing before becoming a CLN. When seeking a new challenge in mental health nursing and considering the CLN role one nurse undertook a secondment to an acute mental health crisis team, thinking that brushing up on their 'hands on' nursing skills after ten years in a mental health service coordinator role was required. The nurse had hypothesised the court liaison nurse role "*would be something fairly complex, and it turned out to be exactly that*". The range of experiences in forensic mental health, Maori mental health settings, education and project management were described as invaluable when commencing the CLN role.

A high uptake of post-graduate education was a commonality amongst the six CLNs. One CLN had completed a Masters degree and another was well on the way through a Masters degree. Others had completed individual post-graduate papers. Access to and relevance of post-graduate education is explored further in theme four.

Even though all the CLNs referred to the diversity of their nursing experiences as being integral to CLN practice, the extent of the CLNs' prior nursing experiences did not prepare them for this position. The role was very removed from accepted understanding and experiences of "nursing". One CLN, who had experience in forensic inpatient and general adult inpatient settings both in New Zealand and overseas for nearly thirty years prior to starting in the CLN role, stated, "*It was a whole different sort of kettle of fish*". The intensity of this experience of being out of place comes to the fore throughout the following themes.

Summary

The universal feature of the professional nursing backgrounds of the CLNs included exposure to a variety of nursing experiences both within forensic mental health and general adult mental health services, across acute, rehabilitation and community settings. Likewise, completion of post-graduate education was a common element. A vast array of professional experiences provided valuable experience prior to commencing the CLN role.

Theme Two - No normal day

An account of the CLNs' day-to-day practice is revealed in this theme. Predictably, CLNs reported that they were involved in routine administrative tasks. They commenced their days checking faxes, emails, phone messages for referrals, requests for information, advice regarding court processes, assessments and updates, as well as checking court lists for people known to the service. However, other than the routine administration tasks, defining a normal day was problematic for the CLNs, as communicated by Lynn:

There's probably no typical day to be honest, there's no normal day...//...
It's an absolutely unique role in many ways. Often I don't know what I'm going to get from day to day, or I don't know where I'm going to be.

Once at court, the CLNs hit the floor running. They did not know what they would encounter, people they would be asked to assess, or services they would negotiate with. The diversity was conveyed by Peter:

I have people in four different courts sitting and one might be sitting there at nine o'clock and then you have to run down to another court...//... you can facilitate that by going to counsel and saying couldn't it be in this one or do you mind calling it later on or wait for me to turn up or text me when you go in...//...and then you run in breathless, and they're like here he is.

CLNs may be involved with an extensive array of people and services over the course of a day. The day-to-day practice is presented through six sub-themes.

Setting the scene

The CLNs covered a variety of courts including District, High, and Youth Courts. Some CLNs had involvement in Family Court and Family Violence Court. However, most of the CLN work took place in District and High courts. CLNs attended all court list

hearings and indicated they were also available “on call” to the courts if they were not present on site. Nicole depicted the on call aspect:

I'll often go to court between those times if I'm called by, usually the registrars, or police, or our psych emergency have picked someone up and they're going across [to court] and there's bail issues and things like that, and they want mental health involved, or there may be question mark health assessments, if they're being held in custody.

Prioritising the immediate

The principle role of forensic services within the courts is to provide triage and advice (MoH, 2001). The CLNs perform these functions. This requires prioritisation of both existing workloads and triage of new referrals. Bridget, who practices in a large city court alongside another CLN, described this process:

We sit down together and work out balancing who will cover which cases. Predominately we try to follow through with our own individual cases, that's not always possible. The reason for that is that you've got an interest, you've done the initial assessment on the person usually, so you have the clearest picture about them as well, and if you followed the case through you know the process, you know the finer points and subtleties of what's gone down.

Triage skills were crucial for CLNs given the variety of requests for assessments, information, and discussions that took place within a short space of time. For example, some matters had to be dealt with before court sittings commenced. Therefore, a small window of time exists to obtain information from the prosecution, mental health services, general practitioners, families, support persons, and probation services. Once all the collateral information had been gathered and the assessment completed, the brokering process began. Bridget provides an example of this negotiation process:

There may be a range of issues that we've got to deal with, ...//... like in the Registrar's Court there may have been a letter come through from an inpatient service or a crisis team suggesting that this person's meant to be in court, could we get matters deferred because they're quite acutely unwell at the moment. So we'd deal with that primarily, get that resolved first off, and get the matter adjourned.

The CLNs were able to employ a flexible approach to their work which enabled them to respond and process on the spot requests. Bridget's comments were typical of this phenomenon.

And then you are at the whim of the lawyers as to their timetables. They can throw you and your timetable all up the buwai. You get lawyers then, ‘Could you come and see this person? Can you do this?’.

Triage and negotiation skills along with flexibility in thinking were key stones of CLN practice. Prioritising workloads and deciding who to assess and what type of assessment to use were central skills in the role.

The centrality of the assessment

Assessment was the core of the CLN role. These ranged from completing full comprehensive mental state and risk assessments to assessments conducted in a few minutes as part of the triage process. Several very different types of assessments were conducted by the CLNs. Examples included assessments regarding: fitness to plead (FTP) (including learning disability), mental state (often relating to whether a formal court report was necessary regarding insanity), sentencing options, hospital admission, risk (including harm to self and/or others in relation to mental illness), and co-existing problems such as addiction. (Refer to Appendix G regarding screening assessments).

Bridget outlined key elements to the assessments:

(T)his is what most of my reports entail, they are either risk, an assessment relating to mental stability, which may warrant initiation of the Mental Health Act ...//.... Assessment about whether or not a person really is unfit and, associated with that, whether or not there may be an element of insanity at the time of their actions. Another factor may be purely to provide, there’s no evidence or any form of mental health, but there may be other factors in their background, they’ve been seen by mental health previously. Just providing information to the courts so that they have a better understanding of the social context of that person as well.

CLNs referred to carrying out “stand down assessments” (the court stands a person down, usually in custody, to allow the CLN to conduct a screening assessment). Lynn explained the value of these screening assessments:

I see without that filtering [by a screening assessment], it’s costly and it’s time consuming and it [formal report pursuant to CP(MIP)Act] has to be indicated, so absolutely screening is a big part of it.

Hence Lynn referred to the gatekeeping element embedded within the aims of the court liaison service. CLNs protect both health and justice resources through ensuring requests for formal court reports and referrals to mental health services are appropriate (MoH, 2001).

Dealing with risk factors (risk assessment and management) in relation to mental illness was considered a priority. CLNs agreed that ascertaining the reason for conducting an assessment, in particular when it was about risk in relation to mental illness, was essential. As articulated by Bridget, this involved an understanding of the wider context within the justice environment:

A lot of work is risk assessment. Sometimes I'll sort of do a little giggle to myself and think. I'm saying no risks, but they've been charged for assaulting someone and I think oh dear...//... I have to say, no risk due to mental illness, but then when you look at it sensibly you think they were drunk last night the person they hit was drunk.

The burden of risk assessment (McKenna & Seaton, 2007) was intertwined through many of the practice stories shared by the CLNs. The constant juggling the CLNs undertook to work within the seemingly contradictory factors that are at play within the court setting is explored in the following themes.

The value of the written word

On completion of an assessment, CLNs provide advice and recommendations to the court. CLNs preferred to provide written, rather than verbal, information to the court. If information was presented verbally to the court, the CLNs endeavored to follow up with a formal report. Michael's statement reflects the CLNs' practices regarding the balancing involved in managing time, prioritising work and considering privacy in their reports:

Yes I do, I try if I get time. I try to convey a lot of my information to the court in writing just for people's privacy, but I don't always get the chance. But any recommendations around reports [reports recommended under CP(MIP)Act by CLN] I always write. Yes, so it's on their court file.

Despite practicing in isolation from each other, the CLNs had developed a very similar structure to their letters and reports. The CLNs described the structure of their reports and provided examples. Generally, the format included explaining the context in which the person was seen, why the referral was made, background relevant health history and contact with health services, summary and recommendations.

Exercising discretion to divert

Being involved in diverting people with mental health and learning disability concerns from the justice to a health setting was routine for all the CLNs. John frequently facilitated court diversion and described the process:

If there's someone in the cells [sic] who are really unwell, I have to sort out with the police, whether they're opposing bail or not, so whether they go to general mental health or forensics with diversion [to mental health services for treatment].

Facilitating diversion to inpatient mental health services required DAO duties.

Coordination and liaison with respect to the statutory DAO role featured as a significantly time consuming but necessary factor of the CLN role. In line with the unpredictability and complexity of the CLN role it was not possible to foresee when the DAO role would be required. Bridget hinted at the breadth of liaison activities and flexibility required in diversion from court cells to hospital. At the same time the CLN continued to manage the multitude of other requests for input:

If a crisis team is seeing someone and they've said we're very concerned about this person, we couldn't actually get them into hospital. There may then be some discussion and negotiation about how to go about that, do they want to do the Section 9? Have they got 8A and 8B papers? Do they want us to do the Section 9? Do they have a name, a time, and a date, for the section 10 and 11 assessment?...//... getting some understanding about where things lie...//... Getting everything coordinated and that does take some time and a bit of scrambling around usually.

(Sections 8A, 8B, and 9 refer to sections under the Mental Health (Compulsory Assessment and Treatment) Act 1992). The above scenario was not unusual. CLNs were obligated to ensure the person received appropriate health intervention although the person had already been seen by mental health professionals. If the person was in police custody, police bail may not have been an option. Therefore, the person comes before the court with the CLN dealing with matters and admission to hospital from court. However, it appeared to the CLNs that opportunities for early intervention were often missed by mental health services with many people coming to the attention of the criminal justice system as a direct result of the mental health difficulties.

Interweaving the liaison role

A core CLN function involved keeping communication alive between mental health services and forensic services. CLNs are a vital link between the court and a range of other health organisations. For example, Nicole discussed how CLNs negotiate for an inpatient bed, and arrange follow up if the person is remanded in custody:

Forensic beds, there's always pressure for them...//... My task is to tell the court quite plainly when lawyers are saying my client needs to be in hospital; my response can be they actually don't need to be in a hospital. That's a clinical call not a judicial call.

As noted in Nicole's example, having role clarity was important. In order to achieve appropriate outcomes for the person, Nicole emphasised the importance of having established good relationships:

If someone does need to go to hospital, I've got to get on the phone and ring [regional forensic service] and determine the bed state ...//... If there isn't a bed available I'll get somebody remanded off to prison and then we'll [the regional forensic service] take them when a bed opens up under section 45 [MH(CAT)Act] into our unit and look after them there. It's not a situation we're comfortable with because we'll often end up with people in prison whose acuity means they should be in hospital. There's no beds and so we have to nurture them and look after them and that's where our relationships with the officers comes in and pays off in spades.

Effective liaison activity required ongoing communication between CLNs, the other services and stakeholders. The liaison took various forms from an as-needed basis, to regular team meetings across services such as Corrections, non-governmental organisations (NGOs) and general adult mental health services. The CLN role did not cease once the assessment and recommendations had been made. This excerpt from Michael demonstrated the extent and breadth of the ongoing liaison activities, including weekly meetings with stakeholders such as corrections:

[I] say these are my concerns about this person, plus I also bring ...//... up anyone that I see in the court that I am concerned about or I know is under mental health care that's gone into custody. I'll always report it in our [community forensic nurses] morning meeting and say I've talked to the prison about this person and there should be a referral coming. I try and keep a bit of an eye on that 'cause sometimes the prisons miss those things, and so I'll chase up on those and make sure the referrals have come through.

Having oversight and their finger on the pulse was important in ensuring smooth movement of people between the forensic mental health hospital and the court.

Likewise, CLN interaction with police was pivotal as John described:

Most of the ones [inpatients] in the forensic services, the police or prison officers bring to court, so they always come through me. I go and talk to the police and say, hey, have you remembered so and so's coming in? They're out at the hospital, and we sort it all out.

Liaison activity incorporated communication with the wider mental health service; thereby ensuring staff were informed and understood what was happening at court. This was particularly important because of constant staff changes, as John related:

On the whole, at the moment it's really, really good, but occasionally it goes in waves, you know staff changes. I do a lot of work liaising with teams. I

put a lot of effort making sure they know what happened in court, what's expected, and I try and encourage them to actually come to court when their clients are first arrested, because that way I think they've got a buy in on it, and they can see them straight after offending. Sometimes it's difficult and I can understand if they're busy, but if they say no to me too often I start pulling them up.

Michael outlined using both a formal (via Service Provision Framework) and an informal approach to ensuring his expectations were known and services knew what to expect from the CLN service:

...//... If they're [patient] under the Mental Health Act they have to be escorted. They can't just turn up with anyone cause there's been quite a lot of problems with that in the past...//... We reviewed my court liaison role, what I do and who I interface with, and all of those things. As part of that we've identified that I need to have ongoing regular updates with sector based teams, psych emergency, those kind of people So I just ring them every now and again and, and offer them an in-service or just an informal simple let's get together and talk about what we do and see if there's anything that needs to be changed and that kind of thing.

In order for liaison to be effective and the CLN role understood, the CLNs provided education sessions across the variety of professions and organisations. Educational topics ranged from mental illness to legislation. For example Peter reported:

We're doing Public Defence Service at the moment. So I've got an education in-service with them next month and then just tap into their service once a month just to see how they're going, but we work alongside each other in court.

However, mostly the educational sessions appeared to occur as needed rather than in a planned manner. Nicole, for example, had spent considerable time teaching communication skills in relation to working with people with experience of mental illness to police and corrections officers:

I had a good relationship with the police in-service educator and so every time he was running courses he would set time aside ...//... I would speak to them all about the Mental Health Act and, and how they might deal with DAOs because there were folk in the local service who were less than forthcoming with information. I taught them skills about asking for and responding to indirect answers, particularly when folk were being precious with information.

In doing so, Nicole bridged a gap between mental health services and the police and created common ground for communication to take place:

There were some DAOs at that time who were ah, unhelpful. I have done teaching sessions in the prison, spent a lot of time talking and under-girding the officers.

The CLNs' educative and liaison role was underscored by nursing advocacy. They reached across services and hierarchies confidently; attempting to ensure people had correct knowledge to enable appropriate outcomes for people with mental health concerns.

CLNs perform a valuable advocacy role as described here. Nicole questioned the lawyer regarding the person's ability to understand the charge he had entered a guilty plea on:

Well I [lawyer] asked him if he did it and he said yes, good enough - guilty. I said no, if you asked him would he like a nice warm cup of paraquat to wash down his lunch time sandwiches he'd have said yes to that as well. The bar of discernment used by the lawyer was too low and I said to the lawyer you've got to actually go looking beyond that. He was a duty solicitor, did you do it? Yep – guilty, done, we're out of here.

Nicole's excerpt provides an example of the CLNs' knowledge in relation to the intersection between law and mental impairment. It also demonstrates their role in advocating to ensure the person's rights to have their health needs taken into account in the legal setting.

These liaison activities were viewed as an integral part of the CLN practice, interwoven through every interaction. An inability to liaise with the broad range of persons/services would render the CLN ineffective. Some of the challenges regarding diversion and liaison are considered in theme three. Liaison activities are difficult to quantify and hence it is easy to underestimate their value.

Summary

The theme detailed the key aspects of CLN practice. There was no normal day. This phenomenon comes through the descriptions of practice in the six sub-themes. The CLNs work across a number and variety of courts. Assessment was the core function of their practice. They conduct a number of specialised assessments. CLNs practice at a fast pace, manage multiple referrals, triage, and conduct screening assessments. CLNs provide advice and recommendations to the court, both verbally and in written reports. Facilitating diversion from court to health settings was standard practice for the CLNs. Enabling diversion utilised sophisticated skills in communication and liaison. Liaison activity is interwoven throughout every aspect of their practice.

The breadth of CLN practice is evident through the education provided to a range of stakeholders such as: mental health services, non-governmental organisations, police, lawyers, court staff, and corrections staff. Furthermore, the CLN was a strong voice advocating for appropriate health care for the people they worked with. CLNs described the deeper levels and layers of knowledge that are translated into their decision making (e.g. type of assessments conducted, when to intervene, what level of intervention, who to talk to). Some of the challenges and tensions that arise from practicing at this interface are explored in theme three.

Theme Three – Part of but not part of

CLNs face multiple tensions in the course of practice. This theme examines the multiple complexities that emerged, through eight sub-themes.

Unfamiliarity

The lack of a tailored orientation to the CLN role was identified in the survey. Despite this role being in existence for over twenty years, commonly, the CLNs described learning the role through making mistakes in court (even with all being senior experienced mental health nurses).

As a relatively new practitioner to the CLN role, Peter could well recall the feeling of inadequacy and sense of disorientation. Like the others, he sought any information he could find to up skill and inform his practice. Clearly he was a very experienced nurse coming into the role; however, his previous practice and education had not prepared him to practice in that environment:

I picked up anything that I could put my hands on and read and read and read. So when I first started, we've got district inspectors at [forensic service] and I'd go in there and go, help. It was a whole lot of self directed learning, it was a lot of tripping up in court, being a senior nurse and then feeling inadequate in court.

Becoming familiar with court processes and protocols was emphasised by all the CLNs.

Lynn depicted this:

It's such a protocol around the courts. You have to learn that protocol and no one teaches you. There's no instruction or anything and you just observe and you learn through observation. And things like you speak when you are asked to speak, you don't speak unless there's an absolute need to for clarity, otherwise you wait until you're asked. I think a lot of my confidence in a court setting now is familiarity.

In contrast to the others, one CLN benefitted from an orientation package that was produced by a team leader who was familiar with the CLN role. This was not the common experience of the CLNs. However, despite that package and available support, Bridget described his sense of alienation and difference:

Repetitively I would find myself out of water, out of my depth, we went through all the theory and discussion before I started, but the reality was the only way I learnt was on the job. How can you anticipate and have comprehension of the complexities of what you are dealing with?

CLNs conduct specific assessments in court but are usually ill equipped for this as new CLNs. For example, assessing whether fitness to plead is a concern is not within normal mental health nursing practice. CLNs were self taught regarding the specialised assessments they conducted. Michael's comment was typical of the CLNs' experience:

Hopefully I'm not getting it too completely wrong. I just think someone would have told me by now. But yeah I've made some complete [muck ups]. I've had doctors that have looked at me and gone "what the hell are we doing reporting this person forward". And I'm like I don't know? I didn't know what to do.

The CLNs' experiences highlight the importance of role preparation, sharing of knowledge, transfer of knowledge and continuity of practice. Other than Bridget, the CLNs reported they had to create the role without any guidance. Peter elaborated regarding acquisition of the relevant skills:

I got this blank canvas. I had to feel my way through it. I think having the skills as a CNS, and then being really kind of process orientated, I started putting those processes in for myself, right down to assessments where...//... I stabbed in the dark what this role was supposed to be ...//... it was trial and error.

As an introduction to the CLN role, commonly CLNs were handed a cellphone, laptop and court files and that was it. Following his experience, Michael fought long and hard to ensure that other nurses were trained and supported in the CLN role. He was adamant the nurses had enough regular exposure to the role to cope:

I spent a good six to nine months having not a clue what I was doing a lot of the time, really ...//...I had no idea of how the court worked, ...//... I think that people need to have a really good overview of the forensic service and how that functions before they can step into the court.

Outside the usual

CLNs described novel practice that fell outside their usual mental health nursing practice. They experienced anxiety when they assessed people with possible intellectual disability (ID). The number of assessments regarding this group increased markedly with the advent of the CP(MIP)Act and the ID(CCR) Act. All participants relayed a feeling of not being prepared to assess and work with the increasing number of people with intellectual disability appearing in court. Michael, like other CLNs, reported, “*I feel quite undereducated around ID really*”.

Complex issues arose in working with people with intellectual disability in the court setting. It was beyond the scope of this study to investigate this further. However CLNs were often left in the middle of a busy court list day attempting to find accommodation and support for people who had significant learning disabilities. Michael conveyed the sense of frustration and responsibility the CLNs experience:

I end up having to race around trying to sort something out and intellectual disability services will not own the role at all...//... Everyone says yeah we know it's a problem...//.... I actually feel like writing to the Ministry and saying what are you going to do about it? ...//...Last week I rang a care giver who was supposed to come to pick this woman up from court, she didn't turn up. So I rang [xx] and they had an answer phone on and I left an urgent message and four hours later someone responded. It's a huge issue and I actually don't think that it's my role. I don't see that it's part of my role, but you just have no choice, what do you do?

CLNs were frustrated because this problem was well known but nothing seemed to change. As Michael described:

I've been raising it for about the last two or three years. What I find interesting is everyone says, oh yes we're well aware that it's a service provision gap but no one actually then says well this is what we're going to do about it.

Of note, CLNs have direct knowledge of the vulnerabilities and needs of people, however, they are powerless and feel not heard or consulted. The lack of role preparation is underpinned by the assumption that mental health nurses are some form of generic nurse who can do everything. CLNs described the sense of difference they experienced and the need for a robust orientation package. The intricacies surrounding the CLN practice are not well understood. The next sub-theme outlines communication differences that affected the CLNs practice.

Modification of language

CLNs had to learn the workings of a criminal court, to comprehend legal terminology and adapt their own professional language. CLNs altered accepted nursing practices of communicating health information, in order to facilitate mutual understanding. They used more commonly understood descriptive language both written and verbal. To fulfil the role, CLNs had to communicate effectively. Doing this required translating information across disciplines, as Bridget conveyed:

I had to modify all my language definitely. Writing reports using terms that, in a clinical context, are very standard...//... all of a sudden you're in an arena [court] that people have no comprehension of these terms unless you explain them ...//... You put an explanation out in clinical terms and people don't understand it, there's no point in putting a report out to that effect, because people just don't absorb it, and it has no account.

The CLNs recognised this adaptation of their nursing language should be part of orientation and training. Michael recounted that when a new CLN still used clinical nursing terms, he was not understood in the legal setting:

Some of the feedback that I got from the lawyers, from the way he [the new CLN] used to communicate was they've had no idea what he was talking about, and they'd say, at least when we talk to you we know what you're saying. He was still in clinical mode and hadn't managed to adapt his language.

Additionally, CLNs discovered they had to modify the legal language for their nursing colleagues within both forensic and general mental health services. This further emphasised the separation between the CLNs and their nursing colleagues, and the sense of isolation. Peter explained how he had to rephrase, clarify, simplify and interpret her work for his mental health colleagues:

It's like I speak another language to everybody else and people don't get what I'm saying. So I have to ...//... dumb down my response to them. And it's reflective in my nursing notes as well that people don't get it...//... It's trying ...//... I know what I'm saying but no one else is getting this. So it's not until we have monthly meetings with the other court liaison nurses that we all sit there and talk the same talk, but our manager's not getting it so we have to say, no this is what we mean, and so it's an education time with her.

CLNs also had to be able to defend their perspectives in the court setting. However, back in the health setting, the CLNs found this confidence was often viewed negatively. John described the challenges in adapting their practices and approaches between the health setting and the court setting:

We're the trouble makers. When in actual fact I think we come out of the situation where people see us as the experts. We are so scared that we're going to make a mistake, because our mistakes are going to be very public ...//... But working round here [court] you've got to be quite clear on what you're saying. Sometimes when I go out there [health setting], and they'll say we're going to do this, or that and the other thing, and I'll say that's stupid. And of course it's interpreted as you're negative ...//... People want our opinion here [at court], back at the [health] service they don't want our opinions. Well you can tell CLNs they're bossy, don't back down.

The CLNs interviewed were all strong, confident nurses. They had become used to practicing alone, formulating opinions and recommendations and expressing them confidently in the court setting. This confident manner did not endear them to their health colleagues.

Disconnect

As practitioners working outside the health setting CLNs experienced disconnection from other health professionals. Invariably, CLNs experienced some degree of isolation, whether this was professionally, geographically or a combination of both. Geographical remoteness from regional forensic services and being the sole forensic health practitioner in their region contributed to the sense of isolation. The sense of not completely belonging in either the health setting or the justice setting was pervasive throughout the interviews. John's comment captured the sense of not belonging:

Even working in a crises team they work in pairs, you discuss it, you come to some agreement. I guess working here independently by yourself you're no longer a team-player, I don't know, because you're not part of the police, not part of probation, not part of the other support groups, not part of the court, not part of the lawyers, you get on with everybody, because you have to get on with everybody but you're not. You're part of but not part of.

Despite the solitary practice, the CLNs frequently referred to embracing the autonomy and variety that the CLN role offered. For example, Michael stated:

What I love most about the role is the autonomy, the diversity, the fact I can go to work and I'll have no idea what's going to happen in my day.

Similarly, geographically isolated CLNs preferred independence afforded by the remoteness of their location, as Nicole described:

I'm well isolated from the mother ship and I love it. I wouldn't have it any other way.

However, the “disconnect” had a significant impact on the CLNs throughout many facets of their nursing. For example, they reported a distinct lack of opportunity for meaningful practice discussions due to the disconnect from peers. The CLNs recognised the importance of access to ongoing education, peer contact and the value in being able to discuss specific cases. Professional support for CLNs is explored in the section titled “Supervision and support”. Other facets with respect to the ‘disconnect’ are now discussed.

Solitary practice

Being removed from the health setting without easy access to peers, health professionals and services, and health information generated particular challenges. Stress, anxiety and the burden of working alone were common issues identified by all the CLNs. Not being able to contact their forensic colleagues whilst at court to discuss matters, sound out their assessment and seek advice was a major concern. Therefore, normally the CLNs were alone with their assessment, decision making and recommendations to the court. Additionally, dynamics related to space, privacy, time frames and the public nature of the setting affected decision making. Making decisions in isolation was at times fraught with anxiety for the CLNs, as portrayed by John:

I think there's always the ethical problem of, this is your story but I'm going to have to tell others what you're saying. I have to give your lawyer a heads up on, yes they are known to mental health, and just all these little things. That's one I always fight with. I think some days it's having to make that choice working by yourself, and having to make the choice of going to the court and saying there's no risk, and you sort of think, oh god are they going to walk out of court and have some “P”, and then become different people. You know it's, I think working by ourselves. We all have to make these decisions that are pretty borderline really, and that's quite stressful some days.

Also, some CLNs were not able to access collateral health information to inform their assessment and recommendations in a timely manner, although the court usually required the assessments on the same day. Time scales were very limited and the pressure on the CLNs was immense. There appeared to be little understanding that CLNs had significant difficulties in obtaining collateral information to inform their assessments and recommendations. CLNs reported that most health professionals and health services did not respond quickly to a call from them. It appeared most health services did not appreciate the urgency of the court process.

Furthermore, CLNs referred to the importance of professional credibility. Being a senior respected nurse was no longer enough. Credibility had to be re-earned in this setting hence the importance of having collateral information available in a timely manner. Gaining respect was described as hard work by Bridget:

Like, you can't presume that people will take everything you have to say, in the same depth that in an acute hospital setting that would be taken into account reasonably strongly, same in a crises team setting, it would have quite a bit of clout. All of a sudden you don't have the credibility, you don't have the clout, they don't know you, and you have to build up that credibility, that level of respect on their part for you, through proof, and its hard yakka, I have found.

Time frames impacted on the assessment. Generally, the CLNs reported assessments had to be conducted at a fast pace within a very limited time frame and with constraints on space. For example, John described practice in a busy urban court:

Sometimes fifteen minutes is a luxury and this is why I don't write screeds and screeds, I call them my snap assessments. Often time is limited with lawyers wanting to speak to them, the limited interview rooms that we share with others, being called into court half way through an interview.

Indicative of the isolation and impact of solitary decision-making, all the CLNs described significant scenarios they had been involved with at court, which had caused them considerable angst, both professionally and emotionally. One CLN described how having their practice investigated influenced subsequent nursing practice. The intensity of this experience that had occurred some time ago was palpable:

I've had a couple that have been scrutinised in detail...//... that's when files got uplifted and scrutinised by police, by probation, by [forensic service]. I had to go through a two hour interview with probation, but all they really wanted to know was what I meant by certain words and the notes in the file...//...and it's got to a point now that, because of that, I will not go home at the end of the day without having finished all my clinical notes, and even if it means I've got to finish at seven o'clock. I get criticised by the hospital and my team for that. But I won't actually go home without having finished my notes because there's always the possibility that your notes will get uplifted if something occurs within twelve hours, and there's nothing you can do about it. It got to a point where the detail I'd gone into was getting a bit hard to, to maintain, but it just reinforced that I need to maintain that level.

CLNs had to manage multiple demands on their own. However, despite the adversity often experienced by the CLNs they persevered to obtain appropriate health outcomes. Some CLNs experienced extremely stressful situations resulting in summonses to Coroner's Court to defend their assessments, liaison, interventions and

recommendations. Of interest, it was reported that, following these experiences, individual forensic services initiated a roster of forensic consultants who were always available to take calls from the CLNs. Unfortunately, this was not extended and applied nationally for all CLNs and court liaison services.

Work ethic

Encompassed within this sub-theme is the work ethic of the CLNs in relation to practicing alone. Many CLNs worked extensive hours. There was a sense of responsibility to follow through until the job was finished. This was a burden for the CLNs. Concerns were expressed that they were not compensated for the extra time worked. Furthermore, the often changeable and lengthy court process also impacted on CLNs' ability to complete tasks within an eight hour day. The CLNs were at the mercy of the court process and often CLN duties could not be completed until the court outcome was decided.

The CLNs articulated that they may be the last health professional to have assessed the person going into the prison or being released on bail. If their assessment and outcomes have not been written up and there was still liaison required with the admitting prison or a mental health service, the CLNs considered it was more practical and safe to complete that work themselves.

Ethics

The nature of the court environment is well described in the literature as potentially coercive in relation to the mental health professional and patient relationship (Evans, 2007). The underpinning ideologies of justice and health can be at odds with one another. This may manifest in tensions for the nurse as a health professional in relation to therapeutic endeavours and when providing information and advice to the court, which is a shift from a traditional nursing focus. CLNs referred to several ethical tensions during the course of the interviews. The tensions relating to potential ethical concerns are presented under six headings.

Tension between the aims of the two systems-justice and health

The CLNs expressed that they were at the nexus of two very different systems. The complexities the CLNs were working with were described by Michael:

Well I think they're two totally different systems and that's something I often feel really aware of. I can think of a woman recently, they gave her a long term inpatient admission, they were trying to help get her stabilised...//... she ended up pulling a knife on these two nurses who were working on nightshift demanding the drug cupboard key. The judge gave her two months, and she'd already done it twice before. I just thought this is really wrong, and the other judge is like, I don't agree that the justice system is the place for you. I felt very conflicted about that. But from a totally different point of view. Sometimes I think there is a time and place where people need to be held accountable for what they do.

Michael expressed a common concern for the CLNs. They are situated in between the mental health system and the criminal justice system. The perspectives often conflict. There was potential to be drawn into the justice culture. However, this potential dilemma had not been raised with the CLNs through mentoring, education or training.

The CLNs repeatedly referred to the strangeness of the environment and the role; for some, it took at least six months to feel comfortable. Michael expounded on the role discord he experienced:

I really hate seeing people go into custody and sometimes I feel quite conflicted where I feel tempted to wade into bail issues for people. But I think, well, it's not part of my role. We can provide mental health care to someone wherever they are.

The CLNs developed knowledge and ways of managing as they encountered various scenarios within the justice setting. This took time, as they became familiar with the contradictions and started to explore them.

Court as the client

The CLNs described feeling at odds regarding what they viewed as their role as an agent of the court and the relationship they had with the person at court. They referred to the shift in focus from the traditional nurse patient relationship. Bridget captured how initially being at variance with the role of being a nurse in that setting felt:

I felt like a fish out of water cause I wasn't quite sure. I'm a nurse. How the hell do I go about doing this sort of stuff and being impartial and objective, providing information to the [Court] and not even caring about the patient? It's no longer a patient that you're dealing with, you're actually dealing with the court which is your client.

Bridget discussed the vulnerability of the people she assessed and the issue of consent. A shift had taken place in her thinking; she viewed the *court* as the client.

The CLNs were very cognizant of their role in protecting people's health information. They acknowledged that providing health information to the court was complicated. The potential for slippage of nursing ethical standards was recognised by the CLNs in the areas of consent and information sharing.

Confusion existed regarding their responsibilities as nurses in providing advice and recommendations to the court. This was particularly an issue when judges directed the CLN to provide specific information for which CLNs may not have the relevant person's consent. Therefore, a very real tension exists between patient's rights and the nurses' role in providing information to the court. Bridget's perspective aligned with that of the other CLNs:

There's an element of justification in [providing health information to the court] I think. ...//... I had a real run in with the judge about putting someone in hospital and, [the judge said] well no this isn't mental health this is criminal and I'm in charge of this court and, you're not here to look after that person you're here to provide me with information.

Another contradiction occurred when CLNs' opinions regarding risk were used by the court as justification for a person to be remanded in custody. Michael reflected on the internal conflict he experienced having to remain firm because of the court's decision and not be in his standard nursing role. He had assessed someone who had posed a risk to the community and himself with a firearm; follow up with mental health services would have been ideal. However, he was remanded in custody:

The judge had the information and they still made their decision based on the information that they had. I think as long as you've given the information. And you can't sit on that information you have to disclose it ...//... I guess the judge has to be satisfied that those risks are going to be able to be managed and sometimes if you don't have a clear plan it can be hard for the court. But I think it is definitely an ethical conflict.

The perspective of the CLNs was that the aim of the role was to assist the court which the CLNs sometimes felt was at odds with being a nurse.

The dilemma of informed consent

Obtaining consent is a fundamental principle in health care. The CLNs articulated a great awareness of the potentially coercive environment they practiced in and that obtaining consent was fraught with anomalies.

CLNs had considered whether gaining consent from potentially mentally disordered or cognitively impaired individuals in court cells could ever truly result in a valid consent process. Bridget's example showed the particularly coercive situation when people were "stood down" in custody or in the court cells and told by the court they were to speak with the CLN:

I don't think you can actually get informed consent on their part. But, say for example I go down [to the cells] to see someone. They give their consent, but they are obviously quite unwell. If I think the person's acutely unwell then I would be wanting to initiate papers and it would be included in my explanation as part of the letter to the court. I would be asking for an adjournment.

Despite the person not giving consent to speak with the CLNs, the nurses usually provide some information to the court about the person. Lynn had contemplated whether written consent would be meaningful if legally challenged and whether the process the CLNs went through would stand up to scrutiny:

I didn't worry about it in the end, I thought, well no there's no point in it because it wouldn't stand up to be honest. I still think it could be challenged, and it could be ultimately used against you. Because I don't know that you can change, it's a coercive environment as I say.

In attempting to manage informed consent, CLNs all described a clear process of introducing themselves, their role, and the limits to confidentiality.

Evidence of having obtained consent is important for health professionals. The only way to achieve evidence of having obtained informed consent is with a written record. The feasibility of obtaining written consent from people subject to the criminal justice system was clearly a troubling issue for the nurses. As Michael described:

It's been something I've been thinking about. I sign that they have consented but, I don't ask them to sign it.

There were a variety of practices occurring. Some CLNs obtained written consent, others did not, and sometimes they stated it was not possible. According to John, asking people to sign consent to be interviewed generated mistrust:

I used to [get written consent] quite regularly and then I found if I got them to sign it, they became a bit suspicious and a bit guarded because it became a little bit formal. Most of the time I will say to them, look I'm going to talk to your lawyer about this, so you need to tell me if there's anything you don't want your lawyer to talk to. Anything I'm going to tell the court or

the judge I will talk to you about first. But I don't actually very often get in writing. And that, sometimes I think about that.

Importantly, even if the person does not consent, the CLNs submit an opinion. CLNs reported they felt unsupported and isolated regarding consent processes. Lynn suggested that CLNs “*need some sort of definitive ruling on it*”.

Disclosure

CLNs expressed a variety of concerns regarding sharing information in court and in the health setting. They reported the potential for the information they provided to be misinterpreted or used for other purposes.

CLNs provide information and recommendations from their assessments to a public forum – the court. Three issues were evident: the judges' authority, the CLNs' autonomy, and CLNs' lack of control. CLNs clearly felt as if they had no choice as to what information was shared with judges. Michael's description typifies the general understanding the CLNs conveyed with respect to judges' powers:

When I'm training people that's the first thing they ask me is, what do I say when the judge asks me [has this person got any mental health issues]. I said well I think that you have to tell them because I don't think you can say to a judge 'I'm not going to tell you it's none of your business.' I guess at the end of the day, you're in this court of law and it's their court.

Practicing in a rural setting, Lynn alluded to a fluid arrangement regarding information sharing. A unique set of relationships and understandings had developed. However, the need for maintaining clear boundaries with particular professionals was evident. It is important to appreciate the context: these understandings and relationships had not occurred overnight. They took years to form. Once again the importance of developing credibility was referred to. Lynn described that credibility as enabling her to work with the other professionals in the setting with this fluid arrangement:

Within our established network, which is corrections, police, court staff, we have a very good working relationship. If the registrar in [xx] rings me about somebody we will discuss all the aspects of it in total confidence and trust, purely to get advice and direction. So there's no issues around that. I don't cross boundaries when it comes to liaising with lawyers because they have a specific purpose and they'll utilise whatever they can.

“I don’t know if it’s just us”

The CLN documentation may or may not contain offence-related information such as criminal histories, summary of facts and description/details of the offence(s). Whether this information should be placed in health files was an issue for CLNs. A number of matters contributed to this dilemma: privacy, misinterpretation and future stigma. In particular, placing information about offences in the health file leaves the potential for judgmental attitudes and discrimination if the information is not understood. Michael described this dilemma:

I also often have their summary of facts and things like that attached to [the CLN assessment]. So I think that shouldn’t be in the health file, and especially with how concerned people are around privacy. And yet there’s probably pockets of stuff like that all over the place where people have gathered all this information and it just kind of sits there, and no one knows what to do with it.

Furthermore, CLNs discussed the potential for misunderstanding offence-related information by health professionals when it was used out of context. The CLNs attempted to provide a more balanced view when this occurred and to correct the misinformation, as Peter’s example demonstrated:

Everyone including the consultants, it’s, oh this person’s done aggravated robbery and they’ve done this and this. And I was like well hang on, no it’s not as extreme as you’re saying. They say they’ve got a guy on the inpatient unit at the moment; they’re calling him a rapist. I said he exposed himself, he’s not a rapist. So things can be easily misinterpreted.

The importance of understanding the information and the context can be lost if random bits of information are included in health files and assessments, as John referred to:

I have difficulties quite often with the CAT [Crises and Assessment Team] if they see someone at the police station. They [CAT team] might put aggravated burglary or aggravated something, that stays on their mental health file forever. I’m always very careful, especially on the big charges, because sometimes by the time they’ve finished in court, it’s a minor theft. And I always think gosh, if this goes on their file, someone will pick it up one day and look at it and voila.

Because CLNs work within forensic mental health services, CLN assessments and contacts are recorded on the health system databases as a forensic mental health contact. The CLNs used various means to minimise the potential for future stigma because of a recorded contact with forensic mental health services for people with no mental health history, but who were assessed at court by the CLN. Such means included handwriting

assessments so they were not lodged on the District Health Boards' (DHB) electronic record systems.

CLNs also have documentation requirements and standards to meet within their respective DHBs. This added to CLNs' pressure regarding documentation. It was clear each CLN was unaware of the documentation practices of other court liaison services. Peter elaborated on how he managed information that was considered to belong to the court:

What they say here [forensic service], and I don't know if it's just us, is our assessment is a court only document because we're contracted to the courts. Therefore our assessments belong to the courts. Therefore no one [other than court] has access to that information. What I do is, do the mental health stuff only onto the clinical notes that's it, all the other stuff in terms of their recall, their ability to instruct is kept separate. And it doesn't go up on [the DHB health system]. I don't even put their charges up. Because it's confidential information and you don't know what people are going to do with it. Even their 38 reports we don't put that in a clinical file.

The variety of documentation recording practices across the CLNs included: all the CLN documentation information placed in the health file: all the information remains in the CLN office at court where no one else (health or justice) has access to it: the health assessment goes in the health file but offence related information is withheld and stays in the community forensic team offices. Some CLNs' assessments were placed in the court file with their report to the court.

Providing reports to the court

This section considers the ethical problems that occurred in relation to providing advice and disclosing health information to the court. CLNs ruminated about several facets of the assessment and report writing. They deliberated on the discussion they had with the person about the alleged offending to determine whether there were fitness or mental state concerns. While the structure of their reports was similar the depth of content and detail included varied. How much of the offending information they should document, and how much health information should be included in their reports, were troubling issues for the CLNs. There is no official guide or template for consistency regarding what CLNs report to the court. The individual CLNs appeared to have learned from what worked best following adverse experiences. Guidance and mentorship in this area was nonexistent. One CLN who practiced in isolation from the regional forensic service provided very lengthy detailed reports to the court, which varied from the practice of the

other CLNs. Another CLN had very clear templates to use for reports to the court developed by his or her team leader who had previously practiced as a CLN. These templates were used across that regional forensic service by all the CLNs.

Most of the CLNs indicated they had learned that “less was best” and therefore kept their reports as brief as possible and preferably to one page. Learning through exposure and having to shift their focus from a comprehensive nursing assessment perspective to incorporate other types of assessments was described by all the CLNs. Lynn conveyed this:

When I first started in 2000, I was writing court assessments up from a comprehensive assessment perspective. These days if I can't put it on one page, I will go back until I can. Because learning about it, the reality is that whatever you're writing to the courts is obviously, it's a legal document. There are issues around consent and informed consent. There's a perspective that regardless of the fact a client may give consent, it's a coercive environment. So, quite frankly, I write very little.

As mentioned above, the CLNs were making judgement calls about how much information they disclosed, recognising the public nature of the court setting. The CLNs were attempting to protect people's interests. In a similar vein, Michael describes managing confidentiality in the assessment and documentation process:

For example, when you're talking to someone about their fitness you've got to really talk to them about what they've done and their view of it and what they've talked to their lawyer about. So I'll say to people, look what you tell me about your offending, I'm not actually going to write it down, I'm going to write a general statement about whether I think you understand what you're charged with, not what you tell me about it. So that I'm really clear when I've been training [a new CLN] you don't write down what they say about their offending because you can have those things subpoenaed, and cause they're actually property of the court. But you can make a general statement this person has discussed their offending and they are clear about what they're charged with, how they want to plead, how they're going to instruct their lawyer, which is what the issues are.

Of interest was the belief that the assessment documentation belongs to the court. This was an area of discrepancy across CLN practice and adds to the role confusion in the absence of clear guidelines for CLNs. Written communication was a regular requirement of the CLNs' role. They were responsible for several categories of written communication, to the court, for the DHB files, and for data collection systems. Practicing nursing in the public and justice environment influenced the CLNs' decision-making regarding recording information and information exchange with the court.

“Wading through the mud”: outlining the requirements for professional clinical supervision and support

CLNs were exposed to potentially emotionally disturbing scenarios through frequent exposure to serious and often bizarre offending behaviour. The CLNs were asked to talk about their experiences of clinical supervision. All the CLNs shared stories of assessments they conducted involving people who had committed horrific offences. CLNs described the personal effect on them of assessing people who detailed their offending behaviour.

The repeated exposure to anti-social behaviour had an impact. They articulated the potential danger of repeated exposure to the serious and intense situations becoming the “norm”. The repeated impact of these “everyday” factors and of listening to what was happening in the court had the potential to de-sensitise CLNs to the people and their circumstances. Michael described that CLNs could lose the essence of what a mental health nurse is:

Just sitting in court sometimes and hearing lots of stuff that people have done. I think you could get a really distorted view of humanity. I think that sometimes when you're not talking with other court liaison nurses who are dealing with the same stuff then ...//... you're not even perhaps aware that you are getting de-sensitised.

The majority of the CLNs had not been able to access suitable clinical supervision with nursing peers. One CLN had access to a nurse consultant in the forensic service and a team leader who had practiced as a CLN, who the CLN used informally to discuss practice with. In the normal course of events, CLNs should be able to reflect on their nursing practice during routine clinical supervision. However, they found the context they practiced in, the potential consequences of the decisions they were making, and the scope of their practice were beyond most nurses' experience and understanding. Some CLNs utilised forensic psychiatric consultants to thrash these scenarios out, because they understood the impact of the legal and psychiatric issues.

The CLNs were constantly working within two very different systems. CLNs reported the importance of being able to reflect on a practice setting that was fraught with potential ethical issues in a safe environment with health professionals who understood the context. Not being able to access suitable clinical supervision was another means of isolating the CLNs and exaggerating the impressions of not being part of the health system.

Organisational processes

Within this sub-theme, three distinct categories emerged in relation to organisational processes: access to adequate resources, the importance of maintaining a competent presence in the court and changes in systems and services.

Resources

CLNs raised issues that impacted on their ability to provide advice and recommendations to the court in a timely and professional manner. As identified in the survey data, discrepancies existed across the CLN group nationally regarding access to relevant information communication technology and DHB health care information whilst at court. These disparities generated significant barriers to providing a timely service to the courts. Not having the required resources to carry out their role competently and professionally added to the sense of their work not being valued.

A cumbersome and time consuming process ensued for CLNs who handwrote reports to the court, then photocopied them and handed them up to the court registrar. Some CLNs had access to a computer at court to produce reports but no access to DHB health databases. For example, Nicole had to leave court, go to her office to write reports and then print them:

I've got a laser printer in the office. ...//... It's just a nonsense and I don't know whether other DHBs have a similar kind of problem. There's a lot of failure to talk, failure to learn from each other's experience, particularly in IT.

Only the two rural CLNs did not have a desk or space available in the court building. They used their laptops on their knees in the court or in the waiting area.

For instance, Nicole was provided with a laptop by her service but expressed her frustration with management who clearly had no understanding of the practice setting. There was nowhere for her to plug it in and use it in the court:

So when they're [forensic manager] saying about expecting us to take a laptop I'm thinking to myself, okay, well that's all well and good but where would you plug it in? Where would you be able to sit with it?

Lynn described the ideal world where she was using a laptop with access to DHB health files. She wrote reports while either sitting in the courtroom or in a court office, then was able to email them directly to the court registrar. However, others did not have this

facility. They faced delays obtaining information or not being able to incorporate pertinent health information into their reports. The potential was for the CLN to be exposed and vulnerable if they did not have the relevant mental health information to inform their recommendations to the court.

Presence

Many CLNs expressed dissatisfaction that there were no nurses trained and able to fill in whilst they took leave. Furthermore, because of their work ethic, CLNs felt that they could not take leave because the role was not adequately covered. The larger forensic services were able to train other nurses within their community forensic teams to provide cover. However, the CLNs identified issues regarding enough exposure to the role and having the confidence to provide the necessary cover in court.

Additionally, the importance of maintaining a “presence” in court was highlighted. CLNs found that if they were not present in court, then processes were not followed. For example, screening assessments were not requested, often resulting in orders for formal court reports that were usually inappropriate. This meant the gatekeeping function of the CLN role was not being utilised. Inappropriate orders for court reports cost health and justice resources. Other examples of what was missed if experienced CLNs were not present in court included people with possible mental health difficulties not being assessed until further through the court process. Therefore, the opportunity for early assessment and identification of mental illness and referral to further assessment and treatment was delayed or lost.

Some CLNs attempted to maintain the presence in court by taking leave in slots of a week at a time therefore minimising the potential for lack of CLN cover in the court. Others in a rural setting managed leave by taking it in-between court sittings. The inattention to the need to have nurses trained and able to provide competent cover in the courts added to the sense of the practice not being recognised and valued.

Changes in systems and services

Commonly, CLNs were not consulted, informed, or educated regarding changes to processes relating to people with mental impairment in the criminal justice system. Ironically though, CLNs are the people who have to work with any changes and are considered the expert resource in court regarding this interface. Again, CLNs demonstrated their adaptability and willingness to make the role work and obtain the

best outcomes for mentally impaired people in the criminal justice system. CLNs were proactive in seeking information and education after such changes.

Also, CLNs noted significant changes that occurred in Legal Aid Services and the way the duty solicitors were allocated. Following this change, CLNs encountered duty solicitors and assigned counsel who had not worked with people with mental health issues and the relevant services. Previously, there was a group of lawyers in most courts who worked with this client group and were aware of the court liaison service. The impact of this change was significant for the CLNs and the people with mental health difficulties in the criminal justice system. CLNs were not consulted and the impact these changes may have on their role or people with mental illness appears to have not been considered.

CLNs reflected on how they had managed changes to legislation with the advent of the CP(MIP) Act and the ID(CCR) Act. At the same time, there was significant change to service configuration for people with intellectual disability. On the whole, the CLNs reported they had to educate themselves regarding the legislation. They also had to become familiar with services and staff. The CLNs were not informed regarding significant legislative and funding changes, though the CLNs were the key people in court who had to understand the legislation, provide advice and liaise with the wide variety of relevant services.

Barriers to negotiating appropriate outcomes for people seen at court

Several barriers were identified as hindering the smooth transition and negotiation of appropriate outcomes for people with mental health concerns. These included deficits in knowledge and resources, establishing and maintaining reciprocal collaboration, and negative attitudes. Overcoming these barriers required fortitude and creativity on the part of the CLNs. They considered that they were viewed as not part of the wider mental health service and felt that better knowledge and understanding of the court liaison service and the CLN role would help overcome these barriers.

Knowledge barriers

A barrier to negotiating smooth facilitation of mental health interventions from court appeared to be the misunderstanding of the parameters of forensic mental health services amongst the wider mental health service. To affect suitable outcomes, CLNs

had to be able to defend decisions and have the resilience to carry through, despite attitudes and barriers. Bridget provided an overarching summary of this:

I was guilty of this when I worked in general mental health. There was a perspective that forensic psychiatry is, if it's a crime, it's forensic full stop. It's black and white. There is a boundary. It's not until you work within the arena of forensic psychiatry that you realise that it's actually not that concrete. It's not that black and white and that the boundaries of what really is forensic and what may be forensic is a very grey area and one that often has political connotations.

The other key frustration experienced by all the CLNs with respect to liaison with mental health services was the unavailability of inpatient beds for acutely unwell people, both in general and forensic mental health services.

Reciprocal collaboration

The importance of relationships with the various stakeholders in the legal setting was emphasised by all the CLNs. However, establishing and maintaining relationships was demanding. CLNs were exasperated when they were not consulted or asked to conduct screening assessments. Nicole like others was powerless. Despite having met with one judge to agree on processes, the judge later disregarded the processes by not requesting a screening assessment prior to ordering a formal report. The result was that Nicole then had to backtrack to find out why the report was ordered, so she could inform her colleagues.

At the end of the day, the judges have the final say. Sometimes it was frustrating for CLNs when judges did not request a screening assessment and simply followed the request from a lawyer, prosecutor or probation officer. Other situations, such as inappropriate admissions to forensic mental health units, resulted when CLNs advice was disregarded or not sought. The chaos generated from these scenarios invariably resulted in taking many people away from valuable clinical time.

Being able to work collaboratively was crucial in order for the CLN to function. However, there needed to be reciprocal relationships with clear boundaries of roles supported by service level agreements.

Overcoming problematic attitudes

Unhelpful attitudes and derogatory language regarding people with vulnerabilities negatively impacted on the CLNs both professionally and emotionally. On the whole,

the CLNs managed these attitudes through using an educative role-modelling approach. They maintained their role as nurses in advocating for the people with health concerns. Michael described how he viewed the CLN role in this:

I think also being able to feel there's someone in that system advocating for people with mental health problems because it's a shit of a system. Sometimes I look at the court staff and I think they're often very anti the offender and it's like they develop this attitude and I think, gosh you've forgotten that these people are people.

All CLNs referred specifically to the attitudes and culture of the police. Novice CLNs particularly found this troubling if they had not encountered such attitudes previously. However, Michael described some positives occurring:

I have a lot more conflict around the police. I don't think it happens as much now. But when I first started in the role I really felt that they were definitely trying to use me for a fishing expedition on all sorts of things. But at the end of the day I think that's their mentality, and most of them I find actually really good. Like the police that managed the escort team I think are amazing. I have a great relationship with them ...//... Although there is still some of it [negative attitudes] around, there is definitely a change in that culture.

Correspondingly, the way language is used can generate powerful responses in people and influence outcomes. This is particularly evident within the court environment where the entire setting appears to rest on oral skills. CLNs reported gaining credibility, being accepted and developing relationships within the court setting were key to changing negative attitudes. Negative attitudes were directed at the person with mental health concerns and the CLNs. Nicole's comments typified the common experiences of the CLNs before they had become "accepted":

When I started here, I spent probably the first two years ingratiating myself in with the legal fraternity. I felt like an impostor. I would dutifully go and sit in court and was studiously ignored by everybody really. As the years have gone on I've developed a good relationship with the legal fraternity.

Commonly, the CLNs referred to being spoken to in a derogatory manner by some of the judges. Lynn captured the impact this humiliating treatment had on the CLNs:

We had a district court judge here, Judge X who ...//... absolutely castigated in open court anybody who was unable to fire the answers back that he wanted when he wanted them...//... He had a go at me and picked on me three times in two days. All I can say is his attitude was demeaning.

The CLNs had no recourse to address these issues with the judges other than to discuss matters with their managers. Unfortunately, CLNs largely felt unsupported due to their managers' lack of understanding of the CLN role, what they face and had to deal with.

Professional requirements

Meeting professional requirements was a considerable concern for CLNs. In seeking recognition of an expert level of practice in New Zealand, nurses are able to submit to Professional development recognition programmes (PDRP) which provide the means for assessment of competence on a scale ranging from beginner to expert. The Nursing Council of New Zealand (NCNZ) provides guidelines regarding PDRP programmes (NCNZ, 2013). The aim of the PDRP process is to assess competency and ensure that nurses are competent to practice as per NCNZ and Health Practitioners Competence Assurance Act requirements (NCNZ, 2013). Unfortunately, national variation exists in the PDRP programmes and they are not accessible for all nurses (Kai Tiaki, 2009). The levels of practice under the PDRP are linked with remuneration (NCNZ, 2013).

Given the level of skill and expertise, the CLNs were devastated when they were not accepted for level 4 expert PDRP. This emphasises the different knowledge and practices required of this role compared with other mental health nursing roles and the sense of not being professionally valued. Bridget did not achieve his goal of becoming a level 4 expert nurse. Her frustration was echoed by all the CLNs:

I've actually applied for my level 4 [PDRP] and got turned down on it. I sweated like a stuck pig putting it together, and when I went into my interview of explanation, was told, well we can see you practice at level 4, but your documentation doesn't indicate that.

A difficulty existed for the CLNs finding peers who were familiar with their practice to provide peer reviews, due to the CLNs everyday practice not being with other nurses.

Michael captured the sense of frustration:

They've [manager] just brought through this new thing now saying that unless you're doing PDRP, you're going to get no study assistance. PDRP's been an issue for me in terms of, I tried, I had a couple of goes at it. Every time I got to the peer reviews I got stuck because I didn't have any peers and they weren't prepared to accept non nurses.

Additionally, CLNs did not have the opportunity to take nursing students or work with enrolled nurses and therefore were not able to demonstrate they met the professional PDRP criteria to supervise students and enrolled nurses.

As with the survey data, the CLNs all expressed dissatisfaction regarding lack of recognition for the complexity and responsibility the position entails. Lynn's thoughts captured this:

I want the job recognised as a sub-specialty. My immediate clinical nurse manager is supportive and our clinical director is very supportive ...//... there's several limbs to what I do ...//... I essentially do court liaison, community case management, I represent our DHB from a forensic perspective.

CLNs articulated frustrations regarding limited ability to attend conferences to network with peers and be exposed to contemporary research and practice developments in forensic mental health. It was their opinion that bureaucracy generated a block to practice development and recognition. The need for support regarding these issues is apparent throughout all the themes.

Summary

This theme portrayed the multiple dimensions that contributed to CLNs' sense of isolation and identity concerns. The first three sub-themes (unfamiliarity, modification of language and disconnect) document the CLNs' experiences of commencing in a role where the practice setting was completely unfamiliar. The experiences were compounded through lack of role preparation. One example of this inadequate preparation and unrealistic expectations for CLNs involved working with people with intellectual disability. Undergraduate education and work experiences had not equipped CLNs with the expertise required to practice in this legal setting.

The sub-themes of work ethic, organisational processes, and barriers to negotiating appropriate outcomes for people at court provide insights into the dedication of these nurses working under often onerous conditions. Many CLNs work with inadequate resources. On a daily basis, they encounter inadequate understanding by their managers of the hours they work, what is required of the role and how the court functions. Despite constantly coming up against negative attitudes and resistance from colleagues in mental health services, they persevere in seeking appropriate outcomes for people in the courts with mental health difficulties.

Ethical concerns including obtaining consent, disclosure and exchange of information cut to the heart of matters that are troubling for CLNs. They were not adequately

prepared when commencing in the role and nor is there an ethical framework to assist the CLNs with these concerns.

The sub-theme professional supervision and support details the importance of ensuring the CLNs have access to credible professional supervision and support. The section culminates with professional requirements. Because of the distinctive practice setting the CLNs were not viewed as practicing at an expert level. This appears incongruous given the extensive nature of CLN nursing. Unfortunately, these factors reinforce CLNs' sense of difference and not being valued.

The theme "part of but not part of" provided details of the significant difficulties the CLNs faced in their daily practice. This assists with understanding the sense of not holding a place of worth in either the health setting or the court but more particularly in the health setting. However, despite these complexities the pervading sense was of a group of nurses who although practicing individually were exposed to similar tensions and had applied themselves to meet these challenges.

Theme Four – Added layers

This theme synthesises the particular competencies the CLNs developed in addition to their mental health nursing knowledge and skills. The four sub-themes are: wisdom and professionalism, knowledge of legislation and medico legal environment, diverse assessment skills, and collaborative practices.

Wisdom and professionalism

This sub-theme considers the additional expert knowledge CLNs have attained and how this is manifested in their practice as their confidence grows. CLNs had a sound foundation of mental health nursing and risk assessment skills. This was clearly apparent and, in fact, the dialogue about practice quickly indicated the CLNs' level of practice was expanded in many aspects.

The CLNs reported extensive knowledge of mental health services and wider organisations. The above analysis illuminated that CLNs possessed extra layers of knowledge and skills. These included report writing, conducting particular assessments, and collaborative practices with a sophisticated awareness and appreciation of the entire court setting.

The CLN remains focused on the care of the person while being aware of and managing potential ethical quandaries within the criminal justice system. This demonstrates a sophisticated level of awareness and thinking. An example of the level of thinking involved is evident in Lynn's depiction, which captured the need for experience and the potential that exists for the unwary CLN to be unduly influenced:

It's not a role that you would want to put someone in that has very little mental health experience, because a lot of what you're being asked to give judgments on, will be influenced by your experiences and time. I think it's a very specialised role definitely, but it's one that I think needs a lot of experience attached to it, because you can be coerced by lawyers into making decisions that you may not necessarily have made without that pressure.

The concepts of credibility and professionalism extended to wisdom, according to Nicole:

The single greatest thing that anybody coming into this role, is it's not so much a question that your face has to fit, but your capacity to conduct yourself in a professional manner. To have sufficient certainty about your knowledge base and to speak with some authority about what you know and to speak in a manner that demonstrates your professional credibility, is what catches folk.

Bridget reported that the advice she offers the court is an example of expanded nursing practice. In a more traditional mental health nursing setting, the role of the nurse does not involve providing explicit interpretation and opinions, particularly in a public forum:

What I like about having a summary is that if you are doing purely clinical notes you can't do interpretation, it's got to be purely factual. Whereas in a summary, you can put down your interpretation of clinical fact. So there's actually a bit more licence to explain things. From that, I go onto my recommendations to the court, like due legal process or another factor.

It is not part of normal practice for mental health nurses to submit reports to District Court Judges. But report writing has become a standard part of the CLNs' practice. Furthermore, mental health nursing does not normally require in-depth comprehension in specific areas such as the law. In order to function as a CLN with credibility, knowledge of specific aspects of law were vital.

Through the establishment of those vital relationships with extensive services and organisations, the CLNs facilitate the diversion of people to health services. Lynn

depicted the coming together of mental health expertise, the knowledge of legal processes, and the flexibility CLNs must have:

I work closely with corrections and when there are maybe some psychiatric issues but they don't fully meet criteria for a health assessment, I can offer my/our mental health knowledge and experience when they're [probation] doing pre sentence reports ...//... I like to use health assessments [formal court reports] when they're indicated, but otherwise, because it's costly and timely, I try and look at alternatives and corrections and supervision is actually very helpful because people can be directed to attend mental health [services].

CLNs need to know the questions to ask and the issues to explore regarding mental impairment within the justice system. This background knowledge enabled CLNs to have those crucial discussions with defence counsel. Lynn described the robustness required of the CLNs backed by their knowledge base and familiarity with the area:

I was very pressured by a lawyer to ask for a 38 [section 38 report CP(MIP)Act] on sentencing for a lady that has never had any mental health involvement at anytime. But because of the nature of her offending ...//... he [lawyer] was quite determined that a sentencing report would be helpful. But from my position, what role would mental health have after the report? She hasn't had mental health input up until now. It's certainly not indicated that mental health would be the appropriate kind of intervention as such.

(Refer to Appendix G regarding section 38 reports). Remaining impartial and articulating the possibilities, while defending their opinions, signified CLNs as confident and mature practitioners. In this aspect of their practice, as in Lynn's example, CLNs perform a protective role for the person; they ensure the person is not unnecessarily stigmatised through having a "psychiatric report" completed for the court. At the same time, they are ensuring there is prudent use of justice and health resources.

The "knowing" was borne out of experience, time in the role and being critical thinkers seeking knowledge and who were able to assimilate and apply it. The ability to think critically was signalled in descriptions of advanced nursing assessment and management of complex scenarios. CLNs creatively, resourcefully sought health outcomes for people with vulnerabilities in the criminal justice system. Accordingly, CLNs had to be adaptable, confident and establish the relevant relationships.

Knowledge of legislation and medico legal environment

CLNs' expertise regarding the medico legal environment fell into two components. First, they were expert resources for members of the criminal justice system regarding

mental health issues, and second they were expert resources for health professionals regarding the mental health/legal interface.

Expert resource regarding mental health issues for court and justice agencies

CLNs reported that they were contacted for advice by the court registrars, the prosecution, corrections and lawyers. The resource role provided by the CLNs extended beyond the court setting. They all gave examples of being contacted by police and other services and organisations. John's example depicted this:

I get phone calls from those little police stations ...//... We don't really want to arrest [xx] but what should we do? I guess I'm the same voice at the end of the phone. If you ring the CAT team you get someone different all the time, and I guess the police all know I'm here.

CLNs gave many examples in which they were consulted as experts regarding the mental health law processes. CLNs applied expert knowledge on the spot in the courtroom. They provided examples of judges requesting their input, thanking them and acknowledging they were right. With the professional confidence gained over time, CLNs were able to speak confidently to judges and intervene in the courtroom, as John portrayed:

I've had a couple lately where one doctor's saying insane and the other doctor's saying not, and in the end he [judge] decided he was going to err on the insanity bit. Yesterday, I had one come up and the same thing happened again, and I jumped up so quickly, and said to the judge, Sir, maybe you might like to get a third report. ...//... He said [xxCLN] I think that's a good idea.

They routinely provided advice to the court, lawyer, police and others regarding processes if the person they assessed was mentally unwell. While the CLNs all reported being self taught regarding relevant legislation, all CLNs were frequently approached by legal professionals seeking advice regarding the CP(MIP)Act. CLNs were beneficial as a resource around mental health issues for the courts and those in the justice setting.

Expert resource for mental health professionals regarding the mental health legal interface

CLNs were also expert sources of knowledge regarding the law for health professionals, mental health service and wider non-governmental organisations. Peter elaborated on the role of the CLN in interpreting the legal process to a member of her team:

...//... even the consultants, they're like Peter this person's going for a call over I've got a section 38 [order for a formal section 38 CP(MIP)Act report]. [I say] all you have to worry about is the 38, put it up, and they're like, okay. Or they ring me and they go, Peter we did the 38 report for disposition but then we got another report he's come back on another 38 (2)(c), I [explain] ...//... that they want to enter pleas but they have to do it before a judge, but there was no judge available they went before the [magistrate]...//... So I had to get him [patient] back to [xx hospital] back on a 38 (2) (c) the second one.

Also CLNs performed a valuable role supporting the staff in the foreign court environment. CLNs familiarity with the court system assisted other health professionals and support workers. For example, as Michael reported:

One thing I often do is, having to support really anxious mental health staff who are escorting their clients to court.

Similarly, the CLNs supported, educated and prepared carers from non-governmental organisations and their clients for court. CLNs offered support either one-to-one at court or through education sessions.

Keeping the interface open between services and providing ongoing education was a significant part of the CLNs work. Bridget maintained a relationship with general mental health teams:

When I first started, for example, at the [xx] court I tried to establish, and with one team was successful, every four to six weeks I would have a meeting with them. We could discuss whether there were any issues relating to court process, their clients going through court that they had concerns or questions about. Or if I had concerns about the way they had dealt with something that I needed to engage with them on.

The CLNs demonstrated they were able to comprehend the wider context for people, services and staff interfacing with the criminal justice system. The role extends beyond providing advice to the court to advising health professionals, outreach education and maintaining important links between services.

Diverse assessment skills

CLNs have highly developed and well honed skills in conducting assessments under pressure in the court environment. The main types of assessments were described earlier in the theme "no normal day". The fitness to plead assessment is highlighted here to emphasise the additional knowledge required to carry out the particular assessments

necessary in this unique role. It is important to acknowledge that CLNs themselves acquired the expertise regarding these assessments in the absence of formal training.

Fitness to plead

Not only do CLNs assess people regarding mental illness, they also assess for cognitive impairment. That may be a result of learning disability, mental illness, organic brain disorder, brain injury, intoxication, or other physical health concerns. Conducting screening assessments regarding a person's ability to take part in court proceedings (fitness to plead) and ascertaining whether the court would benefit from a formal report is a key function of the CLN role.

The CLNs were confident in their dialogue regarding processes with respect to the CP(MIP)Act and mental impairment. To any nurse who does not practice in the setting the "CLN speak" does not make any sense. Bridget's description demonstrated the complexity and knowledge of the legal process with respect to mental impairment in the setting CLNs have:

I may recommend that we go straight onto a section 9 with a view to obtaining further 38 reports depending upon the outcome of the section 9 hearing. Sometimes you just make suggestions for sentence, you know things like, there's no clear evidence of any mental illness, there is evidence of psychosis in a drug induced state consistently, and more in crisis at emergency departments than an alcohol drug induced state. I would recommend residential drug and alcohol ward. Residential completion of a drug and alcohol programme depends upon how serious and how historic it is too.

(Section 9 CP(MIP) Act is entitled "Court must be satisfied of defendant's involvement in offence (CP(MIP)Act, 2003, p.6). The CLN makes an evaluation of whether to advise the court to order a report to address fitness to plead. CLNs were clear that they did not decide whether a person was unfit. Rather they ascertained whether there was a valid concern regarding fitness to plead and which pathway was appropriate and to advise the court.

An appraisal of fitness to plead encompasses a different focus to a mental state assessment. The assessment of fitness to plead requires understanding of what stage the person is at within the legal process, knowledge of legal processes and expertise to recommend suitable pathways for the court to follow. Simultaneously, the CLN encounters a range of court players with a range of understanding as to what mental illness/impairment is and how that may manifest in different people. The assessment

incorporates knowledge of the thresholds, outcomes and possibilities that their recommendations can lead to. Often the decision about what to do next was complex.

The CLN assimilates all the above to provide coherent information to the court in a short space of time. This is where the CLNs' experience and need for access to robust clinical support and discussion comes to play. The CLNs work with several Acts. This is complex. They need to know the potential impacts of their recommendations.

Collaborative practices

In order to fulfil the main requirements of the CLN role (that is early identification of mental illness with diversion to suitable health care), the CLNs had developed a collaborative way of working. This practice included a significant consult liaison aspect to the role, being able to balance many factors, and the ability to convey information in many different ways. Finally CLNs referred to the importance of "familiarity" in being able to practice collaboratively.

Consult liaison

CLNs described the consultation advisory aspect of liaison. CLNs not only provided advice but also understood the person's situation in the legal and mental health systems. They attempted to discern appropriate recommendations regarding the options at a given time. CLNs were a conduit, guiding people:

I think there's a huge liaison part of the role where I'll say to lawyers, write or ring this person and ask them to put something in writing, and go and stick it under the nose of the prosecution. He'll talk to the officer in charge and see what you can get, what you can achieve doing it that way. Then if you're still having trouble come back to me. Nine times out of ten that will work.

CLNs often referred to building trust and gaining respect in the court setting. The extent of those relationships needed to be maintained but with clear boundaries. It took time to develop the trust and credibility within the relationships, as Nicole described:

As the years have gone on I've developed a good relationship with the legal fraternity. And the newer lawyers that are coming through practicing at the criminal bar are more inclined towards asking for information rather than their older colleagues who never ask.

All the CLNs described that they developed positive working relationships with probation, corrections, and court staff over time. Nicole's statement captured the

approachability and consult liaison feature that was evident in the CLNs descriptions of the relationships they had with the staff of these services:

I have a good relationship with the CYFS, staff particularly those in youth justice who will share information...//... I've had consultations with youth justice workers in supermarket aisles and out on the street as they're about to cross the road. "Oh I must just ask you about"...

Equally, developing constructive working relationships with other agencies such as the Salvation Army and Victim Advisors was seen as pivotal to obtaining optimum outcomes. John outlined how this relationship resulted in interventions for a person:

I work quite closely with Salvation Army, because they're really good for the people that are falling outside mental health, the social problem ones.

The complexity of the situation involved comprehensive liaison activity and the CLN taking into account the physical health and social needs of the person and not just a narrow mental illness perspective.

Balancing and negotiating

Commonly, the CLNs had to delicately manage various players within the setting. Many scenarios were provided which ranged from discussions with lawyers regarding whether formal court reports were necessary to an expectation that the nurse would talk with or sit with people who were upset. Therefore, importantly, before any assessment was carried out the CLNs sought clarity regarding the reason for the referral. Their time in court was precious and in managing multiple referrals in a day they needed to be very clear. Clarifying the reason for the referral was significant in deciding on what type of assessment was needed, if at all, and what information the CLN required in order to carry out the assessment. CLNs had to utilise tact and diplomacy to negotiate agreed pathways.

Familiarity

The CLNs finely tuned skills in managing and working with certain players in the setting were portrayed. Diverse ways of communicating with the court were used to convey information. The relationship with others, acceptance and credibility had developed over time to such a degree that they are able to work in this way. Familiarity and trusting relationships evolved with judges in particular. As trust was established and

respect grew, CLNs could communicate with the court using non-verbal communication. Lynn's example depicted this:

I know all the judges, the judges all know me so it can get to a stage where an issue can be raised in open court. I've been looked at by a judge and looked away and that speaks volumes when someone is trying to come from a mental health angle so to speak, because I'm well aware of all the dynamics and I don't want to get up and say anything in open court unnecessarily. A look can do things. It's a good alliance. Judges will say does [xxCLN] have an opinion on this. So there is that confidence within the judiciary that the role is valued, and it is valued and they do use the court liaison role for clarity.

CLNs utilised this way of communication to protect people's privacy by not relaying health information in open court. Well-honed communication skills allowed CLNs to build relationships and effectively liaise with a wide variety of people and organisations. CLNs fostered professional relationships through consultation and liaison.

Overall, CLNs felt that despite the time it takes to gain credibility within the court that their work and opinions were valued. Bridget conveyed her perception:

I just find that particularly these last two or three years ...//... the communication, the standing that we have has gone up, the credibility has gone up with that, and the respect for what we do and that our opinion is valued and brought into consideration in court hearings.

The CLNs did not often receive any feedback from the judiciary as to whether they were providing a useful service or what could be improved. Nor was there any forum for them to provide feedback to the judiciary.

Summary

The findings revealed within this theme indicate unique differential knowledge, wisdom and professionalism that move this nursing practice into another sphere. The depth of the CLNs knowledge in several areas within this setting and application of it provide evidence of expert and specialist nursing practice that occurs within a defined area. Differential knowledge, i.e. knowledge that is different from other nursing roles (Kent-Wilkinson, 2009), is found in particular in the CLNs' expertise regarding the medico legal interface.

The CLNs demonstrated well developed characteristics of working collaboratively, advocacy, dedication, responsibility and seriousness. The following theme specifies

requirements for CLNs in order to provide a competent service, and sustain the knowledge and workforce for this nursing practice.

Theme Five - Requirements for practice and recognition

In the interview and survey data, the CLNs identified clear requirements for effective practice. These areas of need have been grouped into five themes: education, professional supervision and support, national consistency, and recognition.

Education

No specific formal education was expected or available for nurses commencing in the CLN role or in an ongoing manner. Both interview and survey data indicated orientation to the role was not adequate and CLNs were not supported for a long enough period. Training is required regarding legislation, court etiquette, how to speak in court and court report writing. Michael's statement regarding the necessity for education on court processes was typical of CLNs' experiences:

I think the biggest learning curve for me was around the whole court processes. But also those court specific legal things like insanity and fitness and even things like epilepsy and insanity and those issues, head injuries, all that stuff that comes up that you think, oh christ, I'm not sure about that.

He highlights the extent of mental impairment and the link with the concepts of insanity and FTP. All the CLNs reported they had educated themselves. Given the concepts of FTP (which involves whether the person can communicate with their defence counsel adequately), insanity, the dynamic nature of mental illness, the importance of the screening assessment and that courts follow the advice of CLNs, it appears incongruent that there was no formal training or education. As Nicole commented:

Familiarity – time spent on the water – no one teaches these nurses about these things – this is crazy – would we send a nurse into an operating theatre without any instruction about the processes.

CLNs were concerned about inadequate continuing education because they were expected to provide advice and recommendations to the court on some complex issues regarding the mental health justice interface. Bridget referred to topics that should be discussed as part of ongoing reflection and guidance so that CLNs can practice from an informed base:

Discussions about things like the complexities of insanity at work when a psychiatrist is giving a report relating to that. What sort of details they need

to look for, what are the finer points they need to look into? So that we could explain to lawyers. You need to be aware that this is what will happen this is what they'll look into.

The interview participants were of two minds as to whether there should be a formal education pathway to practice as a CLN. They expressed concern it could cause the role to become too prescriptive and they would lose autonomy. However, they unanimously agreed regarding the need for a longer robust orientation and access to specific ongoing education. Bridget conveyed that they did not want to lose the autonomy in this unique nursing role:

One of things that attracts me most to this position, is that this is the most autonomous position that I have ever come across, and I thrive in that sort of perspective. That autonomy gives me an incredible amount of leeway; it also gives me an incredible amount of responsibility, and accountability, which I'm very happy to take on.

One of the concerns about an education pathway for CLNs related to the individual nature of the courts and personalities and how the courts function, as Bridget reported:

...//... every judge deals with things differently, all the lawyers are very different in their manner about that, they will come at matters relating to criminal procedure act, and each different police team and police team in the cells will handle those sorts of things in a totally different way, and, you can't actually structure it so that there's a universal approach, I don't think, until there's a universal approach to courts.

CLNs were very clear about the need for opportunities for on-going training and education specifically related to the role. They were forthright in stating that DHB mandatory training was not helpful in that the topics covered were not relevant to the CLN practice. All the CLNs commented on their experiences of organisational barriers to accessing relevant training. These predominately included comments about access to funding, time committed to study and paid time off from the organisation.

Professional supervision and support

The importance of professional clinical supervision for nurses practicing in mental health is well established (McKenna et al, 2010). However, CLNs require access to further support in the form of peer support and immediate access to relevant professionals to be able to discuss practice issues whilst at court.

Clinical supervision

The CLNs agreed access to robust clinical supervision with supervisors who were fully cognizant of the practice setting was essential. As Bridget observed, consistent supervision was the most valuable aspect of any supportive forum or educational pathway:

Even relatively standard situations that cropped up for assessments and reports initially were traumatic for me. So to actually be able to talk that through, and to discuss with someone else and sound off the logic of how I had gone through this and how realistic it was, so that I could clarify it for myself, and as things got more complex, being able to continue to do that.

CLNs referred to examples of having to consistently listen to and be exposed to horrific details relating to sex offences and other offending. They expressed concern regarding the impact these had and the potential for transference and counter transference. Michael expressed concern that CLNs, and other court staff, could “*get a really distorted view of humanity*”.

CLNs reported they were exposed in two ways. Firstly, they were emotionally vulnerable (to horrific details e.g. of sexual offences). Secondly, their practice was potentially open to scrutiny because they had unique and visible functions.

Support

CLNs also articulated requirements for professional support from management, in terms of being consulted and their knowledge respected. They also indicated support was required when they were attempting to obtain access mental health interventions including inpatient admission. Support for provision of appropriate resources required to perform the role was discussed.

A variety of experiences were reported with management support. Some of the CLNs had supportive management. However, the majority felt isolated, misunderstood and undervalued. Whether the “disconnect” stemmed from inadequate understanding about the court liaison role by managers is not able to be clarified without interviewing managers, but this was the CLNs’ perception. An almost “out of sight, out of mind” attitude seemed to prevail. This was evident in statements such as this example from John:

(My managers) -- haven't been here, so how can they know what I do? I find that quite disappointing, that they [don't] even show an interest, or once a year say, hey can I come in and hang out with you for a morning or something. ...//... it just, shows a bit of interest.

In the course of carrying out their role, CLNs have regular contact with and knowledge of a wide range of organisations and services. The CLNs are the face of the mental health service in the courts. They observed that as senior nurses they expected they would be included in organisational decision-making and interaction with wider organisational development, projects and activities. However, it was not common to be included in such.

CLNs felt particularly unsupported by management with respect to acknowledgement and recognition of their level of expertise. An example of this expertise was provided by Michael. When he was out of town he was contacted by the consultants to run court matters past him:

The clinical team I think are quite aware of the expertise of the role. I mean the doctors will come and sit themselves down in my office and say I just need to pick your brains. When I got stuck in [XX] with the snow they were texting me saying do you mind if we ring you we've got some court stuff we need to talk to you about.

Commonly, CLNs met unwillingness to consider specialist status for the role. They struggled to obtain support for ongoing education, PDRP, and study assistance. Conversely, CLNs found clinical directors supportive which indicates an understanding of the practice setting. A reciprocal relationship appeared to exist with the psychiatrists.

Access to forensic consultant expertise and support from court

Although this topic has been referred to earlier, it has been given a separate sub-theme to highlight the importance of forensic consultant support for CLNs because the CLNs stressed this factor. Nurses are in a vulnerable position in the court setting. They have received no formal training or education in practicing in this forum and minimal informal training, unlike their medical colleagues. CLNs must be able to access expertise, support and mentoring, both as required and on a regular basis. The forensic psychiatrists also have formal links to the judiciary which enables them to be informed. Currently, CLNs can only access this information through the forensic consultants.

“Commonality of experience”: National consistency

CLNs called for national consistency in the delivery of the court liaison nurse service. This was borne out of the sense of isolation, not knowing how others practiced and not having peer support readily available. They recommended consistency across all aspects of the role, e.g. orientation, ongoing training and education, templates for reports to the court, and standards for practice. John’s comments relayed the sense of not knowing:

...discussions on court decisions, conference meeting, inter- Regional discussions, because I don’t know how you do things down there. I don’t know how they do it in [xx]. We’re looking through all our policies and procedures, I’ve just been reading one from [xx] ...//... Ours is so out of date it’s meaningless now.

Simultaneously, CLNs did not want to lose their individual autonomy and ability to further develop their nursing roles. They also recognised regional idiosyncrasies would need to be taken into account. Similarly, while the CLNs agreed guidelines for and standards for practice would be useful, they were cautious regarding the potential for them to become too prescriptive, as articulated by Nicole:

I think National Standards are fine but that you can get into becoming overly prescriptive ...//... no two places are the same. They have commonalities but the role and the tensions that go with your stakeholders change things quite spectacularly.

As with developing an education pathway, they all articulated a need for some flexibility based on regional variances and personalities. CLNs’ comments reflected the need to be flexible in their practice and taking into account how the different judges worked. Once again they echoed that they did not know how other CLNs managed these situations.

CLNs provided rationales for a nationally coordinated forum to discuss nursing practice. They articulated that they required education that was practical and customised to the circumstances of the role, e.g. discuss cases, 38 reports (refer to Appendix G), roles and clarity regarding the parameters of the CLN role. As John articulated:

I think we come across issues that no other nurses come across and that’s one of the big things dealing with things on your own.

CLNs considered there would be educational value and improvement in consistency through discussion and debate as a group on matters such as legislation and the way they interpreted it. As John reflected:

Just to be able to sit down and talk about like that McKay thing with all of us, and our interpretation on it would have been really, really good. We were sent it and that was it, and I'm still finding that different judges are interpreting it a little bit differently.

(The participant is referring to the Court of Appeal decision in *R v McKay*¹).

The importance of being able to question and reflect with their peers on what the CLN role is in certain matters is echoed in this excerpt from John:

I'm just going with whatever judge is on. I did have one the other day ...//... the judge was floundering a little bit, so I had to say to him, well Sir you know McKay would state you must have two, (two health assessors reports) he said you're quite right. But I thought, oh I don't know whether that's my place to say it or...

Writing reports to the court is another aspect of practice the CLNs indicated could benefit from some formal guidance. This is a new facet to a mental health nursing role. As already alluded to earlier, the CLNs are not educationally prepared for this aspect of the role. CLNs reflected on details such as the appropriate structure, length, depth, content, and how to frame their opinion.

Suggestions were made regarding using online forums or teleconference links as a means to have contact with one another. However, it was discussed that these may be difficult to establish and maintain. CLNs are already fully occupied, according to the participants. The impression was these nurses have to be so involved in the day to day business. They do not have dedicated time for ongoing training/education or practice/role development. They agreed wholeheartedly that a regular national forum would be beneficial. This reflected the CLNs' thoughts of the value of having face to face contact with each other. They discussed the vulnerability for the nurse in providing opinions to the court and the benefits to be had by interacting with other CLNs and in finding the commonality of experiences.

They relayed a sense of affirmation after contact with fellow CLNs, as Nicole said, knowing it was "*not just you*". The discussion about practice and sharing of experiences helped keep her going in the knowing that she was not actually alone. These types of forums need to be promoted and CLNs assisted to attend and take part.

¹ CA391/2008,[2009]NZCA 378.

Recognition

All the CLNs expressed a desire for the position to be recognised as a specialty nursing position attracting greater remuneration. They articulated that they carried out broader and advanced aspects in the course of CLN nursing compared to other nursing roles such as the extensive liaison and education they undertook coupled with wider service engagement, specialist assessments and providing advice and recommendations to the court. The level of expertise was expressed by Bridget:

I think it does equate to a nurse specialist position, and it should be on that level, because the responsibility, the accountability and the autonomy is overwhelming. I don't know that there's any other job quite as responsible when you look at the arena you're working in with criminal courts, and you're assessing, evaluating and giving some suggestions and direction to the court about potentially highly serious charges that people are undergoing and providing some direction.

All the CLNs advised that they had attempted to have the position recognised at a higher level with no success. They suggested the reason for this was that nursing management did not understand the intricacies of the role and actually what CLNs do, as John relayed:

I think it's a specialty role. It's all part of the not being recognised. I suspect it's because management and everybody knows it's a needed role, but because they don't know what we do, we just sit there.

Evolving role

Because the dynamics of the setting include continually changing interpretations of legislation, changes to health and justice systems and services, the CLN continues to evolve. But at the same time, this fluidity within the context emphasises the importance of having clarity regarding the core function of the nurse within the setting. Lynn referred to the necessity of having role clarity:

People want things for their own reasons, and that's why it's really helpful to know what your purpose is, and not to be led outside of it. It is a role that I think deserves specific recognition, it's an evolving role and you're always learning.

The more time in the role, the greater the awareness of the complexities. Initially, CLNs were overwhelmed at the court, the relevant parties, how the legal process worked and court protocols. They became familiar with these aspects and grew in confidence and knowledge of the medico-legal interface and information exchange over time. Awareness of subtleties and nuances in the medico-legal interface and socio political

scene developed after at least six months in the role, adding yet another dimension for the CLNs:

It's interesting because I've been doing this role now for ten years and it's very much kind of like the more time you spend on the water the better you get at it and the more you know and as you know the courts are a very hallowed territory aren't they, they're amazing, you know.

Summary

Building on the findings from the survey and analysis of the in-depth interviews the nursing practice was illuminated through the five themes '*wealth of experience*', '*no normal day*', '*part of but not part of*', '*added layers*', and '*requirements for practice and recognition*'.

A very skilled group of nurses prior to commencing in the CLN role experienced a pervading sense of being out of place. They encountered a setting for which they had no frame of reference to guide them. Compounding this, each day brought new and different challenges and opportunities. No day was predictable. The extent of the role was considerable, from the range of services, organisations and professionals they liaised with to the focus of the role requiring in-depth expert understanding of a field of practice with a narrow focus - the mental health legal interface.

The theme "part of but not part of" was significant and underpinned the multiple elements that contributed to the sense of isolation of not belonging and identity concerns the CLNs experienced. Contributing to the identity concerns included modifying their nursing language, the "disconnect" from health colleagues and practicing in a completely unfamiliar setting. Inadequate role preparation compounded this. CLNs had no choice but to identify their learning needs and up-skill themselves. The distinctive practice setting and lack of understanding about the role was an impediment to demonstrating they met an expert level of nursing practice.

Insight into the dedication and professionalism of the CLNs came through. They remained focussed on seeking health outcomes for people with mental health issues in the court system despite encountering organisational barriers, and negative attitudes.

A requirement for an ethical framework to guide CLNs in the issues of obtaining consent, disclosure and exchange of information was identified. Access to credible professional supervision and support was a major concern for CLNs. Disparities were

identified regarding various functions. These differences were centred on documentation processes, sharing and storing of information. Not knowing what other CLNs did contributed to the sense of not belonging.

The knowledges that differentiate the CLN nursing compared to other mental health nursing roles were examined. In particular, they hold expertise regarding the mental health legal interface. Finally, the analysis considered requirements for practice and recognition. These included national consistency across guidelines for practice, formal education, including robust role preparation, and professional supervision and a support structure. Addressing the inadequate understanding of the extent of CLN practice was viewed as crucial to assist with issues such as recognition and support.

Confidence in their nursing practice and knowledge enabled assimilation of information on the spot, partaking of those necessary discussions and conversations, and providing a considered opinion to the court. The CLNs demonstrated well-developed characteristics of working collaboratively, advocacy, dedication, responsibility and seriousness.

The following chapter presents the findings from phase three of the research: the two week audit.

Chapter Six: Findings of the audit

Introduction

This chapter presents the findings from the third phase of the research, which was the two week audit. The audit was designed to shed light on the everyday tasks of the CLN. As previously noted, CLNs had advised that they considered the breadth of the activities they undertook were not well known or understood. Two data collection tools were used for the audit. One data collection method sought specific details regarding discussions, queries and referrals to the CLN such as: type of court, referrer, the basis for the referral, demographic details of the person referred, offence related information, interview details, outcomes and documentation requirements. The second method was used to record any non-direct patient related activities carried out by the CLN such as: education and training provided by CLNs, professional development, seeking opinions and advice, and travel.

The audit described the CLNs' day-to-day professional activities. The methodological approach, simple descriptive statistics were described in Chapter Three. Five of the six CLN interviewees participated in this phase of the research.

The data is presented in five sections: referral details: characteristics of the person referred, offending details, CLN interventions from referral through to final outcome for each referral, and finally other activities/interventions undertaken by the CLN.

Given the research targeted CLNs within adult forensic mental health services, it was not surprising that the primary area of practice for the CLNs was the District Courts. One hundred and two (96.2%) of the referrals originated in district courts, one (1%) in a rural youth court, and three (3%) in high courts. Three of the CLNs noted the period of data collection had been exceptionally quiet for them compared with normal circumstances.

Referral information

Table 6: *Referral sources to CLNs*

Referrer variable	Primary referrer		Other referrers	
	Number of responses (N = 106)	Percentage	Number of responses (N = 21)	Percentage
Family/support person	4	4	1	1
Defence lawyer	38	36	3	3
Duty solicitor	12	11	1	1
Prosecution	1	1	5	5
Police in cells	7	7	1	1
Other mental health service	19	18	1	1
CLN initiated	7	6	1	1
Forensic prison liaison	2	2	1	1
Forensic inpatient	8	7	1	1
Client refers self	1	1	1	1
Judge	3	3	3	3
Member of public	1	1		
RIDCA	2	2		
Watch house nurse	1	1		
Community alcohol and drug service			1	1
Court registrar			1	1

Table six features data regarding the origin of each primary referral. One hundred and six individuals were referred to the five CLNs during the ten day audit period. Twenty one (19%) of the individuals were referred to the CLN by two or more referrers. Of those twenty one, eleven (10 %) had three or more referrers indicating a high level of concern across agencies for the individual. The majority of the primary referrals (n= 50; 47%) were made by defence lawyers and duty solicitors. Twenty nine (27%) were received from Mental Health Services, whether adult mental health or forensic mental health.

Table 7: *Primary reason for referral to CLN*

Primary reason for referral variable	Number of responses (N = 106)	Percentage
Assessment /advice consult liaison/support- not specified	29	27
Assessment /advice/ consult liaison fitness to plead	16	15
Assessment / advice/ consult liaison insanity	2	2
Assessment /advice/ consult liaison mental illness	29	27
Assessment /advice consult liaison alcohol and drug	2	2
Assessment /advice consult liaison risk of suicide/self harm	4	3
Assessment / advice/consult liaison risk to others	6	6
Assessment /advice/consult liaison head/brain injury	3	3
Advice/consult liaison CP(MIP)Act	6	6
Advice/consult liaison MH(CAT)Act	2	2
Advice/ consult liaison potential intellectual disability	5	5
Assessment /advice/consult liaison ID(CCR)Act	2	2

The primary reasons for referring to the CLN are grouped into broad categories in Table seven. As would be expected major concerns were expressed regarding mental illness (n = 29; 27%) and fitness to plead (n= 16; 15%). Similarly, twenty-nine (27%) sought out the CLNs expressing concerns but were not clear exactly what the issue was and asked for an assessment and or advice and support for the person who was appearing in court. Often, the CLNs were asked to make contact with people who were experiencing mental health, cognitive or other difficulties in a supportive capacity. This support took many forms, such as speaking with the person to ensure they had support persons either with them at court or to go afterwards, had spoken to a duty solicitor, were engaged with the relevant health service, or simply providing a friendly hello and letting the person know that if there were any concerns they could ask to speak with the CLN.

For sixty-one (58%) of the total 106 referrals, multiple reasons were given to the CLNs with respect to requesting their involvement, for example twenty-four (23%) concurrent assessments, thirty-five (33%) advice and information and two (2%) for support for the person.

Table 8: *Stage in court process when referral was made*

Stage in court process variable	Numbers of responses (N = 106)	Percentage
First appearance	28	26
Second or subsequent hearing	40	38
Defended or status hearing	10	9.5
Hearings related to CP(MIP)Act	10	9.5
Sentencing	18	17

Referrals were made to CLNs across the criminal proceedings. The most common stage in criminal proceedings for people to be referred to the CLNs occurred during the person's second or subsequent court appearance (n = 40; 38%).

Characteristics of individuals

Table 9: *Demographic characteristics of people referred to CLN*

Demographic characteristics variable	Number of responses (N = 106)	Percentage
Gender		
Female	19	18
Male	87	82
Age group		
17-20	16	15
21-25	26	24
26-30	15	14
31-40	18	17
41-50	23	22
51-60	6	6
61 +	1	1
Unknown	1	1
Ethnicity		
Maori	37	35
New Zealand European	55	52
Pacific	7	6
Asian	5	5
African	1	1
Maori and Pacific	1	1

Gender and age

The data for the age of people referred to the CLNs is consistent with statistics for age according to 2012 data for adult multiple offence type convicted offenders (Statistics NZ, 2013). This is also similar to data in the audit conducted by Sly et al (2009) of an Australian court liaison service.

Ethnicity

The ethnicity of the individuals referred to CLNs who identified as Maori at 36% was slightly lower than was expected in this setting. Despite comprising about 12.5% of the total population aged fifteen years and over, 41% of the sentenced prison population consists of people who identify as Maori (Department of Corrections, 2012). Nor did the data reflect overall ethnicity statistics of people seen by mental health services.

According to the Ministry of Health report; Mental Health and Addiction: Service use 2009/10 (Ministry of Health, 2013), the rate for Maori seen by mental health services was 1.7 times higher than the Pacific rate, more than 5 times higher than the Asian rate and almost 1.5 times higher than the other ethnic groups (including NZ European).

Therefore, the research would expect that 1.5 times the number NZ European referrals would be made to the CLN for Maori. The actual number of Maori referred to the CLNs was under half of what would therefore be expected. This raises significant concerns regarding the attention to the health needs of Maori in the criminal justice system.

Similarly, Sly et al (2009) found referral rates for indigenous people were low, given their over-representation in justice populations.

Table 10: *Mental health information regarding people referred to CLN*

Mental health information variable	Number of responses (N = 106)	Percentage
Known client of mental health services		
Yes	93	88
No	13	12
Primary health issue		
Schizophrenia and other psychotic disorders	27	26
Mood disorders	10	9
Anxiety disorders	5	5
Personality disorders	9	8
Attention deficit hyperactivity disorder	3	3
Substance abuse - alcohol	5	5
Drug induced psychosis	7	7
Intellectual disability	11	10
Unknown	29	27

The statistic for known clients of the wider Mental Health Services (n = 93; 88%) referred to CLNs who were involved with the criminal justice system is concerning. Of those ninety three referrals only twenty-nine (27%) were initiated by the wider mental health service. For eleven (10%) individuals the primary health issues concerned intellectual disability. This has ramifications in terms of the scope of CLN practice, knowledge requirements in terms of intellectual disability, legislation and services. Inferences can be made as to requirements regarding education and training for CLNs in working with people with intellectual disability.

Of the known clients seen by the CLN engaged with the wider mental health services forty-eight (45%) identified as New Zealand European, thirty-seven (35%) as Maori, six (5.7%) as Pacific, one (1%) as African, and one (1%) as Maori and Pacific. Therefore, the ethnicity statistics for people seen by CLNs who are known clients of mental health services are essentially reversed compared to the data reported in the Mental Health and Addiction: Service use 2009/10 document (Ministry of Health, 2013). The NZ European and other ethnicities are 1.35 times higher than Maori and 8.3 times higher than Pacific ethnicities. As noted earlier referral rate of Maori to CLNs requires review. Whether this low rate of referral was due to attitudes on the part of police, legal, and health professionals, stigma and discrimination is not known.

It was beyond the scope of this research to explore details regarding the referred person's mental state at the time of the alleged offending and whether that contributed to the person's involvement in the criminal justice system. Similarly the nature of the person's involvement with mental health services was not explored. Participants were asked simply to indicate "yes" or "no" as to whether the person was a known client of Mental Health Services. Also the CLNs were not asked for details regarding the referrals other than to indicate a broad category as the reason for the referral.

Given the high number of known clients of mental health services referred to the CLNs, the data regarding the primary health issue being identified as a mental health, addiction or intellectual disability was not surprising. Twenty (19%) of the referrals had more than one mental health, addiction or intellectual disability issue. Alcohol or other substance (n = 12; 11%) was the most common co-occurring mental health concern of the people referred to the CLNs.

However, of the clients known to Mental Health Services (n= 93; 88%) only nineteen (18%) of these were referred to the CLN by mental health services other than forensic mental health services. It was beyond the scope of this research to explore this issue further, but there are serious implications here for future research. A number of questions emerged. Was the referred person mentally unwell at the time of the alleged offending? When were they last seen by mental health services? Was the person lost to follow up? Were they engaged in treatment? Was a compulsory treatment order in place? These topics are worthy of future research. For forty-two (40%) of the total referrals, further health interventions were initiated by CLNs.

Offence details

Table eleven provides details of the offence categories for the main charge the person referred to the CLN was facing.

Table 11: *Offence categories*

Offence categories variable	Number of responses (N = 106)	Percentage
Offence categories		
Violence	64	60
Sexual	9	9
Drug and anti social	6	6
Dishonesty	11	10
Property damage	10	9
Property abuse	4	4
Breach of community work	2	2

In addition to the data recorded in the above Table, forty-four (42%) of the 106 people referred were facing multiple charges. Of those facing multiple charges, property damage (n=14; 13%) and property abuse (n = 11; 10%) were the most common additional offence categories. The data in Table 11 are not broken down into pre and post conviction. Several factors affect the reliability of the data, such as some data may be self report by the person being assessed, also the offence categories for the audit were based on broad offence categories. However, when crudely compared to data for prosecuted offence categories (Statistics New Zealand 2013), it appears the violent and sexual offences here are elevated. Violence offences comprised approximately 18% and sexual offences approximately 1% of all prosecutions in New Zealand in 2012 (Statistics New Zealand 2013).

Because this audit was small and focussed on illuminating the nursing practice, it is difficult to make comparisons with other audits of court liaison services. However, it is useful to consider other audits. Sly et al (2009) undertook a six year audit of a court liaison service in Newcastle, Australia. When comparing offence categories data, the offending data here is grossly elevated in the seriousness of the initial offences, in particular the offences against people (violent and sexual offending) 69 % compared with Sly et al (2009), 32 %. The largest category in the Newcastle audit were offences against public order, 48% compared to 18% in this audit (drug and antisocial, dishonesty, breach of community work).

CLN interventions, activities and processes

Assessment interviews

Over half (n=62; 59%) of the people referred to the CLNs were formally assessed by the CLNs. The assessment interviews most frequently took place in cell block interview rooms (n= 26; 25%). The waiting room area (n=12; 11%) and the waiting area interview room (n = 11; 10%) were the other most common settings in which assessment interviews were conducted.

Of concern, were the number of assessment interviews that took place in locations whereby it would not be possible to ensure the person's privacy was maintained (n = 16; 15%). This included waiting room areas (n= 12; 11%), cells (n = 3; 3%), and the footpath outside the court building (n=1; 1%). It is also dubious as to whether the cell block interview rooms (n=26; 25%) would provide a private space.

The time required to conduct the assessment interviews ranged from 10 to 50 minutes. The most common duration for interviews was within 30 minutes (n= 20; 19%). Eighteen (17%) of the interviews took from 40 – 50 minutes.

DAO

Nine referrals (8.5%) involved DAO duties. Details were provided for seven (7%) of the DAO contacts. Those seven were referred for further mental health intervention either in a prison setting or a general mental health setting or via an order under the CP(MIP)Act.

Liaison

Liaison activity was a significant factor in the CLNs day. There were 241 liaison interventions recorded in addition to the initial (N=106) referral contact. This aspect of practice involved liaising with a range of people and services in the course of seeking suitable outcomes for the person with whom the CLN had contact. The most common liaison interventions took place with the defence lawyer (n= 77; 73%), followed by mental health services (n = 55; 52%), prosecution (n = 37; 35%) and forensic mental health services (n = 23; 22%). There was only one recorded liaison contact with probation services.

Advice provided to court

The CLNs indicated they provided formal advice and recommendations to the courts for fifty-five (52%) of the referrals. The advice was provided orally (n = 20; 19%) or in writing (n = 31; 29%). In two (2%) matters, advice was provided in both verbal and written formats. For two (2%) of the referrals there was no data provided regarding the format used to supply advice to the court.

Outcome from contact with CLN

Forty two (40%) people were referred by the CLN for further mental health interventions. These included orders for formal reports being made under the CP (MIP) Act (n = 32; 30%) and s.333 of the Children, Young Persons, and Their Families Act 1989 (n = 1; 1%). Seven (7%) people were referred on to general mental health services for further assessment, two (2%) were referred to Forensic Prison Liaison Services for follow up.

Time

The CLNs recorded data regarding the estimated time they spent on each individual referral from initial referral through to completing DHB documentation and statistical collecting requirements. The period of time the CLNs were occupied with each referral ranged from 10 to 175 minutes with the most common duration being 60 minutes.

Other CLN activities and interventions

The aim of this part of the audit was to collect data regarding any CLN related activity that took place outside of the court setting or information that was not captured in Dataset one. CLNs were asked to record details regarding education, mentoring, clinical supervision, travel, research undertaken, and any other relevant practice information. Significantly, the findings bring to light the amount of CLN time spent on consultation and liaison activities. The data is presented as weekly percentages.

25% of CLN time outside of court was devoted to provision of advice, coordination and consult liaison services regarding the criminal justice mental health interface and relevant legislation, court reports, and admissions. Services and people who consulted CLNs included general mental health services, family, non-government organisations, court staff, legal professionals, and forensic mental health services. This also incorporated delivering formal education (regarding CLN role and relevant legislation).

CLNs did not receive any training and education during the audit period. Only one CLN obtained professional clinical supervision during this period; in contrast, two CLNs provided clinical supervision to nurses (who were not CLNs). Time spent travelling to and from court accounted for 10% of the two rural CLNs' working week.

Summary

This audit took place with a small number of participants in which daily practice information was sought. The data reveals the complexity surrounding the person the CLN is involved with in the court setting. The individuals referred to the CLNs are highly likely to be clients of Mental Health Services with multiple mental health issues, and to be facing serious charges. A picture of the CLNs' practice begins to emerge with the substantial liaison data that came through in the audit. The CLN spends a large portion of their time engaging with professionals in the judiciary, and mental health services, advocating for appropriate health outcomes for individuals they have assessed. The findings of the three phases of the research are brought together and discussed in the next chapter.

Chapter Seven: Discussion

Introduction

The last two decades have seen radical changes in health provision to mentally unwell people in justice populations, including the development of nursing roles within criminal justice settings (Peternelj-Taylor, 2008). To meet the increasing demands of the new practice settings, mental health nurses have been creative in adapting their practices and developing expert knowledge pertinent to the settings. However, some factors were not immediately evident in these roles: the necessary skills to practice in these settings, precisely what was required of the nurses, and what their perceptions and concerns were. This qualitative descriptive research used mixed methods (survey questionnaire, in-depth interviews and an audit) to clarify nurses' concerns, explore, analyse and describe the nature of mental health nursing practice in criminal courts in New Zealand.

The four research questions were:

1. What is the nursing background and professional experience of CLNs?
2. What are the daily professional activities of CLNs?
3. What ethical tensions are experienced by CLNs and how are they managed?
4. What are the education, training, supervision and support needs of CLNs and should there be a specific framework or model for their practice?

The findings generated from the three phases of the research were presented through Chapters Four, Five and Six. This chapter synthesises the key findings from the three methods of data collection and integrates relevant scholarship. The key findings are summarised into six overarching themes. Finally, consideration is given to possible ways forward to develop and support this unique nursing practice in the courts and gain recognition for CLNs.

Court liaison nursing

The overarching aim of the research was to explore and describe this novel nursing role. A brief outline of the role of the CLN derived from the CLNs' information and integrated with literature follows. The significance of the findings with reference to existing literature is then discussed.

CLNs are routinely available to courts (Youth, District and High), mental health services and wider organisations and services. They provide mental health expertise regarding the intersection of mental health and criminal justice matters. This is achieved primarily through attendance at court sittings whereby the CLN is available to consult and to assess people who are referred to them. Following assessment, there are a number of functions the CLN is involved in including court diversion and court liaison. Only three quarters of the CLNs surveyed were DAOs. Of note, in Western Australia all clinicians providing services to the courts are designated authorised mental health practitioners under mental health act legislation (Brett & Blumberg, 2006). Authorised mental health clinicians have the ability to refer the person for an examination by a psychiatrist as per s.29 MHAAct 1996 (Mental Health Act 1996). Given the CLN is potentially working with mentally disordered and cognitively impaired people in a justice environment, holding DAO status was deemed a necessary statutory role to have in the setting. As McKenna & Seaton state when civil commitment is required to achieve mental health intervention for the person:

the role of the CLN is to facilitate rapid assessment by a psychiatrist and rapid transfer to appropriate mental health services by acting in the statutory role as Duly Authorised Officers under the Mental Health (Compulsory Assessment and Treatment Act) 1992 (2007, p.457).

Key functions of the CLNs work include facilitating court diversion and court liaison. Seventy five percent of the CLNs' understandings of court diversion concurred with the definition of court diversion as discussed in Chapter Two: "involves the transfer of people suffering mental illness from criminal justice settings (court, remand, prison) to hospital or community settings" (McKenna & Seaton, p.449). The gap in knowledge regarding what "court diversion" means in the CLN role emphasises the need for nationally coordinated training for the CLN role. Facilitating diversion is multi factorial involving negotiating with prosecution, defence counsel and health services to arrange court diversion to health services if this is appropriate, and advising the court either verbally or through provision of written reports. Considerable coordination and liaison skills are required of the CLN to effect court diversion.

CLNs' description of the role reinforced that it entails a broader focus than court diversion (Greenberg & Nielson, 2003; Sharples et al, 2003). Additionally, court liaison includes interaction with a variety of agencies and services to ensure the mental health needs of people involved in the criminal justice system are attended to (James, 1999;

McKenna & Seaton, 2007). CLNs outlined that this involved liaising with relevant organisations to ensure ongoing health assessment and intervention is in place.

However, the research found the CLNs extended the liaison role to provide ongoing oversight. For example, they kept their “finger on the pulse” regarding the people they have contact with at court. They perform a valuable role in linking services. As described by Turnbull and Beese (2000), the criminal justice system is “a complex web of interconnecting parts” (p.290), with each agency having its own agenda and financial constraints. The person with mental health concerns may be particularly vulnerable with multiple agencies involved. Therefore, the integrated model of court liaison as articulated by the CLNs provides a fundamental role and link in working alongside the person and general mental health services to ensure all are informed.

The research uncovered the extent of the liaison activities undertaken by the CLNs. Liaison activities and acting as an information broker constituted a key nursing function provided by CLNs. Liaison also included providing education.

Liaison activities are difficult to quantify and therefore it is easy to underestimate the value of these endeavours. If a superficial view of the liaison role is taken, then the deeper levels of and layers of knowledge involved in the practice decision making the CLNs undertake are not immediately evident. The decisions CLNs must make, such as when to intervene or not and who to talk to or not, are complex. The difficulties surrounding this phenomenon of CLN practice is discussed later, in particular, in relation to consent and information exchange.

In addition to knowledge of which pathways to pursue, knowing when to advise the court and others that referral to mental health services was not appropriate was a fundamental feature of the role. This is referred to as the gatekeeping function: “to ensure court referrals to mental health services are appropriate – that is, those referred have or may have a mental illness and require mental health services” (MoH, 2001, p.35). In doing so, the CLN makes certain that referrals to health services are suitable, including, but not limited to, orders pursuant to the CP(MIP)Act 2003 and admission to hospital from court. The CLN therefore has a part to play in protecting health and justice resources.

Another facet of the role entails CLNs providing information and explanations regarding how both settings can work together and interweave. Therefore, the CLN is a

resource for both justice and health services and personnel. Further extension of this facet of the role is the interpreter function the CLNs carry out. This is congruent with, but extends, the aims of the court liaison service as described in the framework for forensic mental health services: that the clinicians "...interpret the judicial system for assessed individuals" (MoH, 2001, p.36). CLNs are able to relay details regarding the court process in a manner that can be understood by assessed individuals and support persons, care givers, health services and their staff.

Most importantly, the CLNs viewed themselves as advocates for the person with mental health difficulties in the criminal justice system. They endeavour to make sure the person's mental health concerns are known and understood and the person has access to relevant health services. This understanding of their function as nurses in working with the person who is mentally unwell concurs with Smith's (2004) view. Despite the difficulties CLNs encountered with the therapeutic focus of nursing and the CLN role in that setting, they continued to express caring and concern for the person. This is congruent with caring nursing ideology. The concept of caring, and therefore the CLNs role in advocacy for the mentally unwell person, came through strongly. The notion of caring as "primary in nursing because it sets up the possibility of giving help and receiving help" is put forward by Benner and Wrubel (1989, p. 4). "Caring interactions appeared to be the central tenet of the psychiatric nursing role" (Cowman, Farrelly, & Gilheany, 2001, p.752). The caring and helping nursing functions performed by the CLNs came through in their expressions of "advocacy" for the person's health needs to be met.

Achieving all the above is fraught with many uncertainties. The CLN practices at the meeting point of two systems that have disparate underpinning ideologies. Each system occupies differing professional spaces. With this dynamic and being the sole health practitioners in this environment, CLNs continually encounter situations that generate ethical challenges to the very core of their nursing ethos. The multifarious and complex nature of the nursing practice and the requirements necessary to maintain safe ethical nursing practice in criminal courts are discussed through the below themes.

The overarching themes

Discussion regarding the key findings from the research follows. The findings have been grouped into six major themes with some sub themes.

Theme One - Wealth of experience

The first theme discusses the breadth and depth of experience the CLNs brought to this position. The participants had substantial professional nursing experience in relevant areas prior to commencing in the CLN role. Many participants also had extensive experience as CLNs. It is pertinent to note that, despite the considerable work and nursing practice experiences, CLNs felt un-prepared for practicing as a nurse in the criminal courts and experienced “role shock”. This concept is discussed further in Theme Three - *part of but not part of*. Correspondingly, experience of role shock aligns with Smith’s (2004) experience and the findings of Turnbull & Beese (2000) where mental health nurses recognised their education and nursing background had not adequately prepared them for the practice environment.

The CLNs had a high uptake of post-graduate education. Additionally, they were very motivated to seek out educational opportunities relevant to the practice context. However, accessing pertinent training and post-graduate education was problematic. Access to and relevance of post-graduate education is discussed further in Theme Four.

The average age of the CLNs at 55 is greater than the average age of all nurses in New Zealand at 45.6 years (NCNZ, 2012). The fact that the age composition of the New Zealand nurse workforce is a matter of serious concern is well documented (Cook, 2009; North, 2010). Several key papers make recommendations aimed at addressing the ageing nursing workforce and promoting retention and recruitment of nurses (MoH, 2006; Cook, 2009; North, 2010). Given the number of CLNs approaching retirement age, it is important that the CLNs’ experiential knowledge is captured and available to inform successive CLNs. North (2010) suggested that working towards self sufficiency within the New Zealand nursing workforce to create a “sustainable stock of domestic nurses to meet service requirements” (p. 41) is required. She suggested overarching planning that takes into account factors such as entry and exit to nursing, supply, productivity, mix, distribution, and service requirements. This research identified that there was a lack of continuity and transfer of knowledge regarding nursing practice in the CLN role. Therefore, applying a national framework such as that suggested by North (2010) to review the position and plan for the future seems sensible. It is disturbing and seems unnecessary that in the majority of situations each new CLN started with a blank canvas and had to re-create the role.

Theme Two – “No normal day”

The impacts on the CLN that stem from practicing in such an unpredictable practice setting are introduced in this theme. Diversity exists across the entire setting, from the dynamics surrounding the people referred to the CLNs, the types of assessments, to the diverse range of people and agencies and organisations the CLN interacts with in a given day. In-depth discussion regarding the complexities is explored in the following themes.

The uniqueness of each day was an element of the role the CLNs thrived on. No day or type of scenario the CLN will encounter is predictable. This makes designing an orientation package and providing support to CLNs problematic. Traditional support structures do not work for CLNs and need to be reconsidered in the light of nurses moving into non traditional practice settings.

Part of the daily diversity related to the uniqueness of every client. Of particular note is that the numbers of people and their age and gender characteristics were consistent with criminal justice statistics regarding offenders in New Zealand apart from Maori. The referral rate of Maori to the CLNs was lower than would be expected. As discussed in Chapter Two, Maori are over-represented in correctional (Statistics New Zealand, 2009) and forensic mental health services (Tapsell, 2007). Maori are also over represented in mental health services (MoH, 2013). Approximately half of all criminal justice offenders and victims are Maori (Statistics New Zealand, 2009; Webb, 2009).

Given The Mason Report (1988) clearly delineated the need to develop services that provided high quality culturally acceptable care and effectively engaged Maori (Tapsell, 2007), review of the accessibility to mental health services for Maori in justice populations is required. This should include attempting to understand the reasons for low numbers of referral of Maori to CLNs and whether the low referral rate of Maori to CLNs is actually reflective of mental health needs of Maori in the criminal justice system. It follows that issues regarding stigma and discrimination should be explored and what the CLN role in this should be.

Although the majority of referrals to the CLN were received through the District Court, CLNs may practice across a range of courts. A caveat to this is that the research targeted adult forensic mental health services CLNs. Consequently, only one CLN survey participant practiced solely in Youth Court and five others routinely worked in Youth

Court as well as other courts. To practice capably in these settings requires the CLNs to attain knowledge and experience across a wide range of legislation, court and legal protocols.

The complexity involved with the people with mental health concerns in the criminal justice setting is revealed in the audit data. People referred to CLNs are highly likely to be known clients of mental health services, diagnosed with a major mental illness and be charged with multiple and serious offences. Nearly a third of the people referred had co-occurring mental health and addiction concerns. For just under half of the people, mental health intervention was initiated by the CLNs. These details raise significant questions regarding accessibility to mental health services and ongoing models of care.

The CLN liaises and communicates with a broad array of personnel and organisations. Developing and maintaining inter-professional and interagency collegial relationships in order to facilitate court diversion and court liaison was viewed as crucial. However, it was also noted that this aspect of the role could be extremely arduous to maintain with the CLNs considering the effort to do so rested with them. These new ways of working together were different to how things were done within the health organisation. The importance of robust inter-agency relationships has featured in several studies regarding court mental health interactions (Turnbull & Beese, 2000; Parsonage, 2009; Pakes & Winstone, 2010).

Central to the CLN role was the capability to conduct a variety of assessments in the fast-paced court setting with limited time available. Simultaneously, the CLN also gathers collateral information, assimilates a range of information and then provides advice and recommendations in their reports to the court. Therefore coherent responsiveness “in the moment” is required involving well developed triage skills, and the ability to assimilate information, think, act quickly and communicate clearly.

The impact of the responsibility and isolation the CLNs experienced on a daily basis was at times expressed explicitly and at others teased out through stories about practice. In particular, the weight of risk assessment and the subsequent decision making without another health professional to discuss that with was palpable. Likewise, Seaton (McKenna & Seaton, 2007) referred to risk assessment as a burden in the CLN role. Risk assessment in the court setting was described as extremely complex involving the consideration of multiple factors. Smith (2004) reported that providing advice to the court regarding an individual’s risk factors was fraught with many complications.

The CLNs expressed that trying to maintain a therapeutic focus in relation to risk assessment and management placed the CLNs in a position that generated dissonance for them as nurses. They attempted to separate the court/criminal aspect by suggesting that care and treatment could be provided wherever the court sent the person. CLNs tried to provide the court with appropriate options of intervention for care to reduce the possible associated risks with the illness. They were very aware that an over-emphasis on risk factors may impact on the court's decision. These situations resulted in the CLNs questioning their duty as nurses to "do no harm" to the person against their duty to society (NZNO, 2010).

Theme Three – Complications encountered by nurses practicing in courts

Several factors influenced CLN practice and generated potential impediments to obtaining ideal outcomes for the person with mental health concerns. For the CLN, being situated external to the health setting and immersed in a different culture (the court) was significant. The notion of being "part of but not part of", the isolated nature of the role and having to alter their nursing language underpin the difficulties the CLNs encountered. These are discussed in this theme. Several ethical matters which posed substantial concerns for the CLNs are considered. The section concludes with discussion regarding organisational processes such as inadequate resources and problematic attitudes. All of the above served as barriers to negotiating care for people from court and the delivery of a consistent service to the courts. Inattention to these factors contributes to role confusion and, as Turnbull and Beese (2000) suggested, they work to bring the CLNs' identity as nurses into question.

Bridging disciplinary boundaries

A CLN encapsulated their status as "*part of but not part of*". This means that CLNs felt as though they did not have a place or sense of belonging in either setting. Nurses do not have a traditional role in the criminal justice system. There is no formal preparation for the role, unlike other professional roles such as lawyers and police. Forensic psychiatric consultants receive specific formal training in forensic psychiatry. The CLNs described general disquiet with the unfamiliar environment. In particular, CLNs experienced feelings of inadequacy and disorientation when commencing in the position, despite their seniority and skills. It is significant that CLNs felt as if they no longer belonged in the health setting but also did not have a sense of place within the

justice structure either. This sense of estrangement raises questions not only regarding the relevant stakeholders' understanding regarding the CLNs' role but also of the absence of professional supports. How the role fits within nursing values and beliefs, and therefore the CLNs very identity as nurses, was raised.

Adding to the sense of being out of place, CLNs had to make adaptations to their familiar ways of working. In particular, modifying their language in order to facilitate communication was noteworthy and unexpected. They described that, unless they changed the way they communicated, they were not understood. This emphasises the difference of the practice environment and the sense of alienation experienced. The lack of role preparation was evident. CLNs had to learn the workings of the criminal court, legal terminology and legislation. This took place in an informal manner dependent on the individual CLNs.

Modification of their nursing language had significance in terms of role identity. It was the nurses who adjusted their professional language to fit in within this setting. Likewise, Turnbull and Beese (2000) found the nurses had to modify their language to be understood. In contrast to usual health settings, CLNs spend the majority of their time communicating with non-health professionals. The relevance of this comes to the fore when discussing some of the dilemmas concerning consent and information sharing.

Additionally, there was not any organised and ongoing professional structured guidance available for CLNs. They experienced difficulties obtaining the level of expertise, advice, professional supervision and support they required both immediately at court and ongoing. Furthermore, because the practice situation is physically separated from health services, they were not able to readily access relevant professional supports. Working alone in this manner and not being able to contact forensic colleagues from court to discuss matters was a major concern. This is discussed further below. The physical separation from health colleagues was a considerable contributor to the sense of not belonging within either setting, and the lack of professional support emphasised the sense of aloneness.

According to Barker (2000), development of new and evolving nursing roles do challenge what it means to be a nurse. He suggests "new roles need to be integrated into nursing with a sound understanding of how such roles articulate with the philosophy and practice of nursing" (Barker, 2000, p.90). This is relevant for the CLN role; while it

has been fulfilled for over twenty years, there has not been any examination of it from a nursing perspective. A change in role has meant a potential change in orientation of the nursing practice for CLNs. This has generated ambiguity for the CLNs compounded by inadequate mentorship. A contradiction existed for CLNs. Having to adapt their accepted style of communicating as nurses, a lack of structured guidance and professional support and the culture of the environment contributed to the contradiction of feeling professionally undervalued. On the other hand, they appreciated the autonomous practice and valued the independent practice setting and the sense of achievement they attained. Autonomy is not synonymous with isolation. In the face of these issues, the CLNs' resilience and intention to continue in a position they treasured as nurses was admirable.

Ethical concerns

CLNs drew attention to ethical concerns which arose due to the different practice setting. The criminal justice environment is described as a potentially coercive environment (Evans, 2007) and as such then generates several potential ethical tensions for the nurse. According to O'Brien and Golding (2003), clinicians have a "duty to have the principle of least coercive care at the forefront of their decision making and to develop their ability to provide the least coercive care" (p. 173). In this nursing role there is tension between the therapeutic and coercive; the CLN is situated in between two powerful perspectives – justice and health. These viewpoints often conflict. A collision of values is predictable.

Balancing the demands of therapy and public safety

One of the core components of forensic mental health nursing involves being able to balance the competing demands of security and the role of forensic mental health services in ensuring public safety whilst, as nurses, providing ethical therapeutic nursing care (Burrows, 1998; Mason, 2002; Peternelj-Taylor, 2004). However, for CLNs there is the added dimension of the justice philosophy to understand and manage and work within.

Jacob et al (2008) urge that new ways to conceptualise forensic nursing are needed. They argue that it is within the dualism of managing therapy and social control that idealistic views of care can be lost. Therefore they suggest that defining the roles of nurses who work in these environments where "punitive actions are intertwined with

therapeutic actions” is crucial (Jacob et al, 2008, p.229). From examination of the CLN role, it was evident the CLN has not just dual responsibilities but multiple responsibilities: to the court, to the person they assess, to the health service (their employer), and to society. The responsibility to the court involves public dialogue about the people assessed and their mental health concerns. This created internal conflict for the CLNs. The ability to balance these competing demands and continue to be true to nursing ideology is the crux of potential role conflict in this nursing role situated in the courts.

Role conflict

Role conflict is used to describe the ambiguity nurses can experience in relation to the therapeutic role of the nurse with the potentially controlling aspects of practice forensic nurses may have to engage in (Brennan, 2006). Not only do the CLNs have multiple responsibilities, but this can be viewed as performing multiple roles. Having to carry out multiple roles leads to potential for role conflict and is the cause of ethical dilemmas. Loyalty to the patient can be seen as caring, loyalty to the court can be seen as complicity.

The role conflict or strain is a result of the stress experienced when prescribed roles, e.g. the role of the nurse and that of the role the nurse actually carries out, are in conflict with one another (Simpson, 2005). Furthermore, role blurring or role ambiguity exists when the boundaries of traditional roles are confused. It is also suggested that lack of role definition can create role conflict and affect role performance (Bowring-Lossock, 2006). Therefore, it is not surprising that CLNs practicing in a role for which there is no recognised nursing definition or standards for practice in a setting that is not a traditional role, creates uncertainty about aspects of their role which result in internal conflict.



Figure 3: Demonstrates the relevant fields and potentially conflicting ideologies that the court liaison nurse role interacts with. The shaded areas demonstrate the unique dimensions that through their interactions have contributed to the development of the CLN role. The person the CLN assesses sits within the overlap of the three dimensions.

The court environment reflects a power dynamic. CLNs had to negotiate therapeutic activities within those powerful constraints. Holding a therapeutic focus within the court setting meant the nurses were constantly juggling opposing viewpoints. Festinger (1957) proposed that whenever someone holds two thoughts simultaneously that are psychologically conflicting, they experience dissonance, which results in a state of disquiet or tension. This in turn affects how the person responds. The resulting feeling of discomfort contributes to an alteration in one of the attitudes, beliefs or behaviours to reduce the discomfort and restore harmony. Smith (2004) gave an example of this discomfort when he reflected on the need to focus on the role of the nurse and not be “drawn” into the justice culture. CLNs expressed disquiet in particular with consent, sharing health information (with the court and offence related information in the health setting), and risk assessment. These three aspects are inextricably linked.

Complications in the relationship – consent, information sharing and ethical guidance

The process of informed consent involves ethical responsibilities and legal requirements. Informed consent is considered a fundamental patient right involving two-way communication (Evans, 2007). Informed consent is underpinned by principles that the interaction should be for the patient’s benefit, there should be an absence of any coercion, and the patient should make voluntary choices about treatment interventions (Evans, 2007). These are problematic in the context within which the CLN practices. The person being assessed may be cognitively impaired in some manner and therefore their capacity to make decisions about their health care is also impaired. The person’s ability to understand the purpose of why they are speaking with the CLN may be

compromised. Furthermore, the nature of the coercive and powerful court setting may influence the person's decision to consent to an interview with the CLN.

Additionally, the basic notion that the person is seeking health advice and intervention in a health professional-patient relationship (Forrester, 2001) is complicated in the court setting. Usually, the assessment and interaction with the CLN is initiated by others, whether that be the court, lawyer, prosecutor, police or family. There are no procedural protections during the initial screening assessment process for either the CLN or the person. In contrast, in a normal health setting there are likely to be other health professionals and family or support persons present during the initial assessment and, if required, the Mental Health Act (MHA) can be initiated. For example, The MHA provides procedural protection of the individual's rights with the obligation on the health professional to gain informed consent (McKenna & O'Brien, 2013). CLNs can initiate the MHA. However, not all CLNs are DAOs. Additionally, not all situations require the use of the MHA, but that does not mean the person's ability to comprehend the reason for the interview with the CLN is not compromised. CLNs attempted to ensure the people they were assessing were provided with an explanation of the purpose of the assessment. However, these practices were not standard across the CLNs.

Significant questions regarding sharing health information in a public forum arose. Similarly concerns regarding information sharing were identified in research in England and Wales (Turnbull & Beese, 2000; NARCO, 2005; Pakes & Winstone, 2010). Consideration regarding how much information it is appropriate for the CLN to share, in what circumstances and for what purpose is required. Likewise, attention to what happens with the offence related information the CLNs collect is required. These aspects of their practice need clarification.

CLNs were very aware that they could breach health professional patient confidentiality with respect to rule 11 (2) d of the Health Information Privacy Code, 1994. This section of the Code allows health professionals to pass on information disclosed to them when "the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to-(i) public health or public safety; or (ii) the life or health of the individual concerned or another individual" (HIPC, 1994). However, not all assessments carried out by the CLN involve situations where rule 11 (2) d would apply.

Another important concern raised by the CLNs was whether the person they were assessing understood the nature of the relationship with the CLN. They also mused

whether the person shared information with them because they are a “nurse” and therefore saw the relationship with the CLN as a strictly health professional-patient relationship. Whether that relationship is different in the court setting requires examination and is linked to the purpose of the role. Williams (2007) poses the fundamental question, which is worthy of consideration for CLNs:

Does the forensic nurse have a greater duty to the wellbeing of the offender/patient or to society under the ethics of care system? In other words where does the greater nursing relational duty exist – with society or with the offender/patient? (p.94).

The fact that the CLNs expressed unease with these factors, and were extremely keen and grateful to be able to express them, indicate there is a great need for some guidance and opportunities for structured reflection. The dissonance generated in this setting for CLNs and how that affects their decision making requires further exploration using an ethical framework for guidance. Gadow (2003) suggested that only nurses can address whether their practice decisions are congruent with nursing values or whether they contradict them. Eastman (2006) refers to mutual contamination “where cooperation between highly differentiated agencies will drift into mutual contamination of what should be their different social functions, properly pursued by each through its own distinct set of legal and ethical rules” (p.459). What is not clear for CLNs is where the boundaries of their practice lie within the court. Without professional guidance and reflection on practice the potential for ethical slippage is high.

By way of comparison, Eastman and Mullins (1999) advocated for forensic psychiatrists to establish and determine for themselves and demand of others, an effective separation between their functions directed at welfare on the one hand and the objectives of justice on the other. Austin et al (2009) argue that a forensic ethic needs to also inform and support the “forensic-therapeutic relationship”. If the forensic ethic is only applicable to the “forensic–legal relationship” then this separation needs to be clearly defined (Austin et al, 2009). It follows that engagement in reflection to guide roles and shape practice and to enable nurses to act ethically in keeping with their underpinning principles as nurses is necessary (Jacob et al, 2008). CLNs need, at the very least, to commence a dialogue and debate regarding these pivotal matters as they relate to nursing. The current silence is deafening.

To successfully steer through the criminal justice mental health service maze, the CLN must come to terms with practicing in an environment that is alien to nursing. Without

adequate professional guidance, CLNs expressed feeling professionally vulnerable. Urgent attention should be paid to issues of consent and information sharing and seeking national consistency regarding these practices. A framework to promote ethical awareness and reasoning needs to be considered.

Development of a framework to guide decision making and practice to ensure CLNs are practicing in a consistent manner could be achieved through the National CLN Forum in conjunction with other bodies such as Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc (The College). CLNs could work with The College on capturing the specialty in existing ethical frameworks. Drawing on expertise external to nursing, such as legal and forensic psychiatric expertise, may be useful. Furthermore, once the role has been articulated and standards and competencies for practice developed to provide a framework, CLNs will be able to engage in dialogue to meet their commitment to maintaining therapeutic relationships as nurses. A framework for practice in this area will need to give weight to both aspects of their role: the commitment as nurses to the therapeutic relationship and their responsibilities to the court (O'Brien & Kar, 2006).

The multi-agency multi-professional context the CLN practices within has the potential to impact on their values as a nurse and decision making. The disconnectedness created by practicing within the justice culture generates the very real tension for the CLNs which stems from the inability to “care” as nurses. CLNs have assumed a position of integrating clinical and legal roles without clear guidance and support. The parameters of the CLN role need to be clearly defined to assist with and avoid the potential for role blurring and boundary transgressions.

Organisational processes

Two areas stood out with respect to organisational processes: firstly, in relation to resources and tools required to practice competently and efficiently, and secondly, with respect to neither valuing nor using the CLNs' extensive knowledge of the interplay between wider services and the needs of the mentally unwell person.

It is important to understand that CLNs practice under often onerous conditions (e.g. in a fast-paced, pressured setting), as well as being the sole health professional in the courts. Over half of the CLNs surveyed did not have access to a dedicated office space/interview room at court, access to a computer at court or to DHB health records

online. Implications stem from inadequate resourcing such as timely access to health data to inform the CLNs' assessments and recommendations to the court, and producing professionally presented reports. Furthermore, the ability to enter CLNs' reports and assessments into health databases at the time would enable immediate access to the CLN documentation by forensic prison liaison services and other mental health services. Urgent attention is required to address adequate resourcing needs.

Inadequate resourcing contributed to feeling devalued and frustrated for the CLNs. In support of the claims for adequate resources and tools, in a study of mental health liaison and diversion schemes in England, Pakes and Winstone (2010) found well performing teams had "office space, interview facilities and ICT facilities available at the criminal justice sites where they operated" (p.882). These well performing teams had Service Level Agreements or a Memorandum of Understanding to regulate practice with key stakeholders. Likewise Paulin & Creswell (2010) emphasised the importance of Watch house nurses being able to access relevant IT from DHB databases from day one. This was considered necessary to facilitate rapid assessment, treatment planning and crucial regarding follow up with case managers.

CLNs reported not being able to conduct interviews in private. Only half of the participants in the research had access to spaces to conduct interviews in private at court. Therefore, attention to the basic requirements for CLNs to be able to practice in a manner that meets The HDC Code of Health and Disability Services Consumers' Rights 1996, in particular, Right 1: Every consumer has the right to have his or her privacy respected, is required (Health and Disability Commissioner, 2009). This could be established through a Memorandum of Understanding between the Department of Courts and Forensic Mental Health Service, clearly identifying which organisation is responsible for providing which resources. It is critical, given the environmental pressures they face at court, that CLNs have access to technology and private interview spaces.

Given the vastness of their contacts, links and exposure to multiple organisations involved with people with mental health difficulties coming before the courts, CLNs expressed frustration at not being included or consulted with respect to proposed changes in systems and services. CLNs gain extensive knowledge that extends beyond the immediate legal mental health interface. Their knowledge includes an overview of

wider health services and community organisations and the interplay with mental health services.

CLNs have a very real understanding of the dynamics involved with people with mental health issues coming before the criminal courts. CLNs' expertise could be harnessed to drive and contribute to evaluation of court liaison services and even reform of mental health services. Evaluation of New Zealand court liaison services is overdue. Similarly, international scholarship recommends that greater evaluation of court liaison services is required (Pakes & Winstone, 2010; Ogloff et al, 2011; McKenna & Seaton, 2007). Research that is inclusive of the CLNs' extensive knowledge and understanding will assist with bringing to light both what works well and where there are gaps and obstacles to effective service delivery for mentally unwell people coming to the attention of the courts.

Barriers to negotiating care and appropriate outcomes for people seen at court

CLNs consistently encountered barriers to facilitating court liaison and court diversion. Inadequate understanding by wider services of the role of forensic mental health services, insufficient acute mental health and forensic mental health beds, the absence of collaborative relationships with stakeholders and mental health services, and problematic attitudes featured. CLNs are not alone in encountering multiple barriers to effective practice. In a systematic review and meta synthesis of role development and effective practice in specialist and advanced roles, Jones (2005) found that "research has shown that nurses working in innovative roles encounter a range of barriers and facilitators to effective practice" (p.191).

CLNs reported inadequate knowledge and understanding of the parameters of forensic mental health services and the role of the CLN within the wider mental health service. This contributed significantly to obtaining the outcomes they sought for people from court. Consequently, CLNs had to be able to defend their decisions and have resilience to carry these through despite consistently encountering negative attitudes and obstruction to working in a collaborative manner. These negative attitudes are concerning given that nearly all the people referred to CLNs were clients of mental health services.

Another obstacle in facilitating court liaison and diversion related to availability of inpatient beds. CLNs found it extremely demanding to arrange admission to hospital for

people from court (court diversion) without the added dimension of not enough available acute mental health and forensic mental health inpatient beds. This issue has previously been highlighted in New Zealand (McKenna, 2011) but is not unique to New Zealand as noted in Western Australia (Brett, 2010) and in England (Parsonage, 2009; Pakes & Winstone, 2010). CLNs described the sense of frustration and ineffectiveness they felt when people were remanded in custody when ideally hospital admission was required. As noted above, the CLN voice could contribute to systemic improvement regarding mental health services. They are at the forefront of the impacts stemming from inadequate resources, inpatient beds and community resources. It should be noted that seeking an admission to an inpatient bed was not the CLNs only response. Their actions were dictated by legal requirements if a person's bail was opposed. For those people whose bail was not opposed CLNs referred to and liaised with primary and secondary health services.

Questions arose as to whether the CLN role really does or can encompass the recovery philosophy. However, when reflecting on the Recovery competencies as defined by the Mental Health Commission (2001) it is clear the CLNs practice meets multiple competencies. CLNs role in advocating and endeavouring to ensure that people's mental health needs are understood and opportunities for follow up facilitated, stigma is challenged, access to health care is equitable, the individual's rights are protected, works in partnership with many agencies in the community, culture is acknowledged and family/support persons included where possible, and it could be argued they are working within a recovery philosophy as much as is possible within the constraints of the CLN role.

Likewise, there is a need for ready access to forensic psychiatrists for the CLN from court in a supportive role when attempting to access admission. Similarly, research (NARCO, 2005; Parsonage, 2009) identified there was a lack of beds and inadequate input from psychiatrists or psychologists in court liaison and diversion schemes in England and Wales, and made recommendations regarding remedying this. Likewise, Pakes and Winstone (2010) found "[a]ccess to a consultant forensic psychiatrist is essential: both for the timely production of reports to the court and also to facilitate access to psychiatric beds" (p.879).

Collaborative relationships with stakeholders (police, prosecutors, probation, and court) were crucial to effecting court liaison and court diversion. However, establishing and

maintaining these inter-agency relationships was demanding and time consuming for CLNs. The long term viability of relying on individuals within court liaison and diversion schemes in England to create and sustain these inter-agency relationships was critiqued by Pakes & Winstone (2010). Expectations and roles of services and professionals need to be clear (Hean et al, 2011). The long term feasibility of relying on these inter-professional and inter-agency collegial relationships established by individual CLNs requires consideration. As noted with respect to resources, service-level agreements outlining expectation and roles of services need to be in place at a national level. Paulin and Carswell (2010) recommended that relationship management meetings, service level agreements, and developing interface protocols between relevant services was necessary to facilitate successful implementation of Watchhouse Nurse Services. Court liaison services could benefit from revisiting these matters.

It is acknowledged that social and political influences create the wider context of CLNs' practice. There is ongoing media and public pressure to lock people away with mental illness who have offended. This influences attitudes, often resulting in marginalisation of people with mental health concerns in justice populations. Forensic psychiatric patients represent a highly stigmatised group (Brett, 2002; Peternelj-Taylor, 2005; Simpson & Penney, 2011). The stigma and discrimination directed at people with mental health concerns extends to those who provide treatment and care, that is, the CLN, resulting in stigma by association. The CLN is positioned at the front end of the assessment process for future patients of the forensic mental health service and mental health services in the public eye. There was no means or recourse for CLNs to address the way they were treated at times in court.

Brett (2002) suggested it is important that these negative and stigmatising attitudes are addressed to prevent further marginalisation of the already vulnerable and disadvantaged people with mental health concerns in the justice system. This approach is fitting with the aims of forensic psychiatry defined by Gunn and Taylor as "the prevention, amelioration and treatment of victimization which is associated with mental disease" (1993, p. 2). One of the underpinning principles of care for forensic mental health services in New Zealand is that "service provision should minimise negative public perceptions of people with mental illness, including those who have both a mental illness and contact with the criminal justice system" (MoH, 2001, p.31). Similarly, Sly et al (2003) highlighted that the role stigma and victimisation play in the treatment of people with mental illness in justice populations requires research. Also

suggesting this should include their relationships with health and legal professionals (Sly et al, 2003). Brett (2002) suggested good court liaison services play an important role in decreasing stigma and positively influencing management of mentally unwell people in courts. On the whole, CLNs managed these situations through role modelling appropriate behaviours and language and not joining in on the negative dialogue. Therefore, CLNs play an important role in demystifying mental illness and ensuring that principles of equivalence (Birmingham et al, 2006) apply and the mentally unwell person has access to mental health care.

Theme Four – Requirements for sustaining and maintaining practice

The findings of this study have established that the complexity of the CLN practice is not well understood. This section addresses what CLNs require to ensure the practice is supported, consistent and competent. Undoubtedly, CLNs require adequate educational preparation and to have access to appropriate professional support structures. CLNs established the need for national consistency, standards for practice, role guidelines and templates, and for workforce planning to ensure continuity and role development.

Educational preparation required

According to the findings, CLNs neither received an adequate orientation nor were they formally educationally prepared to practice in the CLN role. Relevant ongoing education was not available. Furthermore, accessing role specific tailored education applicable to CLN practice was difficult. CLNs felt they were not supported in these endeavours because managers did not understand the requirements of the role. Standard post registration nursing post-graduate papers were not applicable and attending DHB mandatory training was considered a waste of valuable CLN time.

Inadequate attention to role preparation and education stemmed from the court not being a common practice setting for nurses and that there was poor understanding from others of the practice tensions CLNs experience. This phenomenon was documented abroad. According to Turnbull and Beese (2000), in England, there was a pervasive sense of nurses being unprepared for their role in a Magistrates Court. This stemmed from lack of preparation or instruction regarding how the criminal justice system worked, and without any reference point for assistance and support (Turnbull & Beese, 2000).

Similarly, Smith (2004) described how the lack of formal training in law and not knowing how the court system worked contributed to his lack of confidence when he

commenced as a CLN. In another circumstance, where nurses are expected to contribute to legal processes surrounding MHA legislation, research revealed the nurses require more information regarding court process, and to practice report writing (McKenna, O'Brien, & O'Shea, 2011).

The literature reveals nurses are not prepared in either undergraduate or post-graduate education for practice in a legal environment (Turnbull & Beese, 2000; Kent-Wilkinson, 2011). Similarly, with respect to Mental Health Act hearings and the role of the second health professional, McKenna et al, (2011) found that mental health nurses were not educationally prepared for court-related responsibilities. Historically, role development in forensic mental health nursing has occurred before educational development (Kent-Wilkinson, 2009, 2011). Brennan (2006) outlined that knowledge is more often than not gained by an apprenticeship style of learning with no evidence of theoretical evidence based practice, followed by theoretical development. However, this role has been in place for over twenty years in New Zealand and, according to the CLNs, the role requires definition, standards and role-specific education and support. To date, role-specific education has not been possible, as Baxter (2002) suggested, without a clearly defined role and set of skills, ascertaining educational and training requirements is difficult. Initiation of specific education regarding this role that encompasses theory and practice should now follow. The participants have clearly specified training and education needs.

By way of comparison, Brookbanks (2006) suggests lawyers practicing in this area of mental health and law should ensure they are familiar with the legislation and up-skill. Likewise, CLNs should have basic education in these aspects, remembering that CLNs are usually commencing from a position of minimal knowledge and education of legislation or legal systems. Brinded's critique of New Zealand Forensic Psychiatry academic and service developments that "further expansion in academic forensic psychiatry is urgently needed in New Zealand to complement, further improve the national network of interlinking of forensic psychiatric services" (2000, p.463) aligns with the CLNs' perceptions of what is required to further the role and ensure consistency in delivery of the mental health service to the court. While these needs may have been addressed for forensic psychiatrists there is an urgent need to attend to this for the nurses who play a central role in court liaison and forensic mental health services.

Importantly, ongoing practice development is crucial in fostering focussed effective nursing care (Walker, 2008). Walker suggests education is one of the central components of practice development. Nursing knowledge that is credible and evidence based (McArthur, 2002) should underpin the planning and implementation of professional nursing care. There is a dearth of formalised education, foundational and ongoing, addressing the role of the CLN. All CLNs should have opportunities to share knowledge and information, to support and encourage others to seek out information and knowledge. Such opportunities will assist with developing best practice court liaison nursing. Without a solid educational grounding and experiential background in forensic mental health for CLN practice, there is a risk the role will continue to develop in an uncoordinated manner, and not in accordance with any standards specific to practice demands, or with any evidence base to support the nursing practice. An educational pathway incorporating ongoing education for CLN practice should be mandatory.

Furthermore, while it is important to acknowledge the value of learning on the job and practical experience, if CLNs are to move forward professionally and justify their role as specialist, then role-specific education will be required. As Kent-Wilkinson (2010) suggests, advanced practice education is crucial to the development of forensic nursing.

The sense of alienation the nurses experienced going into the criminal justice environment coupled with the lack of preparation and support available makes it vital succession planning is put in place. Encapsulating the knowledge the experienced CLNs hold will facilitate the ability to build on the knowledge and further develop the role and awareness of the intricacies involved. However, despite encountering significant difficulties, CLNs relished the autonomy the role afforded; this was supported by the length of time the CLNs stayed in the role.

Education regarding cultural and disability factors

CLNs focused on two specific groups of the people appearing in courts, albeit for different reasons – people who identified as Maori and people with intellectual disability. There was a low referral rate of Maori to CLNs. The CLNs did not consider that they were educationally or experientially equipped to work with people with intellectual disability.

Proportionally, Maori are over represented in the justice system (Statistics New Zealand, 2009; Webb, 2009). Of significance is that there is a higher prevalence of mental disorder experienced by Maori (Toki, 2010). One response to these factors has been the development of a Kaupapa Maori team to provide treatment services to clients within a Maori cultural context (PUWAI, 2011). These principles are of value. It was unfortunate the CLNs practicing in the Kaupapa Maori court liaison team were unable to take part in the research. Undoubtedly, future evaluation of this service will provide helpful insights to all CLNs.

According to Duff and Sakdalan (2007), there is minimal robust data regarding the demographics of people with intellectual disability coming before the courts. However, the clinical picture for CLNs reflects there are increasing numbers of people with a diagnosis of intellectual disability appearing in the criminal justice system (supported by interview and audit data). This picture raises implications for CLNs in regards to comprehension of legislation and knowledge of intellectual disability, conducting assessments, working with people with an intellectual disability, and services.

An explanation for minimal experiential and educational preparation in working with people with intellectual disability may be due to changes to nursing education. Following the introduction of comprehensive nursing education in New Zealand, as Taua reiterated, “nurses are now required to work in complex areas with a generic knowledge only” (2005, p.25). CLNs’ reflections concurred with Taua, that their broad nursing education and forensic mental health nursing work experience had not prepared them to work with this group, in particular in relation to the specific requirements in the CLN role. Similarly, in England, Pakes and Winstone recommended access to learning disability expertise was required (Pakes & Winstone, 2010). They also found in relation to learning disability in the England schemes that “issues of dual diagnosis are not dealt with uniformly, if at all”, however they noted some schemes cover them comprehensively (Pakes & Winstone, 2010, p.884). This matter is worthy of deliberation for future developments regarding the CLN role: whether CLNs require access to identified people with expertise in intellectual disability and whether this should form a specific component of the CLN educational pathway.

Other significant concerns regarding people with an intellectual disability in the court system were relayed by CLNs; however, it is beyond the scope of this research to comprehensively address the issues. However, for purposes of future research, the

topics include evaluation of services for people with intellectual disability in the community and exploration of the education and support needs of carers working with people with intellectual disability in the community.

Professional support structures

The research has highlighted the isolated practice situation of the CLN and the lack of adequate professional support structures. Several key issues stood out with respect to access to and provision of applicable and accessible professional supervision for CLNs. While most CLNs were engaged in and recognised the need for clinical supervision, the majority indicated it did not meet their needs as CLNs. In particular, they referred to the intersection of mental health with legal matters, and in teasing out ethical issues were not currently met. On the whole, CLNs reported they did not feel supported by management and attributed this to the fact that the intricacies involved in the role and the practice setting, and hence the role the nurse plays, is not understood.

The CLNs reported the potential to become de-sensitised or emotionally affected through repeated exposure to serious offending. They expressed concern this reaction may affect their ability to remain therapeutic and caring. This concern is highlighted in the literature regarding forensic mental health nursing (Woods, 2002; Jacob et al, 2009) prison nursing (Walsh, 2009) and forensic psychiatry (Birmingham et al, 2006). As Benner and Wrubel (1989) assert “The same act done in a caring and noncaring way may have different consequences” (p.4). The CLNs “cared” for the people they worked with. This was evident in their reflection of the potential impacts their recommendations and role with the court may have on the outcome for the person. Hence, this emphasises the importance of clinical supervision and relevant professional support for CLNs. Engagement in clinical supervision attends to several aspects of practice. It is vital in enabling the nurse to critically reflect on practice, enhance understanding of practice and the roles of the nurse (Handsley & Stocks, 2009). Reflection on practice for forensic nurses is also essential to maintaining a therapeutic caring approach that is non-judgmental (Hammer, 2000; Rask & Levander, 2002).

CLNs work with a highly vulnerable, disadvantaged group of people (Chaplow, 2007) in a complex setting. Therefore, access to professional supervision to maintain a therapeutic focus is essential. Professional supervision also provides a formalised means of supporting nurses in the work they do that enables development of knowledge and

competence, responsibility and promotes safe practice and positive outcomes for service users (MoH, 2006).

A significant professional resource issue identified by CLNs was supervision and mentorship. Barriers to clinical supervision faced by CLNs were similar to that experienced by mental health nurses in general in New Zealand. Time constraints, unwillingness to engage in clinical supervision and access to a pool of clinical supervisors were identified as barriers to engaging in clinical supervision (McKenna et al, 2010). CLNs revealed logistical difficulties including: time factors, a small pool of available nurses to provide clinical supervision and of feeling not supported to take time out for clinical supervision. Of concern was commentary related to clinical supervision not being available or offered. Importantly for clinical supervision to be successful, McKenna et al (2010) refer to the need for a model of supervision inclusive of processes and procedures to ensure there is “human resource management that enables the supervision to take place” (p.274). Finding suitable “credible” clinical supervisors was a significant concern for the CLNs. In acknowledgement of these issues, McKenna et al (2010) recommended “the development and competency maintenance of a pool of supervisors” (p.274). A national pool of supervisors with identified experience of the setting may be of use to CLNs.

The geographical spread of forensic mental health services in New Zealand posed a barrier in accessing clinical supervision. The use of technologies such as video and telecommunication was considered by CLNs. However, face to face clinical supervision was deemed ideal or, at the very least, CLNs suggested they would need to have the opportunity to meet the clinical supervisor in person prior to commencing the supervision.

Other professional support in the form of access to forensic psychiatry colleagues featured. Immediate access to the forensic psychiatric consultants in a supervisory and educative capacity for the CLN is crucial until there is specific education for forensic mental health nursing in New Zealand with a court liaison component. Forensic psychiatric consultants are trained in the specialist field of forensic psychiatry, unlike nurses who receive generic nursing training. If nurses are employed with DHBs they will complete a twelve month Nurse Entry To Practice (NETP) programme in their first year of practice (HWNZ, n.d.). The NETP programme provides a generic introduction to mental health nursing.

There is no forum for forensic mental health nurses in New Zealand to obtain specialist education in forensic mental health nursing and to contemplate the issues from a forensic nursing perspective. Therefore, it is important CLNs have access to the expertise and support they require and have the opportunity to reflect on practice with professionals with specific education and training in the arena. Similarly, McKenna et al (2011) found nurses involved in Mental Health Act hearings required specific training such as regular opportunities to reinforce learning, supervision or debriefing opportunities and support in the workforce, for example, adequate time allocated to complete the requirements for the court.

The development of formalised support structures would help minimise the feelings of isolation and of not being valued. The topics relating to clinical support, clinical supervision and opportunities to discuss and reflect on practice and seek advice are laboured in this study. “Clinical supervision offers the promise of both reflection on and in action – bridging the gap between technical knowledge and the artistry inherent in applying such knowledge” (Barker, 2000, p.91). The relevance of this cannot be overestimated, especially for nurses who are expected to practice in isolation from professional colleagues.

National consistency

Clearly the CLNs are a fragmented group, largely due to the small number of CLNs and their geographical spread. They would benefit from a unifying body. There were disparities in how the CLN role was interpreted and applied across the country. These differences in practice incorporated assessment tools, documentation, consent processes, report writing, and information exchange and storage. A lack of uniformity in these practices is not unique to New Zealand as emphasised in research regarding information sharing between the National Health Service and criminal justice system in the United Kingdom (Lennox, Mason, McDonnell, Shaw & Senior, 2011). Furthermore, CLNs articulated that they did not know what the practices were in other areas, emphasising the disconnection CLNs experience from one another and health services. There is a need to address these inconsistencies. Nursing practice in the courts is different and pushes the boundaries of nursing, therefore professional support, orientation, education and training need to be customised to the circumstances of the role and then national consistency in the delivery of CLN practice would follow.

Being supported to attend regular national forums, teleconference links, and an email network were suggested as solutions to strengthening the CLN role, supporting CLNs and addressing inconsistencies. Such forums should be structured and incorporate supervisory and educational components. Participation in such forums and the opportunity to reflect on ethical concerns such as consent, information sharing, justice culture, and the role of the nurse would assist with providing a safer supported work environment for CLNs. These processes would also assist with role clarity and role definition. However, CLNs stated that they could foresee problems with having dedicated time to facilitate a national forum given their current workloads. They have already articulated difficulties obtaining support and time for professional development.

Theme Five - Extraordinary practices

Court liaison nursing was advanced in many respects. They had additional legal knowledge. They attained in-depth comprehension of application of certain aspects of law. CLNs developed knowledge and skills to conduct particular assessments and to complete reports for the court. They had extensive knowledge of and contact with the mental health service and wider organisations. The ability to practice in a collaborative manner required a sophisticated awareness of the entire court setting. On its own, offering advice and recommendations in a report to the court is an expansion of regular mental health nursing practice. Doing so involves assessment, interpretation and provision of explicit nursing opinions in a public forum. Nurses working in courts are often sole practitioners and are therefore expected to function at higher levels than nurses employed in other mental health settings. These factors and their skills and knowledge differentiate CLN practice from other mental health nursing roles.

CLNs were frequently approached by legal professionals and police seeking advice regarding the CP(MIP)Act, the ID(CCR) Act and corresponding processes. Given the complexity of these pieces of legislation and the interface with mental health and people's rights it was bewildering that CLNs were not expected to partake in nor have ready access to post-graduate education in law and psychiatry. 25% of the CLN time outside of court involved providing advice, coordination, and consult liaison services regarding the criminal justice mental health interface and relevant legislation, and court reports.

Similarly, CLNs are an expert resource for mental health professionals regarding the mental health legal interface, significantly including forensic consultants. These pieces

of legislation are complex and the CLNs are the people who are dealing with it on a daily basis, hearing the court's interpretations and use of it. Their "knowing" is borne out of exposure and experience. They perform in a supportive capacity for staff escorting patients to court. CLNs will walk people appearing in court (especially those with intellectual disability) through court before court commences explaining processes so they have some familiarity with the environment and an idea of what they are to face.

To achieve practice at this expert level, CLNs present as confident practitioners. They are capable of establishing diverse collegial relationships. They were critical in their thinking, questioning and exploring issues. Resourcefulness and creativity in seeking health outcomes for people with vulnerabilities in the criminal justice system was evident. A level of robustness was apparent in CLNs being able to remain impartial, articulate the possibilities, and defend their positions and opinions in public surroundings. These attributes signal mature confident expert practitioners.

A complicating factor for CLNs exists regarding recognition of their expert level of practice and meeting PDRP requirements. The designation of "expert" rests with individual employers and nurses and competency assessors through the PDRP process. Concern had been expressed by CLNs regarding their perception that the PDRP process was not nationally consistent. Kai Tiaki (2009) reported that inconsistencies in PDRP programmes generated barriers for nurses. Some CLNs believed that the extent of the practice and function of the CLN was not understood through this process. Benner (1984) referred to the wealth of untapped expert knowledge embedded in practices and how the know-how of expert nurses remains unrealised until it may be articulated by nurses. Hopefully, this research will assist CLNs with commencing a dialogue and articulating their expert nursing practice.

"Expert" is linked to a particular level of nursing practice (Benner, 1984). The "expert" is at home with the entire context of the practice setting. An example of this came through in the CLNs exemplars of explaining and interpreting the mental health legal interface for others. When the CLNs discussed the setting, their language flowed, they had in-depth comprehension of the particular situations and were able to interpret and explain these for others. Barker (2000) describes "expert" as being not about the task but the "knowing". The CLNs relayed many examples of "knowing", "caring" and "advocacy" which are examples of expert practice.

The CLN is a sub category of forensic mental health nursing which sits within mental health nursing under the umbrella of the registered nurse scope of practice (refer to Diagram 2). When viewed in this manner it becomes apparent that there should be identifiable layers of knowledge, expertise and proficiency required to practice in the CLN role.

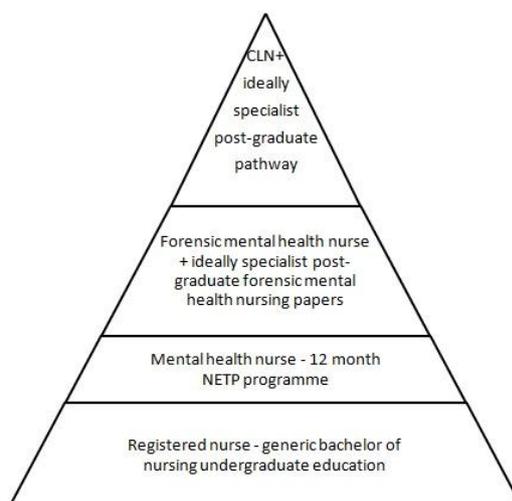


Figure 4: Simply demonstrates the layers of knowledge and specialist experience that contribute to the knowledge and expertise required in CLN practice.

Benner (1984) described the expert nurse as having an extensive background of experience, who develops an intuitive way of working and therefore understanding of each situation and is able to focus on the relevant issue without being sidetracked (1984). The CLNs described this process: once they were established in the role, they were quickly able to ascertain what the concern was and how that needed to be managed. The experienced CLNs were able to ignore extraneous matter and focus on the mental health concerns with the “know-how” of the impact of the legal matters. Ironically, Benner (1984) discusses the difficulty expert practitioners experience in telling all they know because they “operate from a deep understanding of the total situation” (p.32). Perhaps this is part of an explanation for CLNs not articulating their practice to date; by the time they have come to understand the foreign practice setting, educated and established themselves, the practice becomes second nature.

The expert exemplars presented in this research demonstrate the notion of good and caring practice and the expert knowledge embedded in an advanced level of nursing practice. By articulating the CLN practice, the thesis can be used as a basis to further develop understanding and clarity regarding the practice. By examining the participants practice experience, it is hoped that the practice will be made more accessible to other

CLNs and tap the wealth of knowledge and “know-how” embedded in the CLNs practice (Benner, 1984).

Assessment expertise

CLNs conduct a variety of assessments, some of which differ from routine mental health nursing assessments. These assessments require that CLNs must be familiar with thresholds for impairment, and make decisions regarding capacity. They must know how the legislation works, and the potential impact of their recommendations. This is complex. There is no training for CLNs regarding this. At the same time, the CLN is working with people from other professions within the court who have a range of understandings regarding mental illness and mental impairment. CLN assessment is significantly expanded when compared to the Mental Health Nurses in New Zealand Standards for practice (NZCMHN, 2012). To date, accepted understanding of comprehensive mental health nursing assessments do not incorporate or articulate details regarding the types of and features of assessments CLNs conduct. The specialist knowledge of these nurses is beyond the baseline requirements of mental health nurses (McKenna & O’Brien, 2013). As Lyons emphasised, to achieve this level of practice the forensic nurse, “must be an advanced practice nurse with well grounded knowledge in both the medical and the legal fields” (2009, p.57). Currently, the CLNs demonstrate the advanced skills in practice and have sought to up-skill themselves regarding the legal aspects.

Of significance is that CLN assessments are generally conducted at a fast pace in spaces that are less than ideal to conduct a health assessment, thirty minutes being the most common time spent on assessments. Therefore, CLNs must be absolutely focused and sure of their assessment skills and assimilate everything for the court post the assessment. The usual circumstance means there is no ability to go back and interview the person again later in the day or seek a second opinion from a colleague. The court demands a response as soon as possible. Once again, this highlights that access to collateral health information to inform their assessments at the time at court is crucial.

Collaborative practices

CLNs were well able to liaise with and establish positive constructive working relationships with multiple professionals, services and organisations. Developing a mutual understanding between parties was a crucial element and usually facilitated by

the CLN. This is necessary to practice effectively and therefore understanding of the roles and limitations of the relevant services and agencies is important. Similarly, Turnbull and Beese (2000) found that success in the position was reliant on collaboration. It is necessary for the CLN to be clear as to their position within the court, to continually reflect on that and adjust their approach when working with other services and agencies. Hean et al, (2011) emphasised the importance of role clarity in interagency work suggesting if distinctions in roles were not clear poor interrelations could result. Frequently, for CLNs the interagency work involved delicate balancing and managing of situations, organisations and people. They often acted as a conduit guiding people, including lawyers as to options and possibilities, who to talk to, for example, general practitioner, responsible clinician or other health professional. The necessity for forensic mental health nurses to be able to work in a collaborative manner within a multi-disciplinary team is established (Mason, Williams, & Vivian-Bryne, 2002). The dynamics involved and the need to be able to work collaboratively for forensic mental health nurses practicing outside of the hospital setting is not well explored. This research articulates the extent of this part of the CLNs' practice.

The knowledge and skills required to perform the CLN role fit with Benner's description of expert clinicians as "not difficult to recognize because they frequently make clinical judgments or manage complex situations in a truly remarkable way" (1984, p.34). This was evident in CLN practice through the management of complicated scenarios, the collaborative way of working, the range of assessments and the ability to successfully traverse the court setting to obtain fitting outcomes for people with mental impairment. This is in-line with the international picture of forensic mental health nursing emerging as an advanced speciality area of nursing practice (Kent-Wilkinson-2010).

Theme Six - Recognition

The complexity, depth and breadth of the court liaison nursing practice has not been previously recognised. Furthermore, the CLNs nursing practice has developed without a clear structure of professional supports. Ongoing professional development is hindered by the lack of recognition and the stress of the role as well as lack of release time for study, clinical supervision, networking and discussion with other CLNs. Engaging in professional development should be mandatory for any nursing position but is absolutely critical for the CLN position.

Similar to their forensic mental health nursing peers CLNs expressed a sense of not being valued (Bowring-Lossock, 2006; Gillespie & Flowers, 2009). CLNs considered the lack of acknowledgement was due to the inadequate understanding by management and the organisation regarding the extent of the functions they performed in the role. Furthermore, the situation is compounded by the CLNs' inability to devote time to professional development pursuits due to the pressures under which they practice. However, advancing the expertise in the nursing practice of the CLNs can only occur if the right conditions are fostered, such as education, professional supervision and support. Of interest, regarding Australian rural nurses there are parallels to the CLN role. Drury, Francis & Dulhunty (2001) report that advanced practice is not a new role, it has been carried out by nurses for many years but "requires clarity of function and identification of responsibilities" (p.21).

Neither a definition nor a description of the CLN role has been proposed regarding court liaison nursing by nurses. Turnbull and Beese (2000) suggested the precise role and particular functions were still being defined. Their description is the closest defining description for the CLN role that can be found:

Community mental health nurses working within the criminal justice system undertake an important function with regard to strategic intent that wherever possible, mentally disordered persons should receive care and treatment from health and social services (2000,p. 289).

The New Zealand Framework for Forensic Mental Health Services (MoH, 2001) refers to the functions of forensic court liaison staff in describing the Court liaison service. There is no definition for CLNs.

According to Taylor & Field:

The defining feature of a profession is generally considered to be its distinctive knowledge, based on credentials gained through advanced training. Distinctive knowledge is the basis for creating exclusive control over a particular area of work (2007, p.253).

While the thesis recognises the CLNs practice at an expert level of practice, at this time the practice is not comparable with advanced practice roles because attention to and meeting of additional defined processes are required. However, the CLNs' recommendations regarding necessary educational preparation for the CLN role lends to the argument for specialty status or advanced practice scope in the future. CLNs very clearly specify the education and training required which undoubtedly is not

encompassed within the generic NETP programmes or current approved nursing post-graduate papers. Therefore, an assumption is made that the level of educational preparation considered as necessary to practice in the CLN role raises the nursing practice from a specialist mental health nursing role to another skill level.

The failure of nursing leaders to recognise and attempt to understand the complexity of this role and support CLNs has meant the contribution of nurses at this important interface has been marginalised. CLNs require a support structure. They have been largely isolated without adequate supports for many years. Comparisons can be made with rural Australian nurses working in isolated practice situations (Drury et al 2005). Research found lack of professional development, status recognition, supervision, and education support were key factors in the challenges for these nurses. Similarly to the CLNs, the rural nurses practiced as sole health professionals, often in geographically isolated areas resulting in increased responsibility and accountability.

It was envisioned that this research would assist managers and nursing leaders to understand the complexity of the CLN practice and therefore assist with alleviating some of the CLNs' concerns regarding inadequate understanding of the role and professional support requirements.

A possible way forward

The issues of status and recognition are important to the CLNs. However, it is not enough to have extensive experience in an area of nursing to be considered a specialist. A case for specialist status requires recognition and articulation of the existing body of knowledge specific to the nursing role.

While The College (NZCMHN, 2012) sets out Standards for Practice for Mental Health Nursing the six standards are broad and do not have measurable performance criteria. As a beginning to gaining recognition and status, the research recommends the establishment of a framework of standards and competencies for practice for the CLN role. While there is an abundance of nursing standards and competencies, the development of clearly defined standards and competencies may provide a way forward in terms of a structure and a means to measure practice.

Articulating a common understanding of the CLN role has commenced with this research. CLNs use a language that is common to CLNs but is not common to other mental health nurses. Developing a common descriptive language and comparable

observations (Benner, 1984) is important to further enhance the CLNs' nursing practice and make it accessible to new CLNs.

In searching for solutions to embedding the practice for the future, there are several possibilities that can be considered, including credentialing, and the various specialist and advanced practice options.

Credentialing

The responsibility of credentialing regarding mental health nursing sits with Te Ao Maramatanga New Zealand College of Mental Health Nurses.

Credentialing is a process used to assign specific clinical responsibilities to health practitioners on the basis of their education, knowledge and skills. It commences on appointment and continues for the period of employment (NZCMHN, n.d).

Professional recognition for mental health nurses (certification) is being developed by The College. If CLNs were to pursue this pathway they could identify specific aspects to their practice that could be credentialed, for example, knowledge of the CP(MIP)Act , specific assessments and report writing. The credentialing process would ensure there was a framework, identified measurable competencies, education, support structures and a means for evaluation (NZCMHN, n, d). Being credentialed in court liaison nursing would be specific to the role. Credentialing may form part of a solution for recognition and status for CLNs. However, the findings from the research indicate CLNs should aim to expand the definition of the role to reflect the expanded scope of their practice.

Advanced practice roles

The options regarding scope of practice are advanced practice roles: Nurse Practitioner (NP) and Expanded RN Scope (NCNZ, 2011). Advanced practice forensic nursing according to the International Association of Forensic Nurses (IAFN):

...incorporates expanded and specialized knowledge and skills. It is characterized by the integration and application of a range of theoretical and evidence-based knowledge acquired as part of an advanced practice nursing graduate education (ANA, 2009, p.14).

A defined pathway exists for the NP in New Zealand. At this time, the CLN role would not meet criteria for nurse practitioner. Although, as one participant suggested, NP may be an option in the future:

...//... with an established post-graduate educational pathway for the CLN role and further expansion of the function of the CLN in the future towards CLNs providing formal court reports could mean NP status could be sought.

However, expanded RN scope may provide a pathway for the CLN role. Expanded RN practice is defined:

Expanding the boundaries of nursing practice occurs as a professional strategy in response to changing health care needs with increased range of autonomy, accountability and responsibility. There is a formal pathway to role expansion that entails further education and credentialing (NCNZ, Jan, 2011).

CLNs have articulated the increased range of autonomy and responsibility in their practice in the research. In addition, the position developed as part of a professional response to a change in health care needs i.e. increasing numbers of mentally unwell people coming before the courts (Peters & Wade, 1996).

The Nursing Council of New Zealand (NCNZ, 2011) provides a clear process for recognition of expanded RN scope. Gaining recognition as an expanded practice scope would require CLNs to collaborate with employers to assess whether the role would meet criteria for expanded practice (NCNZ, 2011). A role description and evidence the practice meets the competencies for expanded RN practice scope will be required, as well as means to evaluate the role.

Framework: standards and competencies for practice

Clearly the first step towards role definition and recognition is to bring CLNs together to develop a nationally consistent understanding as to the interpretation, function and delivery of the CLN role. This should include developing a framework of standards and competencies for practice, an ethical framework, and an educational pathway. A framework provides a structure enabling a process of professional judgement to take place (Forrester, 2001). A framework assists nurses to identify their concerns, consider these within the particular context of their role (in the court), then apply the relevant principles (Forrester, 2001). As Barker suggests, “advancing nursing practice can only occur if the right conditions are fostered for the development and provision of expertise in nursing practice” (2000, p.89). Standards and competencies for practice would assist with the ability to measure and evaluate practice. They would assist the CLNs with evidence for PDRP requirements.

Furthermore, a framework for practice would validate the advanced practice of the CLNs. Doing so may support the CLNs in their quest for recognition and remuneration that reflects the level of practice. Standards would outline expected levels of competency nurses must meet to perform in the CLN role and provide the basis for public accountability and evaluation of nursing performance.

Specialist opportunities

Consideration of specialist status seems a plausible route for valuing and formalising the CLN expertise. Possible options include “specialty area of nursing practice” or recognition as “specialist nurses”.

Specialty area of practice is defined as:

Specialty practice focuses on a particular area of nursing practice. It is directed towards a defined population or a defined area of activity and is reflective of increased depth of knowledge and relevant skills. Specialty practice may occur at any point on the continuum from beginning to advanced practice (NETS, 2011).

Whereas specialist nurse reflects an individual nurse’s level of practice. A specialist nurse is defined as:

...a nurse prepared beyond the level of a generalist nurse and authorised to practice as a specialist with advanced expertise in a branch of nursing field (Affara, as cited in Holloway, et al, 2009, p.270).

Recognition of specialty practice in New Zealand is able to be progressed through a Specialty Standards Endorsement process which has oversight by a National Nursing Consortium (Feb, 2011). CLN practice meets the above criteria for specialty area of nursing practice. The CLN practice focuses on a defined area – the mentally unwell or impaired person in the courts. Increased depth of knowledge is found in the assortment of specialised assessments conducted by the CLNs, the provision of reports advising the court and their knowledge regarding legal matters intersection with mental health.

Paradoxically, the CLNs identified that, although there is a need for recognition which will involve development of a framework of standards, competencies and an educational pathway, at the same time they were apprehensive these may mean the practice would become restricted and too prescriptive. Similarly, Drury et al (2005) discuss that defining practice in itself has a limiting effect on the scope of practice, suggesting

nurses themselves should generate the move forward, stating what they see the future of their role is.

A national body of CLNs will need to consider where they want to position the CLN role within the above options. Pursuing any of the above except specialist nurse will require consensus amongst the group. Benefits for CLNs progressing as a unified body towards recognition of their level of practice will be evident in collegiality, opportunities for discussion, clarification of the role, and the CLNs' voice being the one that drives this initiative. This can only enrich the nursing practice.

Although expanded RN practice scope refers to new roles or activities or health services, the fact that the CLN role has been in existence for twenty years, in the researcher's opinion, should not preclude application for Expanded RN practice scope. CLNs have been practicing autonomously since the inception of the CLN role in the early 1990s in New Zealand. This role requires a greater degree of autonomous judgment and intervention than other forensic mental health nursing roles, which is recognition of another consideration of expansion of practice. Aiming for recognition as a speciality area of practice or expanded RN practice scope appears the most suitable place to position the CLN role at this time.

However, it is asked whether a defined advanced practice scope will provide the status and recognition required for the role. The concerns identified in the research were more extensive than having a consistent role description and defined scope of practice. The CLNs require a level of authority to back their recommendations so the court knows they have standing and authority within the mental health service. A level of authority would also ensure CLNs were heard within the health service. Awareness of the role would be raised. CLNs require status so that when they speak and advise, their expertise is taken into account. A statutory role, in combination with a defined scope of practice such as "speciality area of practice" or "expanded RN practice scope", may assist with this and would carry a clearly defined forensic mental health nursing- legal education pathway. Several statutory roles are already established under the MHA.

The DAO statutory role is often undertaken by nurses (McKenna & O'Brien, 2013). It is a defined role with associated training. A key focus of the DAO statutory role is to promote the human rights of proposed patients if it is thought they meet criteria for compulsory assessment (McKenna & O'Brien, 2013). As noted earlier, not all situations the CLNs are involved in require consideration of compulsion although the person they

are assessing may be impaired in some way. These issues are complex for the CLN, compounded by the dynamics of the setting. Issues regarding consent and the nurse-patient relationship require attention in the first instance. Consideration of a statutory role for the health professional at court would raise many questions. Whether it is necessary to pursue this or whether other processes would suffice are beyond the scope of this thesis. Whether the role of the health professional, and the person with whom they are working with at court, would best be served by some statutory power may be an issue worth future consideration.

A comprehensive approach is required to support and advance this nursing role. As Barker (2000) suggests, education, defining scope and regulating advanced practice is required but not enough to advance practice. Supporting the development and expression of nursing expertise in practice through professional supervision and support requires similar consideration.

Summary

This chapter has presented a summary of the key findings of the research in six overarching themes integrated with the literature. The research has demonstrated that the CLN role is multifaceted and complex. Of concern, is that nurses are not educationally prepared to practice in a legal environment. CLNs were adept at identifying their needs to practice safely and competently in the role. An overwhelming level of information, which was remarkably consistent in its content, was provided in the survey and in-depth interviews regarding educational and professional support needs. This underscores a primary need for CLNs.

Two pervasive impressions come from the research. The CLNs overwhelmingly reported they loved the autonomy, the increased accountability and responsibility and the many challenges they faced. On the other hand, they felt undervalued and not appreciated within their health services. The autonomy and independence were closely aligned and are factors supporting the need for experienced CLNs. There are many dualities and complexities present which created role ambiguity for the CLNs. Particular tensions exist for CLNs in relation to obtaining consent and information exchange within the context of multi-agency working. CLNs currently weave a delicate dance in relation to information sharing. How these tensions influence clinical decision making requires further exploration in conjunction with an ethical framework.

CLNs encounter many complications and barriers to facilitating care through court diversion and liaison. These range from inadequate resourcing to encountering negative attitudes. However, CLNs were adept at working collaboratively with multiple organisations. The research uncovered the extent of the liaison role. The diversity of their practice was evident in the range of professions and organisations with whom the CLNs worked, the types of assessments, and the range of the people referred to them. The demographics of the people referred to the CLN exposed some surprising findings regarding the referral rate of Maori to CLNs.

Nursing practice in criminal courts pushes boundaries of traditional nursing roles. The CLNs have attained expert skills and advanced knowledge in the legal mental health interface. Consideration of a way forward for CLN practice to support the bedding in and longer term sustainment of this nursing practice was discussed. Gaining recognition and status was important to CLN practice. Possibilities were explored such as: credentialing, an advanced practice scope, or speciality opportunities. The research supports expanded RN practice scope or speciality area of practice. As a national group, CLNs will need to decide where to position the role.

A multi-pronged approach is required to support these nurses and further advance the practice. Development of a framework for practice including standards and competencies for practice is a first step. This should be coupled with progression of a role-specific educational pathway, an ethical framework, and a professional support structure to realise the needs of the CLNs and the future potential for the role. The next chapter concludes the thesis, with discussion of implications for practice and policy. Limitations of the research and recommendations for future research are presented.

Chapter Eight: Conclusion

Introduction

This research examined the role of the nurse in criminal courts in New Zealand through the use of three data collection methods: survey questionnaire, in-depth interviews and an audit. The research methods were underpinned by qualitative descriptive methodology. Given the background of silence and lack of recognition and understanding of forensic mental health nursing and court liaison nursing in New Zealand, it was important the CLNs' voice came through in this research. The methodological stance of qualitative descriptive methodology informed by naturalistic inquiry enabled this.

The research was based in the premise that it was time for CLNs to mature and own this role, delineate the parameters of it, and outline their requirements to practice competently and safely. This was essential because the setting and the focus of the role does not represent a traditional nursing role. Given the dynamics involved with the practice setting and the expectations of the nurse it is critical for the future to continue a dialogue about what makes this nursing work, and appropriate that it is nurses carrying out this role.

Nursing can only be understood within a particular context. To date, not only the CLN practice but also the contextual practice information surrounding these nurses was unknown. Therefore, it was important to try and understand court liaison nursing in terms of its relationship with influencing factors in the court system. This study grew out of ambiguity in understanding of the role of mental health nurses working within criminal courts. Therefore, this thesis also articulated factors that have contributed to shaping the nursing practice and the development of the CLN role.

This thesis was constrained in focus to mental health nursing interventions at the courts in relation to people who may be mentally unwell or impaired. The shape such interventions take with the nurse may be dependent on the law, the court environment, other professionals, the mental health service, and the forensic mental health service. Awareness of the way interactions between mental health services and the criminal justice system have developed historically was an important consideration, given that historical beliefs and values of health professionals and services impact on the way the CLN can function.

The thesis asked questions about who the nurses were, their nursing and educational background, what their preparation was for the CLN position, any ongoing education attained, role specific details, what their professional support structures entailed, interprofessional relationships, and tensions and challenges experienced in their practice. Finally, they were asked what they enjoyed the most and least and for their thoughts about the future of the role. In this concluding chapter, the future implications and research directions for this nursing role and research are discussed in relation to the findings. The limits of the study are outlined.

Summary of the findings - CLNs since the early 1990s in New Zealand

Mental health nurses have been formally practicing in criminal courts in New Zealand since the early 1990s, following the recommendation for establishment of court liaison services in the Mason Report (Mason et al, 1988). The CLN role is an example of the rapid changes that occurred in provision of mental health services since de-institutionalisation and of nurses adapting their practice to meet patient need (Peternelj-Taylor, 2008; McKenna, 2011).

The original mental health court liaison nurses should be applauded for venturing into unknown and uncharted territory. Unfortunately, twenty years later, in the majority of situations, mental health nurses are still venturing into CLN positions in a similar manner. The only difference now being the stakeholders in the judiciary expect a CLN to be present and have expectations about what the nurse can and cannot do, or should and should not do. While each individual CLN has worked extremely hard to establish their position and credibility within the courts, they remain a fragmented group of mental health nurses, largely ignored by nursing leadership and management.

Professional support and educational needs have not been considered or attended to.

As outlined in the thesis, the landscape of the CLN has altered since the early 1990s with increased prosecutions (MoJ, 2008), and continual erosion of inpatient mental health services. Furthermore, changes to existing legislation, and introduction of new legislation (Brookbanks, 2006) significantly impacted on CLN practice. CLNs have largely been excluded and not consulted regarding a number of significant changes regarding the court mental health intersection.

The interplay between the themes of isolation, autonomy and expert practice were evident in the practice stories. Although the CLNs overwhelmingly indicated they loved the position, the autonomy, the ability to develop a role and expand their nursing practice, equally overwhelmingly, they expressed feeling undervalued by their forensic nursing colleagues. The feelings of not being valued stemmed from insufficient professional support and understanding in relation to resources, clinical supervision, recognition and remuneration, and the complexity of this nursing practice. CLNs are also poorly represented in current clinical and managerial approaches. A sense of isolation and lack of support prevails for this small group of nurses.

The research provides a common language to begin identifying this nursing role. Rather than putting forth a definition of CLN nursing, the thesis explored the unique knowledges that characterise CLN nursing. Court liaison nursing pushes the boundaries of traditional working models that may require the blurring or melding of traditional roles and systems. Court liaison nurses are resilient, robust and caring nurses who have steadfastly embraced this role. Important issues are raised in this research in relation to the direction and support for these nurses, given that the CLNs' work is situated within the judicial system.

Despite their vast nursing experiences, generally mental health nurses commenced the CLN position ill-prepared for the setting. The description of "forensic psychiatric settings as places of unusual circumstance" (Austin, Goble & Kelecevic, 2009, p.836) is nowhere more apt than for these nurses. CLNs articulated a number of tensions in their nursing practice arising from the clash of nursing values with that of the aims and culture of the justice system and those working within it. Significantly, CLNs experienced great anxiety regarding sharing health information and obtaining consent. CLNs experience internal conflict when they were not able to guarantee confidentiality and trust when health information they have gathered becomes public in the court. These findings are analogous with the only comparable study regarding the role of the nurse in courts. Turnbull and Beese (2000) showed that nurses were ill equipped to practice in the court setting. Nevertheless a strong flavour of "advocacy" and "caring" and of holding onto nursing values was apparent in the CLNs' description of practice.

A number of differences in operation of the court liaison services were identified as they relate to CLNs' practice. These included practices relating to consent, information exchange and storing and filing of CLN documentation.

It is not acceptable that CLNs are self educated regarding legislation and the mental health law interface. Nurses are not legally trained. Most concerning is the apparent lack of awareness of the practice situation of these nurses and their needs. CLNs have charted the waters of the court and the mental health system largely unsupported, not valued, and not recognised for the level of knowledge and skills they hold since inception of the role. They could form a valuable resource for the wider mental health service in strategy and policy development and even for government bodies. There is currently no contemporary model to guide their practice. The research has demonstrated a model or framework is required.

Future research directions

Further research is required to develop a framework for practice, encompassing clinical guidelines for this area of nursing. It will be important to identify how CLNs manage complex situations and how they develop solutions to these.

Examination of the conflicts resulting from the dominating ideologies surrounding CLNs' work is a suitable focus for future research. The results from such research could inform practice and contribute to the formulation of educational programmes designed to address learning and professional support needs specific to CLNs.

Considerably more work needs to be undertaken to explore consent and information exchange in settings involving multiple agencies. A call for codes of ethical conduct for mental health nurses working within the criminal justice system is not new (Mason et al, 2002; Austin et al, 2009). CLNs should explore whether an ethical framework is required for practice. This could be undertaken in conjunction with Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc (The College).

Further international nursing research is required regarding nursing practice in courts. Global research that examines and compares the role of the nurse in court diversion and court liaison schemes, and that seeks their perspectives and knowledge may be useful. Whether a common conceptual framework is possible and would be beneficial for nursing practice in courts should be explored.

Although small individual evaluations of court liaison services have taken place (Peters & Wade, 1996; Brinded et al, 1996; Barnes, 1997; Peters et al, 2000), national evaluation of the court liaison service in New Zealand is overdue. As a small nation with an overarching Framework for Forensic Mental Health Services (MoH, 2001) and

a single funding stream, an opportunity exists to undertake comprehensive evaluation of court liaison services. Evaluation should include the perspective of the CLN. It will be important to include the wider consultation contacts the CLN has to garner a picture of the extent not only of their role but of the people with mental health concerns coming before the courts. The evaluation should review whether the identification of people with mental health and cognitive concerns in justice populations and referral for screening assessment is at an appropriate level. Consideration as to whether there is a need for collaborative interprofessional and interagency education should follow.

Given the numbers of people in the criminal justice system with alcohol and other drug issues (Statistics NZ, 2009) the findings related to frequency of and quality of contacts with Addiction services indicate this is an area that requires further attention. This thesis was restricted in focus to the role of the nurse in criminal courts concerning potentially mentally unwell people. The shape such interventions take was dependant on the CP(MIP)Act, the Framework for Forensic Mental Health Services (MoH, 2001) and the historical development of services. It may be timely to review the focus of the CLN role and consider whether it is fitting and there is capacity for CLNs to have a greater role in screening and undertaking brief intervention work regarding alcohol and other drugs, and providing recommendations to the court regarding this.

The high percentage of known clients of mental health services referred to the CLN was surprising. For just under half of the referrals, the CLNs initiated interventions with mental health services. It was beyond the scope of this research to investigate this further. However, this issue raises serious implications for future research and mental health services. Examining details of the person's situation and level of engagement with mental health services and follow-up at the time of offending may assist with identifying where the need for services and policy and funding and planning should be focussed.

Limitations of the thesis

A number of limitations to the research need to be considered. Firstly, the research is not generalisable, although it was never designed to be so as dictated by the methodology and academic requirements. However, that does not preclude other nurses recognising common ground in the research and finding usefulness to their practice.

The current study has only examined the nursing practice and the nurses' perspectives and therefore presents one aspect of this arena involving people with mental health concerns in criminal courts. To understand the practice setting in its entirety and the CLN contribution obtaining the perspectives of the people the CLNs work with would have provided a wider perspective.

The current research was not able to include the perspective of the CLNs who work within the Kaupapa Maori court liaison service. This perspective would have added value. While the researcher did take steps to ensure the aims of the research and processes were understood through engaging with the manager of the Kaupapa Maori court liaison service prior to data gathering and through NAFFAG future research should incorporate time in the early phases of research to follow a process of initiating consultation with Maori (HRC, 2010). Visiting the Kaupapa Maori service to meet the team in person and explain the research face to face may have assisted with understanding and developing a trusting relationship and enabled meaningful consultation, fostered the ability to work in partnership and co-operation (HRC, 2010).

The flexible approach taken for the third phase of the research meant the audit period was reduced from four to two weeks in line with the participants' suggestions. A larger number of participants and a longer data collection period would have provided more robust data. The audit findings have provided a small snapshot of CLNs' day-to-day activities and the demographics of the people referred to CLNs.

The researcher held an insider position having previously practiced as a CLN and was employed as a clinical nurse specialist with a forensic mental health service at the time of the research. Therefore, there was a risk the researcher influenced the interviews and the data analysis. The researcher was very aware of this possibility and reflexive processes were in place.

Contribution of thesis

This work contributes to existing mental health nursing knowledge by providing an extensive portrayal of the New Zealand mental health nursing practice in criminal courts. This is the first study of its kind in New Zealand to capture the nurses' perspective at this interface and therefore provides a base for further research. It goes some way to recognising the expert and specialist nature of CLN practice. Furthermore, it examines court liaison nursing practice from a national perspective.

This study adds to the voice of nurses in New Zealand and, specifically, to the silent voice of forensic mental health nurses. It contributes valuable knowledge and literature to inform forensic mental health nursing practice and other nursing roles that intersect with the justice sector. The thesis may provide guidance to nurses who practice in this setting. The findings enhance our understanding of the challenges the CLNs' encounter and how they manage them. It provides a rare insight into the ethical dilemmas the CLNs experience.

Importantly, the findings provide significant recommendations for the education and professional support needs for nurses in such roles. This research will serve as a base for future studies of the mental health legal interface, particularly in relation to court liaison nursing, to further define the role and articulate the practices in relation to ethical decision making.

Many factors shape the work of the CLN, including nursing, psychiatry and law. Emerging from this research is a greater appreciation of the degree of the power dynamics that are so pervasive to forensic mental health nursing but exaggerated even more so for the CLN. It is easy to see the obvious differences in the two systems, but at another level there is silence in relation to the human cost to the CLNs practicing in this role. Ethical values guide the behaviour of nurses; however, in carrying out those values, CLNs may be constrained by the setting and other agendas. Working with those constraints generated internal disquiet for the CLNs. The impact of this was tangible. The thesis has commenced a dialogue regarding the dissonance experienced by CLNs generated from practicing within systems with differing values. CLNs need to continue this dialogue with development of an ethical framework pertinent to their practice.

This thesis also contributes to the growing body of international forensic mental health nursing literature and knowledge regarding nursing roles situated within the justice institutions. There is scope for further research internationally that explores the role of nurses in court liaison and diversion schemes, seeking their perspectives and knowledge, commonalities and differences.

Final reflections

Undertaking this research has led to consideration of the wider configuration of mental health services in New Zealand and to reflect on service delivery and underpinning

attitudes to “care”. There is a sense that the “care” in provision of services has been lost under issues of fiscal tightening and budget constraints.

Perhaps it is timely to consider whether there needs to be a paradigm shift and change of focus within wider mental health services in New Zealand. The CLNs encountered so many barriers in trying to facilitate “care”. The needs of the person with mental health concerns should be at the centre of the service. Urgent review of the reasons why there are such high numbers of people who are known clients of mental health services coming to the attention of justice agencies is required. Principles of early intervention, assertive follow up, and seamless service provision need to be considered.

The quest for future CLNs will be to ensure that the future of their nursing role is self-determined. They will need to decide where the boundaries of their practice lie. How they function and maintain their values within the justice setting will be important considerations. An ethical framework or lens to see through and reflect on what is taking place will assist with remaining true to nursing ideals of caring, concern and advocacy for the person with mental health concerns. Furthermore, the CLNs’ perspective has value. As Kent Wilkinson (2010) reiterated, internationally, forensic nurses are proactively influencing government in multiple areas including policy development for changes in areas of human rights, and mental illness.

It is time to embed this role as a recognised senior forensic mental health nursing role. Several possibilities for the role for the future have been put forward. A case for specialist status for CLN requires articulation of the specific body of knowledge to this nursing practice and role-specific education (Taylor & Field, 2007). Ethical and political discussion acknowledging the tensions, as well as more research, will assist with theoretical development. Creating a national conceptualisation of CLN practice is essential (Kettles & Woods, 2006). Establishing a theoretical basis for practice with a framework for practice will be important to advance this role.

All nurses have a key role in leading the changes required to improve health outcomes (MoH, 2006). The challenge is to build capability and capacity in CLN and ensure the CLN workforce is robust, resilient, and is adequately prepared to meet service requirements in the future. A cohesive, sustainable approach must be developed to ensure the progression of workforce development in this specialised area of practice for mental health nurses in New Zealand.

This research highlights some of the distinctive features of court liaison nursing such that, with consensus and development of a framework including standards and competencies, education and professional support, a decision about specialist status or expanded practice could proceed. However, a word of caution was put forward by the CLNs: they did not wish the practice to become too prescriptive and risk losing their autonomy and independence. Interestingly, Barker (2000) cautions regarding the development of advanced practice roles, suggesting that rigidity in role descriptions, a constrained scope of practice, clinical pathways, and the demands for evidence based practice may serve to constrain the expression of expertise through limiting the repertoire which nurses may draw upon in a given situation. The challenge for CLNs will be to develop a framework of standards and competencies that allow the “art” of the nursing to continue to expand and be responsive to the needs of the people with mental health concerns in the justice population.

Where the CLN practice will sit in the future is to be determined by CLNs and nursing leaders. Ultimately, practice will be judged on the ability of the CLNs to facilitate interactions with and the relevant interventions for people with mental health concerns in the courts. CLNs achieve these admirably despite encountering adversity at this time.

The relationship between justice and mental health systems is continually evolving. The development of new courts such as mental health courts and alcohol and drug courts may mean new roles are implemented for mental health nurses within legal settings. Although attention to the CLN role is well overdue, the current CLNs are well positioned to take a lead role and provide expertise and mentoring regarding new nursing roles.

Finally, despite all the angst, the CLNs absolutely cherished this exciting and evolving nursing position. A final comment from Michael reflects the passion:

Oh I love it Mate, I, I love this job. It's the best job I've ever had. I love the challenge of it. I love the unpredictability of it. You know that you've got to think on your feet in every case, and the challenge of that, being able to work it through, and to come out with a well thought out process. I find really satisfying. And the style of the job where you have that autonomy to do that and that responsibility ...//... for me it's the principle that you do the bloody job, and you do it as well as you can, and it's satisfying to do that you know.

In conclusion, this study goes some way to recognising the complex, expert and specialist nature of CLN practice. The research has identified some areas for further

examination and expansion of the knowledge base and role of mental health nurses in criminal courts. Attention to these will ensure that nurses are supported in their practice. The CLN is an important role in relation to equivalency of access to health care for mentally unwell people in the justice population. Participants in this study have demonstrated that they are deeply and profoundly committed to the people they serve.

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APPENDICES

Appendix A: Ethics documents

MREC



Multi-region Ethics Committee

Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington 6145
Phone (04) 470 0655
(04) 470 0646
Fax (04) 496 2340
Email: mullregion_ethicscommittee@moh.govt.nz

30 September 2010

Ms Patsy-Jane Tarrant
34 Bayne Terrace
Macandrew Bay
Dunedin 9014

Dear Ms Patsy-Jane Tarrant

Re: Ethics ref: **MEC/10/067/EXP** (please quote in all correspondence)
Study title: An exploration of the role of court liaison nurse within the New Zealand criminal courts
Investigators: Ms Patsy-Jane Tarrant

This study was given ethical approval by the Multi-region Ethics Committee on the 30th of September 2010

Approved Documents

- Survey, version dated September 2010
- Guide to interview, version dated September 2010
- Court liaison nurse 2 week data collection tool, version dated September 2010
- Instruction Sheet for Court liaison nurse 2 week data collection tool, version dated September 2010
- Survey Cover letter, version dated September 2010
- Survey Participant Information Sheet, version dated September 2010
- Survey Reminder Letter, version dated September 2010
- In-depth interviews and 2 week data collection activity Cover letter, version dated September 2010
- In-depth interviews and 2 week data collection activity Participant Information Sheet, version dated September 2010
- In-depth interviews and 2 week data collection activity Reminder Letter, version dated September 2010
- Consent Forms, AUT administrator, version dated September 2010
- Consent Forms, Transcriber and typist, version dated September 2010
- Consent Forms, In-depth Interviews and 2 week data collection activity, version dated September 2010
- Letter to New Zealand Forensic Psychiatry Advisory Group, version dated September 2010

— Letter to Forensic mental health service managers AUT Counselling and Wellbeing, version dated September 2010

This approval is valid until 30th of September 2011. A Final Report is required at the conclusion of the study. The Final Report Form is available at www.ethicscommittees.health.govt.nz.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

We wish you all the best with your study.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Claire Lindsay', written in a cursive style.

Claire Lindsay
Administrator
Multi-region Ethics Committee
Email: multiregion_ethicscommittee@moh.govt.nz

AUT



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Kate Diesfeld
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 23 December 2010
Subject: Ethics Application Number 10/279 **An exploration of the role of the court liaison nurse within the New Zealand criminal courts.**

Dear Kate

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 13 December 2010. Your application is now approved for a period of three years until 13 December 2013.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 December 2013;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 13 December 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

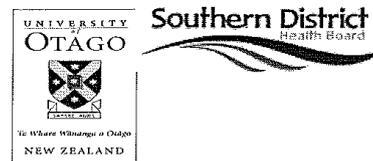
Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Patsy-Jane Tarrant patsy-jane.tarrant@southerndhb.govt.nz

Locality agreements

Southern DHB lead

Health Research Office
Dunedin School of Medicine and Southern District Health Board



18/01/2011

Project ID 00668

Dr. Alison Dixon
SDHB

Dear Alison

REF: An exploration of the role of the court liaison nurse within the New Zealand criminal courts

I am writing on behalf of the combined Southern District Health Board and Dunedin School of Medicine, Research Advisory Group (RAG) to confirm that the project mentioned above has been granted approval to proceed.

According to my records:

This project is due to commence: 30/09/2010

It is due to be completed by: 30/09/2011

If you have any questions with regards to this project please contact me quoting the project ID shown above.

Yours sincerely

A handwritten signature in black ink that reads 'Ruth Sharpe'.

Ruth Sharpe
CLINICAL RESEARCH ADVISOR

CC ELAINE CHISNALL, SDHB
PATSY-JANE TARRANT

Health Research Office, Private Bag 1921, Dunedin 9054
hro@otago.ac.nz; www.otago.ac.nz/hro

Ruth Sharpe, Clinical Research Advisor, Ph: 03 470 3843 (Hosp 7979); Ruth.Sharpe@otago.ac.nz

Patsy-Jane Tarrant

From: The Knowledge Centre [knowledgecentre@waitematadhb.govt.nz]
Sent: Monday, 7 February 2011 07:44
To: Patsy-Jane Tarrant
Cc: Brian McKenna
Subject: WDHB Approval to Commence

Dear Patsy-Jane

The Knowledge Centre has now received the relevant approvals for your study:

Title: An exploration of the role of the court liaison nurse within the New Zealand criminal courts.
Registration #: RM 0980711841

Please continue to forward to us copies of any correspondence regarding ongoing ethics approval for this study (if required).

Good luck with your study. We would be interested in receiving a copy of any outputs or publications.

Regards

Knowledge Centre
Waitemata District Health Board
(09) 4868920 ext 2071

CC Brian McKenna

Waitemata DHB confidentiality agreement



Confidentiality Agreement

Personal responsibility to maintain confidentiality, privacy and security of WDHB information

Contract code 000030404 **Project:** 0980711841 **An exploration of the role of the court liaison nurse within the New Zealand criminal courts.**

WDHB Primary Contact Brian McKenna **Project type** Observational research
WDHB Host Dept & Service FORENSIC MH Service Level **Regional Forensic Psychiatry Services**

Ethics Committee Number MEC/10/067/EXP **Ethics Start Date** 30/09/2010 **Ethics Expiry Date** 30/09/2011

Areas required for security access

1 I understand that at all times I must maintain the confidentiality of information that I become aware of during the course of my role as researcher/research assistant. Information about Waitemata District Health Board, its patients and employees must not be disclosed to persons not entitled to know.

I will comply with the Privacy Act and Health Information Privacy Code at all times (both of which can be viewed on www.privacy.org.nz). I am aware that an inappropriate use or disclosure of information could result in disciplinary action, referral to a professional body or complaint to the Privacy Commissioner.

Initial: 

2 I understand that I must only access health information directly related to the research protocol specified. I will not use my authorised access inappropriately. I may be called upon to account for my access to information when its justification is not immediately apparent.

Initial: 

3 Where I have approved access to a security password or other identifier I am personally responsible to not disclose this to someone who does not have approval to use it i.e. I am responsible for the electronic identity and signature.

Initial: 

4 I acknowledge that:
- Upon completion of my work for WDHB, I must return to WDHB all ID, security access cards, keys, documents and material containing information on patients, services, finances, commercial operations or information systems of WDHB.

Initial: 

5 I will adhere to the requirements of the Ethics Committee as regards to storage and destruction of research materials and patient information.

Initial: 

6 I will take all reasonable actions to:
- Make sure that confidential information is not accessible to unauthorised people, i.e. no discussion of information in a public place; papers and records will be kept secure and not able to be accessed by the public; careful faxing and emailing of information; transporting information securely using formal processes; turning screens away from public viewing and using screen lock-out; not discussing patient information in public places.
- Check the identification of anyone i) accessing confidential information or ii) present in areas where they do not have approved access

Initial: 

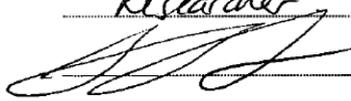
7 Immediately report any breach or compromise relating to Clause 6, verbally and in writing.

Initial: 

I have read and understood my responsibilities

Full name (please print) Patsy-Jane Tarant

Position on project Researcher as researcher external to WDHB

Signature  **Date** 24/01/2011

Canterbury DHB

Kirsten Deuchrass (Kirsten.Deuchrass@cdhb.govt.nz) You moved this message to its current location.
Sent: Thursday, 16 December 2010 12:41:31 p.m.
To: Paul and Patsy Tarrant (pptarrant@hotmail.com); patsy-jane.tarrant@southerndhb.govt.nz

Hi Patsy,

I have received confirmation from the Forensic Dept at CDHB that they are happy for you to conduct your research here.

You are welcome to contact Paula Mason (Clinical Manager, Forensic Court Team, Hillmorton Hospital 027 2756625) when you want to get started.

All the best,

Kirsten

Kirsten Deuchrass
Research Advisor

Research Office
Canterbury District Health Board
Room 502a
Christchurch School of Medicine Building
PO Box 4345
Christchurch 8140
New Zealand

Tel: +64 3 364 1513
Fax: +64 3 364 1490

Capital & Coast CDHB

From: Marina Dzhelali [CCDHB] [mailto:Marina.Dzhelali@ccdhb.org.nz]
Sent: Wednesday, 8 December 2010 1:19 PM
To: Patsy-Jane Tarrant
Subject: research

Dear Patsy,

i have asked our DON to provide contact details of the court liaison nurses in CCDHB, for you to contact. I have also forwarded your email to the Forensics Team leader, and will let you if she has any comments. Please don't hesitate to get in touch should you have questions.

Kind regards,

Marina Dzhelali
Service Leader, Research
CCDHB, Private bag 7902, Wellington South
mobile 0274568791

ph 64 4 8062562, fax 64 4 385 5843

Appendix B: Letters

NZFPAG

C/o Ward 9A Wakari Hospital
Forensic Psychiatry Service
Southern District Health Board (Otago)
Private Bag 1921, Dunedin
Telephone: 03 4740999 : Fax: 03 4766029



13 December 2010

Dr Rees Tapsell
Chair
New Zealand Forensic Psychiatry Advisory Group

Dear Dr Rees Tapsell

An exploration of the role of the court liaison nurse within the New Zealand criminal courts.

This letter serves as a request for support. I am a registered nurse employed by the Southern District Health Board in the Otago Forensic Mental Health service. I am a doctoral candidate in the School of Public Health and Psychosocial Studies at AUT University. I have ten years nursing experience with forensic mental health services, five of those as a court liaison nurse. Currently I am the clinical nurse specialist for the Otago Forensic Mental Health Service. I am writing to inform the New Zealand Forensic Psychiatry Advisory Group of the proposed research and seek to obtain the support of this Group for this research. Expedited ethics committee review is being sought for this research through the Multi Regional Ethics Committee. The research meets the criteria for low-risk observational research as per the "Ethical guidelines for observational studies: Observational research, audit and related activities (MoH, 2006). A brief outline of the research follows.

The focus of the research is the court liaison nurse role in New Zealand. There is a paucity of literature regarding nursing roles in this context both nationally and internationally. This research is a beginning step to redress this and explore and describe this nursing role in the New Zealand context. This in turn will inform nursing practice. The final report from this research will be submitted to the AUT University as a DHSc thesis.

The supervisors for this research are: Associate Professor Kate Diesfeld JD, and Associate Professor Brian McKenna.

This project aims to:

- a) Identify and describe current nursing practice at the criminal justice mental health interface of courts in New Zealand
- b) Gain an in-depth understanding of the challenges and facilitators to nursing practice at the criminal justice mental health interface
- c) Identify training, education and supervision needs for court liaison nurses

Mixed methods will be employed for this study consisting of three phases. The first phase involves an anonymous survey questionnaire of all the nurses in New Zealand practicing as court liaison nurses. The survey seeks to obtain; background demographic information about this group of nurses, the work environment, the preparation for the role, education and training needs, supervision and support needs and role challenges and facilitators to practice. The data from the survey will inform the second phase of the study in which in-depth interviews will be conducted with six court liaison nurses. The purpose of the interviews is to explore the

themes that come out of the survey questionnaire in greater depth. Specific focus will be on education and support and whether there is a need for a model of practice.

The third phase of the study involves data being collected by six court liaison nurses over a 2-week period on a daily basis to obtain a detailed picture of their role. The data collection tool will be designed to require minimal time from participants. This important phase will provide a comprehensive picture of the role. The current means of collecting statistics relating to work performed in the role do not capture the range and extent of activities and interventions that the court liaison nurses conduct daily. I understand that taking part in this phase of the research will require quite a commitment from these nurses whose working day is generally very busy. Therefore it will be important that the forensic mental health services as a whole support these nurses taking part in the research.

Court liaison nurses will be chosen by the researcher to represent the main regions as defined by forensic mental health services, for the second and third phases of the research. The nurse will not be identified by name or region in the data analysis and research report.

SPSS descriptive statistics will be used to analyse the survey data and the 2-week data collection. Content analysis will be used to analyse the in-depth interviews and the relevant questions in the survey.

I will also be writing to the managers of each regional forensic mental health service and the manager of the respective court and prison liaison service regarding this research and enlisting their support to distribute the surveys to nurses practicing in the court liaison nurse role. I would also appreciate the support of the forensic service managers for the court liaison nurse completing the 2 week collection of data.

I would be happy to provide updates and to present the findings of this research to the New Zealand Forensic Psychiatry Advisory Group. Please let me know if you require any further information. I would appreciate any advice or suggestions that the group may have.

Yours sincerely

Patsy-Jane Tarrant RN BNursHons

Researcher Contact Details:

Patsy-Jane Tarrant RN
Ph- 0274341966
Email: patsy-jane.tarrant@southerndhb.govt.nz

Project Co- Supervisor Contact Details:

Associate Professor Kate Diesfeld JD
McKenna
Phone: 09 921 9999 X 7799
Fax: 09 917 9780
Email: kate.diesfeld@aut.ac.nz
brian.mckenna@auckland.ac.nz

Associate Professor Dr. Brian
09 373 7599 X 89554
09 367 7158

Attached
Letter to FMHS Managers

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.
Approved by the Auckland University of Technology Ethics Committee on 13 December 2010, AUTEK.
Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010, Reference number MEC/10/067/EXP.

FMHS managers



Date

An exploration of the role of the court liaison nurse within the New Zealand criminal courts.

Dear Manager

I am a registered nurse employed by the Southern District Health Board in the Otago Forensic Mental Health Service. I am currently enrolled as a doctoral candidate in the School of Public Health and Psychosocial Studies at AUT University.

I am writing to you to seek your support and that of your service with this research. The research is briefly outlined for your information.

The focus of the research is the court liaison nurse role in New Zealand. There is a paucity of literature regarding nursing roles in this context both nationally and internationally. This research is a beginning step to redress and explore and describe the role in the New Zealand context. This in turn will inform nursing practice. The final report from this research will be submitted to the AUT University as a DHSc thesis.

The supervisors for this research are: Associate Professor Kate Diesfeld JD and Associate Professor Brian McKenna, PhD.

This project aims to:

- a) identify and describe current nursing practice at the criminal justice mental health interface of courts, in New Zealand
- b) Gain an in-depth understanding of the challenges and facilitators to nursing practice at the criminal justice mental health interface
- c) Identify training, education and supervision needs for court liaison nurses

Mixed methods will be employed for this study consisting of three phases. The first phase involves an anonymous survey questionnaire of all the nurses in New Zealand practising as court liaison nurses. Completing the survey should take approximately 20-30 minutes of each court liaison nurses time.

The data from the survey will inform the second phase of the study in which in-depth interviews will be conducted with six court liaison nurses. The purpose of the interviews is to enable the nurse to describe their role and experiences and to explore, in greater depth, the themes and data that come out of the survey questionnaire. Specific focus will be on education and support and whether there is a need for a model of practice.

The third phase of the study involves data being collected by six court liaison nurses over a 2-week period on a day to day basis to provide a detailed picture of exactly what it is that nurses are doing every day in this role. The data collection tool will be designed to require minimal time from participants out of their day to day work load.

Court liaison nurses will be chosen by the researcher to represent the main regions as defined by forensic mental health services for the second and third phases of the research. The six nurses will not be identified by name or region in the data analysis and research report. The same nurse in each region will take part in the in-depth interview and the 2 week data collection phases of the research.

SPSS descriptive statistics will be used to analyse the survey data and the 2-week data collection; content analysis will be used to analyze the in-depth interviews and the relevant questions in the survey.

Support for this research is being sought from The New Zealand Forensic Psychiatry Advisory Group.

The researcher would appreciate it if you would forward this letter and the enclosed packs which contain the following; participant information sheet, survey, stamped self addressed return envelope to the manager of the court liaison service for distribution. Or alternatively forward enclosed packs to all the nurses in your region who practice as court liaison nurses. Please include nurses who work full time, part time or who 'fill in' in the court liaison nurse role. Please contact the researcher if you require further packs. The researcher will send you a reminder letter to pass onto the nurses within three weeks.

Your support would also be appreciated for the final phase of the research when a nurse from each region will be asked to participate in collecting data for a 2 week period on the daily activities that they perform in the role. The researcher understands that the nurses' days are busy enough as they are, without having to collect extra information. The data collection phase is important to obtain a comprehensive picture of the role. The current means of collecting statistics relating to work performed in the role do not capture the range and extent of activities and interventions that the court liaison nurses are carrying out every day. It is understood that taking part in this phase of the research will require quite a commitment from these nurses. Therefore it will be important that the forensic mental health service as a whole supports these nurses taking part in the research.

Please feel free to contact the researcher or one of the supervisors if you have any questions, or would like more information regarding this research.

Yours sincerely

Patsy-Jane Tarrant RN BNursHons

Researcher Contact Details:

Patsy-Jane Tarrant RN

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

Project Co- Supervisor Contact Details:

Associate Professor Kate Diesfeld JD
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09 373 7599 X 89554

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Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Approved by the Auckland University of Technology Ethics Committee on 13 December 2010, AUTEK. Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010, Reference number MEC/10/067/EXP.

Survey cover letter



Date

An exploration of the role of the court liaison nurse within the New Zealand criminal courts - Survey.

Dear colleague

Your manager has identified that you are practicing in the court liaison nurse role. This letter invites you to take part in the first phase (the survey) of this mixed method study to explore, analyse and describe the role of the court liaison nurse in New Zealand. The survey will be sent to all court liaison nurses in New Zealand through managers of the Regional Forensic Mental Health Services.

A participant information sheet, the survey and a stamped self addressed return envelope is enclosed. Please take some time to read through this information and consider being a participant in this research.

Thank you for considering this. Your participation is greatly valued.

Sincerely,

Patsy-Jane Tarrant RN
C/- Otago Community Forensic Mental Health Service
Private Bag 1921
Wakari Hospital
Dunedin
Ph- 0274341966
Email: patsy-jane.tarrant@southerndhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee on 13 December 2010. AUTEK Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010. Reference number MEC/10/067/EXP.

Survey reminder letter



Dear Colleague

I am sending out this reminder letter giving you another opportunity to participate in this research exploring the role of the court liaison nurse in New Zealand. I realise you may be intending to respond but have not yet had a chance to action this.

Included with this letter are the participant information sheet, survey and self addressed stamped return envelope. If you are still interested in participating in this research please complete the enclosed survey and return in the envelope provided.

Again thank you for considering this request.

Yours sincerely

Patsy-Jane Tarrant RN BNurs Hons

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee on 13 December 2010. AUTEK Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010. Reference number MEC/10/067/EXP.

In-depth interviews and audit cover letter



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92006
Auckland 1020,
NZ
T: +64 9 921 9999
www.aut.ac.nz

Date

An exploration of the role of the court liaison nurse within the New Zealand criminal courts – in depth interviews and 2-week data collection.

Dear Colleague

The researcher has identified you as practicing in the court liaison nurse role and invites you to participate in this mixed method research to explore, analyse and describe the role of the court liaison nurse in New Zealand. Recently you received a survey form which was the first phase of this research. The second and third phase to the research involves taking part in an in-depth interview and a two week period of collecting data about your day to day activities in the court liaison nurse role.

The researcher will select six court liaison nurses to represent the main regions as defined by forensic mental health services for the in-depth interviews and the data collection phases of this research. If you are selected, I hope that you agree to participate.

A participant information sheet, consent form and self addressed stamped return envelope are enclosed. Please take the time to read through this information and consider participating in this research by returning the consent letter to the researcher in the envelope provided.

Yours sincerely,

Patsy-Jane Tarrant RN BNursHons

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Reference number 10/279.

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In-depth interviews and audit reminder letter



Date

Dear Colleague

I am sending out this reminder letter giving you another opportunity to participate in this research exploring the role of the court liaison nurse in New Zealand. I realise you may be intending to respond but have not yet had a chance to action this.

Included with this letter are the participant information sheet - in depth interview and 2 week data collection and a self addressed stamped return envelope. If you are still interested in participating in this research please complete the enclosed consent form and return in the envelope provided.

Again thank you for considering this request.

Yours sincerely

Patsy-Jane Tarrant RN

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

**Approved by the Auckland University of Technology Ethics Committee on 13 December 2010, AUTECH.
Reference number 10/279.**

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Appendix C: Participation information sheets and consent form

Survey participant information sheet



Date

Participant Information Sheet - Survey

An exploration of the role of the court liaison nurse within the New Zealand criminal courts.

You are invited to take part in the first phase (the survey) of this mixed method study to explore, analyse and describe the role of the court liaison nurse in New Zealand. The researcher is a registered nurse and a doctoral candidate in the School of Public Health and Psychosocial Studies at AUT University. The survey will be sent to all court liaison nurses in New Zealand through managers of the Regional Forensic Mental Health Services. Your participation in this research is voluntary; you have no obligation to participate. Once the survey is returned it is not possible to withdraw at that point due to the anonymous nature of the survey. Consent is considered granted by the return of the survey.

Purpose of this research

This project aims to:

- a) identify and describe current nursing practice at the criminal justice mental health interface of courts in New Zealand
- b) Gain an in-depth understanding of the challenges and facilitators to nursing practice at the criminal justice mental health interface
- c) Identify training, education and supervision needs for court liaison nurses

Articulation of the court liaison nurse role as it has developed in New Zealand is the first step towards gaining an understanding of nursing practice at this interface.

The survey will obtain background demographic information about this group of nurses and the work environment. The data from the survey will also help inform the second part of the study, the in-depth interviews that will be conducted with six court liaison nurses. The third part of the study involves data being collected by six court liaison nurses over a 2- week period on a day to day basis to provide a detailed picture of what the role entails. SPSS descriptive statistics will be used to analyse the survey data and the month long data collection, content analysis will be used to analyze the in-depth interviews and the relevant questions in the survey.

Managers from the Regional Forensic Mental Health Services were contacted by the researcher and provided with envelopes containing the information sheet, the survey and a return self addressed envelope to the AUT University administrator. To ensure your anonymity as a participant in this research your name is not recorded on the questionnaires. No identifying details are asked in the survey. The AUT University administrator will open the returned envelopes and forward the completed surveys to the researcher. This will ensure confidentiality as the researcher will not know which region the survey originated from. The returned surveys will be given individual numbers. This is to track the responses during the analysis phase and cannot be linked back to the participant. Should you agree to complete the survey it should take approximately 20-30 minutes.

One reminder letter will be sent out to you by the researcher within three weeks, via your manager. If you have already returned your survey please ignore these reminders.

Once the raw data from the surveys has been analysed it will be stored for 5 years in a locked cabinet at the School of Public Health at AUT University and will then be destroyed by the researcher. Only the researcher, supervisors and the AUT University administrator will have access to the locked cabinet. Prior to analysing the data it will be kept in a locked cabinet in the researcher's office at the Southern District Health Board which only the researcher has access to.

It is not envisaged that there will be any discomforts or risk associated with completing the survey. Whether you complete the survey and return it or not will have no effect on your employment.

In the event that you experience any psychological discomfort from participating in this survey, you may be eligible for 3 free counselling sessions in person or by phone through AUT University Health and Wellness Centre. Phone 09 921 9992 or 09 921 9998 to make an appointment. You will need to let the receptionist know that you are a research participant and provide your contact details to confirm this. You can find out more information about the AUT counsellors and the option of online counselling via http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing.

Please contact the researcher if you would like to receive a summary of the survey data. The final report from this research will be submitted to the AUT University as a DHSc thesis and available from the AUT University library.

The New Zealand Forensic Psychiatry Advisory Group supports this research.

Researcher:

Patsy-Jane Tarrant RN

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

Any concerns regarding the nature of this please contact the Project Co –Supervisors.

Project Co- Supervisors:

Associate Professor Kate Diesfeld JD
McKenna

Phone: 09 921 9999 X 7799

Fax: 09 917 9780

Email: kate.diesfeld@aut.ac.nz

Associate Professor Dr. Brian

09 373 7599 X 89554

09 367 7158

b.mckenna@auckland.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Your contribution to this research is valuable. Thank you for taking the time to complete this survey.

Approved by the Auckland University of Technology Ethics Committee on 13 December 2010, AUTEK. Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010, Reference number MEC/10/067/EXP.

In-depth interviews and audit participant information sheet



Date

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and 1020, NZ
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Participant Information Sheet – In depth interviews and 2-week data collection

An exploration of the role of the court liaison nurse within the New Zealand criminal courts.

You are invited to take part in this mixed method study to explore, analyse and describe the role of the court liaison nurse in New Zealand. The researcher is a registered nurse and a doctoral candidate in the School of Public Health and Psychosocial Studies at AUT University. There are three phases to the study. Your participation in this research is voluntary; you have no obligation to participate. Nurses who have current experience in the court liaison nursing role are being invited to participate in this study.

Purpose of this research

This project aims to:

- a) Identify and describe current nursing practice at the criminal justice mental health interface of courts in New Zealand
- b) Gain an in-depth understanding of the challenges and facilitators to nursing practice at the criminal justice mental health interface
- c) Identify training, education and supervision needs for court liaison nurses

The study consists of three parts. The first is a survey of all the nurses in New Zealand practicing as court liaison nurses to obtain background demographic information about this group of nurses and the work environment. This has already been sent to you.

The survey data will inform the second part of the study, the in-depth interviews that will be conducted with six court liaison nurses. The third part of the study involves data being collected by six court liaison nurses over a 2-week period on a daily basis. This will provide a detailed picture of what the role entails. SPSS descriptive statistics will be used to analyse the survey data and the 2- week data collection, content analysis will used to analyze the in-depth interviews and the relevant questions in the survey.

Articulation of the role as it has developed in New Zealand is the first step towards gaining an understanding of practice at this interface and will in turn inform practice. The final report from this research will be submitted to the Auckland University of Technology as a DHSc thesis.

I am inviting you to participate in the second and third stages. Court liaison nurses were explicitly chosen to represent the main regions as defined by forensic mental health services.

Interviews

You will be asked to participate in an interview with the researcher of up to two hours duration. Participants may feel uncomfortable with an interview situation and are welcome to bring a

support person. The interview will be audiotaped. The researcher will also take notes during the interview. During the interview, nurses are invited to describe their role and experiences in depth based on themes from the initial survey. It is envisioned that the participants discuss any tensions and barriers to the role, as well as facilitators to carrying out the role. A specific focus will be on education and support and whether there is a need for a model of practice. The researcher is a mental health nurse with experience in the court liaison nurse role and with interviewing people. The interviews will take place in familiar surroundings in a room at the participant's place of employment, at a convenient time for participants. Refreshments will be provided during the interviews and breaks. A written consent will be provided. The participants can decline to answer any particular question, and ask for the audio tape to be turned off at any stage.

In advance of the interviews, questions that indicate the content of the interviews will be given to participants.

The transcribed audiotape will be given to participants for checking and clarifying. The transcriber will be asked to sign a confidentiality agreement.

2- week data collection of day to day activities of the court liaison nurse role

The information obtained from the surveys and the interviews will inform the development of the 2-week data collection tool. Participants will be asked to collect data on their day-to-day activities on a spreadsheet over a 2-week period. The spreadsheet will be designed to require minimal time from participants.

Collecting detailed information about daily activities is important to develop an understanding of the role has developed nationally and to describe the nurse's role. The current means of collecting statistics relating to work performed in the role do not capture the range and extent of activities and interventions that the court liaison nurses are carrying out daily.

The researcher requires the participant to provide an email contact address on the consent form so that the 2- week data collection tool can be emailed to them.

Once the raw data from the 2 week data collection period and the in-depth interviews has been analysed it will be securely stored for 5 years in a locked cabinet at AUT University and will then be destroyed by the researcher. Only the researcher the supervisors and the AUT administrator will have access to the locked cupboard. Prior to this the raw data will be kept in a locked cabinet in the researcher's office at the Southern District Health Board that only the researcher has access to.

The confidentiality of the participants will be maintained. The nurse participants will choose a pseudonym for the interviews. Only the researcher, the supervisors and Forensic Mental Health Service Manager will know which nurses have been invited to participate in the interview and 2 week data collection. All identifying information will be removed from the interview transcripts and checked by the participants. The 2 week data collection tool will not require collection of the participant's identifying information or the specific court that the nurse is practicing within. Neither your name nor your area of practice will be identified in the research.

The researcher has sought the support of the National Forensic Psychiatry Advisory Group for the research. The researcher has also written to the managers of Forensic mental health services informing them of the research and asking for their support.

If you experience any psychological discomfort from participating in the in-depth interviews and 2 week data collection, you are eligible for 3 free counselling sessions in person, online or by phone through AUT University Health and Wellness Centre. If you would like further information or an opportunity to discuss issues raised as a result of participating in this research please phone 09 921 9992 or 09 921 9998. Please inform the receptionist that you are research participant and provide your contact details to confirm this. You can find out more information about the AUT counsellors and the option of online counselling by visiting the website http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing.

Please consider your participation in the interviews and 2 week data collection phases of this study over the next two weeks and feel free to contact the researcher with any questions during that time. Written consent is required for participation in the in depth interviews and 2 week data collection. If you agree, please complete the enclosed consent form and return it to the researcher in the self addressed stamped envelope.

If you do not respond within two weeks the researcher will approach other court liaison nurses in your region and invite them to participate in the research. You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate you may withdraw from the project at any time until data analysis has commenced.

If you have commenced the 2-week collection of data and cannot continue due to work commitments, please feel free to contact the researcher regarding this. The researcher will endeavour to accommodate your schedule so the research can continue.

Please tick the required box on the consent form if you would like to receive a copy of the final research report.

In appreciation for participating in this research you will receive a \$20.00 book or CD voucher.

Researcher:

Patsy-Jane Tarrant RN BNurs Hons

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

Any concerns regarding the nature of this project should be notified in the first instance to the Project Co Supervisors.

Project Co- Supervisors:

Associate Professor Kate Diesfeld JD.
McKenna

Phone: 07 856 2889 X 8976

Fax: 07 838 4417

Email: kate.diesfeld@aut.ac.nz

Associate Professor Dr. Brian

09 373 7599 X 89554

09 367 7158

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Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

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In-depth interviews and audit consent form



In depth Interview and 2 week data collection Consent Form

Private Bag 92006
Auckland
1020,
NZ
T: +64 9 921 9999

www.aut.ac.nz

Project title:

An exploration of the role of the court liaison nurse within the New Zealand criminal courts

- I have read and understood the information provided about this research project in the Information Sheet 16 May 2011 regarding In depth Interviews and 2 week data collection.
- I have had an opportunity to ask questions and to have them answered and understand that I am free to request further information at any stage.
- I understand that notes will be taken during the interviews and that the interviews will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to commencement of data analysis, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to provide the researcher with my email address to enable the researcher to email the data collection tool.
- In appreciation of my contribution to the research I will receive a donation of a \$20.00 book or CD voucher.
- Please circle your preference, a book or CD voucher Book
- I wish to receive a copy of the final report from the research (please tick one): Yes
No

If you tick yes please ensure you have provided contact details below.

- I agree to take part in this research.

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details:

.....
.....
.....

Participant's email address :

.....

Date:

Researcher contact details

Patsy-Jane Tarrant RN
Ph- 0274341966
Email: patsy-jane.tarrant@southerndhb.govt.nz

Project Co- Supervisor Contact Details:

Associate Professor Kate Diesfeld JD.
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Note: The Participant should retain a copy of this form

Appendix D: Data collection tools

Survey questionnaire

Survey



An exploration of the role of the court liaison nurse within the New Zealand criminal courts

Thank you for reading the Participant Information Sheet and agreeing to complete this survey. It is divided into four sections. For each question please indicate your answer by ticking the appropriate box, or providing a written response. Further space for comments is provided at the end of the survey.

Section 1:

Demographic/background/information

1. Do you currently work in a court liaison nursing role in New Zealand ?

Yes / No

if you circle No then you do not need to complete any more of the survey – thank-you

2. What gender are you?

Male

Female

3. Which ethnic group do you belong to?

Tick the box or boxes which apply to you.

1. New Zealand European

2. Maori

3. Pacific Island

4. Asian

5. Indian

6. Other () Please state

4. Please state your age in years

_____ years

5. How long have you been practising in the court liaison nursing position?

_____ years _____ months

Please state years practicing as a registered nurse
_____ years

6. Please state years of experience in Mental Health Nursing
_____ years

7. Please state the average number of hours per week that you are practising in the court liaison role
_____ hours per week

8. Please indicate any other nursing roles you may perform as well as the court liaison role for the Forensic mental health service (FMHS).

- 1. Forensic prison liaison nurse
- 2. Forensic psychiatric district nurse
- 3. Forensic inpatient staff nurse
- 4. Other – please specify _____

9. Are you a trained Duly Authorised Officer under the MH(CAT)Act 1992?

please circle Yes / No

10. Is there a role/job/position description in your region regarding the court liaison role?

please circle Yes / No

11. Please tick the boxes to indicate which courts you regularly cover

- 1. District court
- 2. Youth court
- 3. High court
- 4. Family court

12. Please record how many court list days YOU provide cover for over a 4 week period

No of days per 4 weeks

- | | |
|-------------------|-------|
| 1. District court | _____ |
| 2. Youth court | _____ |
| 3. High court | _____ |
| 4. Family court | _____ |

14. Over a four week period which other sites would you visit?

Please tick the boxes

- | | |
|---|--------------------------|
| 1. Forensic mental health service | <input type="checkbox"/> |
| 2. Community mental health teams | <input type="checkbox"/> |
| 3. Police station | <input type="checkbox"/> |
| 4. Other hospitals | <input type="checkbox"/> |
| 5. Inpatient units at different locations | <input type="checkbox"/> |

15. Do you have an office/interview room space available to you at court?

please circle Yes / No

16. Do you have access to a computer at court?

please circle Yes / No

17. If you answered yes to Q.16 are you able to access health records and information from the

District Health Board? *please circle* Yes / No

Section 2: Preparation for role, education and training

18. Have you completed any postgraduate study?

please circle Yes / No

19. Have you completed postgraduate study specific to forensic mental health/psychiatry?

please circle Yes / No

20. If you answered yes to Q 18 or 19 please provide details of the paper(s) or course(s)

21. Are you currently engaged in post graduate study?

please circle Yes / No

If you answer No go directly to Q.23

22. Please state the course or paper you are currently engaged in

23. Please tick the boxes to indicate as many qualifications you have

- 1. Bachelor degree
- 2. Postgraduate certificate
- 3. Postgraduate diploma
- 4. Masters
- 5. Doctoral
- 6. Other (please specify)

24. Do you consider your orientation to the court liaison nurse role was adequate?

please circle Yes / No

25. Should there be a formal, specialised educational/training pathway for court liaison nurses (other than the undergraduate nursing degree or equivalent)?

please circle Yes / No

26. If you answered 'Yes' to the above please briefly outline what you think the pathway would look like.

27. Do you think a formalised means of communicating as a group of nurses to discuss nursing practice issues in the court liaison role would be useful?

please circle Yes / No

28. If a group was formed please tick the boxes to indicate whether the following activities/functions assist you

	Yes	No	
1. Educational opportunities		<input type="checkbox"/>	<input type="checkbox"/>
2. Information sharing		<input type="checkbox"/>	<input type="checkbox"/>
3. Peer support		<input type="checkbox"/>	<input type="checkbox"/>

29. Please briefly outline what additional training would have been helpful in your induction to the role

Section 3: Supervision and support

30. Do you receive clinical supervision?

please circle Yes / No

If you answer No go directly to Q,33.

31. Does this clinical supervision meet your needs as a court liaison nurse?

please circle Yes / No

32. If not how could it be improved?

33. If you are not receiving clinical supervision, please briefly explain why.

34. Do you provide clinical supervision?

please circle Yes / No

35. Do you provide clinical supervision to other court liaison nurses?

please circle Yes / No

36. Do you consider there are adequate opportunities within your service to discuss and reflect on practice for you as a court liaison nurse?

please circle Yes / No

37. Please briefly outline what these 'opportunities' are

38. Please outline what could be put in place to improve opportunities for discussion and reflection on practice for you as a court liaison nurse.

39. Do you discuss your practice with court liaison nurses outside your region?

please circle Yes / No

40. If you answered Yes to the above, is this a formal or informal arrangement

1. Formal

2. Informal

41. Please briefly outline the exact nature of the formal or informal arrangement

42. Please briefly outline any other thoughts or recommendations regarding clinical supervision

Section 4: “Working relationships”

Turnbull and Beese (2000) identified in their study in the United Kingdom exploring the role of the community mental health nurse in Magistrate’s courts that success in the post was very much dependent on collaboration with other agencies. The value of those relationships was identified by participants as important involving, building lines of communication, establishing trust, credibility, and mutual respect.

43. To gain an understanding of the relevance of these relationships in the New Zealand court liaison nurse context please rate the frequency of contact with other agencies by ticking the appropriate box.

	Often	Regularly	Sometimes	Rarely	Never
Judges					
Court staff					
Police					
Police prosecution					
Crown prosecution					
Defence lawyers					
Probation					
Alcohol and Drug Services					
General mental health services					
Forensic inpatient mental health service					
Salvation Army					
NGOs					
Forensic prison liaison teams					
Cultural services					
Other organisation – please specify e.g. early intervention teams					
Other organisation – please specify e.g. early intervention teams					

44. Please rate the quality of the contact with others by ticking the relevant boxes

	Excellent (1)	(2)	(3)	(4)	Poor (5)
Judges					
Court staff					
Police					
Police prosecution					
Crown prosecution					
Defence lawyers					
Probation					
Alcohol and Drug Services					
General mental health services					
Forensic inpatient mental health service					
Salvation Army					
NGOs					
Forensic prison liaison teams					
Cultural services					
Other organisation – please specify e.g. early intervention teams					
Other organisation – please specify e.g. early intervention teams					

45. Please tick the box which indicates how important you consider the different functions of the court liaison nurse role

	Vital (5)	Very important (4)	Sometimes Important (3)	Rarely important (2)	Not important (1)
Liaison					
Diversion					

46. What is your perception of the importance of the 'diversion' aspect of the court liaison role?

47. Please briefly note any specific barriers or facilitators to being able to carry out the diversion aspect of the role.

48. Do you believe that communication between the court liaison team, the prison liaison team and forensic inpatient settings is adequate?

please circle Yes / No

49. If you answered No to Q. 48, please briefly list the barriers to the communication.

50. Please identify areas where you experience particular challenges in your practice as a court liaison nurse (tick as many boxes as appropriate)

- | | |
|--|--------------------------|
| 1. information sharing | <input type="checkbox"/> |
| 2. confidentiality | <input type="checkbox"/> |
| 3. informed consent | <input type="checkbox"/> |
| 4. documentation | <input type="checkbox"/> |
| 5. client-nurse relationship | <input type="checkbox"/> |
| 6. dual role – regarding responsibilities
to health care system and criminal justice system | <input type="checkbox"/> |

51. Have you experienced cultural or ethical issues that have caused you concern?

please circle Yes / No

52. If you answered Yes to the above, please provide one example

53. Do you use Maori models or frameworks in your practice when relating to situations involving Maori?

please circle Yes / No

54. Are you able to access Maori or other cultural workers if required at court?

please circle Yes / No

55. Please tick the box or boxes to indicate to whom you provide education sessions or in-service education,

- | | |
|----------------------------------|--------------------------|
| 1. Nurses | <input type="checkbox"/> |
| 2. Other health professionals | <input type="checkbox"/> |
| 3. Nursing students | <input type="checkbox"/> |
| 4. Community mental health teams | <input type="checkbox"/> |
| 5. Inpatient mental health teams | <input type="checkbox"/> |
| 6. Lawyers | <input type="checkbox"/> |
| 7. Court staff | <input type="checkbox"/> |
| 8. Probation | <input type="checkbox"/> |
| 9. Police | <input type="checkbox"/> |
| 10. Other (please specify) _____ | |

56. What do you enjoy most about your role? (Comments and explanations very welcome)

57. What do you enjoy least about the role? (Comments and explanations very welcome)

58. What would you like to see changed? (Comments and explanations very welcome)

Your contribution is valuable. Thank you for taking the time to complete this survey.

Please return the survey in the stamped addressed envelope provided to the AUT University Administrator.

Please feel free to add any further comments here.

Approved by the Auckland University of Technology Ethics Committee on 13 December 2010. AUTEK Reference number 10/279.

Approved by the Multi Regional Ethics Committee Low-risk observational research as per the Ethical Guidelines for Observational Studies: Observational research, audit and related activities (MoH, 2006). 30 September 2010. Reference number MEC/10/067/EXP.

Guide to interview



Guide to Interview

An exploration of the role of the court liaison nurse within the New Zealand criminal courts

The following topic areas and questions are indicative only: the interview is intended to be semi-structured.

Background

How long have you been in the court liaison nurse role?

What led to you becoming a court liaison nurse?

Can you tell me about your previous (related) experience prior to becoming a court liaison nurse?

Areas to explore: experience in mental health nursing, forensic mental health nursing, corrections,

Justice, cultural services, support for people with criminal behaviour.

Education and Training

Did you undertake or were you asked to undertake any other training/education in preparation for this role?

Are you aware of any formal training/education available related to this role?

Have you received any specific education regarding the relevant legislation and the role of the court liaison nurse in working with that legislation? (E.g. CP(MIP)Act, ID(CCR)Act, MH(CAT)Act).

Have you completed any post graduate study relating to Forensic mental health/psychiatry?

Do you receive any ongoing education or training specific to practicing in the court liaison role?

Have you had the opportunity to take part in any other form of training/education that has informed your practice in this role? (For example Legal workshops).

Who initiated this training/education – yourself or the FMHS, others? Are you supported in your training needs by the FMHS?

What do you think the training/educational needs are for nurses to practice in this role?

Do you think there is any need for a more formal pathway or qualification regarding this role?

Functions of role

Can you describe the court liaison nurse role? Perhaps talk me through a routine day from when you arrive at work to finishing?

Is there a role description or outline for the court liaison nurse role in your region? Is this helpful?

What are the key aspects of the role as you understand it?

Explore liaison and diversion roles. Explore if there are any challenges to facilitating follow-up for people with mental health issues from court. Explore what the nurse views as important in the role.

Clinical supervision/ peer supervision, mentoring?

What are your views regarding clinical supervision? Do you use clinical supervision? Are you able to access clinical supervision?

Does this clinical supervision meet your needs as a court liaison nurse? If so/or if not can you elaborate on this?

Do you have contact with your peers from other regions to discuss issues relating to the court liaison role? Is this useful? If you do not have contact with the other court liaison nurses in the country do you think this would be useful to on a regular basis?

Support – what does this mean to you, where do you get support from? Did you have a mentor when you commenced in this role? Do you mentor others in this role?

Relationships

Can you describe the key relationships that you have with others in this role?

How significant are these relationships to being able to function as a court liaison nurse? Is the nature of these relationships similar or different to the relationships that you have with health professionals? Have you experienced any challenges in developing these relationships?

What are your thoughts about the relationship that you have with the person you are assessing at court or supporting through the court process?

Do you have contact with family and significant others? Is it possible to do so? Do you believe that these contacts are adequate? If not why not and what do you think could be done about this?

Areas of conflict and challenges to the nursing role

What are the significant challenges for you as a nurse on a day to day basis in the role if there are any?

Can you describe to me any particular aspects of this role whereby you experience conflict as a nurse in this role?

Have you been exposed to cultural or ethical issues that have caused you concern? Can you elaborate? Can or do you have access to appropriate cultural professionals and support persons at court if required? Do you use any particular frameworks for assessment?

Would you describe this nursing role as similar, or not, to other nursing roles you have practiced in?

Framework or model for practice.

Do you think that there needs to be a specific framework or guide developed for nursing practice in this role? Do you have any thoughts about how the role could be structured differently? How do you see the role developing in the future?

There has been debate throughout the country about where this nursing role sits within the nursing hierarchy what are your thoughts on this topic? Do you think this role should sit in a senior nursing position?

Have you any other comment regarding the court liaison nurse role that you would like to share?

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Data collection instruction sheet and key

Court liaison nurse: data collection instruction sheet and key

Thank you for agreeing to take part in this 2-week data collection activity as part of the wider study into the role of the court liaison nurse in New Zealand. Please refer to the participant information sheet included for further information regarding this study and the researchers contact details.

The aim of this phase of the study is to collect as much data as possible regarding the day to day activities of nurses in this role across New Zealand. The functions of the court liaison nurse role in terms of liaison and consultation and acting as a resource person are not recognised and recorded in usual statistical collection. Potentially this means that a large portion of the work undertaken by court liaison nurses is not described or captured. Also the involvement of the nurse in brokering the appropriate outcomes (such as diversion to mental health services, or linking people in with other health and support services) for people and their significant others at this interface is not widely known about and understood.

The researcher acknowledges that the court liaison nurse role is often pressured and that it may be difficult to find the time to capture the data. However it is important that this is undertaken as there is no substantial New Zealand based research or literature into this nursing role.

Instructions

Please fill out data collection sheet (1) for every inquiry and contact that you have at court whether or not the inquiry or contact leads to an assessment. The sheet reads from left to right. If you would like to include more information in certain sections then please use more than one line for that referral. Please fill out the data collection sheet (2) for any non- direct patient related activity you may be involved in during this period.

For accuracy, it is advisable to complete the forms hourly rather than leaving them to the end of each week. It is important to capture the daily significant conversations that court liaison nurses have, no matter how brief.

Please feel free to include as much information as you consider necessary. The key (below) includes suggestions; please use whatever terms or abbreviations suit you. Please contact the researcher if you have any questions.

Court	Referrer <i>Note – do not record name of person being referred or referrer</i>	Primary Reason for referral (A) Assessment (CL) Advice/consult liaison	Demographic details of person	Known client of MHS Y/N Diagnosis	Type of offending categories	Stage in court process	Interview Y/ N Location Time	Liaised with/ consulted with (please specify)	DAO Role Y/N	Advice provided to court by CLN	Outcome in court and from contact with CLN (please specify)	DHB processes (please elaborate)
D – District Y- Youth H- High F -Family	F -Family/support person DL -Defence lawyer DS –Duty solicitor P -Prosecution PC -Police in cells MHS -Other MHS CLN -CL Nurse initiated PL -Forensic Prison liaison FI -Forensic inpt GP -General Practitioner S –Client refers self SA -Salvation Army PR- Probation Other – please specify	FTP - Fitness to plead I -Insanity MI -Mental illness A&D- Alcohol and Drug LD- Learning disability RS –Risk: Suicide/self harm RO- Risk to others HI -Head/brain injury M -Medication query S -Support Query regarding legislation M- MH Act C -CP Act ID Act ?KC - Query whether person is known to MH or ID Services	M - Male F - Female Age 1: 17-20, 2: 21-25, 3: 26-30, 4: 31-40, 5: 41-50, 6: 51-60 7: 61+. Ethnicity U -unknown M -Maori E -NZ European PI - Pacific Island Other – please specify	Include diagnosis if known	1 -Violence offence 2- Sexual offence 3 -Drug and anti-social offence 4 -Dishonesty offence 5- Property damage offence 6- Property abuse offence 7- Administrativ e offence 8. Other – please specify	1-First appearance 2- Second or subsequent remand 9- s.9 Hearing D - Defended hearing SH -Status hearing S- Sentencing C- Disposition (CPAct) I – Disposition IDAct Other please specify	C - Cells CI - Cell block Interview Room W - Waiting room area WI- Waiting area interview room Other location Please specify	F -Family/ significant other GP MHS Other mental health service – specify e.g. Youth, Crisis team. P -Police PS – Prosecution PR – Probation Other – please specify		O – Oral W - Written	RIC – remand in custody ROB – remand on bail RAL – remand at large RCP -Remand under CP(MIP)Act – state section O -Observation recommended in cells RPL - Referred to Forensic Prison Liaison /Corrections Health/ARU RGP - Referred for a General Psychiatric assessment	D - Documentation M – MDT review S – Stats completed Other please specify

Court	Referrer	Primary reason for referral (A) Assessment (CL) Advice/consult liaison	M/F Age Ethnicity	Known client MHS Y/N Diagnosis	Type of offending	Stage in court process	Interview person Y/N Location Time	Liaised/ consulted with - specify	DAO role Y/N	Advice provided to court Y/N Oral Written	Outcome in court and outcome from contact with CLN	DHB processes Documentation MDT stats	Estimated total time spent on this matter including interview time

Court	Referrer	Primary reason for referral (A) Assessment (CL) Advice/consult liaison	M/F Age Ethnicity	Known client MHS Y/N Diagnosis	Type of offending	Stage in court process	Interview person Y/N Location Time	Liaised/ consulted with - specify	DAO role Y/N	Advice provided to court Y/N Oral Written	Outcome in court and outcome from contact with CLN	DHB processes Documentation MDT stats	Estimated total time spent on this matter including interview time

Appendix E: Confidentiality agreements

Confidentiality agreement - AUT administrator



Confidentiality Agreement

Project title:

An exploration of the role of the court liaison nurse within the New Zealand criminal courts

Project Co Supervisors:

Associate Professor Kate Diesfeld JD
McKenna

Associate Professor Dr. Brian

Phone: 09 921 9999 X 7799

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b.mckenna@auckland.ac.nz

Researcher:

Patsy-Jane Tarrant RN

Ph- 0274341966

Email: patsy-jane.tarrant@southerndhb.govt.nz

-
- I understand that all the material I will be asked to open and forward to the researcher is confidential.

 - I understand that the contents of the Surveys, Consent Forms, tapes, interview notes, and 2-week data collection can only be discussed with the researchers.

- I understand that all the material I am asked to store in a locked cupboard at AUT University is confidential.

- I will not keep any copies of the information nor allow third parties access to them.

AUT Administrator's signature:

AUT Administrator's name:

AUT Administrator's Contact Details:

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.....
.....

Date:

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Note: The AUT Administrator should retain a copy of this form

Confidentiality agreement - Transcriber

Confidentiality Agreement



Project title:

An exploration of the role of the court liaison nurse within the New Zealand criminal courts

Project Co Supervisors:

Associate Professor Kate Diesfeld JD
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Associate Professor Dr. Brian
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Researcher:

Patsy-Jane Tarrant RN
Ph: 0274341966
Email: patsy-jane.tarrant@southerndhb.govt.nz

- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

.....
.....
.....

Date:

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Note: The Transcriber should retain a copy of this form.

Confidentiality agreement - Typist

Confidentiality Agreement



Project title:

An exploration of the role of the court liaison nurse within the New Zealand criminal courts

Project Co Supervisors:

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Researcher:

Patsy-Jane Tarrant RN
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- I understand that all the material I will be asked to type is confidential.
- I understand that the contents of the notes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature:

Typist's name:

Typist's Contact Details (if appropriate):

.....
.....
.....

Date:

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Note: The Typist should retain a copy of this form.

Appendix F: Psychological support

Psychological support - AUT Student Services



MEMORANDUM

TO Patsy Tarrant
FROM Kevin Baker
SUBJECT Psychological support for research participants
DATE 19 May 2010

Dear Patsy

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

"An exploration of the role of the court liaison nurse within the New Zealand criminal courts"

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

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Appendix G: Screening assessments and the Criminal Procedure (Mentally Impaired Person) Act 2003

CLNs refer to conducting “screening assessments” in relation to fitness to plead (FTP) and insanity. The CLNs recommendations following the screening assessment advise the court whether a formal report pursuant to section 38 of the CP(MIP)Act may be useful for the court. This appendix briefly outlines what this process involves and provides a brief explanation of section 38 of the CP(MIP)Act.

s. 38 – Criminal Procedure (Mentally Impaired Persons) Act 2003

Subpart 5—Assessment of defendants

38 Power of court to require assessment report

(1) When a person is in custody at any stage of a proceeding against the person, whether before or during the hearing or trial, or while awaiting sentence or the determination of an appeal, a court may, on the application of the prosecution or the defence or on its own initiative, order that a health assessor prepare an assessment report on the person for the purpose of assisting the court to determine 1 or more of the following matters:

- (a) whether the person is unfit to stand trial:
- (b) whether the person is insane within the meaning of section 23 of the Crimes Act 1961:
- (c) the type and length of sentence that might be imposed on the person:
- (d) the nature of a requirement that the court may impose on the person as part of, or as a condition of, a sentence or order (CP(MIP)Act, 2003, p23).

Screening assessments

CLNs may be requested to conduct an assessment regarding whether a person’s mental state is affecting a person’s ability to take part in the court process.

There are many factors that may affect a person’s mental state and ability to take part in the court process, such as mental illness, intellectual disability, intoxication, brain injury and other physical health issues.

The CLN screening assessment involves the following activities:

The CLN obtains relevant information such as the details regarding the alleged offending and history of offending. The CLN’s assessment includes a mental state and risk assessment. In addition the CLN assesses the person’s level of comprehension of the following: what guilty and not guilty means, the court processes, and what the person is charged with, whether the person understands the roles of various people, such as the lawyer, the police, and the judge. The CLN ascertains whether the person has an understanding of what the possible outcomes may be from entering a particular plea. The CLN collates all this information incorporating

past offending and cultural issues. The CLN makes a decision as to whether there are concerns regarding the person's ability to take part in the court process and whether a formal Section 38 report may assist the court.

Following the assessment, the CLN will prepare a brief report to the court advising whether a formal report under the CP(MIP)Act may assist the court. CLNs refer to the formal reports under the CP(MIP)Act as Section 38 reports.

CLNs may also make other recommendations in their report to the court in relation to mental health care and interventions they have initiated or that may be useful for the person.

Formal Section 38 reports pursuant to the CP(MIP)Act are completed by forensic psychiatrists or psychologists. Section 38 reports determine issues of fitness to plead, whether the person is insane within the meaning of s.23 of the Crimes Act 1961, the type and length of sentencing, and any special requirements the court may impose at sentencing, for example: alcohol and drug treatment, anger management, compliance with mental health treatments and so on.

The CLNs also assist the court by advising the best place for the assessment to take place. The person may be remanded on bail, or detained in prison or a hospital or secure facility, for the purposes of the Section 38 assessment. Where the person is directed for the Section 38 assessment to take place depends on the nature and severity of the alleged offending, the person's mental state and the perceived risk to self or others.

The above was collated from information provided by the CLNs in the research, McKenna and Seaton (2007) and the CP(MIP)Act.