1

Abstract
There has been growing interest about procedural justice in mental health tribunals. A process considered procedurally just increases adherence to treatment, increases compliance with judicial decisions and allows efficient community reintegration. Yet, little is known about how procedural justice is carried out and the role of professionals in its implementation. Stemming from the results of a critical ethnography of the Ontario Review Board, in this article we examine how procedural justice materializes during Review Board hearings and the role of nurses in this materialization. We do so by leveraging Goffman's work on total institutions and institutional ceremonies. Our findings suggest that nurses participate in activities that provide a perception of procedural justice, rather than serve their patients' right to true procedural justice. We conclude by recommending that nurses engage in reflections about the distal effects of their clinical practice to broaden the possibilities for resistance within the forensic psychiatric system.

Key Words critical ethnography, forensic psychiatry, mental health tribunals, procedural justice, review board hearings

Nurses and the Discursive Construction of Procedural Justice in Review Board Hearings

JEAN-LAURENT DOMINGUE, JEAN-DANIEL JACOB, PIERRE PARISEAU-LEGAULT, AMÉLIE PERRON & THOMAS FOTH

Introduction

In recent years, increased attention has been paid to the notion of procedural justice in mental health tribunals [1-8] and in mental health nursing.[9] Broadly defined, procedural justice is the way in which individuals evaluate "the fairness of the processes by which legal authorities make decisions and treat members of the public [including themselves]".[10 p284] In mental health tribunals, a process considered procedurally just has been found to increase adherence to treatment,[1] reduce psychiatric symptoms,[4] reduce future involvement in the criminal justice system,[6] increase compliance with judicial decisions and allow for a more efficient reintegration of offenders in the community.[1,2,6,8] Yet, little is known about the way procedural justice is carried out before, during and after hearings held by mental health tribunals and para-judiciary tribunals, and the role of different professionals in its implementation, including that of nurses.

Supported by the results of a critical ethnography conducted in Ontario, Canada, the aim of this article is to examine how procedural justice materializes during Review Board (RB) hearings, a para-judicial mental health tribunal, and the role of nurses in this materialization. The article is divided in five sections. First, an overview of RBs and their hearings is presented followed by a brief description of procedural justice. Second, the methodological and theoretical considerations of the study are detailed. We then present our results and discussion. We illustrate that procedural justice in the context of RB hearings is illusory; its operationalization places patients in staged social situations where their voices can be heard, but is rarely considered. Finally, we provide a reflection on the implications of such findings for nursing practice.

Review Boards and their Hearings

In Canada, RBs determine the modalities of detention and the supervision conditions that must be imposed on persons found unfit to stand trial (UST) or not criminally responsible on account of mental disorder (NCR) to maintain public safety.[11] During regularly scheduled hearings, evidence is presented by the person UST/NCR's attending psychiatrist to the RB; a panel composed mainly of legal and medical experts. This evidence is produced based on the observations and assessments made by nurses and other health care professionals which are documented and compiled in the medical file.[12] At the end of each hearing, the RB must determine, based on the evidence presented to them, whether the person UST/NCR poses a significant threat to the safety of the public.[11,13,14] If so, it formalizes conditions ranging from in-hospital detention to community-based supervision, in a document entitled a disposition.[11] Another document, the reasons for disposition, provides the RB's justification for the disposition. Considering the significant impact RB decisions can have on the lives of persons UST/NCR, there is a growing interest related to the notion of procedural justice within RB processes.

Procedural Justice

According to Tyler [10], two elements define whether decisions rendered by authorities, such as judges, police, or administrators, are procedurally just. First, decisions need to be perceived as having been rendered with objectivity and without prejudice; authorities must take an unbiased approach and provide opportunity for the subjugated party to present their version of events.[10] Second, and somewhat complementarily, during the process by which the decision is taken, the subjugated party must be treated with dignity and respect, and their situations/concerns must be taken into consideration.[10] In recent research, mental health tribunals were generally found to be procedurally just by various groups of stakeholders to the extent that courts engage accused individuals in conversations with legal and medical professionals with whom they have a high differential of power.[15-18]

To this date, we only identified one Canadian study [18] that has specifically explored stakeholders' perceptions of procedural justice during RB hearings. Stakeholders in this study include persons UST/NCR, family members, mental health professionals and legal professionals. Although the authors of this qualitative study find that RB hearings are generally perceived as procedurally just, they identify certain factors which can impede such a perception, namely the adversarial tone of the hearing, inaccuracies in the evidence presented to the RB, and the punitive sentiment associated with dispositions rendered. Livingston et al. [18] provide recommendations for changes to RB hearings processes to increase the perception of procedural justice, including the use of strength-based risk assessment tools and the suggestion that mental health professionals should "meet with people found NCR prior to each RB hearing to discuss what should be expected in relation to the procedures as well as the evidence and recommendations that will be offered by the team". [18 p181] They explain this last intervention might help the person NCR build and maintain a therapeutic alliance with mental health care professionals. Other Canadian studies of stakeholder perception of procedural justice in other para-judicial mental health tribunals, such as Consent and Capacity Boards,[3,5] have provided similar findings/conclusions.

While Livingston et al. [18] elicited stakeholder accounts through interviews to assess the perception of procedural justice in RB hearings, we believe including observations as sources of data to understand how procedural justice materializes in RB hearings is essential. Aside from a similar study conducted during the same timeframe in another jurisdiction,[19] our study is the only one to use observations to study the operationalization of procedural justice during RB hearings and the role of nurses in its realization.

Methodological Considerations

Results presented in this article stem from a critical ethnography of the Ontario RB, the purpose of which was to explore how the forensic psychiatric system produces specific identities for persons UST/NCR, and the role of nurses in this identity construction process. This study constituted the first author's PhD project. Critical ethnography was used as a methodology as it allowed for various practices and rituals inherent to the forensic psychiatric system, such as those that contribute to perceptions of procedural justice during RB hearings, to be investigated and problematized.[20-22] Data was collected from interviews with forensic psychiatric nurses (n=6), from observations of RB hearings (n=27 hearings, 41 hours), and from reasons for disposition (n=18). Fairclough's [23] three-step critical discourse analysis framework was used to analyse the data. This framework allowed for a problematization of the ways in which contemporary structures, such as RB hearings, and public safety discourses enabled the production of specific identities for persons UST/NCR. The first step aimed to understand why, how and by whom the data was produced, and why, how and by whom it was used. The purpose of the second step was to look at the language used in the data and to critically examine the words mobilized, the grammatical choices made and the overall thematic and discursive content of the data. The findings were subsequently interpreted

using theories that consider concepts of privilege and power relations to understand how the data collected sustain the structures in which they materialize;[21] these include the theories of Foucault, Goffman and Garfinkel. For this article, we leaned primarily on Goffman's [24] work regarding institutional ceremonies to achieve this interpretative task. We decided to combine a critical ethnography methodology with a data analysis method rooted in critical discourse analysis because it allowed us, as clinicians in the field of mental health, to maintain a critical stance throughout the research process. Such an approach prevented us from feeling constrained and compelled to produce results consistent with disciplinary expectations in the field of nursing, while permitting us to reflect on the way nursing care both supports and perpetuates certain discourses.

Research Ethics Board approval for this project was obtained from the forensic psychiatric hospital where nurses were recruited (#2019014) and from the first author's institution (# H-07-19-4797). Ethics approval was not required for observations of RB hearings, nor was it required for accessing the reasons for disposition of persons UST/NCR as both were publicly accessible. Nevertheless, prior to accessing RB hearings, we communicated with the hearings administrator of the Ontario RB to inform them of our presence and to request the hearing schedules. Further, at the beginning of each hearing observed, the first author presented himself as a PhD candidate in nursing if given the opportunity by the chair of the hearings. Reasons for disposition were publicly available through the Lexis Advance® Quicklaw® database. Nurse participants were recruited by e-mail and by face-to-face contact at unit meetings. Informed consent was obtained before proceeding with the interviews. Given the small number of participants required for the project and its sensitive nature, anonymity and confidentiality were central considerations. Anonymity was achieved by giving participants the power to decide where interviews would take place (i.e., local coffee shop, library, office), by anonymizing the content of their interview during the transcription, by not collecting or reporting demographic information and by giving every participant an alphanumerical code (i.e., N01, N02…, N06). Confidentiality was achieved through secure storage of raw data, deletion of interview recordings once transcription was completed, and by limiting access to raw data to the first three authors.

Theoretical Considerations

Goffman [24] identified that the social condition of psychiatric patients was not different from the social condition of inmates detained in other institutions with similar characteristics, such as prisons, monasteries, and army barracks, which he named "total institutions". Goffman [24] explained that total institutions create a separation between the inside world of the institution and the outside world, thus allowing for the development of intra-institutional societies that recreate a reality similar to the outside world (e.g., work, leisure and eating schedules). Within such institutions, all facets of inmates' lives, including sleep, play, and work, are conducted in proximity to other inmates. [24] These activities are carefully planned to meet the goals of the institution, which include reform, societal protection, penance, and community reintegration, and their execution is closely monitored and documented by the staff.[24-27]

The inside/outside separation is also replicated within total institutions insofar as a marked separation exists between inmates and staff.[24,26,28] Indeed, Goffman [24] explains that the points of juncture between the inside and outside worlds represent a risk to the sustainability of the total institution. These may include when visitors enter the institution and when inmates are authorized to leave the institution. On one hand, such interactions between both worlds may expose the total institutions' stark living conditions to the outside world. On the other, they may allow for inmates to catch a glimpse of the outside world, thereby disturbing the inner functioning and purpose of the institution. To limit and control the interactions between both worlds, total institutions heavily regulate and sanitize the information entering and exiting its confines.[24]

The RB hearings are events during which the inside world of the forensic psychiatric hospital has the potential to be exposed to the outside world via RB members who act as formal visitors to the institution. Goffman [24] explains that in preparation for such visits and during these visits, institutions strongly control which information they will share. For example, staff members carefully plan which areas of the institution are visited, what information about inmates is shared and which therapeutic activities are highlighted to visitors. In his book, Goffman dedicated a whole section to these visits, which he named "institutional ceremonies".[24 p93] In interpreting Goffman's writings for this study, the concept of "institutional ceremonies" refers directly to RB hearings or what Goffman might also conceive as a form of "theatre" where social interactions can be compared to a play, where people (patients, families, caregivers, judges, etc.) are actors on the stage of life.[29]

Indeed, institutional ceremonies are theatrical performances, serving as opportunities to display total institutions in their best light.[24] In anticipation of institutional ceremonies, various activities are conducted to decide which truths about the inside world of the institution are to be shared with visitors. These activities may include vigorous cleaning efforts, enhancement of food offerings, and glamorous portrayals

of modern treatment modalities.[24] With this framework in mind, we continue with the results of the study.

Results

Our results illustrate nurses' involvement in intricate processes that allow for RB hearings to be considered procedurally just. Through this illustration, we challenge the purported humanistic intent of procedural justice and suggest that, through staged "institutional" ceremonies, persons UST/NCR are given the illusion that their voices are heard during RB hearings. The results are presented in two sections. In the first, we highlight the minutia with which health care teams composed of nurses and other professionals prepare for RB hearings. In the second, we demonstrate the structured way in which RB hearings unfold and the limited opportunities for the voices of persons UST/NCR to be heard within this structure.

The Staging of Procedurally Just RB Hearings

Nurses mentioned participating in clinical activities directed towards ensuring RB processes appear to be as procedurally just as possible to persons UST/NCR. Some of these activities were geared towards ensuring the voices of persons UST/NCR were heard during the RB hearing, while others were directed at supporting them on the day of their hearing.

In the weeks preceding the RB hearings, nurses disclosed that the clinical care team met formally with the person UST/NCR during "pre-RB conferences" to make a team decision regarding the significance of the person's threat to the safety of the public. Health care teams did so by considering various factors, sometimes presented in a risk assessment format:

> [Reports] included information about the mental status of the patient throughout the year, including the presence of any suicidal or homicidal ideations, the presence of any 'symptoms,' how the patient engages with their activities of daily living, the interactions they have with their peers, the presence of any family contact, any medical issues that may have come up during the year, the medications they are taking, the 'PRN usage' [as needed medications]. Nurses [also] list and describe any incidents that have occurred over the past year and indicate whether they are verbal or physical. Beyond any aggressive incidents, they would also indicate if there were any other significant incidents such as an elopement. (Nurse 2)

Nurses explained this team discussion served to provide psychiatrists with the necessary information to justify the hospital's opinion regarding a person UST/NCR's threat to the safety of the public and to prepare them to be "cross-examined" during RB hearings:

> All the disciplines, including nursing, will typically give a one-year summary report to the psychiatrist that really help them build a good compilation of data so the psychiatrist can show up prepared to be cross-examined and have a good understanding [of the person's clinical status] (Nurse 5).

Pre-RB conferences were thus described as a venue for "team[s] to come to a conclusion about doing what is best for the patient" (Nurse 2) and as an opportunity for a "snapshot of the [person UST/NCR]'s whole year" (Nurse 1) to be shared with the team and the psychiatrist in preparation for an RB hearing.

Some nurses explained that during pre-RB conferences key conversations often took place without the involvement of persons UST/NCR. On that topic, participant 2 specified that the involvement of persons UST/NCR was typically limited to them "checking-in" at the end of the meeting: "the meeting begins without the patient. Every person gives input and discusses what the patient wants out of the hearing. Then the patient would check in". Indeed, it appears persons UST/NCR were only permitted to "speak for themselves" after the multidisciplinary health care team had already discussed their case and their treatment plan:

> The team meets, the doctor and the team that's involved with that patient. And the nurse will go too and then the team leader will read off the conference notes and we all share, we'll go around the table and give our opinion or our thoughts on how they [persons UST/NCR] have progressed, or the opposite, and then after everybody has their say and we discuss what might change or might not change. Then, we bring the patient in and they get to speak for themselves, and sometimes it seems rushed, I'm just being honest here, you know these people, they waited six weeks for this, or they have waited a whole year, and I think they should have their say, you know, whether it takes half an hour or ten minutes. This is about them, . . . so they have to be able to say how they feel, and how they feel they're progressing, they should be able to have their time (Nurse 6).

Only involving persons UST/NCR at the end of case conferences is a covert form of exclusion. It gives the appearance of including them in a team-based discussion about their future and induces a feeling of agency in RB hearing processes—a core principle of procedural justice [10]—all the while excluding them from crucial conversations. In such circumstances, health care teams appear to uphold the perception of procedural justice only, rather than serve the interest of persons UST/NCR and their right to true procedural justice.

Another clinical activity in which nurses were involved to ensure RB processes appeared to be procedurally just was to provide persons UST/NCR with various forms of support.

One nurse explained this support took the form of general reassurance on the day of a person UST/NCR's RB hearing:

> First thing would be to check in with that patient, make sure they're feeling, or they seem stable and that they're able to be in a room with a number of people who might be saying potentially hard things to hear, that tends to be my focus is, this person going to be going through some challenges maybe today and, how do they, how do they, how do they look like; I'll deal with that (Nurse 3).

By providing support to their patients on the day of RB hearings, nurses attempted to preserve the dignity of persons UST/NCR while they were exposed to harsh and sometimes inaccurate information in a public venue.[18] One nurse believed that this type of supportive intervention served to align the expectations of persons UST/NCR with what the hospital believed to be the likely outcome of the RB hearing:

> I like to verify their expectation of the hearing is pretty clear. . . Patients don't always have a clear understanding of what they can get out of a review board hearing, sometimes, they want something that's already on their disposition. Or they think there's going to be maybe big changes coming up, but really the hospital is the one that hasn't moved them forward in terms of full utilization of their disposition, so the review board isn't necessarily going to make big changes because the disposition is already quite generous. . . I usually don't just do this the morning of though, I'll usually [start] weeks before, I just try to . . . gently point toward what the reality of it is (Nurse 5).

Aligning the expectations of persons UST/ NCR with the "reality" of the RB amounts to preparing persons UST/NCR to agree with the recommendations put forward by the forensic psychiatric hospital. Although being presented as a gentle way to reduce potential surprises out of respect and dignity for persons UST/ NCR, this nursing intervention helped prevent behavioural challenges by preparing patients to be exposed to negative information being said about them and by preparing them to accept the outcome of the RB hearing. Strikingly absent from nurses' descriptions of their role was providing general information to persons UST/NCR about RB hearing procedures, coping mechanisms that could be used during the hearing and all possible outcomes of the hearing.

Later in the interview, the same nurse went on to mention that "most of the time" their impression was that RB hearings were mere formalities meant to inscribe the hospital's recommendations in a disposition:

> Sometimes, there are those interesting moments where [persons UST/NCR] are going to request a conditional or absolute discharge [disposition], right, and we [the hospital] are not too sure. The psychiatrist has said he probably won't support it, but they might have a chance, they have a good lawyer, so those are obviously more interesting. But most of the time, it's not really how it works. [RB hearings] are formalities almost, we go through it, and hope that, they have this sense of importance (Nurse 5).

The ways in which nurses speak about the process suggest that they see themselves as extensions of the forensic psychiatric hospital; their practice is aimed at bringing persons UST/NCR to accept and internalize recommendations/decisions made by the hospital. The "sense of importance" infused by forensic psychiatric nurses in persons UST/NCR about "what they can get out of RB hearings" provides a smokescreen for procedural justice. Despite being presented as a venue that theoretically gives persons UST/NCR an opportunity to refute the claims of forensic psychiatric hospitals, most of the time RB hearings are ritualistic, wherein recommendations made by forensic psychiatric hospitals are formalized in a disposition. In effect, Crocker, Charette, et al. [30] highlighted that, in Ontario, 92 percent of the recommendations put forth by forensic psychiatric hospitals were upheld during RB hearings.

Although the outcomes of RB hearings seem to favor forensic psychiatric hospitals, as highlighted above, these hearings can nevertheless represent an institutional threat for the hospitals to the extent that they represent instances where the inside world of forensic psychiatric hospitals is exposed to the outside world.[24] During RB hearings, members of the RB are given the opportunity to identify and evaluate institutional incoherencies and dysfunctionalities related to the treatment/ management of persons UST/NCR. Thus, when psychiatrists are not well prepared for RB hearings or when their requests lack rigorous clinical and procedural justification, members of the RB may put in question the psychiatrists' expertise at treating/ managing persons UST/NCR. The following excerpt illustrates the case of a psychiatrist being scolded by an RB member for requesting that a person NCR be absolutely discharged from the RB instead of being gradually reintegrated in the community:

> The RB member asked when the patient became "suitable" for community placement. The psychiatrist answered that given the patient's numerous medical problems, the team didn't get to try community placements given that long-term care is what was needed. The RB member mentioned that the patient's

previous community placement was in a long-term care facility and that it didn't work out and, as a result, the patient was readmitted. The RB member pointed out that the patient didn't need an absolute discharge to try long-term care placement. The psychiatrist explained the hospital didn't move forward given medical concerns. The RB member pointed out that "adjustment to community facility" hasn't been tested. The RB member to the psychiatrist said "With the current detention order, you could have tried, but you didn't." (Observation 22)

While overt questioning of psychiatrists' expertise at treating/managing persons UST/NCR occurred rarely, they nevertheless illustrate that RB hearings represent threats for forensic psychiatric institutions. Therefore, the information shared to RB members must be carefully selected to preserve the institution's legitimacy at treating persons UST/NCR and at protecting the public.

The Structure of RB Hearings

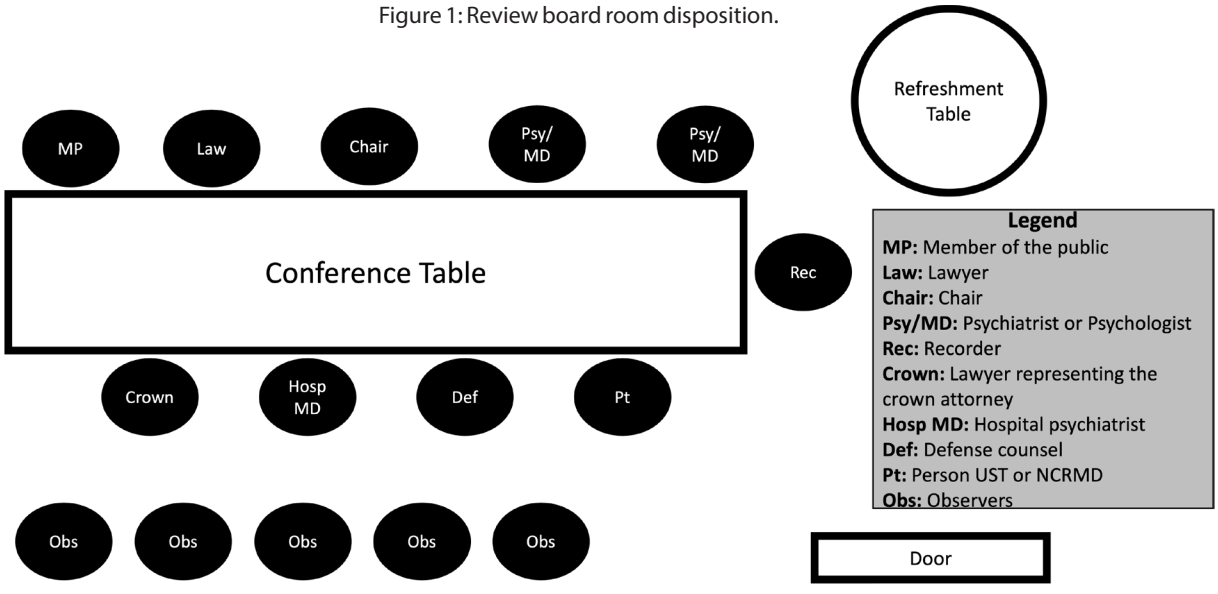
The inquisitive nature of RB hearings [11] and the structured way in which they unfold provides a sense of objectivity and fairness to the process. By allowing both the psychiatrist and the person UST/NCR to share their own evidence, RB hearings appear procedurally just to the extent that they symbolically place, for a short period of time, persons UST/NCR on an equal footing with psychiatrists.

Procedural thoroughness, another core tenant of procedural justice [10], was achieved by the methodical way in which RB hearings took place: the spatial disposition of stakeholders during RB hearings rarely changed, as did the speaking order of all parties. The RBs typically comprised five members, namely one member of the public, two legal members, one of whom served as the chair of the hearing, and two health care professionals, one of whom was a psychiatrist. These RB members always sat in the same order on one side of the conference table: member of the public, legal member, chair, psychiatrist/psychologist, and psychiatrist/psychologist (see Figure 1). The other parties at the hearing were seated on the other side of the table in the following order: the Crown attorney, the hospital psychiatrist, the defence counsel, and the person UST/NCR. Anybody observing the RB hearing was required to sit along the wall behind the person UST/NCR. When individuals deviated from this specific order, RB hearing attendees were reminded of the rules and instructed accordingly: "Once we all sat in the room, one of the community workers sat at the table between the psychiatrist and the defence lawyer. The psychiatrist told her to sit back with the observers" (Observation 2).

Similarly, the speaking order of parties at RB hearings rarely changed. The following discernable pattern, reminiscent of criminal tribunals, became evident through our analysis of RB hearing observations:

1. Introductions—during this period the chair spoke directly to the person UST/NCR.
2. Chair confirms the list of exhibits—these always included the most recent reasons and disposition, and a report submitted by the hospital.
3. Initial positions of the parties (Crown, hospital & defence).
4. Highlights the psychiatrist wants to make about his report and the progress of the person UST/NCR.

Figure 1: Review board room disposition.



5. Questions from Crown and defence counsel [to psychiatrist].

6. Questions from the board members [to psychiatrist].

7. Questions arising from the board members' questions [to psychiatrist].

8. Any new evidence from parties—Crown and defence counsel.

9. Final positions.

10. The chair adjourns the meeting, thanks the person UST/NCR and informs them that a decision would be rendered within one week and that the reasons would follow. (Observation 16)

Individuals engaged in dialogue with others only when it was their turn to speak and in accordance with the above-mentioned sequence. During one RB hearing, the chair inadvertently violated this order by asking the hospital psychiatrist if he had additional evidence to present (Step 8) before asking other RB members if they had questions for him (Step 7). The chair was reminded by the hospital psychiatrist that he had missed a step: "The chair then asked if the psychiatrist had any more evidence to submit. The psychiatrist then said, 'maybe you want to ask your colleagues if they have questions first'" (Observation 14). The psychiatrist's intervention demonstrated the internalization of the RB's order of speaking, which ensured that the correct order was maintained and that procedural rigor was preserved.

Similarly, when persons UST/NCR deviated from this speaking order, by reacting to the things being said about them, for instance, they were either ignored or reminded to remain silent until they were given the right to speak. We documented in our fieldwork journal numerous occasions, like this one, where a person UST/NCR was ignored by the RB:

> Crown then asked if the patient was currently limited to directly supervised privileges. Psychiatrist confirmed and said that the patient only entered the community accompanied by staff on two occasions at which he accessed local shops. Crown then said: "So on the five occasions he tested positive [for drug use], he was on the grounds?" The patient said, "It was only once." The board ignored the patient and the Chair asked the defence if he had any questions for the psychiatrist (Observation 10).

On other occasions, the defence counsel of persons UST/NCR actively asked them to remain quiet:

> Psychiatrist then mentioned that overall, in the past 18 months, he did see some progress in that the patient was no longer smoking in the washroom and that he is cooperative, although there remains some issues relating to substance use. Patient said: "I only tested positive once." Defence said to the patient "shhhh." Psychiatrist then added: "and impulse control" (Observation 10).

Defence counsels most likely silenced their clients because they feared such interjections might substantiate claims suggesting lack of self-control, negatively affecting the outcome of the hearing. In the above excerpt, for example, the hospital psychiatrist took the unauthorized verbal interjection of the person NCR as proof of their impulsivity. Despite the underlying reason for the person's interjection—to clarify the veracity of the information being shared about them—precedence was given to respecting the order of speaking during the RB hearing.

On the rare occasions where persons UST/NCR spoke for themselves and provided evidence during RB hearings, RB chairs ensured they spoke in very constrained ways. For instance, RB chairs would ask the person NCR to modify the way they presented information if it was felt they were "leading the delivery of evidence" as opposed to answering questions specifically formulated by their defence counsel:

> The defence counsel asked the patient if he would continue treatment should a conditional discharge be ordered. The patient said yes. He continued saying he sees the benefits. He said he wants to go to independent housing; not supervised. That is why he wants a conditional discharge. The patient said "I've got a lot of protective factors" and then started listing them. He said that he participates in 20 hours or more a week of vocational jobs, […] attends numerous alcoholic anonymous meetings, has a sponsor, sees the psychologist, volunteers at Alcoholics Anonymous, goes to the YMCA, has job prospects. […] The chair interrupted telling the patient to "let the counsel lead, she will ask you questions (Observation 4).

On other occasions, persons NCR were simply ignored by RB members or even mocked by other individuals in the conference room while they provided evidence:

> The defence then mentioned that the patient would

like to speak. The patient said that he was first brought into hospital in [year] and that he has been in detention for 15 years without reason. Fifteen years of medication. He said: "I've never been sick in my life. The doctor is telling lies, he is punishing. No nurse is qualified here." The defence asked the patient if he would like to return to his apartment. The patient said "Yes, anytime. I've had a perfect condition for 15 years. I want to live in my own apartment." The defence asked the patient how he felt about his treatment team. The patient says that they come to him with threats and accusations. **Nurse and other unspecified hospital staff laughing while patient spoke** (Observation 26).

In our ethnographic field notes, we also noted: "when the patient gave his testimony, all the parties at the board, except the defence [counsel], were writing and not paying attention to the patient speaking . . . in striking contrast to when any other of the parties speak, such as the psychiatrist" (Observation 26). Although the language of the person NCR's testimony did not contain the typical words contained within expert testimonies, the truths it conveyed, namely that they felt the psychiatrist was punishing them and that staff members were threatening them, were relevant. However, the lack of seriousness associated with the testimony subjugated these truths. It is worth noting that the laughter of hospital employees was tolerated by the RB chair despite the otherwise stringent rules.

In all our observations, persons UST/NCR were the only actors to have been ignored or requested to wait their turn to speak. When other RB actors asked questions or sought clarifications, albeit infrequently, they were not reminded of the speaking order or required to conform to a particular way of speaking. Furthermore, persons UST/NCR were expected to be docile and remain quiet when hospital psychiatrists presented evidence about them—even if this evidence was identified in the literature as being difficult to hear and strewn with inaccuracies.[18] This was particularly apparent during one defence counsel's intervention at the end of an RB hearing: "The defence said the [person NCR] did not want to 'rock the boat' [during the RB hearing] so he asked [the defence] not to introduce a contrary position [to the one presented by the hospital]. He did not want to upset things'" (Observation 18). By adhering to the hospital's interpretation of their character, the person UST/NCR refrained from "rock[ing] the boat" out of fear that the RB would be more stringent in their issuance of a disposition order should they contradict the hospital's recommendation.

Discussion

The results of our study complement those of Livingston et al. [18] in that they illustrate how procedural justice materializes during RB hearings, how it is staged in processes at their periphery, and how it can be leveraged to ensure procedural efficiency. By seeming procedurally just, RB hearings may entice persons UST/NCR to comply with their disposition orders and obediently engage in various activities and treatments to reduce the perceived threat they pose to the public.[1,2,6,8] Thus, procedural justice is not necessarily the end goal; it is a means to an end. The mere illusion of procedural justice is sufficient to achieve docility, compliance, and efficiency. Considering the significant effects of RB hearing outcomes on the lives of persons UST/NCR,[12,18,30] serious ethical questions arise regarding the clinical practice of nurses who participate in the staging of procedurally just RB hearings.

Notwithstanding the humanistic intent of nurses who work in forensic psychiatry, our findings demonstrate that their practices give persons UST/NCR the impression that they are on a level playing field with psychiatrists during RB hearings. In effect, our results suggest that nurses conduct essential work to prepare forensic psychiatrists and, by extension, the forensic psychiatric hospital for RB hearings. They participate in a series of orchestrated clinical activities to determine what information about the person UST/NCR is to be presented to the RB, and how it is to be presented. This work conducted prior to RB hearings allows for truths about persons UST/NCR and about the forensic psychiatric hospital to be regimented and presented to RB members in calculated ways. Seen through Goffman's [24] lens on total institutions, these preparatory activities serve to project a doctored image of the forensic psychiatric hospital, of its processes and of persons UST/NCR to visitors entering hospital; in this case, the visitors being RB members. Preparatory activities provide a safeguard against potential inaccuracies in the testimonies of psychiatrists, against scrutinizing questions of RB members and against "cross-examinations" from persons UST/NCR, or their defence counsels.

Indeed, RB hearings constitute opportunities for psychiatrists to re-establish psychiatry as the medical discipline with the required expertise to define who constitutes a threat to the safety of the public and how this threat should be managed. [31] If psychiatrists were to err when providing their testimony, or if their professional opinions were to be scrutinized by RB members (as illustrated in the first section of the results), their expertise could be put into question as could the forensic psychiatric hospital's legitimacy for treating threatening individuals, thus jeopardizing the sustainability of the total institution [24]. On this subject, Foucault [32] described a

procedure at psychiatric hospitals for presenting mentally ill patients—complete with their life histories and clinical progression—in front of an audience comprising the patient, students, and other clinicians. In such procedures, he wrote, "doctors constitute themselves as masters of the truth".[32 p185 free.trans] Because of this mastery of truth, psychiatrists can "exercise within the asylum an absolute super-power and associate themselves with the body of the asylum, thereby constituting the asylum as a medical body that cures through the eyes, ears, words, and actions of psychiatrists".[32 p185 free. trans] By providing testimonies about the lives and clinical progress of persons UST/NCR during RB hearings, forensic psychiatrists establish themselves as experts and masters in the identification and reform of threatening individuals, and likewise establish forensic psychiatric hospitals as institutions responsible for their treatment.

Nursing activities that are aimed at achieving "procedural justice", such as "gently pointing [the person NCR] towards the reality [of the RB]" or including persons UST/NCR in meetings after decisions have been made, are therefore essential as they serve to prevent errors or inaccuracies during the delivery of evidence, to limit the presentation of opinions contrary to that of the hospital, to reduce potential challenges by persons UST/NCR and to protect forensic psychiatry against threats to its discursive hegemony. Thus, behind the illusion of respect, dignity, equity, and procedural justice, we purport, like Pariseau-Legault et al.,[19] that the decorum maintained in RB hearings highlights and perpetuates the power imbalance that exists between the person UST/NCR and the forensic psychiatric apparatus.

By participating in the preparation and staging of RB hearings, nurses protect forensic psychiatric hospitals, forensic psychiatrists and, 'psych' disciplines more broadly, against threats to their discursive hegemony, sometimes at the expense of the social wellbeing of their patients.[31,32] Framed in this manner, forensic psychiatric nursing is reduced to serving as an extension of forensic psychiatry; that is, nurses are less concerned with advocating for the patient's best interest and are more concerned with protecting the institution of forensic psychiatry and its role in the so-called protection of society. In these circumstances, the specific contribution of mental health nurses to the care of persons UST/NCR, such as the utilization of strength-based approaches, the accompaniment and preparation for RB hearings, and the upholding of equity and human rights,[33,34] seems to get lost insofar as their practice objectifies patients as problems needing to be fixed.

Strength and Limitation

The strength of this project resides in its methodology and methods. This study is only one of two studies, the other being that of Pariseau-Legault et al.,[19] to use observations as a source of data to examine the notion of procedural justice in the context of RB hearings. The study conducted by Livingston et al. [18] relied exclusively on experiential accounts of individuals who had participated in RB hearings, including health and legal professionals, persons NCR and their family members. By using observations, rather than assessing the perception of procedural justice, we were able to see how it materialized, or not, during RB hearings. Interviews with nurses allowed us to take our analysis one step further and to understand the clinical activities and processes that take place within the forensic psychiatric hospital to ensure persons UST/NCR perceive RB hearings as procedurally just. Conversely, we consider the fact that persons UST/NCR were not interviewed as part of this study to be a limitation. Their perspectives could have further contextualized our observations and analysis.

Implications for Nursing Practice

In a context where psychiatric hospital staff "pointedly establish themselves as specialists in the knowledge of human nature, who diagnose [and] prescribe on the basis of this intelligence",[24 p89] the results of this study bring us to reflect on the ethical complexities of providing nursing care in forensic psychiatry. Nurses participate in various coercive processes at the junction of law and psychiatry [35-38] and they have been recognized, in this study, as indispensable actors for the staging of procedurally just and efficient RB hearings. Whether or not, and to what extent, nurses appreciate that the support they provide to persons UST/NCR before, during and after RB hearings may serve additional purposes external to the domain of care, is unknown. Nevertheless, as health care providers with ethical responsibilities, nurses must be able to engage in critical reflections about the effects of nursing care beyond the proximal relationship they develop with patients, such as the effects of aligning the expectations of persons UST/NCR with the "reality of RB". Such a reflection could bring forensic psychiatric nurses to critically examine how they contribute to maintaining a system that discounts patients' voices through a veneer of procedural justice. Like that of others (see, for example, Morse;[39] Pariseau-Legault et al.,[19] Paradis-Gagné et al.[38]), our results identify a need to raise nurses' awareness related to the political and ethical ramifications of their taken-for-granted clinical practices, particularly in the domain of psychiatry and forensic psychiatry.

With such an awareness, much like Cloyes [33] suggests, we see nurses as having a central role in fostering an environment and establishing processes where persons UST/NCR can exert their own agency. In areas where nurses have direct procedural influence, they could advocate for structural changes permitting persons UST/NCR to increase the frequency or intensity with which their voice can be heard, by having them participate during the entirety of their pre-RB hearing conference, for example. In areas where they cannot influence the processes, instead of attempting to silence the voice of persons UST/NCR, like it appeared to be the case in our results, nurses could educate their patients about the different avenues where they could, albeit with many constraints, make their opinions heard.

In this vein, a neutral third party that has no direct relationship with the forensic psychiatric system could provide education to nurses working in forensic psychiatry about the RB hearing procedure and opportunities for persons UST/NCR to make their voices heard. While acknowledging that our results paint a picture of the forensic psychiatric system as a structure that silences certain truths emanating from marginal(ized) discourses while perpetuating other dominant discourses (i.e., those related to psychiatry and public safety), we believe such education could entice nurses to act in a way which could alter the narrative produced about persons UST/NCR during RB hearings. Coupled with opportunities for ethical and critical reflections about their practice, our hope is that nurses who receive such education could advocate for the already limited procedural rights of patients, thereby preventing situations where persons UST/NCR decide not to present positions contrary to those of the hospital, out of fear that they would "rock the boat" and "upset things." In effect, conceptualizing the role of nurses in forensic psychiatry as one that upholds the human rights of persons UST/NCR is closely aligned with Timmons' findings who purported that two core functions of forensic psychiatric nurses was to practice with humanity, and promote equality, diversity, and human rights.[34]

While our recommendations would not inherently change the role of nurses within the forensic psychiatric system, they might destabilize its functioning by providing space for reflection and critique and by broadening the possibilities for resistance. Although focused on forensic psychiatric nurses, these implications are transferable to many other domains of health sciences, including public health, general psychiatry, geriatric nursing, and palliative nursing.

References

1.Canada KE, Hiday VA. Procedural justice in mental health court: An investigation of the relation of perception of procedural justice to non-adherence and termination. Journal of Forensic Psychiatry & Psychology 2014; 25(3):321–340.

2.Cascardi M, Poythress NG, Hall A. Procedural justice in the context of civil commitment: An analogue study. Behavioral Sciences & the Law 2000; 18(6):731–740.

3.Dhand R. Challenging exclusion: A critique of the legal barriers faced by ethno-racial psychiatric consumer/survivors in Ontario (Unpublished master's thesis). University of Toronto, 2009.

4.Kopelovich S, Yanos P, Pratt C, Koerner J. Procedural justice in mental health courts: Judicial practices, participant perceptions, and outcomes related to mental health recovery. International Journal of Law and Psychiatry 2013; 36(2):113–120.

5.Paul S, Nakhost A, Stergiopoulos V, Matheson FI, Simpson AIF, Guimond T. Perceptions of key stakeholders on procedural justice in the Consent and Capacity Board of Ontario's hearings. International Journal of Law and Psychiatry 2020;68.

6.Pratt C, Yanos PT, Kopelovich SL, Koerner J, Alexander MJ. Predictors of criminal justice outcomes among mental health courts participants: The role of perceived coercion and subjective mental health recovery. International Journal of Forensic Mental Health 2013; 12(2):116–125.

7.Simpson AIF, Boldt I, Penney S, Jones R, Kidd S, Nakhost A, Wilkie T. Perceptions of procedural justice and coercion among forensic psychiatric patients: a study protocol for a prospective, mixed-methods investigation. BMC Psychiatry 2020; 20,230.

8.Slocum LA, Wiley SA, Esbensen FA. The importance of being satisfied: A longitudinal exploration of police contact, procedural injustice, and subsequent delinquency. Criminal Justice and Behavior 2016; 43(1):7–26.

9.Galon PA, Wineman NM. Coercion and procedural justice in psychiatric care: State of the science and implications for nursing. Archives of Psychiatric Nursing 2010; 24(5):307-316.

10.Tyler TR. Procedural justice, legitimacy, and the effective rule of law. Crime and Justice 2003; 30:283–357.

11.Criminal Code (CC), RSC 1985, c 46.

12.Domingue JL, Jacob JD, Perron A, Foth T, Pariseau-Legault P. The Forensic Psychiatric Network of Observation and Documentation: At the Intersection of Review Board Hearings and Nursing Practice. Journal of forensic nursing 2022; Advance online publication.

13.Crocker AG, Nicholls TL, Charette Y, Seto MC. Dynamic and static factors associated with discharge dispositions: The national trajectory project of individuals found not criminally

responsible on account of mental disorder (NCRMD) in Canada. Behavioral Science and the Law 2014; 32(5):577–595.

14.Wilson CM, Crocker AG, Nicholls TL, Charette Y, Seto MC. The use of risk and need factors in forensic mental health decision-making and the role of gender and index offense severity. Behavioral Sciences and the Law 2015; 33(1):19–38.

15.Canada KE, Watson AC. "'Cause everybody likes to be treated good": Perceptions of procedural justice among mental health court participants. American Behavioral Scientist 2013; 57(2):209–230.

16.Poythress N, Petrila J, McGaha A, Boothroyd R. Perceived coercion and procedural justice in the Broward mental health court. International Journal of Law and Psychiatry 2002; 25(5):517–533.

17.Wales HW, Hiday VA, Ray B. Procedural justice and the mental health court judge's role in reducing recidivism. International Journal of Law and Psychiatry 2010; 33(4):265–271.

18.Livingston JD, Crocker AG, Nicholls TL, Seto MC. Forensic mental health tribunals: A qualitative study of participants' experiences and views. Psychology, Public Policy, and Law 2016; 22(2):173–184.

19.Pariseau-Legault P, Bernheim E, Ouellet G, Sallée N. Lorsque la maladie mentale s'invite au banc des accusés: Ethnographie de la commission d'examen et des espaces de justice hospitalière. Aporia 2021; 13(2):42-55.

20.Koro-Ljungberg M, Greckhamer T. Strategic turns labeled "ethnography": From description to openly ideological production of cultures. Qualitative Research 2005; 5(3):285–306.

21.Soyini Madison D. Critical ethnography: Method, ethics, and performance. SAGE, 2005.

22.Thomas J. Qualitative research methods: Doing critical ethnography. SAGE, 1993.

23.Fairclough N. Critical discourse analysis as a method in social scientific research. In: Wodak R, Meyer M (eds). Methods of critical discourse analysis SAGE, 2001; 121–138.

24.Goffman E. Asylum: Essays on the social situation of mental patients and other inmates. First Anchor Books, 1961.

25.Berring LL, Pedersen L, Buus N. Discourses of aggression in forensic mental health: A critical discourse analysis of mental health nursing staff records. Nursing Inquiry 2015; 22(4): 296–305.

26.Jacob JD, Holmes D. The culture of fear: Expanding the concept of risk in forensic psychiatric nursing. International Journal of Culture and Mental Health 2011; 4(2):106–115.

27.Perron A. The forensic patient's moral career as a measure of institutional disciplinary processes. International Journal of Culture and Mental Health 2012; 5(1):15–29.

28.Holmes D, Murray SJ. Civilizing the "barbarian": A critical analysis of behaviour modification programmes in forensic psychiatry settings. Journal of Nursing Management 2011; 19(3):293–301.

29.Goffman E. The presentation of self in everyday life. Anchor, 1959.

30.Crocker AG, Charette Y, Seto MC, Nicholls TL, Côté G, Caulet M. The national trajectory project of individuals found not criminally responsible on account of mental disorder in Canada. Part 3: Trajectories and outcomes through the forensic system. Canadian Journal of Psychiatry 2015; 60(3):117–126.

31.Domingue JL, Jacob JD, Perron A, Foth T, Pariseau-Legault P. A Critical Ethnographic Nursing Perspective on Risk and Dangerousness in Forensic Psychiatry. Nursing Inquiry; e12521.

32.Foucault M. Le pouvoir psychiatrique. Cours au Collège de France, 1973–1974. Seuil/Gallimard, 2003.

33.Cloyes KG. Rethinking biopower: posthumanism, bare life, and emancipatory work. ANS. Advances in nursing science 2010; 33(3):234–243.

34.Timmons D. Forensic psychiatric nursing: A description of the role of the psychiatric nurse in a high secure psychiatric facility in Ireland. Journal of Psychiatric and Mental Health Nursing 2010; 17(7):636–646.

35.Holmes D. Police and pastoral power: Governmentality and correctional forensic psychiatric nursing. Nursing Inquiry 2002; 9(2):84–92.

36.Holmes D. Governing the captives: Forensic psychiatric nursing in corrections. Perspectives in Psychiatric Care 2005; 41(1):3–13.

37.Jager F, Perron A. Caring as coercion: Exploring the nurse's role in mandated treatment. Journal of Forensic Nursing 2018; 14(3):148–153.

38.Paradis-Gagné É, Pariseau-Legault P, Goulet MH, Jacob JD, Lessard-Deschênes C. Coercion in psychiatric and mental health nursing: A conceptual analysis. International Journal of Mental Health Nursing 2021; 30(3):590-609.

39.Morse J. Legal mobilization in medicine: Nurses, rape kits, and the emergence of forensic nursing in the United States since the 1970s. Social Sciences & Medicine 2019; 222:323–334.

Acknowledgements
Jean-Laurent Domingue acknowledges the Social Sciences and Humanities Research Council of Canada for the Joseph-Armand Bombardier Doctoral Scholarship.

To contact the authors:
Jean-Laurent Domingue, RN, PhD (Assistant Professor)
University of Ottawa, School of Nursing
451 Smyth Rd, Ottawa, ON K1H 8L1
Email: jdoming2@uottawa.ca
Phone: 819-208-9101

Jean-Daniel Jacob, RN, PhD (Full Professor)
University of Ottawa, School of Nursing
451 Smyth Rd, Ottawa, ON K1H 8L1

Amélie Perron, RN, PhD (Full Professor)
University of Ottawa, School of Nursing
451 Smyth Rd, Ottawa, ON K1H 8L1

Pierre Pariseau-Legault, RN, PhD, LLM (Associate Professor)
Université du Québec en Outaouais, Department of Nursing
5 Rue St Joseph, Saint-Jérôme, QC J7Z 0B

Thomas Foth, RN, PhD (Associate Professor)
University of Ottawa, School of Nursing
451 Smyth Rd, Ottawa, ON K1H 8L1