Exploring the Production of "Dangerous Persons" in Forensic Psychiatry: A Critical Ethnography of the Ontario Review Board (ORB)

by

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Abstract

Forensic psychiatric nursing is a specialty at the junction of two well-researched intersecting systems with two different mandates: criminal justice (public protection) and health care (public good). Nurses' involvement at one of the systems' points of juncture, review board (RB) hearings, has largely been left unexplored. At RB hearings, a panel of legal and health care professionals determines if persons unfit to stand trial (UST) or not criminally responsible on account of mental disorder (NCRMD) represent significant threats to the safety of the public, and orders conditions aimed at keeping the community safe. The aim of this research project was to explore how psychiatric and public safety discourses construct the identity of persons UST or NCRMD during RB hearings, and nurses' contribution to such identity construction. Critical ethnography methodology was employed, mobilizing three data sources: interviews with forensic psychiatric nurses, observations of RB hearings, and RB documentary artifacts. A poststructuralist lens was used to discern how RB culture produces truths about persons UST or NCRMD that sustain the hegemony of public safety and psychiatric discourses. The main finding was that the forensic psychiatric structure leverages therapeutic nursing interventions and documentation as evidence of deviancy, so that persons UST or NCRMD can be objectified and produced as dangerous, prior to socially rehabilitating them. Discursive structures sustaining the forensic psychiatric system inscribe nursing care within a disciplinary scheme, rendering it coercive and punitive. Thus, a care-and-custody dichotomy is insufficient to explain the complex processes at play in forensic psychiatry. These findings have implications for research, practice, and education in forensic psychiatric nursing, nursing ethics, and other nursing specialties on the medico-legal borderland.

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Preface

Gaining access to the field of research is a very important step in any ethnography. In my case, the field was double: the review board (RB) hearings and the forensic psychiatric hospital. Before attending RB hearings, which are open to the public, I informed the Ontario RB that I intended to observe them via email (Appendix A). To access the forensic psychiatric hospital, I requested permission from the administrative and medical directors of the institution. For reasons of anonymity, the name of this institution is not disclosed in this dissertation (including in the appendices). Research Ethics Board approval was obtained from the Research Ethics Board of the hospital and from the University of Ottawa (Appendices B and C).

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First and foremost, I would like to recognize the courage of the nurses who agreed to lend their voices for this project. I hope this dissertation will provide you with the words to explain the feelings of ambivalence and confusion you shared with me. Relatedly, I thank the gatekeepers of the forensic psychiatric hospital where I conducted my doctoral study.

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List of Acronyms, Abbreviations, and Technical Terms

AD	absolute discharge
ADHD	attention deficit hyperactivity disorder
BC	British Columbia
CanLII	Canadian Legal Information Institute
CC	*Criminal Code* (Canada)
CD	conditional discharge
COE	commission ontarienne d'examen
CPIC	Canadian Police Information Centre
Disposition	public document containing detention conditions or supervision conditions (see RfD)
EAP	employee assistance program
HCR-20	Historical, Clinical, Risk Management-20
ISIS	Islamic State in Iraq and Syria
ISP	inaptes à subir leur procès
MDMA	Ecstasy (psychoactive drug)
MDO	mental disorders and offending
MHA	*Mental Health Act* (Ontario)
NCR	not criminally responsible
NCRMD	not criminally responsible on account of mental disorder
NCRTM	non criminellement responsable pour cause de troubles mentaux
NTP	National Trajectory Project
ON	Ontario
ORB	Ontario Review Board

PAE	programme d’aide aux employés
PRN	as needed
PTSD	posttraumatic stress disorder
QC	Québec
RB	review board
REB	research ethics board
RfD	reasons for disposition
RSVP	Risk for Sexual Violence Protocol
SCC	Supreme Court of Canada
SMI	serious mental illness
UST	unfit to stand trial
VRAG	Violence Risk Appraisal Guide
WHMIS	workplace hazardous materials information system

[RB hearings] can be kind of an ugly thing to sit through. It's our documentation. The lawyers use [it] to basically fight with each other over points of disagreements, so yeah, we're the ones recording incidents, we're usually the ones witnessing them, so those will be used by someone, say fighting for a more restrictive disposition. They'll use basically what we recorded as a means to getting [patients] less [human] rights I suppose, so that's it's usually not what we hope will happen with our documentation (small laugh).

—Nurse Participant 03, lines 121–131

Dedication

I dedicate this dissertation to Kim and all others

who have spent time in the forensic psychiatric system.

Introduction

This doctoral dissertation is rooted in my clinical experience as a registered nurse working on a forensic inpatient unit. On this unit, we cared for persons unfit to stand trial (UST) or not criminally responsible on account of mental disorder (NCRMD). For context, a person is found UST if they are "unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so" (*Criminal Code* [*CC*], 1985, s.2). A person is found NCRMD if they committed an act or omitted to commit an act "while suffering from a mental disorder that rendered [them] incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong." (*CC*, 1985, s.16(1)). Going into work one morning, I overheard a group of nurses discussing what I considered to be highly confidential information about one of their colleagues, a health care professional found NCRMD on charges of criminal harassment. This information included childhood traumatic experiences, lifelong substance use history, sexual health history, psychiatric treatment modalities, and more. I was shocked when I learned that this personal health information was contained in a publicly accessible document, available through an online legal database, called "reasons for disposition" (RfD). When I returned home, I logged onto this database, read a handful of RfDs, and was startled when I found that key elements of my nursing clinical work, such as mental status assessments, descriptions of clinical events, and urine toxicology screens, among other things, were included within them. The presence of such personal health information derived from nursing work in public legal documents pushed me to undertake this critical ethnography and to further explore the role of nurses in the identity construction of persons UST or NCRMD in forensic psychiatry.

This dissertation contains six chapters. The first four set out the research problem, present the theoretical framework, review the current literature on the subject, and delineate the

methodology used to investigate the research problem. Chapter 5 illustrates the intricate relationship between the clinical practice of nurses in forensic psychiatry and the legal processes in which their patients are enmeshed. Chapter 6 problematizes the humanistic nature of nursing practice in forensic psychiatry and the therapeutic function of forensic psychiatric hospitals.

Chapter 1: The Research Problem

In custodial environments, providing mental health care has been recognized internationally and in Canada as a minimum standard in the treatment of detainees (Government of Canada, 2021, United Nations, 1955; United Nation, 2015). Despite this, researchers and clinicians continue to highlight important functional and philosophical incommensurability between custodial institutions and mental health-care institutions (Dhaliwal et al., 2021; Holmes, 2002; 2005; Mercer et al., 1999; Peternelj-Taylor, 2004). Where custodial environments create distance between detainees and other members of society for safety or security reasons (Foucault, 1975/1995), mental health care is founded on a proximity between the provider and the recipient (Peplau, 1997; Peternelj-Taylor & Johnson, 1995). Such a fundamental difference, often referred to in the literature as the *care-and-custody debate* (see 3.4), renders the provision of mental health care within custodial institutions very complex.

The conflicting aims of custody and mental health care have led to inadequate and unethical practices, contributing to dozens of deaths annually in Canada; see, for example, the 2019 list of the verdicts and recommendations of the Ontario Chief Coroner (Government of Ontario, Ministry of the Solicitor General, 2021). The highly publicized death of Ashley Smith in 2007 while in custody demonstrates the deadly effect of such conflicting aims. Ashley Smith, a 19-year-old woman, had been sentenced to four years in prison after having committed a petty crime (Canadian Broadcasting Corporation, 2010; Correctional Services Canada, 2014; Murray et al., 2017). In reaction to some of Ms. Smith's behaviours, correctional institutions resorted to segregation policies instead of providing mental health services, which eventually led to her suicide (Murray et al., 2017). Ashley Smith's incarceration had been marked by 17 interinstitution transfers spanning five Canadian provinces before she hanged herself in the Grand Valley Institution for Women in Kitchener, Ontario.

Like prisons or correctional institutions, forensic psychiatric hospitals are institutions where persons deemed dangerous are detained or supervised for purposes of rehabilitation and community reintegration. However, these institutions' dichotomized custodial and caring purposes prove very complex in operation. Although they have a responsibility to ensure public protection, their physical and procedural security measures, looser than those of correctional facilities, seem to facilitate the provision of psychiatric care. This is not without consequence. Boundaries between custodial and therapeutic interventions are blurred. This judiciarization of mental health care gives every custodial intervention a therapeutic purpose, and every therapeutic intervention a custodial intention (Foucault, 1975/1995, 2003; Paradis-Gagné & Jacob, 2020; Paradis-Gagné, Jacob, et al., 2020). Relatively undocumented, these boundaries merit rigorous critical exploration and analysis.

In Canada, the forensic psychiatric system comprises forensic psychiatric hospitals and provincial review boards (RB). The RBs order forensic psychiatric hospitals to detain and monitor persons UST or NCRMD, to supervise their safe reintegration into the community, and to provide them with rehabilitative psychiatric care. In yearly hearings, RBs determine the modalities of detention, and the supervision conditions they must impose on persons UST or NCRMD in order to maintain public safety (*CC*, 1985). During these hearings, an expert report, typically prepared by the person UST's or NCRMD's attending psychiatrist on behalf of the health care team and the forensic psychiatric hospital, is presented. The report is examined to determine whether the person UST or NCRMD poses a significant threat to the safety of the public (Crocker, Nicholls, Charette, et al., 2014; Tribunal Administratif Québecois [TAQ], 2005; Wilson et al., 2015). If so, detention conditions or conditions of supervision are formalized in a public document entitled a *disposition* (*CC*, 1985). Another public document, the *reasons for*

disposition (RfD) provides the RB's justification for the disposition ordered and for the conditions imposed. The RfD also summarizes information presented at the RB hearing, details the board's analysis, and presents the decision itself.

The interconnected custodial and caring aims of the forensic psychiatric system highlight two areas of tension, evident in the RB hearing process, that need further exploration. First, persons UST or NCRMD are objectified by information contained in the medico-legal report prepared by forensic hospitals, in particular when their complex lives and medical conditions are reduced to a series of factors and events to justify a finding of "significant threat to the safety of the public" during RB hearings (*CC*, 1985). This objectification process becomes a source of tension when it legitimizes targeted interventions aimed at protecting the safety of the public while concurrently guiding therapeutic rehabilitation interventions.

Second, there is an issue with respect to the confidentiality of personal health information in the RB hearing process. Clinical information about persons UST or NCRMD is generally considered confidential when initially collected and documented. Transferring it from the health care setting to the RB hearing environment renders it publicly available (see Figure 1), where it is used to establish whether such persons represent significant threats to the safety of the public, and to justify the need for their detention, supervision, and rehabilitation. In Ontario, Canada, this process is facilitated by the articulation of two pieces of legislation, namely the *Criminal Code* (1985) and the *Mental Health Act* (*MHA*; 1990). The former establishes that RB hearings are generally public and the latter stipulates:

> The officer in charge of a psychiatric facility may collect, use, and disclose personal health information about a patient, with or without the patient's consent, for the purposes of . . . complying with Part XX.1 (Mental Disorder) of the *Criminal Code* (Canada) or an order or disposition made pursuant to that. (*MHA*, 1990, s 35(2))

Personal health information produced by health care professionals, including nurses, can thereby be used, in a quasi-unregulated manner, for purposes beyond the provision of care—namely for public safety and risk management—without the consent of persons UST or NCRMD.

The production of personal health information by nurses in the context of forensic psychiatry proves to be questionable from an ethical and professional standpoint. Its subsequent decontextualized use may have detrimental effects on the social trajectories of persons UST or NCRMD.

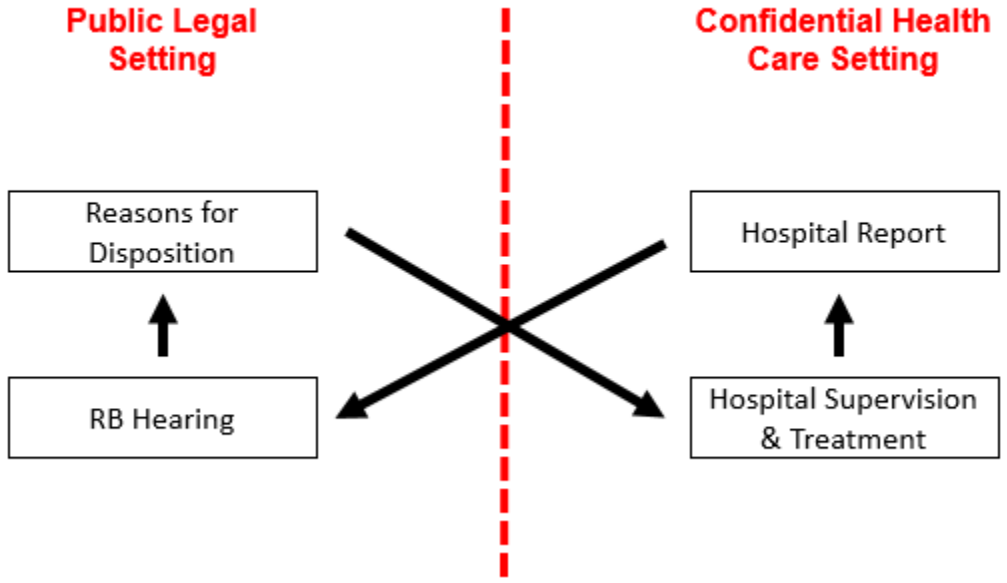

Figure 1. Blurred confidentiality boundaries in public legal settings and confidential health care settings.

Apart from a very recent ethnographic study focused on analyzing the roles of actors during RB hearings in the province of Québec (Bernheim et al., 2020; Pariseau-Legault, Bernheim, et al., 2021), there is a dearth of empirical knowledge aimed at understanding how the clinical practice of health care professionals in general, and nurses in particular, contributes to the RB hearing and to the production of persons UST or NCRMD as posing "significant threats to the safety of the public." The rare empirical studies conducted in Canada about RB hearings

seem to revolve around two specific aspects relating to public safety. On the one hand, they study the RB's efficiency at safely reintegrating persons NCRMD into the community by problematizing their risk of recidivism (Crocker, Charette, et al., 2015; Crocker, Nicholls, Seto, & Côté, 2015; Latimer & Lawrence, 2006; Livingston, Wilson, et al., 2003). On the other, they examine the role of procedural justice, namely the fairness of the process that caused an individual's subjugation, in the context of RB hearings (Livingston, Crocker, et al., 2016) and other parajudiciary tribunals (Paul et al., 2020).

In brief, forensic psychiatric hospitals and provincial RBs are located at the junction of two overlapping systems: the mental health care system and the criminal justice system. The criminal justice system relies on the medico-legal expertise of psychiatry—and forensic psychiatry in particular—to identify, detain, supervise, and rehabilitate persons UST or NCRMD who represent a significant threat to the safety of the public (Chauvaud, 2009; Federman et al., 2009; Foucault, 1999). These systems owe their existence to interdependent discourses, notably those relating to psychiatry and public safety (J.-D. Jacob, 2014; Mercer et al., 1999; Peternelj-Taylor, 2004), that converge in what Foucault (2007) referred to as a security apparatus (or *dispositif*), that is to say an amalgam of institutions peripheral to the state that ensure the safety of the population (see Chapter 2). Here, "'discourse' refers not to language or social interaction but to relatively well-bounded areas of social knowledge" (McHoul & Grace, 1993, p. 31), where "knowledge" represents "social, historical and political conditions under which . . . statements come to count as true or false" (McHoul & Grace, 1993, p. 29). As discursive materializations, the production of these statements about persons UST or NCRMD constitutes a symbolic practice, including others (such as rituals and artifacts) that make up the forensic psychiatric culture. In the context of forensic psychiatry, it is important to understand why these statements

are produced, how they construct the identity of persons UST or NCRMD, and the role of nurses in these processes.

1.1. Research Objectives

1. Explore how psychiatric and public safety discourses construct the identity of persons UST or NCRMD during RB hearings.
2. Explore nurses' contribution to the construction of this identity.

1.2. Research Questions

The proposed research project was driven by the following research questions:

1. How is the RB hearing operationalized?
2. How does the RB construct the identities of persons UST or NCRMD?
3. How is nursing work depicted and used in the RB hearings and RB documents?
4. How do nurses discursively construct their professional role as it relates to the RB hearing process?

1.3. Paradigmatic Positioning

Paradigms, or worldviews, are sets of beliefs and assumptions that allow for persons to make sense of the world in which they live (Guba & Lincoln, 1994; Kuhn, 1962/2012). In the scientific community, these paradigms establish the philosophical underpinnings of the problems investigated, research questions, methodologies used, and validity criteria of the results (Cheek, 2000; Guba & Lincoln, 1994; Kuhn, 1962/2012). I sought to answer the research questions by studying the RB hearing as a forensic psychiatric ritual that produces statements about persons UST or NCRMD. For this purpose, I relied on the paradigm of critical theory, specifically on its poststructuralist subclassification (Cheek, 2000; Guba & Lincoln, 1994).

1.3.1. Critical Theory and Poststructuralism

Critical theory regroups numerous critical approaches—including feminist, postcolonialist, postmodernist, and poststructuralist approaches—each with their ontological, epistemological, and methodological subtleties (Guba & Lincoln, 1994). Postmodernist and poststructuralist approaches originated in the artistic disciplines during the post–World War II era in Europe and migrated to other disciplines, including nursing, throughout the second half of the 20th century (Cheek, 2000; Cusset, 2013).

A poststructuralist critical theory worldview acknowledges historical realism and considers that various historical, political, cultural, social, and gendered contexts have shaped reality into structures. Through these structures, truths are seen to be produced about things and people (Cheek, 2000; Guba & Lincoln, 1994). A plethora of these structures exist. They include physical institutions such as asylums, hospitals, schools, and retirement homes, as well as academic disciplines such as sociology, medicine, psychology, and nursing. The late French philosopher Michel Foucault is thought to be a main contributor to the paradigm of critical theory (Cheek, 2000; Cusset, 2013). He proposed that structures, sustained by various discourses, enable the production of various truths, in the form of statements, through relations of power (Foucault, 1969/2010). Foucault claimed that although they appear quite banal and inconsequential, statements are strange events for three reasons. First, they originate from the act of writing or speaking, and their ongoing existence is reliant on memory or diverse forms of recording (Foucault, 1969/2010). Second, Foucault (1969/2010) wrote that "[the statement] is unique, yet subject to repetition, transformation, and reactivation" (p. 28). Third, statements are not events that stand alone; they exist in relation to situations that allowed for their production, to the consequences they generate, and to other statements (Foucault, 1969/2010).

By the statements they produce, structures constrain what can be known about reality. Therefore, the act of knowing cannot be dissociated from the underlying discourses that have created the structures through which statements are produced. By producing statements, these structures (re)affirm the dominance of certain discourses and place other discourses in a position of subjugation; this cyclically prevents the production of other statements (Foucault, 1969/2010; Halpern, 2013; McHoul & Grace, 1993). Guba and Lincoln (1994) considered the ontological and epistemological properties of the critical theory paradigm to be almost inseparable; enquiries about reality cannot be dissociated from the structures that produce statements about reality.

The epistemological properties of poststructuralism can be separated into two domains, namely the sources of knowledge and the relationship between the researcher and the object (or subject) of research. First, for poststructuralists, sources of knowledge that can be studied and analyzed include any physical object, such as art or architecture, or statements made about that object or subject, such as spoken or written words. Specifically, Cheek (2000) explained that poststructuralism concentrates its attention on the "analysis of literary and cultural *texts*, where *texts* refers to a representation of any aspect of reality" (p. 40; emphasis in original). Texts include, but are not limited to, "pictures, poems, procedures, conversations, case notes, art work or articles" (Cheek, 2000, p. 40). Cheek (2000) further wrote that

> Poststructural perspectives challenge the notion that language is a neutral, objective, value-free conveyer of aspects of reality. Rather, they expose and interrogate language itself as being both constituted by, and constitutive of, the social reality that it seeks to represent. (p. 40)

Thus, texts are sources of knowledge inasmuch as they harbour statements that must be interpreted as products of structures. Furthermore, as Cheek (2000) has reminded us, absent or nonexistent statements—that is to say, those that could have stemmed from marginalized

structures and discourses—must also be considered as sources of knowledge to the same extent as those produced by dominant structures and discourses.

Second, in a poststructuralist worldview, the researcher and the object of research are nondissociable; both are considered products of structures and discourses. Although Guba and Lincoln (1994) identified this relationship as subjectivist and value mediated, I consider that within poststructuralism this relationship goes beyond the question of value mediation and subjectivity, in that subjects can only know and produce knowledge within the discursive structure that has produced them as researchers (Foucault, 1969/2010; McHoul & Grace, 1993). By proposing that "the investigator and the investigated object are assumed to be interactively linked, with the values of the investigator (and of situated 'others') inevitably influencing [the] enquiry," Guba and Lincoln (1994, p. 110) almost distinguished the researchers from their values and implied that the researcher's values merely "influence" enquiry. A poststructuralist epistemology slightly differs from this conceptualization in that it considers both the researcher and the knowledge they produce to be themselves discursive products (Cheek, 2000; Foucault, 1969/2010).

From a methodological standpoint, researchers producing knowledge within a poststructuralist paradigm must explore how statements sustain the dominance of certain structures and discourses, and must challenge the subjugating effects of these structures in order to incite transformations (Campbell & Bunting, 1991; Cheek, 2000; Guba & Lincoln, 1994; Meleis, 2011; Mill et al., 2001). To achieve this aim, poststructuralist researchers first consider and reflect upon the different contexts, structures, and discourses that produced them as researchers (Cheek, 2000; Guba & Lincoln, 1994). Second, they examine various statements that make up the object of enquiry and consider the contexts, structures, and discourses that enabled

their production (Cheek, 2000; Guba & Lincoln, 1994; McHoul & Grace, 1993; Meleis, 2011). Such an exercise allows poststructuralist researchers to critically analyze the dominance of structures and to challenge their subjugating effects (Cheek, 2000; Mill et al., 2001). In this sense, poststructuralists may act, indirectly, as agents of transformation by influencing groups of people to fight for structural changes to render possible the assertion of other (subjugated) truths (Cheek, 2000; Guba & Lincoln, 1994; Weaver & Olson, 2006).

1.3.2. Poststructuralism and the Research Problem

Knowledge produced by poststructuralist researchers has been useful in health disciplines such as medicine, nursing, and psychology. Cheek (2000) wrote that poststructuralist researchers in health disciplines ask questions "about any representation of any aspect of health care reality," which can include

> whether [a certain representation] is the only way [an] aspect of health care practice can be represented; why this representation is the one accepted as "normal" or "given"; what are alternate ways of representing the same reality; and why these ways are absent and/or marginalized and suppressed. (p. 41)

Instead of focusing on health care practices themselves, poststructuralist researchers study statements produced as a result of such practices and the structures that produced them. By doing so, researchers may better understand the hegemony of certain structures over others and to question why other ways of thinking and doing have been silenced. McHoul and Grace (1993) underscored that such questioning is essential when producing knowledges in human sciences, because "the conditions required for the production of truth within these knowledges are much less stable and far more difficult to control" when compared to natural sciences (p. 58). They added that "somewhat disturbingly perhaps, these are also the knowledges most quick to pronounce truths about human nature, human potential, human endeavour, and the future of the human condition in general" (McHoul & Grace, 1993, p. 58). In health care disciplines, such as

nursing and forensic psychiatric nursing, these truths directly impact what constitutes care, how care is provided, and who can and must access care.

My exploration of the ways in which forensic psychiatric structures—including medicine, nursing, the RB, and forensic psychiatric hospitals—produce statements about persons UST or NCRMD was rooted in a poststructuralist critical theory worldview. By questioning the effects of these statements, I problematized the role of nurses in the RB hearing process insofar as therapeutic nursing clinical practices were mobilized to establish persons UST or NCRMD as significant threats to the safety of the public and to justify their prolonged need for detention, surveillance, and rehabilitation.

1.4. Importance of the Research Problem for the Discipline of Nursing

Nursing practice in forensic psychiatry is a relatively new specialty, situated at the junction of medicine and criminology and vested with a dual mandate of care and social control (Dhaliwal et al., 2021; Holmes, 2002, 2005; J.-D. Jacob & Foth, 2013; Mason, 2002; Mercer et al., 1999; Peternelj-Taylor, 2004). The forensic psychiatric nursing specialty goes beyond the capacity of providing professional nursing care within forensic psychiatric environments with everything that this entails, such as safety protocols and the nature of the patient population. It can also engage nurses in understanding the many effects of their therapeutic interventions. This is an underdeveloped area of nursing practice and medical ethics, thus rendering its exploration important.

My study partially fills this knowledge gap by providing an understanding of how the clinical practices of nurses insert themselves into the forensic psychiatric system. By paying particular attention to the identity construction mechanisms inherent in the forensic psychiatric system in general and in RB hearings in particular, I critically examined the effects of nursing practices and engaged in reflections about what constitutes forensic psychiatric nursing care. The

therapeutic nature of one-on-one clinical encounters nurses have with their patients and the documentation that stems from these encounters may have detrimental repercussions for the health and social trajectories of patients. Accordingly, this research project challenged the notion that nursing is a purely a humanistic health care discipline inasmuch as it highlighted harmful effects of nursing practices.

Chapter 2: Theoretical Framework

The work of Michel Foucault, Erving Goffman, and Harold Garfinkel guided my research project from a theoretical perspective. Foucault's conceptualization of subjects as products of a tightly knit relationship between power and knowledge was particularly useful for my understanding of the role of the forensic psychiatric hospital in the production of dangerous persons UST or NCRMD (Foucault, 1975/1995, 1976/1990a, 1999; McHoul & Grace, 1993). Equally important was Foucault's work on biopower, which helped me conceptualize how the forensic psychiatric system, and its RB hearings, act as a security apparatus that maintains public safety (Foucault, 1997, 2007). In parallel, the work of Garfinkel (1956) on degradation ceremonies, and of Goffman (1961) on the effects of what he called total institutions (such as role dispossession and mortification), helped me understand how the forensic psychiatric system reconstructs the identities of persons UST or NCRMD, as well as those of nurses.

As with many nurse scholars working in the field of psychiatry and forensic psychiatry (Corneau et al., 2017; du Plessis, 2011; Perron, 2012), I contend that combining the work of Goffman and Foucault is essential for grasping the multilevel effects of identity construction for purposes of public protection. There remains some contention with respect to the ontological and epistemological incommensurability between these two authors. However, I turn to the work of scholars that reinforce their complementarity as opposed to their differences. In this vein, Hacking (2004) wrote that "[Goffman and Foucault] are complementary. One needs to stand between the two men in order to take advantage of them both. There is a clear sense in which Foucault's research was 'top-down' [and] Goffman's was 'bottom-up'" (p. 278). Indeed, Foucault's work provides the foundations with which to understand the origins and the function of power relations described by Goffman and, complementarily, Goffman's work allows for a

better understanding of how subjects are produced as a result of power-knowledge(s) within these institutions.

2.1. Knowledge(s), Power, and Subjection

Foucault relied on the concepts of power and knowledge to explain how discourses and structures produce identities (Foucault, 1982). He explained that the creation of subjects is achieved through various power relations that produce knowledge about humans; a process he called *subjection* (McHoul & Grace, 1993). Foucault found it problematic to refer to knowledge in the singular. Rather, he preferred the plural—knowledge(s), or systems of knowledge, which are characterized by the discourses that enabled their production (Foucault, 1969/2010). Foucault suggested that discourses are "bodies of knowledge" that allow reality to be represented in a certain way (McHoul & Grace, 1993, p. 26), thus enabling some truths to be said and others to be silenced (Foucault, 1969/2010).

Foucault (1969/2010) studied various systems of truth, including insanity, medicine, punishment, and sexuality, by analyzing the historically circumscribed discourses that permitted their production. Unlike Kuhn (1962/2012), who used examples from natural sciences to propose a similar perspective on systems of knowledge, "the systems of knowledge Foucault scrutinise[d] imply immediate and solid connections to social relations: economics, medicine, and the 'human sciences'" (McHoul & Grace, 1993, p. 58). By producing truths about humans, these systems of knowledge are able to produce subjects with specific identities. In a somewhat cyclical way, such truths perpetuate and sustain the systems of knowledge that allowed for their production (Foucault, 1969/2010). To understand how subjection materializes itself, Foucault spoke of the "micro-physics of power," namely the effects of discourses on persons by means of power relations. He identified three co-existing types of power—sovereign, disciplinary, and pastoral—each of which functions in its own particular way to produce subjects (Foucault, 1975/1995,

1976/1990a, 2003, 2007; McHoul & Grace, 1993). These types of power are summarized in 2.1.1, 2.1.2, and 2.1.3, below.

The work of Foucault on subjection has been used as the theoretical foundation for many studies in the context of forensic psychiatric nursing (Holmes, 2002, 2005; J.-D. Jacob & Foth, 2013; J.-D. Jacob & Holmes, 2011a, 2011b; Perron & Holmes, 2011). Applying such a framework to the forensic psychiatric system, and particularly to the RB, undoubtedly deepens one's understanding of how it produces persons UST or NCRMD as dangerous individuals. It also allows for a critical assessment of the procedures, rituals, and discourses that contribute to such an identity construction.

2.1.1. Sovereign Power

In any given society, sovereign power presents itself in the relations between identifiable individuals who are holders of a sole truth (kings, princes, dictators, fathers, religious leaders) and their subjects (peasants, children, religious followers; Foucault, 1975/1995). In his course at the Collège de France entitled "Le pouvoir psychiatrique," Foucault (2003) described three characteristics of sovereign power. First, sovereign power entails an asymmetrical relation, evident through dynamics of contribution-spending between a sovereign and their subjects. This relationship is asymmetrical in favour of the sovereign; the high value of contributions made by subjects to the sovereign in money, services, and donations of goods is highly disproportionate to the minimal spending activities in which the sovereign engages at Crowning ceremonies, religious celebrations, festivals, winning wars, or weddings. Secondly, sovereigns are placed in a position of sovereignty because of an underlying foundational reason such as being chosen by God, being born into a particular family, being the first male child born, or being the man of the household. Notwithstanding the existence of these foundational reasons, sovereigns cannot take their sovereignty for granted. To maintain their sovereignty, they must constantly engage in

activities that reaffirm their hegemonic position in relation to their subjects, including, but not limited to, conducting public ceremonies and displaying emblematic clothes or signs/marks (Foucault, 1975/1995, 2003). Finally, Foucault (2003) explained, numerous sovereign-subject relationships co-exist within a society. These relationships are heterogeneous and mutually exclusive in nature. Despite their multiplicity, they cannot be combined into a unique hierarchy in which a single sovereign exists. Individuals are subjected to various sovereign-subject relations; they may simultaneously be subject and sovereign.

However, in the constant movement between the multitudes of subject-sovereign relations, one thing becomes apparent: only one subject is produced at the top of any subject-sovereign relation—the sovereign. Using the monarchy as an example, Foucault (2003) proposed that the sovereign must simultaneously have two bodies to maintain a lasting sovereignty: a somatic body and a figurative body. The somatic body is the physical, organic, and perishable body of the sovereign. The figurative body is immaterial, symbolic, and permanent, representing a social position, such as the leader of the kingdom, the landowner, or the father. In order to sustain its figurative body, sovereignty must ensure that it does not perish with the sovereign's somatic body. Foucault therefore explained that the only individualizing property of sovereign power—that is, its only identity construction mechanism—occurs at its peak, namely in the moulding of the sovereign's somatic body to its figurative body in order to ensure the permanency of the latter. Indeed, the raison d'être of sovereign power is to maintain its permanency (Foucault, 1975/1995, 2003). To do so, it relies on unconcealed public displays of force and violence against the bodies of its subject with the goal of instilling a constant state of fear and terror (Foucault, 1975/1995, 2003; McHoul & Grace, 1993). Examples of such displays of force may include, among other things, public torture. In nursing, the use of seclusion rooms

has been associated with such mechanisms of sovereign power (J.-D. Jacob, Gagnon, Perron, et al., 2009). Nevertheless, at the end of the Middle Ages, revolts against overt forms of public torture gave rise to a more insidious type of power: disciplinary power (Foucault, 1975/1995).

2.1.2. Disciplinary Power

Disciplinary power is an invisible and omnipresent form of power. Its functioning proves to be in dramatic contrast to the overt nature of sovereign power. Whereas sovereign power materializes itself through calculated public displays of physical force and violence toward the bodies of persons, disciplinary power relies on instilling an insidious control over the bodies, behaviours, and thoughts of subjects to ensure their obedience and docility. While sovereign power produces subjects at the top in an effort to maintain the sovereignty of the sovereign, disciplinary power produces subjects at the bottom for control and training purposes (Foucault, 1975/1995). Foucault (1975/1995) argued that the subjection properties of disciplinary power operate through disciplinary technologies such as hierarchical observation and normalizing judgement, which converge toward the examination process (these notions are explained further, below). Foucault (1975/1995) illustrated the functioning of hierarchical observation, normalizing judgement, and examination, in his use of Bentham's concept of the panopticon:

> At the periphery, an annular building; at the center, a tower; this tower is pierced with wide windows that open onto the inner side of the ring; the peripheric building is divided into cells, each of which extends the whole width of the building; they have two windows, one on the inside, corresponding to the windows of the tower; the other, on the outside, allows the light to cross the cell from one end to the other. All that is needed, then is to place a supervisor in a central tower and to shut up in each cell a madman, a patient, a condemned man, a worker, or a schoolboy. By the effect of backlighting, one can observe from the tower, standing out precisely against the light, the small captive shadows in the cells of the periphery. They are like so many cages, so many small theatres, in which each actor is alone, perfectly individualized and constantly visible. (Foucault, 1975/1995, p. 200)

The panoptic architecture of disciplinary institutions allows supervisors to efficiently monitor bodies, movements, and behaviours of individuals. Thus, "from the point of view of the guardian," the crowd "is replaced by a multiplicity that can be numbered and supervised" (Foucault, 1975/1995, p. 201). This architecture also permits supervisors to produce knowledge about subjects by documenting their observations in a central location (Foucault, 1975/1995). Compiling this documentation enables the production of knowledge about individuals such as the mentally ill, criminal, deviant, schoolboy, the person UST, or NCRMD. It also allows for certain codes, taxonomies, and instruments, such as pedagogical guides, diagnostic manuals, and risk assessment tools, to be created (Foucault, 1975/1995). Subjection occurs when subjects are compared to and differentiated from these codes and when their individualizing attributes are identified. Foucault (1975/1995) called this process *examination*.

An examination is a highly ritualized ceremony of power that makes visible the invisibility of disciplinary power. The examination procedure produces knowledge about subjects through three mechanisms. First, it is a ceremonial objectification of an individual, further ensuring that they feel constantly feel gazed upon (Foucault, 1975/1995). Secondly, an examination includes documentation: "The examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them" (Foucault, 1975/1995, p. 189). Capturing and "fixing" (inscribing) subjects' characteristics in written documents allows them to be associated, compared to, and differentiated from different codes, such as diagnostic manuals and moral codes (Foucault, 1975/1995). Thirdly, this documentation of the examination procedure makes each individual a *case*, which is simultaneously a product and a producer of knowledge (Foucault, 1975/1995). In this sense, the case is an individual who can be "described, judged,

measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded" (Foucault, 1975/1995, p. 191). By having the ability to monitor individuals in their singularity, supervisors can "distribut[e] [them], know them [and] order[ing] them along a graded scale" (Dreyfus & Rabinow, 1982, p. 193). Observing individuals and the subsequently compiling information about them produces them as objects of knowledge and enables the production normative values against which each of them can be ordered and graded. By fixing the gaps between the individual and this normative value in a network of documentation, the individual's identity is produced according to the degree it differs from the norm. It is in this vein that McHoul and Grace (1993) considered that "differences, peculiarities, deviance and eccentricities are even more highlighted" (p. 72) when individuals are subjected to examination.

2.1.3. Pastoral Power

Pastoral power originates in the relationship between a pastor and their pastorate (Foucault, 2007). Holmes (2002) explained that in its most basic form, "pastoral power is a form of power that requires a person to serve as a guide for another (for example, a sick or vulnerable person)" (p. 86). In Foucault's (1976/1990a, 1984/1990b, 2007) genealogy, the origins of pastoral power in the Western world are traced back to the time of the founding fathers of Christianity, to the notion that the shepherd must save each individual sheep while working in the interest of the whole flock; thus, the use of the confessional in the Catholic church. The confessional is a space where persons confess their sins to a pastor or priest to receive divine redemption (Foucault, 1984/1990b). It places subjects in a "carer–cared for" or "mentor-mentored" type of relationship, thus enabling carers and mentors to have an in-depth knowledge about subjects through the latter's practice of penance and self-examination (Foucault, 1984/1990b; Holmes, 2002). In these

relationships, the mentor/shepherd is the bearer of moral codes guiding the mentored in a process aimed at transforming one's self into an ethical self. Foucault (1984/1990b) explained that this is

> . . . a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve a certain moral goal. And that requires him to act upon himself, to monitor, test, improve, and transform himself. (p. 28)

Pastoral power initiates a process of subjection, whereby mentored subjects, abiding by moral codes, reconstruct their selves into ethical subjects through various practices including "self-reflection, self-knowledge [and] self-examination" (Foucault 1984/1990b, p. 29).

When guides and mentors document statements made by subjects during practices of confession, penance, and self-examination, pastoral power produces knowledge about those subjects (Foucault, 1976/1990a). Transferring confessional practices from the Catholic church to other domains—such as medicine, corrections, or education—has significantly changed the way confessions have been delivered, received, and stored:

> The motivations and effects it [the confessional] is expected to produce have varied, as have the forms it has taken: interrogation, consultation, autobiographical narratives, letters; they have been recorded, transcribed, assembled into dossiers, published, and commented on. (Foucault, 1976/1990a, p. 63)

Subjects are produced as objects of knowledge through pastoral power at the moment when their identity transformation process is textually inscribed within a written network of documentation. Indeed, documenting confessions is intimately linked to disciplinary power's examination mechanism, in that the process produces written truths about "cared for" or "mentored" persons that can be subsequently used to make them a "case."

In summary, Foucault understood subjection to be a result of the relationship between sovereign and the subject, supervisor and supervised, and pastor and congregation. These relations of power—sovereign, disciplinary, and pastoral—produce identities through the

mechanisms described. They can be applied to numerous different settings, including families, day cares, schools, forensic psychiatric hospitals, retirement homes, clinics, and governments. They function simultaneously to produce subjects for very specific purposes. In the forensic psychiatric system, a plethora of relationships between many actors, such as RB members, persons UST or NCRMD, forensic psychiatrists, and nurses, are infused with sovereign, disciplinary, and pastoral power. These relations of power produce identities in a way that upholds the institutional goal of the forensic psychiatric system, namely public safety (*CC*, 1985).

2.2. Public Safety and Biopower

According to Foucault (2007), contemporary societies maintain public safety through the deployment of a security apparatus (*dispositif*)—an intricate array of interconnected structures that permit the protection of societies, their self-regulation, and the subsistence of their population. The security apparatus functions by governing humans as a biological species, to guarantee a sort of social homeostasis by regulating all aspects of life, such as demography (e.g., birth and mortality rates), health (e.g., surveillance of epidemics), education (e.g., school enrolment rate), and the economy (e.g., management of financial, human, and material resources; Foucault, 2007). Foucault (2007) used the term *biopower* to define this form of power that governs biological life. The emergence of this new statistical form of knowledge about humans provides a new domain in which interventions can be deployed (Foucault, 2007).

Biopower operates along two separate axes: anatomopolitics, which ensures the surveillance and discipline of bodies, and biopolitics, which "makes live" by knowing, regulating, and governing populations at a global level (Foucault, 1997; Gros, 1996; McHoul & Grace, 1993; Perron et al., 2005). To sustain and protect populations, biopower relies on the expertise of institutions adjunctive to the state apparatus such as prisons, hospitals, medicine, and

nursing or welfare organizations (Foucault, 2007). The forensic psychiatric system constitutes such an institution inasmuch as it identifies persons UST or NCRMD who present dangers to the public (biopolitics), and the psychiatric hospital ensures that this danger will be neutralized (anatomopolitics; Domingue, Jacob, et al., 2020).

2.2.1. Anatomopolitics, Psychiatric Hospitals, and the Reconstruction of Identities

The prominent place of the psychiatric hospital in anatomopolitics is entrenched in a relatively recent association between medicine and madness. Psychiatry emerged as a medical specialty when physicians were introduced into spaces of confinement in the mid-to-late 18th century (Gros, 1996). During what Foucault (1965/1988) called the Great Confinement (*grand confinement*), madmen and madwomen were grouped and confined in prison-like disciplinary institutions with the poor, the homeless, and criminals. The confinement of madmen and madwomen crystallized somewhat during the Industrial Revolution, when the negative financial implications of confining poor and homeless individuals who could serve as a workforce led to their release. Now, only criminals and madmen and madwomen were left within spaces of confinement (Gros, 1996). This mass release exemplifies the efficiency of power in producing subjects. Confronted with the need to engage with the new capitalist form of wealth production, subjects, once produced as disposable and relegated to the confines of prison-like institutions, were now mobilized as an indispensable workforce (Foucault, 1965/1988).

Foucault (1965/1988) suggested that protests fuelled by a general consternation about having criminals confined with madmen and madwomen subsequently caused the two to be segregated from each other. This new arrangement allowed for the specific conduct of madmen and madwomen to be meticulously observed, documented, classified, and categorized, and for madness to be produced as an independent object of knowledge. When physicians entered these spaces in the mid-to-late 18th century, madness became an object of medical knowledge, and

madmen and madwomen became subjects through which this knowledge could be exploited. The murmured voices of the insane were now buried under a medical discourse. From this point forward, disciplinary institutions where madmen and madwomen were confined redefined themselves as therapeutic spaces and became institutions where deviant individuals could be medically treated and reformed (Gros, 1996).

2.2.1.1. Disciplinary Features of Psychiatric Hospitals

Foucault (2003) explained that the therapeutic properties of psychiatric hospitals originate from their disciplinary features: "The chief function of the disciplinary power is to 'train', rather than to select and to levy; or, no doubt, to train in order to levy and select all the more" (p. 170). Beyond serving to identify the ways in which individuals deviate from institutional ideals, disciplinary institutions deploy an intricate array of training interventions aimed at normalizing them (McHoul & Grace, 1993).

Within disciplinary institutions, subjects are not only segregated from society, they are also separated from one another and from their supervisors (Foucault, 1975/1995; Goffman, 1961; McHoul & Grace, 1993). Every subject in these institutions has a specific location where they must be at all times, and a specific way they must behave and think. They must not step into the space of others, or behave or think in ways that differ from what is expected of them. This spatial distribution allows disciplinary institutions to control all the activities of individuals within them and extract from them the maximum amount of "time and labour" to efficiently attain institutional goals (McHoul & Grace, 1993, p. 69). Disciplinary institutions accomplish this by implementing "the daily timetable; by adjusting movements; . . . by correlating bodily positions and gestures; . . . and by articulating the movement of the body with an object" (McHoul & Grace, 1993, p. 69). Moreover, to increase the efficiency of individuals and to ensure that their bodies, thoughts, and behaviours comply with institutional goals, disciplinary

institutions organize their training programs into distinct and identifiable steps. McHoul and Grace (1993) explain that the most obvious form of this arrangement can be observed in educational systems, where students must learn certain knowledge and successfully apply it before graduating to the next grade where they will have to learn and apply concepts that are more difficult. This knowledge acquisition and application process allows for the close monitoring of the normalization of individuals (McHoul & Grace, 1993). If a disciplinary institution is not successful in training an individual to the ideals espoused by the institution, that individual is excluded from the institution and relegated to another disciplinary system for further normalization (Foucault, 2003). The effectiveness of these interventions is reliant on the state of permanent visibility achieved by the panoptic architecture of disciplinary institutions—in schools through open classrooms, monitors, examinations and tests, and counsellor interventions.

Foucault (2003) noted that many of the above-mentioned interventions are used within psychiatric settings, but that within these environments they are construed as therapeutic. Indeed, he wrote that the observation architecture of psychiatric institutions is organized in a hierarchical manner; a variety of employees, such as nurses, orderlies, and guards, observe mentally ill patients, document their observations in the medical record, and report information up to the psychiatrist (Foucault, 2003). When mentally ill patients deviate from institutional expectations, they are subjected to therapeutic interventions aimed at restricting their bodily movements and at correcting their conduct, by restricting their freedom, administering medications, and coercing participation in self-help groups. The psychiatrist thereby becomes (a) the omnipresent supervisor of the disciplinary institution and (b) the director of all normalizing techniques (Foucault, 2003). Disciplinary mechanisms inherent in psychiatric hospitals are called

therapeutic because of the presence of psychiatrists within their walls. Foucault (2003) also refers to these disciplinary mechanisms as techniques of psychiatric power.

Foucault (2003) provided the psychiatric interview as an exemplar of a technology through which psychiatric power operates. Among other things, the interview gives psychiatrists four mechanisms to structure the immateriality of insanity and establishes them as the experts in the treatment of this insanity (Foucault, 2003). First, the psychiatric interview finds antecedents and collateral information about the families of madmen and madwomen in an effort to give somewhat of a body to the invisibility of madness. This search for antecedents causes for a plethora of information to be assembled to situate madness within the pathological families of madmen and madwomen and introduces the notion of heredity in psychiatry:

> L'hérédité, c'est une certaine manière de donner corps à la maladie au moment même où l'on ne peut pas situer cette maladie au niveau du corps individuel; alors l'on invente, l'on découpe une sorte de grand corps fantasmatique qui est celui d'une famille affectée de tout un tas de maladies : maladies organiques, maladies non organiques, maladies constitutionnelles, maladies accidentelles, peu importe, du moment qu'elles se transmettent, c'est qu'elles ont un support matériel et du moment que l'on rejoint ainsi le support matériel, alors l'on a le substrat organique de la folie, un substrat organique qui n'est pas le substrat individuel de l'anatomie pathologique. C'est une sorte de substrat méta-organique, mais qui constitue le vrai corps de la maladie. (Heredity provides a way to give a body to the [mental] illness in a context where we cannot situate this illness in an individual body; so we invent it, we create a sort of phantasmic body which is one of a family affected by numerous illnesses: organic illnesses, nonorganic illnesses, constitutional illnesses, nonconstitutional illnesses, accidental illnesses, regardless; as long as they can be transmitted, they provide a material support and from the moment where we can access this material support, then we have the organic substrate of insanity, an organic substrate that is not the individual substrate of pathological anatomy. It is a sort of a meta-organic substrate, but that gives a real body to the illness.) (Foucault, 2003, p. 273; my translation)

Heredity establishes that specific illnesses can cause an illness of the same kind, or of any other kind, in descendants. Second, and somewhat complementarily, the psychiatric interview inserts the madman's or madwoman's madness into their own life story. It offers an opportunity for the psychiatrist to explore the events that characterized the madman's or madwoman's entire life. By

identifying what may constitute prodromal signs of madness, Foucault (2003) explained that the psychiatric interview situates the illness within the realm of pathology at an individual (biographic) level. Third, Foucault (2003) suggested that the psychiatric interview serves as some sort of a ritualistic transaction that occurs between the madman or madwoman and the psychiatrist. In exchange for a display of symptoms, the psychiatrist is able to remove the madman's/madwoman's moral responsibility and blameworthiness for the events having led to their confinement within the hospital (Foucault, 2003). Finally, by providing a venue where the last three mechanisms converge, the psychiatric interview situates madness in the realm of pathology and reasserts the role of medicine (and psychiatry) in its treatment. It seeks to extract from madmen and madwomen a confession or a drastic exhibition of symptoms, such as hallucinations or delusions, whereby no doubts can persist about the pathological origin of their behaviours. Furthermore, and somewhat cyclically, this overt exhibition of madness further justifies the need for confining madmen and madwomen and for their medical treatment. Because the reason for the confinement and treatment of madmen and madwomen originates in the domain of pathology, the psychiatric interview formalizes madness as an object of medical knowledge and asserts the role of the psychiatrist as the expert in its management. By having madness formalized as an object of medical knowledge through the psychiatric interview and other disciplinary processes, psychiatry establishes its expertise in the identification of the symptoms of madness, in the management of madmen and madwomen, and in the general conduct of humans (Foucault, 2003; McHoul & Grace, 1993).

Forensic psychiatric hospitals have frequently been described as disciplinary institutions (Holmes & Murray, 2011; J.-D. Jacob & Holmes, 2011a, 2011b). The normalizing techniques that operate within them, including surveillance, punishments, and training, seek to reform the

dangerous conduct of persons UST or NCRMD. The work of Goffman (1961) on total institutions and their effects on the self in terms of moral career, role dispossession, and mortification, is explored in the next section to explain how these techniques function at a local level to construct the identities of mentally ill persons. I also lean on Garfinkel's (1956) concept of degradation ceremonies to make sense of the RB hearing in the construction of these identities.

2.2.1.2. Psychiatric Hospitals and the Reconstruction of Identities

Goffman (1961) spent one year (1955–1956) in a federal American psychiatric hospital to study the social condition of hospital inmates. Within his ethnography, Goffman identified that the social condition of inmates there was not any different from the social condition of inmates detained in other institutions with similar characteristics, such as prisons, monasteries, and army barracks. He gave the name "total institutions" to this group of establishments. Similar to Foucault's (1975/1995) description of disciplinary institutions, Goffman (1961) explained that total institutions create a separation between the inside world of the institution and the outside world of the general public, thus allowing for intra-institutional societies that recreate a reality similar to mainstream society (Foucault, 2003) without having contact with it (Goffman, 1961). The inside/outside separation is further replicated within the confines of total institutions insofar as a marked separation exists between inmates and staff. Furthermore, in total institutions all facets of inmates' lives, including sleep, play, and work, are conducted in close proximity to other inmates (Goffman, 1961). These activities are carefully planned to meet the goals of the institution, which include reform, societal protection, penance, and community reintegration. The execution of activities is closely monitored and documented by institutional staff to ensure the successful completion of institutional goals (Goffman, 1961).

Goffman (1961) proposed that the institutionalization undergone by inmates makes possible the deconstruction and the reconstruction of their identities. He called this process the inmates' "moral career." *Moral career* refers to the oscillations between the intrapersonal and interpersonal effects of institutionalization on the conceptualization of one's self and the positioning of one's self in relations to others (Goffman, 1961). The mentally ill person's moral career takes shape through the tension that total institutions create between their domestic life, where personal liberty is abundant, and their institutional life, where personal liberty is quasi-nonexistent. This tension constitutes the foundation of therapeutic practices inherent in the psychiatric institutions where treatment plans have a single end goal, namely social reintegration (Goffman, 1961).

Before being admitted to psychiatric institutions, mentally ill persons hold social roles that shape and are shaped by their social status, occupation, friendships, family relationships, and leisure activities in which they participate. These roles produce the person's domestic identity, which is maintained through everyday interactions with the world (Goffman, 1959). Whereas the high degree of freedom inherent in the outside world allows for the identities of mentally ill persons to be defined by these roles, the limited degree of freedom within the psychiatric institution prevents their sustainability. Furthermore, and more importantly perhaps, Goffman (1961) explained that dispossessing mentally ill persons of the roles they held in the outside world is an integral part of the hospital therapeutics; it provides a blank slate for moulding their identity to the aims of the institution and the moral codes of society.

Goffman (1961) mentioned that one way mentally ill persons are dispossessed from their roles is to commit them to psychiatric hospitals by holding meetings at which the reasons for such a committal are evaluated by a panel of experts. Without expanding on the concept, he

alluded to how these ritualistic meetings resemble Garfinkel's (1956) "degradation ceremonies" because of the effect they have on the moral career of mentally ill persons. In forensic psychiatry, the notion of degradation ceremonies is very important, considering that RB hearings are venues during which the dangerousness of persons UST or NCRMD is assessed and the conditions they must follow are established to ensure the protection of the public (*CC*, 1985; Ontario Review Board [ORB], n.d.; TAQ, 2005).

2.2.1.2.1. Review Board Hearings and Degradation Ceremonies. The degradation ceremony is a ritual during which a person is degraded by a denouncing person in front of witnesses for the purpose of engaging them in an identity reconstruction process (Garfinkel, 1956). They are sociological phenomena inherent in every society, serving to solidify society's core by excluding certain persons who threaten its rules, moral codes, and hierarchies (Garfinkel, 1956; Lupton, 1999). An obvious example of a degradation ceremony is a criminal trial. However, as David Sibley (1995) explained, this type of social exclusion does not affect all persons in the same way:

> Exclusionary discourse draws particularly on color, disease, animals, sexuality, and nature, but they all come back to the idea of dirt as a signifier of imperfection and inferiority, the reference point being the white, often male, physically and mentally able person. (p. 14)

The utopian notion of a danger-free society is thereby associated with a homogeneous conception of Western societies, where the ideal is the autonomous, rational, and mentally and physically healthy person.

Garfinkel (1956) provided eight criteria that characterize degradation ceremonies:

1. The individual and the event having led to the degradation ceremony must both be perceived as being "out of the ordinary."
2. The individual and the event that have activated the degradation ceremony must have

been put in relation with other individuals and other events that are considered socially acceptable, so that witnesses can feel confident that the individual deserves to be discredited.

3. The denouncing person must associate themselves with witnesses present during the degradation ceremony so that the witnesses can consider the denouncing person to be one of theirs.
4. During the degradation ceremony the denouncing person must ensure that the social values having been violated by the individual are brought to the forefront.
5. The denouncing person must be able to speak as a member of society and share the same values as that society.
6. Witnesses must believe that the denouncing person shares these social values.
7. The denouncing person must create a distance between themselves and the person involved in the event leading to the degradation ceremony, and at the same time ensure that witnesses can also feel distant from this individual.
8. The physical configuration of the degradation ceremony must position the denounced individual at a specific spatial and temporal location, so that all witnesses can understand that the individual does not belong to the group of witnesses; that they are on the margins of it.

With these criteria in mind, RB hearings may be considered as degradation ceremonies. They represent key moments where the dangerous character of persons UST or NCRMD is examined and fixed, where their social exclusion is justified, and where their need for moral reform is legitimized (Domingue, Jacob, et al., 2020). Degradation ceremonies function by instilling a feeling of moral indignation in degraded persons (Garfinkel, 1956). Contrary to

feelings of shame and guilt that simply lead to social exclusion (Lepore et al., 2017), and fostered by an intense resentment toward the moral codes that have excluded them, moral indignation instills in degraded persons a willingness to reconstruct their selves. This willingness to act upon the self is the mechanism that permits degraded persons to engage in an identity reconstruction process, to conform to moral codes, and to reintegrate into society. The RB hearing as a degradation ceremony served as a point of origin for me, explaining why and to what extent persons UST or NCRMD needed to reconstruct their identities. To understand how procedures internal to the forensic psychiatric hospital reduced the dangerousness of persons UST or NCRMD, it was also imperative for me to mobilize Goffman's (1961) concept of "mortification."

2.2.1.2.2. Mortification. In psychiatric hospitals, mortification processes occur continuously, from the moment mentally ill persons are admitted till the moment they are discharged. Goffman (1961) wrote that admission rituals such as forced showers or searches ensure that every mentally ill individual is "shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations" (Goffman, 1961, p. 16). This ceremonial process serves to insert mentally ill persons into systems of surveillance, privileges, and punishments aimed at transforming their identity into one that is in line with institutional ideals. These institutional procedures, which resemble Foucault's (1975/1995, 2003) disciplinary technologies, operate on what Goffman (1961) named the "ward system." In psychiatric institutions, the ward system "consists of a series of graded living arrangements built around wards, administrative units called services, and parole statuses" (Goffman, 1961, p. 148). The functioning of the hierarchical ward system relies on the

graduation of mentally ill persons from restrictive wards to wards with higher levels of freedom; the end goal being reintegrating mentally ill persons into the community.

Each ward has its own set of rules and procedures, which are presented to mentally ill persons by staff as therapeutically indispensable components of their recovery:

> Once lodged on a given ward, the patient is firmly instructed that the restrictions and deprivations he encounters are not due to such blind forces as tradition or economy—and hence dissociable from self—but are intentional parts of his treatment, part of his need at the time, therefore an expression of the state that his self has fallen to. (Goffman, 1961, p. 149)

Therefore, the level of compliance mentally ill persons exhibit in relation to the institutional rules serves as a reflection of their rehabilitation and evokes the degree to which their identity has been moulded in line with institutional goals. Based on the mentally ill person's compliance with the rules of the institution, "the inmate will receive stringent punishments expressed in terms of loss of privileges; for obedience he will eventually be allowed to reacquire some of the minor satisfactions he took for granted on the outside" (Goffman, 1961, p. 148). This system of control ensures that the identities of mentally ill persons conform to ideals espoused by the psychiatric hospital. The discharge of mentally ill persons from psychiatric institutions and their reintegration into the community only takes place once the individual has fully embodied an identity congruent with the goals of the institution and the moral codes of society (Goffman, 1961). Although the reassignment of an inmate to specific wards can be rationalized in relation to the degree to which their behaviours comply to the rules enforced by staff such as nurses, it will never be presented to them as a reward or as a punishment, "but as an expression of [their] general level of social function" (Goffman, 1961, p. 149). The hierarchical ward layout and the tension created by the differential in personal freedom between wards can thereby be leveraged to enforce institutional rules without being directly labelled as a reward or a punishment.

Many nurse researchers in the domain of forensic psychiatric nursing have used Goffman's theory to comprehend the effects of professional nursing practices on mentally ill individuals (Corneau et al., 2017; Perron, 2012; Perron & Holmes, 2011). Perron's (2012) use of Goffman's concepts is particularly noteworthy for my project. She identified nursing documentation as a highly ritualized repertoire of information. It speaks, in part, to the various discourses at play in the reconstruction of mentally ill persons' identity in relation to the ideals of psychiatric institutions, and to the enactment of patients' moral careers during this process. Considering the importance of documentation practices in the fixing of identities (see 2.1), Goffman's theory has served as an indispensable tool for understanding how nurses working in forensic psychiatry act as anatomopolitical agents by participating in the identity reconstruction of dangerous persons UST or NCRMD. That being said, the anatomopolitical role of nurses in forensic psychiatry should not be dissociated from the biopolitical function of the forensic psychiatric hospital (Foucault, 2007). Indeed, the forensic psychiatric system needs to be conceptualized as a biopolitical institution, inasmuch as it, along with its employees and processes, ensures that society's general population is protected from dangerous persons UST or NCRMD. We need to think about the forensic psychiatric system and about forensic psychiatric nursing beyond the therapeutic rhetoric.

2.2.2. Biopolitics and the Forensic Psychiatric Specialty

The idea that humans could be regulated as a population emanated in the 18th century when the Western world saw important demographic growth, development of urban centres, and an increasing need for industrial workers (Foucault, 2007). Coupled with the novel practice of collecting statistics about populations measuring things like mortality rates, epidemics, and pathological phenomena, the new industrial/urban landscape allowed for the human species to become a biological domain in which medicine could intervene (Foucault, 1994, 2007). This left

the door open for psychiatry to treat madness, becoming the medical discipline that could ensure public hygiene and public safety (Foucault, 1994).

In this context, psychiatry entered the domain of law and justice, thereby creating a new subspecialty: forensic psychiatry. Up until the end of the 18th century, in judicial trials the question of insanity related only to whether or not the accused exhibited easily identifiable symptoms of dementia or fury, conditions said to alter a person's consciousness and rationality. However, at the turn of the 19th century, the judicial system referred a series of gruesome, high-profile murder cases to psychiatrists. This changed the relationship between psychiatry and the justice system (Foucault, 1999). In these particular murder cases, there were no apparent reasons to explain why perpetrators committed the crimes; fury and dementia were excluded as contributing factors, as were other rational motives such as adultery or jealousy. Foucault (1999) detailed, for example, the case of Henriette Cormier, a servant who, for no apparent reason, beheaded a neighbour's 19-month old child. When she was asked why she committed this horrendous act, Henriette simply replied "C'est une idée" (It was an idea; Foucault, 1999, p. 104; my translation). Faced with the fact that these murders were not motivated by fury or dementia, psychiatrists at the time proposed they constituted a new type of crime, namely a monomaniac homicide (Foucault, 1994). In its episodic singularity, a monomaniac homicide was seen as an event that represented an individual's first and only display of insanity—the mental illness was invisible without the crime, and the crime was inexplicable without the illness (Foucault, 1994). Such an association between crime and insanity legitimized psychiatrists in becoming "motive experts," the only professionals capable of understanding the link between monomaniac homicides and the "intérêts, . . . au caractère, aux inclinations [et] aux habitudes" (interests, . . .

character, inclinations, [and] habits; Foucault, 1994, p. 453; my translation) of the individuals committing them.

In light of 18th-century penal reform, having motive experts capable of identifying the association between interests, characters, inclinations, and habits of individuals—that is, risk factors associated with them—and their motiveless crimes was crucial for purposes of punishment and sentencing (Foucault, 1994, 1975/1995). Before this reform, convicts were violently and publicly punished to prevent other individuals from committing crimes. After the reform, however, punishment was now aimed at transforming the characters of deviant individuals through disciplinary means; the focus of punishment was transposed from the crime to the criminal. Magistrates were no longer giving sentences based on the nature and gravity of the crimes committed; their sentences were adapted to the conducts, tendencies, and motives of the individuals who committed those crimes. The aim of punishment was no longer terror, but rather the reform of deviancy (Foucault, 1975/1995). Psychiatrists as motive experts then became indispensable penal system actors. Without their expertise in identifying the conduct giving rise to motiveless crimes, monomaniac homicides, judges would not have been able to adequately punish these criminals (Foucault, 1994). Specifically, by placing the conduct of individuals having committed monomaniac homicides in the pathological domain, the judicial system could dissociate itself from motiveless criminals and relegate them to the psychiatric system for punishment in the form of confinement, medical treatment, and psychiatric rehabilitation.

Nevertheless, the idea of monomania as the rationalization for motiveless crimes was abandoned at the end of the 19th century for two apparent reasons (Foucault, 1994). First, the idea that insanity could exhibit itself singularly through crimes was dropped, and replaced by an expanded understanding of insanity. Insanity did not necessarily affect a person’s consciousness

or thought process; it could also manifest itself by affecting a person's instincts and personality. Secondly, monomania was also abandoned in light of the idea of degeneration. That is to say, symptoms of insanity might only become apparent during certain stages of an individual's development; the symptoms might also be attributable to heredity. Degeneration broadened the scope of psychiatry in the justice system. From this point forward, criminality and psychopathology were placed on a continuum whereby all crimes, regardless of their severity, could be linked to a person's psyche and family, and all psychopathologies could result in crime and danger. The expertise of psychiatrists in identifying risk factors indicative of danger, such as individuals' tendencies, instincts, personalities, and patterns of delinquency, could be deployed across the entire domain of criminality, rather than being limited to gruesome, high-profile, but inexplicable murders. In this way, psychiatry became a discipline capable of scientifically identifying who would engage in dangerous conduct, and it assumed the role of protecting the human species from internal threats: for example, persons UST or NCRMD.

Castel (1981/2011) explained that identifying risk factors indicative of danger stemmed from epidemiological observations conducted by the 19th century French psychiatrist, Bénédict Morel. After an analysis of epidemiological data, Morel deduced that individuals having already committed dangerous acts—such as threats, assaults, or murder—and individuals with mental illnesses had characteristics in common. They both engaged in socially and morally reprehensible behaviours like promiscuity and alcoholism, and sometimes they were malnourished. The association between these reprehensible conducts and the potential for dangerousness legitimized the surveillance and reform of mentally ill individuals based solely on the identification of risk factors, independent from the commission of dangerous acts. Risk therefore became dissociable from the concept of dangerousness. The latter is a characteristic

that can be attributed to an individual having already committed a dangerous act such as threat, assault, or murder. However, the former merely constitutes a probability determined by the relation between abstract, morally or socially reprehensible factors such as a person's diagnostic, behavioural, sociodemographic, or socioeconomic situation, and their potential for dangerous conduct.

2.2.2.1. Epistemologies of Risk

The concept of risk has been studied extensively from various cultural, social, and political angles over the past four decades. In an effort to succinctly frame the different tangents taken by scholars studying risk, Lupton (1999) proposed a taxonomy-like arrangement of epistemological approaches to risk. She explained that social science approaches to the concept of risk can be placed on a continuum that ranges from a purely realist approach to a strong constructionist approach (Figure 2). Somewhere along this continuum lies a weak constructionist conception of risk.

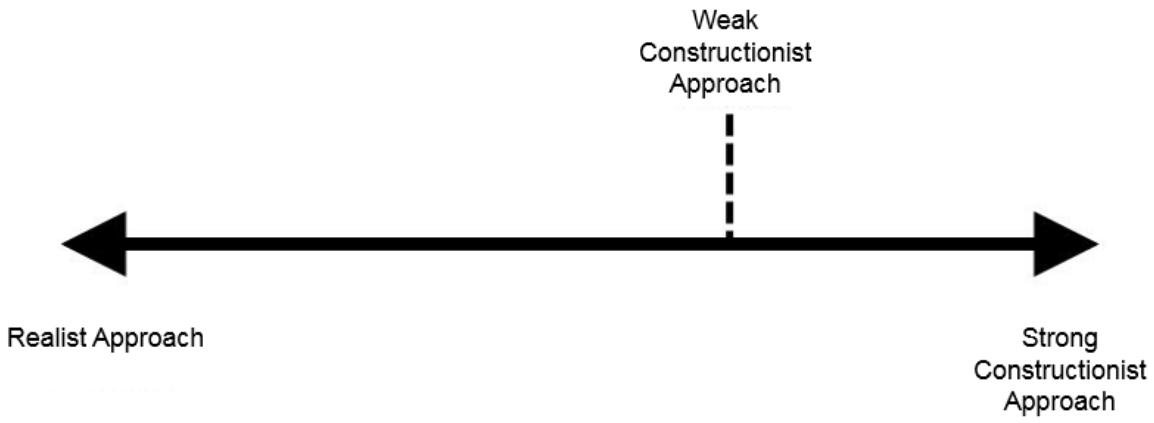

Figure 2. Epistemological approaches to risk. *Source:* Lupton, 1999.

Lupton (1999) suggested that persons who adopt a realist approach tend to see risk as being objective, something that can be measured. Although realists accept that factors like social

and cultural contexts can taint the objective measurement of risk, for them such biases can also be measured and excluded from risk calculations. At the other end of the risk continuum, Lupton (1999) positioned the strong constructionist approach. This approach considers risk to be a socially constructed concept, which only exists as a result of circumscribed discourses that maintain some sort of social hierarchy and hegemony. The notion of risk and the assessment of risk serve as tools to govern the conduct of individuals (O'Byrne, 2008). Lupton's (1999) last epistemological position to risk is the weak constructionist approach. This approach is rooted in an understanding that risk is an objective hazard, threat, or danger modulated by, and not dissociable from, the culture and cultural taboos—such as adultery, alcoholism or promiscuity—of the society in which it occurs (M. Douglas, 1992; Lupton, 1999).

In forensic psychiatry, a variety of risk assessment tools exists, including the Historical, Clinical, Risk Management-20 (HCR-20) tool and the Violence Risk Appraisal Guide (VRAG). These tools, stemming from the realist approach to risk, are used to determine which person UST or NCRMD poses a risk and in is need of detention, supervision, and reform; and which person may safely reintegrate back into society (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015). These are biopolitical technologies that aim to protect society against dangerous persons UST or NCRMD. They are also foundational to the anatomopolitical function of the forensic psychiatric system, to the extent that their results legitimize the implementation of techniques—surveillance, confinement, mandatory treatment—to control and reform the conduct of persons UST or NCRMD.

In summary, this theoretical framework is useful for understanding the forensic psychiatric system as an institution that produces specific identities for persons UST or NCRMD as a way to protect the public. Such a conceptualization is important 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” (Goffman, 1961, p. 89). The institutions that make up the forensic psychiatric system, namely the forensic psychiatric hospital and the RB, are biopolitical institutions in that they regulate the level of risk to which society is exposed by confining, supervision, and reforming dangerous persons UST or NCRMD.

Chapter 3: Literature Review

The following review paints a picture of some current knowledge(s) about forensic psychiatry, persons UST or NCRMD, and forensic psychiatric nursing in relation to mental health review boards (RB). The review comprises relevant pieces of scientific, legal, and grey literature. Most of the scientific literature was compiled from searches of the PubMed, CINAHL, and PsychINFO databases. Key words and phrases used in these searches included a combination of "psych* or mental health," "correction* or forensic," "nurs*" and "review board or mental health tribunal." To make sense of the Canadian forensic psychiatric system, and more precisely the legal literature associated with RB hearings, I relied mainly on the *Criminal Code* of Canada (*CC*, 1985), the *Not Criminally Responsible Reform Act* (2014), and select Supreme Court of Canada (SCC) judgements, namely *R v Swain* (1991) and *Winko v British Columbia* (1999). The review of these pieces of case law pushed me to branch out and review other legal literature cited within them, such as the judgement in *R v Demers* (2004). Finally, pieces of grey literature, such as the Latimer and Lawrence (2006) report and the documents available on provincial RB websites, were included in the review as needed, to contextualize the empirical literature and to provide pragmatic relevance to the legal literature. The literature review comprises four sections: "Review Boards and their Hearings," "Persons UST or NCRMD," "Risk and Its Assessment," and "Forensic Psychiatric Nursing."

3.1. Review Boards and Their Hearings

The *CC* (1985) describes a mental disorder as being "a disease of the mind" (s 2). Although a majority of persons with mental disorders are judged and sentenced within the general criminal justice system (Miladinovic & Lukassen, 2015), others may be found UST or NCRMD (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015; Latimer & Lawrence, 2006). A key tenet of the Canadian justice system resides in the necessity for an accused to be able to distinguish right

from wrong in order for them to be found guilty of their involvement in a crime. This guiding principle was highlighted in successive judgements made by the SCC where emphasis was given to the need of "moral blameworthiness" for persons to be found criminally responsible for a criminal act or for omitting to act when they should have (*R v Oommen*, 1994; *R v M (CA)*, 1996; *Winko v British Columbia*, 1999). Relatedly, section 16(1) of the *CC* (1985) stipulates that "no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong." In other words, if the mental disorder of an accused caused their moral code to be altered to the point where they were unable to distinguish between right and wrong, then, and only then, they might be found not criminally responsible by reason of mental disorder.

The mental disorder of an accused might also prevent them from taking part in their own trial, in which case a judge might find them unfit to stand trial. Section 2 of the *CC* (1985) defines *unfit to stand trial* as being:

> . . . unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to
>
> (a) understand the nature or object of the proceedings,
>
> (b) understand the possible consequences of the proceedings, or
>
> (c) communicate with counsel.

Notwithstanding the etiology of the underlying medical condition rendering a person UST or NCRMD, to protect the public from dangerous persons the court may, after finding a person UST or NCRMD, either (a) hold a disposition hearing and issue a disposition with the various conditions, or (b) let a provincial RB hold a disposition hearing and make a disposition

(*CC*, 1985, s 672.45(1), s 672.47(1)). Provincial RBs are composed of no fewer than five members appointed by the lieutenant governor of the province (*CC*, 1985, s 672.38(1)) and

> . . . have at least one member who is entitled under the laws of a province to practise psychiatry and, where only one member is so entitled, at least one other member must have training and experience in the field of mental health, and be entitled under the laws of a province to practice medicine or psychology. (*CC*, 1985, s 672.39)

The chairperson of the board must either be a federal court or superior provincial court judge, a retired judge of such courts, or have the qualifications to be appointed to such courts (*CC*, 1985, s 672.4(1)). The quorum of an RB is "constituted by the chairperson, a member who is entitled under the laws of a province to practice psychiatry, and any other member" (*CC*, 1985, s 672.41(1)). The RBs must comprise an odd number of members, since RB dispositions are issued through a majority vote (*CC*, 1985, s 672.42). In Ontario, RB members are appointed for two-, three- or five-year terms (Government of Ontario, n.d.). The RB members travel across the province and participate in a handful of hearings every year. Therefore, the membership for a person UST's or NCRMD's RB hearing may vary from year to year (Government of Ontario, n.d.).

During RB hearings, the person UST or NCRMD, their counsel, a lawyer representing the Attorney General, and a representative of the forensic hospital—often, the person UST's or NCRMD's treating psychiatrist—convene to present arguments in order to determine whether the person UST or NCRMD represents a significant threat to the safety of the public and, if such a determination is made, to discuss the conditions necessary to maintain the safety of the public (*CC*, 1985, s 672.5(3), s 672.5(9), s 672.5(11); Latimer & Lawrence, 2006). Although rarely explicitly mentioned in the scientific and grey literature about Canadian RBs, the main piece of evidence provided to the RB in making this determination originates from the "expert report" prepared by the treating psychiatrist of the person UST or NCRMD on behalf of the hospital

(Crocker, Nicholls, Charette, et al., 2014; Livingston, Crocker, et al., 2016; ORB, n.d.; TAQ, 2005; Wilson et al., 2015). This report includes sociodemographic and clinical information about the person UST or NCRMD in addition to information specific to the (static and dynamic) risk factors that render the person a significant threat to the safety of the public or not (Crocker, Nicholls, Charette, et al., 2014; Wilson et al., 2015). Without specifically explaining how, Wilson et al. (2015), and Crocker, Charette, et al. (2015) are among the few researchers to note that health care professionals other than the treating psychiatrist (e.g., nurses, psychologists, case managers, or social workers) may contribute to the production of the expert report. Nevertheless, the way in which the clinical practice of these other health care professionals is used to create the expert report and to support the hospital's position during RB hearings is largely unexplored. Such an exploration reveals itself to be crucial in light of Crocker, Charette, et al.'s (2015) finding that 86.7 percent of recommendations made in these expert reports were upheld by RBs in Canada as a whole, and 92 percent in Ontario.

3.1.1. Review Board Dispositions

In light of the evidence presented at the hearing, including the expert report, if members of the RB determine that a person UST or NCRMD represents a significant threat to the safety of the public, they have the choice of issuing two types of dispositions: a "detention order" or a "conditional discharge order" (*CC*, 1985, s 672.54). The type of disposition they choose and the conditions they decide to include in it is guided by principles outlined here:

> When a court or Review Board makes a disposition, . . . it shall tak[e] into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused. (*CC*, 1985, s 672.54)

The phrase "which is the paramount consideration" was added to the *CC* in 2014 after the *Not Criminally Responsible Reform Act* was given royal assent. This suggests that the four

factors evoked in the preceding sentence are not equivalent and it emphasizes that the safety of the public (a communal good) must have precedence over the individual needs of persons UST or NCRMD.

When an RB issues a detention order, it orders a person UST or NCRMD to be detained in custody within a specific hospital and to comply with a set of conditions (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006). These conditions vary on a case-by-case basis and may include provisions whereby the person UST or NCRMD may, with the approval of the hospital administrator, enter the community and, on occasion, even reside in it (Latimer & Lawrence, 2006; ORB, 1995). Although detention orders serve to detain persons UST or NCRMD within hospitals, the RB may delegate some of their authority to hospital administrators: "the hospital administrator has the power to increase or decrease the restrictions on the [UST or] NCRMD accused" (Latimer & Lawrence, 2006, p. 3). This act of delegation allows hospitals to increase and decrease the liberties of persons UST or NCRMD in accordance with the conditions listed in the detention order.

If the RB decides to issue an order for a conditional discharge from the forensic psychiatric hospital, persons UST or NCRMD are not detained in custody within the hospital. However, they must abide by certain conditions (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006). These conditions vary. For example, persons UST or NCRMD are compelled to be supervised by a forensic psychiatric hospital while residing at a designated location outside the hospital. They may also be required to refrain from consuming alcohol or drugs, submit samples of urine for drug or alcohol analysis, follow therapeutic recommendations, report to a designated person at the hospital on a defined schedule, refrain from possessing weapons, and

keep the peace and limit contacts with victims (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006).

The main difference between detention orders and conditional discharges seems to be that, under the former, persons UST or NCRMD can legally be involuntarily detained in hospitals without the need to rely on provincial mental health Acts (*CC*, 1985, s 672.57). Thus, if a person UST or NCRMD residing in the community while under a detention order needs to be returned to the hospital, the hospital may issue a warrant of committal (the so-called Form 49) compelling peace officers to return the person UST or NCRMD to the hospital. If this same person had been issued a conditional discharge, the hospital would have to leverage specific provisions within their provincial mental health Act (via a Form 1 or Form 3, in Ontario) to involuntarily detain them.

The RBs can also determine that a person UST or NCRMD represents no significant threat to the safety of the public. In that case, the process RBs must use for persons UST is different than the one it must use for persons NCRMD. For the latter, the RB would order an absolute discharge, which would, as its name says, absolutely discharge a person from the forensic psychiatric hospital and the supervisory purview of the RB.

However, the RB may not grant a person UST with an absolute discharge even if RB members find that the person no longer represents a significant threat to the safety of the public (*CC*, 1985, s 672.54). This problem was brought before the SCC in *R v Demers* (2004), where the accused challenged the constitutionality of various section of Part XX.1 of the *CC*. He argued that, in the event he never became fit to stand trial, the law allowed the RB to keep him indefinitely under their purview. In this case, the SCC determined that

> . . . the continued subjection of an unfit accused to the criminal process, where there is clear evidence that capacity will never be recovered and there is no

> evidence of a significant threat to public safety, makes the law overbroad because the means chosen are not the least restrictive of the unfit person's liberty and are not necessary to achieve the state's objective.

Specifically, the judgement indicated that

> . . . Part XX.1 deals unfairly with the permanently unfit accused who are not a significant threat to public safety. The regime does not provide for an end to the prosecution. Permanently unfit accused are subject to indefinite conditions on their liberty, of varying degrees of restrictiveness, resulting from the disposition orders of the Review Board or the court.

R v Demers required parliament to review Part XX.1 of the *CC* and to include a section whereby courts could order an absolute discharge for persons UST who are permanently unfit and no longer pose a significant threat to the safety of the public. Consequently, in 2005, after the proclamation of Bill C-10, section 672.851 was inscribed in the *CC* (1985):

> The Review Board may, of its own motion, make a recommendation to the court that has jurisdiction in respect of the offence charged against an accused found unfit to stand trial to hold an enquiry to determine whether a stay of proceedings should be ordered if
>
> . . .
>
> (b) on the basis of any relevant information, including disposition information within the meaning of subsection 672.51(1) and an assessment report made under an assessment ordered under paragraph 672.121(a), the Review Board is of the opinion that
>
> (i) the accused remains unfit to stand trial and is not likely to ever become fit to stand trial, and
>
> (ii) the accused does not pose a significant threat to the safety of the public.

The inclusion of this language within the *CC* (1985) appears to correct the section 7 violation of the *Charter of Rights and Freedoms* denounced in *R v Demers*. If a person is permanently UST and deemed to no longer represent a significant threat to the safety of the public, the RB must refer the person UST back to the court, thereby giving the latter the possibility of "staying the proceedings" (*CC*, 1985, s 672.851(7)). In such event, all dispositions

made in respect of the person UST are invalidated (*CC*, 1985, s 672.851(9)), which is somewhat equivalent, from a liberties standpoint, to an absolute discharge. Contrastingly, as mentioned previously, under section 672.54 of the *CC* (1985), if an RB cannot establish that a person NCRMD represents a significant threat to the safety of the public, it must order an absolute discharge. This principle was emphasized in the *Winko v British Columbia* (1999) SCC judgement. In this case, the accused challenged section 7 of the *Charter of Rights and Freedoms* by arguing that the notion of "significant threat to the safety of the public" was unconstitutionally vague and that Part XX.1 inherently assumed them to be dangerous, thereby putting the onus on them to prove lack of dangerousness. The accused also challenged section 15(1) of the *Charter of Rights and Freedoms* arguing that the restrictions imposed on them by the RB were discriminatory considering their sentence would have already been completed should they had been found guilty and sentenced for their crimes, as opposed to being found NCRMD. The SCC denied the appeal and, among other things, specified that

> Under s 672.54(a), the court or Review Board must direct that the accused be discharged absolutely if it is of the opinion that "the accused is not a significant threat to the safety of the public." This provision must be read with the preceding instruction that the court or Review Board must make the order that is the least onerous and least restrictive to the accused, and in light of the principle that the only constitutional basis on which the criminal law may restrict the liberty of an NCR[MD] accused is the protection of the public from significant threats to its safety. Read in this way, it becomes clear that unless it makes a positive finding on the evidence that the NCR[MD] accused poses a significant threat to the safety of the public, the court or Review Board must order an absolute discharge.

To paraphrase: the only legal justification for "which the criminal law may restrict the liberty" of a person NCRMD is the need to protect the public from the "significant threat" that that person poses. *Winko v British Columbia* (1999) also gave guidance to provincial RBs in defining the meaning of this term. This definition was later included in the *CC* (1985) when parliament passed the *Not Criminally Responsible Reform Act* (2014):

> For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public—including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent. (s 672.5401)

Specifically, *Winko v British Columbia* (1999) indicated that courts and RBs should differentiate between a "threat to the safety of the public" and a "*significant* threat to the safety of the public," relying on four factors:

> These include: the nature of the harm that may be expected; the degree of risk that the particular behaviour will occur; the period of time over which the behaviour may be expected to manifest itself and the number of people who may be at risk. (para. 139)

In other words, if, at the end of an RB hearing, members of the RB are unable to determine, upon consideration of the above-mentioned factors, that a person NCRMD represents a significant threat to the safety of the public, they must order an absolute discharge.

3.1.2. Rules and Procedures of RB Hearings

Although determining the rules and procedures governing each provincial and territorial RB and their hearings is the responsibility of each province or territory (*CC*, 1985, s 672.38(2), s 672.43), certain guiding principles are evident in the *CC*'s provisions. Here, I detail three that I find important.

First, the *CC* (1985) spells out the composition of the RB and stipulates that its decisions are made as a result of a majority vote. To make such decisions, it specifies that the RB has "all the powers that are conferred by sections 4 and 5 of the *Inquiries Act* on persons appointed as commissioners under Part I of that Act" (*CC*, 1985, s 672.43). This provision allows the chairperson of the RB to summon witnesses and require them to provide any evidence (oral, written, or documentary) required to conduct the RB hearing (*Inquiries Act*, 1985, s 4).

Secondly, the chairperson of the RB has the power to exclude persons found UST or NCRMD from their RB hearing:

> (i) where the accused interrupts the hearing so that to continue in the presence of the accused would not be feasible,
>
> (ii) on being satisfied that failure to do so would likely endanger the life or safety of another person or would seriously impair the treatment or recovery of the accused, or
>
> (iii) in order to hear, in the absence of the accused, evidence, oral or written submissions, or the cross-examination of any witness concerning whether grounds exist for removing the accused pursuant to subparagraph (ii). (*CC*, 1985, s 672.5 (10)(b))

So, despite having the right to be present during their RB hearings (*CC*, 1985, s 672.5(9)), persons UST or NCRMD may be excluded from their hearings if, according to the chairperson of the RB, they interrupt the RB procedures or if they behave in a way that may endanger the personal safety of another person in the RB hearing.

Thirdly, and somewhat correspondingly, the RB also has the right to exclude the public from the RB hearing if it is in the best interest of the person UST or NCRMD and not contrary to the public interest (*CC*, 1985, s 672.5(6)).

Each province is responsible to set out their own rules and procedures (*CC*, 1985, s 672.44(1)) and publish them in the *Canada Gazette* (*CC*, 1985, s 672.44(2)). Some RBs, such as those of Ontario (ORB) and Québec (TAQ), make theirs available on their website (ORB, n.d.; TAQ, 2005). The Ontario RB's (ORB, n.d., p. 1) Rules of Procedure lists a General Principle as its first rule. It states that "these Rules shall be liberally construed to secure the just, most expeditious, and least expensive determination of every meeting before the Review Board." This sets the tone for the rest of the document. Its emphasis on "justice," "time," and "money" provides a framework for all its other rules. For example, Rule 6, stating that "all procedures are to be in French and/or English" (ORB, n.d., p. 2), ensures the just conduct of a hearing. Rule 28,

requiring parties to notify the ORB pre-emptively if they expect a hearing to last more than two hours, allows for a timely flow of hearings. As a final example, Rule 34 permits cost-effectiveness, stating that "the Review Board is not responsible for the payment of any costs, witness fees, or disbursements which may arise from the preparation of any report or attendance at hearings before the Review Board" (ORB, n.d., p. 8). In the event where no rules exist to clarify novel matters being addressed before the ORB, the Rules of Procedure gives the chairperson of the RB hearing the authority to determine the appropriate procedure to be taken (ORB, n.d., p. 1), most likely keeping in mind the three-factor guiding principle (justice, time, and money).

These rules of procedure provide guidelines necessary for the efficient unfolding of RB hearings, but they do not describe the actual way a RB hearing unfolds. Up until very recently, the process by which RB hearings took place still represented a gap in the empirical literature on RBs in Canada. A recent ethnographic study conducted by a group of researchers (Bernheim et al., 2020) documented the form and content of interactions between actors during RB hearings in Québec.

3.1.3. Procedural Justice

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]" (Tyler, 2003, p. 284). Two elements seem to define whether decisions rendered by authorities (e.g., judges, police, or administrators) are perceived to be procedurally just. First, the decision needs 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 (Tyler, 2003). Second, and somewhat complimentarily, 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 (Tyler, 2003). Based on recent research into the perception of stakeholders, mental health courts are generally considered procedurally just (Canada & Watson, 2013; Poythress et al., 2002; Wales et al., 2010). This is most likely because of the courts' ability to engage (alleged) offenders in conversations with legal and medical professionals with whom they may have a high power differential (Livingston, Crocker et al., 2016).

Procedural justice is said to produce certain desired effects on offenders with mental disorders. These effects include an increased adherence to treatment (Canada & Hiday, 2014); a reduction in psychiatric symptoms (Kopelovich et al., 2013); a reduced involvement in the criminal justice system (Pratt et al., 2013); an increased compliance with judicial decisions rendered; and community reintegration of these offenders (Canada & Hiday, 2014; Cascardi et al., 2000; Pratt et al., 2013; Slocum et al., 2016).

Notwithstanding the recent above-mentioned interest in procedural justice and its effects in mental health courts, the perception of procedural justice in parajudicial tribunals, such as RB hearings, seem to have been underexplored, especially in Canada. To this date, apparently only one study—Livingston, Crocker, et al., 2016—has explored the perceptions of RB actors and stakeholders about RB hearings with a procedural justice framework. Such actors and stakeholders include persons under the supervision of the RB, family members, mental health professionals, and legal professionals. Generally, the authors of this qualitative study find that RB hearings are perceived as procedurally just by RB actors and stakeholders. Yet certain factors may impede such a perception, including the adversarial tone of the hearing, inaccuracies in the expert reports submitted to the RB, and the punitive sentiment associated with the dispositions rendered (Livingston, Crocker, et al., 2016).

Other recent Canadian studies of stakeholder perception of procedural justice in parajudicial mental health tribunals, such as Ontario's Consent and Capacity Board (Dhand, 2009; Paul et al., 2020), have shown similarly nuanced results. When offenders with mental disorders are given the opportunity to present their point of view, their compliance increases with decisions issued by parajudicial tribunals, such as dispositions and community treatment orders, and so does their adherence to treatment plans. Similar results are shown when procedural changes are made that increase the perception of offenders' respect, dignity, and objectivity.

In addition to providing suggestions for changes to RB hearings, such as the use of "strength-based risk assessment tools," Livingston, Crocker, et al. (2016) posited that changes in the hospital environment and in the way mental health professionals interact with persons NCRMD prior to their RB hearings may also be warranted. Specifically, they proposed that "treatment team members should consider meeting with people found NCRMD 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" (Livingston, Crocker, et al., 2016, p. 181). Further, this intervention might help the person NCRMD build and maintain a therapeutic alliance with mental health care professionals.

3.2. Persons UST and NCRMD

In 1992, Canadian legislation regarding mentally disordered offenders was changed, leading to the current iteration of Part XX.1 of the *CC*. Since then, two multiprovince studies painting a picture of persons UST or NCRMD have been conducted. The first, conducted because of a recommendation formulated by the Standing Committee on Justice and Human Rights, described mostly demographic information about persons found UST or NCRMD in Canada (Latimer & Lawrence, 2006). The second, the National Trajectory Project (NTP), had nine specific goals including demographic components and components aimed at understanding the trajectories of

persons NCRMD as they entered and exited the Canadian forensic psychiatric system (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015). The NTP was particularly interested in identifying interprovincial differences relating to the forensic psychiatric system in the provinces of British Columbia, Québec, and Ontario. In-depth sociodemographic, clinical, and legal data about the Canadian UST or NCRMD population was very scarce before these two studies.

Latimer and Lawrence (2006) analyzed data relating to 1,228 cases of persons UST or NCRMD dated between 1992 and 2004 from seven Canadian provinces and territories (Alberta, British Columbia, Nunavut, Ontario, Prince Edward Island, Québec, and Yukon). Of all RB cases in Canada, 88 percent were heard within these seven jurisdictions, thereby establishing that results from their study were representative of the Canadian population of persons UST or NCRMD.

Crocker, Nicholls, Seto, Côté, Charette, et al. (2015) focused the NTP study on data (N = 1,800) from British Columbia (n = 1,094), Québec (n = 484), and Ontario (n = 222) sampled between 2000 and 2005. The authors retrospectively longitudinally followed individual cases until the end of 2008. They justified their jurisdictional selection by suggesting that the three provinces were the most populated and encompassed the most cases of persons NCRMD. They also mentioned that the organization of forensic psychiatric services in each of these provinces differed, allowing for interprovincial comparisons to be made: “Ontario represents a middle ground between forensic systems in Québec (highly distributed, with many nonforensic professionals involved) and British Columbia (specialized and centrally coordinated by a single organization)” (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015, p. 99). In brief, these two studies taken together allow for a general portrait to be painted of persons UST or NCRMD in Canada between the years 1992 and 2008.

3.2.1. Legal and Sociodemographic Characteristics

Despite the fact that NCRMD determinations account for less than 1 percent of the cases tried before Canadian criminal courts (Miladinovic & Lukassen, 2015), Latimer and Lawrence (2006) demonstrated that the population of persons under the supervision of RBs grew by 2,500 individuals between 1992 and 2004. They estimated that by 2015 this population would grow to around 4,500 individuals. The growth rate was not homogeneous across the country (Miladinovic & Lukassen, 2015). For example, in 2004/2005, Québec saw their forensic population grow by more than 400 individuals for a population of 7.58 million, while the British Columbia forensic population only grew by around 50 individuals for a population of 4.2 million (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015). Crocker, Nicholls, Seto, Côté, Charette, et al. (2015) suggest that this interprovincial difference may be linked to a cross-country heterogeneous application of *CC* provisions on mental disorders.

Sociodemographically, persons in the forensic psychiatric system generally resembled the population of persons within the criminal justice system (Latimer & Lawrence, 2006). One striking difference, however, was the underrepresentation of Indigenous peoples in the forensic psychiatric system:

> Although Aboriginal status is neither accurately nor consistently reported within existing criminal justice system data, it is clear that Aboriginal peoples are overrepresented within most aspects of the justice system including arrests, convictions, and custodial sentences. However, only 4 percent of accused within the Review Board system were reported to be Aboriginal, which is relatively consistent with the proportion of Aboriginal people in the Canadian population (i.e., approximately 3 percent). (Latimer & Lawrence, 2006, pp. 13–14)

Latimer and Lawrence (2006) speculated that this underrepresentation can be linked either to the fact that data from Manitoba and Saskatchewan were missing from the sample, or that mental disorders were not often brought up or recognized when in the criminal trials of Indigenous peoples. In the same vein, Crocker, Nicholls, Seto, Charette, Côté, et al. (2015)

wrote: “this could reflect the lower access to appropriate legal representation, a general bias in the attribution of criminal intent or the possibility that Aboriginal people with an SMI [serious mental illness] are less likely to get into the criminal justice system” (p. 114). Although Latimer and Lawrence (2006) appeared to phrase the congruence between the general proportion of Indigenous persons in Canada and their representation in the Canadian forensic psychiatric system as somewhat of a celebration, this statistic, coupled with the increasing overrepresentation of Indigenous peoples in the criminal justice system (Statistics Canada, 2019), seems to indicate that Indigenous peoples are perhaps excluded from the Canadian forensic psychiatric system.

3.2.1.1. Age, Sex, Nationality, and Spoken Language

The average age of persons UST or NCRMD was 36.56 years, and women represented about 16 percent of the samples (Crocker, Nicholls, Seto, Charette, Côté, et al., 2015; Latimer & Lawrence, 2006). These numbers appear to remain rather unchanged over time (Miladinovic & Lukassen, 2015). The NTP researchers untangled particularities relating to the nationality of persons NCRMD, finding that persons NCRMD born outside of Canada represented one-third (34 percent) of their sample (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015). Sixty-one percent of their sample was English-speaking, 27 percent spoke French, and 11.6 percent spoke another language. As expected, persons NCRMD from the province of Québec differed from the overall sample as it relates to language; 54.6 percent spoke French, 33.7 percent spoke English, and 11.7 percent spoke another language (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015).

3.2.1.2. Index Offences and Criminal Recidivism

More than half of persons UST or NCRMD in the samples studied had already been convicted of at least one other criminal offence prior to the commission of the index offence for which they were found UST or NCRMD (Latimer & Lawrence, 2006). However, Crocker, Nicholls, Seto,

Charette, Côté, et al. (2015) found that only 8.2 percent of persons NCRMD in their aggregated three-province sample had a previous NCRMD finding.

When Latimer and Lawrence (2006) and the NTP researchers (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015) conducted their surveys, they gathered data relating to the most serious index offences allegedly committed by persons UST or NCRMD. The reason for this *most serious* designation is that, on occasion, findings of UST or NCRMD are in response to a series of offences. Latimer and Lawrence (2006) separated index offences into three categories: violent offences, sexual offences, and nonviolent offences. Violent offences included homicides, attempted murders, major assaults, assaults, robberies, criminal harassment, threats, and other violent offences. Sexual offences included sexual assaults and other sexual offences. Nonviolent offences included arsons, break and enters, thefts, weapons offences, and other nonviolent offences.

Three-quarters of index offences (72.6 percent) committed by persons UST or NCRMD were considered to be violent (Latimer & Lawrence, 2006). Crocker, Nicholls, Seto, Charette, Côté, et al. (2015) explained that "offences against the person accounted for 64.9 percent of index offences, property offences for 16.9 percent, and other *Criminal Code* violations for 18.2 percent" (p. 109). Persons UST were more likely than persons NCRMD to have been charged with a sexual offence (10.6 percent versus 4.3 percent) or a nonviolent offence (30.8 percent versus 19.2 percent). Persons NCRMD were more likely than persons UST to have been charged with a violent offence (76.5 percent versus 58.5 percent; Latimer & Lawrence, 2006). Differences also existed based on the age, sex, and Indigenous status of the accused. Indigenous persons and youth having been found UST or NCRMD were more likely to have been charged with an offence of a sexual nature than non-Indigenous persons (11.3 percent versus 5.4 percent)

and other adults (30.1 percent versus 12 percent), whereas adults and males were more likely to have been charged with violent and sexual offences. By using the Uniform Crime Reporting tool and the Crime Severity Index, a different way of attributing severity to index offences, Crocker, Nicholls, Seto, Charette, Côté, et al. (2015) were able to identify that Québec had a significantly lower index offence severity than British Columbia or Ontario ($p = 0.002$).

The NTP researchers also studied criminal recidivism of persons who had been found NCRMD. Their results demonstrated that "the three-year follow-up recidivism rates . . . of people found NCRMD was 17 percent following index verdict, 20 percent following conditional discharge and 22 percent following absolute discharge" (Charette et al., 2015, p. 131). Various factors were associated with recidivism, including personality disorders, substance use disorders, and a history of involvement with the criminal justice system. Nevertheless, they explained that the rates of recidivism in persons NCRMD "are lower than rates of recidivism found among a general offender population (34 percent) and much lower than rates found among an inmate population treated for mental disorders (70 percent)" (Charette et al., 2015, p. 131). By comparing recidivism rates of persons NCRMD under the supervision of the RB with the recidivism rates of persons NCRMD for whom an absolute discharge was granted, Charette et al. (2015) were able to determine that supervision provided by the "RB significantly reduced the risk of recidivism by 0.77 for all types of reoffences" (p.130). The authors explained that this reduction might also be attributable to the fact that the supervision provided by the RB (and by hospitals) protects persons NCRMD from being charged for minor offences such as theft, drug use, or vandalism—because they may be hospitalized instead of prosecuted.

3.2.1.3. Major Mental Illness

Latimer and Lawrence (2006) and the NTP researchers both noted that the most common diagnoses for persons UST or NCRMD were psychotic-spectrum disorders (between 52.7

percent and 70.9 percent) or affective disorders (between 23.2 percent and 23.7 percent; Crocker, Nicholls, Seto, Charette, Côté, et al., 2015). They also demonstrated that persons UST or NCRMD had comorbid substance use disorders (between 28.8 percent and 30.8 percent) and personality disorders (between 10.6 percent and 17.7 percent). In the NTP research, 72 percent of persons found NCRMD had at least one prior hospitalization for a mental health disorder, thereby suggesting that a finding of NCRMD inserts itself in a trajectory of mental illness that was initiated before the index offence was committed (Crocker, Nicholls, Seto, Charette, Côté, et al., 2015). Latimer and Lawrence (2006) report some significant differences in the major mental illness profiles of Indigenous persons UST or NCRMD when compared to their non-Indigenous counterparts. Specifically, they wrote, "Aboriginal accused were less likely than non-Aboriginal accused to have been diagnosed with the common diagnoses (i.e., schizophrenia, affective disorders) and much more likely to have been diagnosed with mental retardation and substance abuse disorders" (p. 21).

3.2.2. Persons UST or NCRMD, Review Board Hearings, and Review Board Decisions

The RB hearings are significant events in the lives of persons UST or NCRMD. The decisions rendered by RBs constrain the liberties of persons UST or NCRMD, mandating them to comply with the various conditions listed in their disposition and to be supervised by designated forensic psychiatric hospitals. Latimer and Lawrence (2006) reported that most persons NCRMD (60 percent) remain under the supervision of RBs for over five years. That said, after analyzing the trajectory and outcomes of persons NCRMD through the Canadian forensic system (n = 6,748 RB decisions), Crocker, Charette, Seto, Nicholls, Côté, et al. (2015) brought to light significant interprovincial differences in the length of time persons NCRMD spend under the supervision of the RB: "after 5 years [under the supervision of the RB], 19 percent of NCRMD-accused people were still under the supervision of the RB in Québec, 31 percent in British Columbia and 58

percent in Ontario" (p. 121). Other individual factors increasing a person NCRMD's time spent under a detention order included a higher number of past offences, a psychotic spectrum disorder, Indigenous status (70 percent of Indigenous peoples spent at least 10 years versus 22 percent for non-Indigenous peoples), male sex, and a sexual or violent index offence (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006; Livingston, Wilson, et al., 2003).

Researchers also tracked the various actors who participated in RB hearings, as observers or official parties (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006). While there are some interprovincial differences, it appears that the person UST or NCRMD, their lawyer, their psychiatrist, and a representative of the hospital seem generally to be parties at RB hearings (Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006). Albeit less frequently, other actors occasionally participated as observers during RB hearings. These included family members (between 13.7 percent and 15.2 percent), health care professionals (between 16 percent and 38.3 percent), victims of the index offences (between 0.3 percent and 2 percent) and other observers including members of the public and students (between 7.6 percent and 19.7 percent; Crocker, Charette, et al., 2015; Latimer & Lawrence, 2006). Crocker, Charette, et al. (2015) noted a significant interprovincial difference in relation to the presence of other health care professionals during RB hearings; this was a frequent custom in British Columbia (88.5 percent) and less so in Ontario (5.6 percent) or Québec (44.5 percent). The authors were unable, however, to comment about their role in these hearings. In effect, there seems to be a dearth of scientific knowledge about the involvement of these health care professionals upstream and downstream from the RB hearing process.

3.3. Risk and Its Assessment

In *Winko v British Columbia* (1999), the SCC explained that "'dangerousness' is tantamount to 'a significant threat to the safety of the public'" (para 50), and unless the RB determined that a

person NCRMD was dangerous, they must order an absolute discharge. The SCC emphasized that, for an RB to establish dangerousness,

> . . . the threat must [also] be "significant," both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. (*Winko v British Columbia,* 1999, para 57)

Determining whether persons UST or NCRMD represent a significant threat to the safety of the public, which is the primary objective of RB hearings, seems to be a "realist" assessment of risk (see 2.2.2.1), namely an assessment of the likelihood of an undesired effect.

3.3.1. Assessment of Risk

In forensic psychiatry, the dominant conceptualization of risk originates from a realist epistemology—that is to say, an objective thing that can be measured. A plethora of research in forensic psychiatry seeks to identify and understand the various factors that affect a person's risk of committing future violence (Singh et al., 2014). Performing such an exercise is deemed useful in that it provides a framework for health care providers to use when making clinical and custodial decisions, such as pharmacology, talk therapy, group therapy, or increase of freedom (Levin et al., 2018).

Strategies and tools used in forensic psychiatric clinical settings for assessing and managing a person's risk of violence can be placed on a continuum ranging from unstructured clinical judgement to actuarial risk assessments (Skeem & Monahan, 2011; see Figure 3). As its name implies, unstructured clinical judgement allows clinicians to choose, without structure, factors they deem relevant to determine a person's risk of violence. While this method provides a wide range of free choice for health care professionals, it is not recommended, since it is considered to have the least predictive ability with respect to the risk (Harris et al., 2015). At the other end of the continuum, actuarial risk assessments determine the statistical probability for

violent behaviour to occur, based on a series of factors (Hanson, 2009). Somewhere between these two methods of assessment lies a method called *structured professional judgement*, whereby clinicians are provided with the flexibility of individualizing a list of pre-identified factors associated with violence, weighting and combining them to determine the level of risk of violence posed by someone.

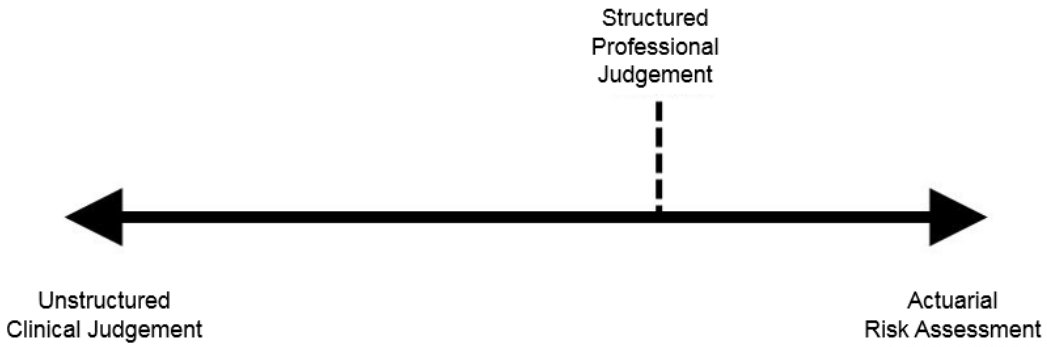

Figure 3. Risk assessment tool continuum.

Risk assessment instruments such as actuarial risk assessments and structured professional judgement can improve clinical decisions, increase transparency in decision making, and enhance communication within the health care team and with community partners (Levin et al., 2018). A multitude of structured risk assessment tools in use in forensic psychiatry, but the HCR-20 and the VRAG seem to be the ones most frequently relied on by clinicians to assess the risk of violence posed by persons under the supervision of RBs (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015; K. S. Douglas, 2014). The VRAG is an actuarial instrument that assesses the risk of long term violent recidivism (for up to 10 years) among men apprehended for criminal violence (Harris et al., 2015). The HCR-20 is a structured clinical judgement tool for assessing a person's risk of violence (Webster et al., 1997). It provides a framework to guide decisions relating to the release of detained persons and for health care professionals to target specific

factors when providing treatment (K. S. Douglas, 2014). The tool comprises 20 factors divided into three sections: historical factors, clinical factors, and risk management factors.

Risk assessment tools are better at predicting the risk of violence than unstructured clinical judgement (Fazel et al., 2012), but their use remains ethically complex, notably because they still cannot predict future acts of undesirable behaviours very well (T. Douglas et al., 2017). Their capacity to determine that a person will not engage in undesired behaviours, such as violence, sexual violence, and general crime, seems to be relatively good (between 81–95 percent). However, their capacity to accurately predict that a person will engage in these behaviours remains poor (between 27–60 percent; Fazel et al., 2012; Ramesh et al., 2018). Moreover, as Siontis et al. (2015) have noted in their review of the external validation of risk assessment tools, most tools (84 percent) had not been validated five years after their development, outside the original group of persons sampled for their creation. This renders problematic their use in groups of persons other than the ones originally sampled for their development, such as minority groups. Scholars (such as Shepherd, 2016) have recently raised questions relating to the cultural safety and applicability of these risk assessment tools for Indigenous populations, suggesting among other things that "a consideration of culturally relevant environmental and historical phenomena extends beyond the accumulation of individual risk items [is necessary]—it provides a contextual understanding as to why and how certain risk items materialise" (Shepherd & Anthony, 2018, p. 217). A recent SCC judgement (*Ewert v Canada*, 2018) acknowledged that the use of not-yet-validated risk assessment tools for Indigenous populations within Correctional Services Canada unjustly disadvantages offenders who seek conditional liberations.

3.3.2. Risk Assessment and Review Board Hearings

Over the past two decades, a few Canadian studies (e.g., Wilson et al., 2015) have focused on identifying factors that RBs consider when deciding dispositions appropriate for persons UST or NCRMD. These factors vary across studies and include undesirable behaviours (Côté et al., 2012; Whittemore, 1999), factors evocative of mental illness (such as lack of insight, personality disorders; Côté et al., 2012; Whittemore, 1999), use of substances (Côté et al., 2012), factors relating to the success of a community reintegration such as availability of accommodation (Whittemore, 1999), and even physical attractiveness (Hilton & Simmons, 2001). Nevertheless, RBs' use of empirically validated risk assessment tools when making decisions remains scant (17 percent of RB hearings, according to Crocker, Nicholls, Charette, et al., 2014).

Using VRAG and HCR-20 factors as codes, NTP researchers attempted to "determine the extent to which items [factors] were reported (i.e., mentioned) by clinicians and cited by RBs in their reasons for decision" (Wilson et al., 2015, p. 24). The authors reported a strong congruence between the factors identified in the expert report and the reasons for disposition, and identified three main categories of factors employed by clinicians and RBs in making their decisions: mental health (major mental illness, lack of insight, substance use, schizophrenia, personality disorder); responsiveness to treatment; and violent criminal history (Wilson et al., 2015).

Similarly, Crocker, Nicholls, Charette, et al. (2014) studied the relationship between (a) the HCR-20's static (i.e., invariable) risk factors and dynamic (i.e., variable) risk factors, and (b) decisions of RBs in issuing dispositions for conditional and absolute discharges. Their results suggest that three static factors were significantly associated with dispositions rendered by RBs: "women were more likely to receive an AD [absolute discharge] decision than a CD [conditional discharge] decision in comparison to men, but were no more or less likely to be detained"; "psychiatric history before the index offence reduced the likelihood of being released from

detention"; and "the more severe the index offence, the less likely the accused was to receive a release decision [absolute discharge]" (Crocker, Nicholls, Charette, et al., 2014, p. 584). Dynamic factors associated with the issuing of discharge dispositions included the lack of aggressive behaviours, compliance with disposition orders, and compliance with medication regimens (Crocker, Nicholls, Charette, et al., 2014). The presence of a substance use disorder was not associated with a decreased likelihood of receiving a discharge disposition (Crocker, Nicholls, Charette, et al., 2014).

3.3.3. Risk Assessment and Health Care Professionals

The concept of risk and its assessment has modulated the professional practice of health care providers (Castel, 1981/2011; Crowe & Carlyle, 2003; Lupton, 1999; O'Byrne, 2008; Perron et al., 2005). By using risk assessment tools, forensic psychiatric health care providers identify factors indicating that a person may engage in dangerous behaviours and, subsequently, provide therapeutic interventions such as containment, treatment, and surveillance to forestall these behaviours (Domingue, Jacob, et al., 2020). They also take on roles of agents for the state, in that their professional practice serves to uphold the objectives of the state as well as that of institution when it comes to things like monitoring behaviours or reforming conduct (Perron et al., 2005).

Thus, in his concept analysis of risk in nursing, O'Byrne (2008) warned health care providers about the subjugating effects of this risk identification/risk mitigation dynamic: "health care providers and researchers naively undertake risk management . . . in the name of altruism, while what they often unknowingly promote is a social order that maintains many current hegemonic systems of thought" (p. 38). By actively engaging in practices of risk assessment and mitigation strategies, and by protecting the public against dangerous persons, nurses act as biopolitical agents (Perron et al., 2005).

The aim of forensic psychiatry is to protect the public by reforming persons UST or NCRMD. Risk assessment tools identify the domains in which therapeutics can be applied in order to achieve this aim, as have various forensic psychiatric care delivery models (Domingue, Michel, et al., 2020; Holmes, Perron, Jacob, et al., 2018; Seppänen et al., 2018). While some of these models focus on the human resources needed to care for persons UST or NCRMD (Glorney et al., 2010; Holmes, Perron, Jacob, et al., 2018), others serve as guides to target specific deviant behaviours or groups of behaviours, and to prevent the occurrence of dangerous conduct (Barnao, 2013; Barnao et al., 2010; Bonta & Andrews, 2016). In conjunction with risk assessment tools, these models organize the provision of care in forensic psychiatry.

3.4. Forensic Psychiatric Nursing

Broadly, the scientific literature seems to acknowledge that forensic nurses practice in extraordinary environments (Kent-Wilkinson, 2009b); environments "where crime interfaces with human suffering" (Mason, 2002, p. 512). Forensic psychiatric nursing situates itself among various forensic nursing specialties – the areas of nursing practice located at the junction of the criminal justice and health care systems – whose practitioners include sexual assault nurse examiners and correctional nurses, amongst others. These nursing specialties emerged in the second half of the twentieth century because of nascent social and advocacy needs related to the pursuit of medico-legal truths for purposes of prosecution, coupled with a need to treat offenders and victims in their individuality (Kent-Wilkinson, 2009a; J. Morse, 2019). Forensic nurses assist the criminal justice system determine if and how crimes are committed, while providing health care to victims and offenders (Kent-Wilkinson, 2009a; J. Morse, 2019).

The particularity of each forensic nursing specialty relates to the various dichotomies to which forensic nurses are exposed such as care and custody, care and collection of evidence, or care and court room testimony (Kent-Wilkinson, 2009a). These dichotomies cause professional

epistemic tensions for nurses who must juggle with the notion of procedural objectivity when collecting or documenting evidence, and that of subjectivity when providing care to patients (Kent-Wilkinson, 2009a; J. Morse, 2019). On that topic, in her socio-legal analysis of the emergence of the sexual assault nurse examiner role, J. Morse (2019) wrote that

> the imbrication of clinical forensic medicine in emergency nursing practice not only transformed the patient-provider encounter, but also created a fundamental tension between, on one hand, the orienting assumption of clinical forensic medicine that an uncertain event has occurred that requires evidence to confirm and, on the other hand, the original assumption […] that healthcare personnel should believe all victims at the time of the initial report and offer compassionate care (p. 324)

Such a tension created by the pursuit of an objective truth becomes even more evident when transposed to the domain of forensic psychiatric nursing to the extent that determining whether persons UST or NCRMD are dangerous brings into play matters of morality, social acceptability, and culture; concepts which are all contextual and rooted in subjectivity (Domingue, Jacob, & al., 2020).

A central tenet of psychiatric nursing is the development and maintenance of an interpersonal therapeutic relationship between nurse and patient (Eckroth-Bucher, 2001; Laskowski, 2001; Peplau, 1952; Travelbee, 1971). This therapeutic relationship also represents the foundation of nursing care in forensic psychiatric environments (Byrt et al., 2018; J.-D. Jacob, 2014; J.-D. Jacob & Holmes, 2011b; Mason, 2002; Peternelj-Taylor, 1998; Rask & Aberg, 2002). In these environments, nurses are required to provide psychiatric care to persons who have committed all sorts of crimes, some more heinous than others, while simultaneously being their custodian (Burrows, 1993; Doyle et al., 2017; Holmes, 2005; Kent-Wilkinson, 2009b).

The diagnostic and legal profiles of forensic psychiatric patients—namely the prevalence of patients with personality disorders and the fact that they have committed a crime—make it difficult to develop and maintain therapeutic nurse-patient relationships (Holmes, 2005; Holmes & Federman, 2003; Peternelj-Tayler, 2004). To protect themselves from forensic psychiatric patients who exhibit manipulative and aggressive behaviours, nurses may distance themselves emotionally by erecting barriers, both physical and psychological (Holmes & Federman, 2003; J.-D. Jacob, 2014; J.-D. Jacob & Holmes, 2011b; Peternelj-Taylor, 2004). Thus, the closeness necessary for therapeutic relationship is inhibited. Although such barriers seem to be necessary for nurses to protect their physical and psychological safety (J.-D. Jacob, 2014), they cause an "us versus them" dynamic to impose itself upon the relationship, and this impedes the provision of care (Holmes & Federman, 2003; Perternelj-Taylor, 2004).

Knowledge in forensic psychiatric nursing has been produced only sparsely in recent years, mostly in this intersectional context of care and custody. It seems to have been developed in a two-pronged, chronological and geographically circumscribed way. First, scholars mainly in the UK, Canada, and Australia have studied the particularities relating to the role of nurses in forensic psychiatric settings. They explored the dichotomy espoused by the custodial architecture of forensic psychiatric environments, including their physical layout and policies, and the therapeutic role of forensic psychiatric nurses. Second, nursing researchers mainly from Canada have employed critical theories to problematize the effects of forensic psychiatric nursing practice on society, on patients, and on nurses themselves. Notwithstanding the forensic psychiatric nursing knowledge developed in these areas, the role of nurses in the legal processes—namely, RB hearings—allowing for the forensic psychiatric system to function remains unexplored.

3.4.1. Forensic Psychiatric Nurses and Their Roles

In forensic environments, the incommensurability of the caring role of nurses and the custodial function of the forensic institution has caused significant role tensions for nurses (Burrows, 1993; Dhaliwal et al., 2021; Holmes, 2002, 2005; J.-D. Jacob & Holmes, 2011a, 2011b; Mason et al., 2008; Peternelj-Taylor & Johnston, 1995; Timmons, 2010). Scholars have investigated the role of nursing in these environments since the mid-1980s (see Burrows, 1993; Byrt et al., 2018; Coffrey, 2012; Doyle et al., 2017; Martin, 2001; Niskala, 1986; Peternelj-Taylor & Johnson, 1995).

Mason's (2002) comprehensive literature review on the subject grouped seven themes to illustrate the role of forensic psychiatric nurses. Referencing the work of Richman (1998), he explained that nurses may have negative views about the patients they care for because of the crimes they have committed. Nevertheless, he found that forensic psychiatric nurses have positive views of their work with these patients and are committed to providing quality services (Burnard & Morrison, 1995). In addition to providing quality mental health services, he found that forensic psychiatric nurses may have the responsibility of carrying out tasks geared toward maintaining security, such as conducting searches, escorting patients to appointments, and counting sharps (such as nail cutters or scissors). In a similar vein, their responsibility for managing episodes of violence on inpatient units can generate feelings of fear and stress (Wykes & Whittingdon, 1994). Mason used the work of Conacher (1993) and Peternelj-Taylor and Johnson (1995) to discuss the reticence of forensic psychiatric nurses to deploy therapeutic modalities and to develop therapeutic relationships with patients. For Peternelj-Taylor and Johnson, this reticence partly lay in the manipulative behaviours this population often exhibited in their interactions with nurses. To avoid these behaviours and to develop a therapeutic relationship with forensic psychiatric patients, nurses are required to communicate, engage in

teamwork, and collaborate with the interdisciplinary health care team (Conacher, 1993; Peternelj-Taylor & Johnson, 1995, Timmons, 2010). Although positing that forensic psychiatric nursing may not be a nursing speciality in and of itself, given that it relies on the same skills as psychiatric nursing in general, Mason shared Peternelj-Taylor and Johnson's finding that nurses working in forensic psychiatric environments needed specific training in how to develop therapeutic relationships, establish and maintain boundaries, deal with confrontations, and enhance self-reflection. Finally, in his 2002 review and also in an article on cultural practices in a special hospital, Mason (1993) highlighted that the nurse in charge has a great deal of influence on the professional culture of nurses working in forensic psychiatric settings.

Similar themes emerged in Byrt et al.'s (2018) more recent critical literature review of evidenced-based practice in forensic psychiatric nursing. The authors found that results from randomized controlled trials demonstrated that antipsychotic pharmacotherapy, psychoeducation, and third-wave cognitive behavioural therapy were effective nursing interventions in forensic psychiatric environments. They also showed that the practice of forensic psychiatric nurses revolved around three axes: assessing and managing risk, providing trauma-informed care, and delivering therapy in secure environments. First, the authors explained that considering the custodial environments in which forensic psychiatric nurses worked, it is imperative for them to develop and maintain therapeutic relationships with their patients to ensure the effectiveness of other therapies, such as pharmacotherapy and psychotherapy. Second, they found that forensic psychiatric nurses have the role of intervening early when situations escalate on inpatient units, in order to prevent the deployment of invasive interventions such as physical restraints, chemical restraints, and seclusion, which can traumatize patients. Finally, Byrt et al. (2018) saw that the practice of forensic psychiatric nurses includes completing, validating, and evaluating risk

assessment tools. They also manage identified risks, and mitigate iatrogenic effects associated with risk management interventions, such as the stigma attributable to having health care providers routinely supervise a patient's whereabouts.

The conclusions from these two comprehensive systematic literature reviews (Byrt et al., 2018; Mason, 2002) about the role of forensic psychiatric nurses and their therapeutic practice give context to the results from a survey conducted by Timmons (2010) with forensic psychiatric nurses (N = 66) in Ireland, which identified six main roles of forensic psychiatric nurses:

1. promoting equality, diversity and human rights;
2. maintaining the patient's skills of independent living;
3. assessing the risks and needs of patients;
4. building therapeutic relationships;
5. protecting patients from abuse; and
6. practising with humanity

Somewhat complimentarily, Mason et al. (2008) surveyed forensic psychiatric nurses (N = 1019) working in the United Kingdom, asking them about their strengths and specific skill set, and about the benefits of working in forensic psychiatry. The nurses responded that their life experience, empathy, and clinical experience were their main strengths. For providing nursing care to forensic patients, the nurses did not emphasize their psychiatric experience but rather their life experience, "suggesting that factors from the social sphere are more significant than those from the psychiatric field" (Mason et al., 2008, p. 127). They identified their listening skills, confidence, and ability to interact with patients diagnosed with personality disorders as the required skill set for work in forensic psychiatry. Finally, they saw the main benefits of working

in this environment as job satisfaction, their patients' progress, and the development of negotiation skills (Mason et al., 2008).

Scholars in this review highlighted that the delivery of psychiatric nursing care is complicated by the forensic environment in which is provided and the population of patients to whom it is provided. In forensic psychiatric institutions, nurses are required to maintain closeness with their patients, to foster the development of a therapeutic relationship. However, they bear the responsibility of security-related tasks that may represent a barrier to doing that. Mason et al. (2008) proposed that the strengths of forensic psychiatric nurses reside in their relational skill set (i.e., negotiation skills and listening skills) and in their capacity for providing care to a complex population of patients with personality disorders. This suggests that nurses have somewhat adapted their psychiatric nursing skill set to the forensic environment. Nevertheless, the effects of these nursing practices serve a larger societal purpose, transcending the individual caring nurse-patient relationship.

3.4.2. Effects of Forensic Psychiatric Nursing Practice

The practice of nurses in forensic psychiatric institutions serves purposes of social control and public safety (Dhaliwal et al., 2021; Mason & Mercer, 1996; Mercer et al., 1999; Peternelj-Taylor, 2004). These purposes have been investigated in ethnographic studies (Perron & Holmes, 2011), grounded theory studies (Holmes, 2005; J.-D. Jacob & Holmes, 2011a, 2011b), and theoretical studies (J.-D. Jacob & Foth, 2013; Lyons, 2009). All have agreed that the professional therapeutic practice of nurses working in forensic settings converges with the public safety ideals of forensic institutions. The assessment and analytic skills of such nurses are leveraged to enact custodial interventions. Such interventions include (but are not limited to) assessing risk of violence, monitoring deviant behaviours, adjusting levels of observations and freedom, managing crisis situations, searching patients and staff, supervising visits, and administering

medications. Consequently, the dichotomization of the care-and-custody goals of forensic psychiatric nursing can be questioned and conceptualized in an integrated way, whereby they converge as tools of discipline in an apparatus (*dispositif*) aimed at normalizing psychiatric patients for the benefit of the population of society as a whole (Holmes, 2002, 2005; J.-D. Jacob & Foth, 2013; J.-D. Jacob & Holmes, 2011a, 2011b).

This normalization seems to operate in a cyclical way. First, the deviant characteristics of forensic patients (i.e., their behaviours and thoughts) are identified. These then serve to justify the deployment of normalizing practices such as pharmacological therapies, cognitive and behavioural therapies, application of restraints, and increased observation (Martin & Street, 2003; Perron, 2012; Perron & Holmes, 2011). Second, the architecture and internal policies of forensic institutions allow for nurses to observe and document the effects of these practices on the bodies and minds of patients (Holmes & Murray, 2011; J.-D. Jacob & Holmes, 2011a, 2011b). Cyclically, this documentation allows for the justification of subsequent normalizing practices (Domingue, Jacob, et al., 2020).

Because of the crimes they have committed and because of the specific behaviours they engage in (Canales, 2000; Peternelj-Taylor, 2004; Peternelj-Taylor & Johnson, 1995), patients in forensic environments are perceived as being dangerous and characterized by how they differ from nondangerous individuals. This Othering dynamic perpetuates an “us versus them” mentality, generating feelings of fear, disgust, and anxiety in nurses (J.-D. Jacob, Gagnon & Holmes, 2009; Holmes, Perron & O’Byrne, 2006; Peternelj-Taylor, 2004). These emotions function, in turn, as reasons to legitimize providing nursing interventions aimed at reducing patients’ dangerousness, such as information gathering, verbal de-escalation, administration of as-needed psychotropic medications, use of physical force, and use of cameras (J.-D. Jacob &

Holmes, 2011a;, 2011b; Perron, 2012; Perron & Holmes, 2011). On occasion these interventions are adopted by forensic institutions and applied to all incarcerated patients without scientific evidence suggesting that they are clinically beneficial for patients' recovery. For example, Holmes and Murray (2011) studied the generalized implementation of a behaviour modification program in a Canadian forensic environment whereby nurses were instructed to implement and monitor the effects of infantilizing interventions, such as "time-outs," and concluded that nurses in these environments "become part of a machine that harms rather than heals" (p. 295).

Consequently, although the practice of forensic psychiatric nurses may be similar to the practice of nurses working in nonforensic settings (Mason, 2002), the Othering effects and the custodial function of forensic environments seem to have modulated the professional identity of nurses working within their confines. The results of Holmes's (2002, 2005) grounded theory project in the Canadian federal psychiatric system suggest that some nurses working in forensic psychiatry cannot simultaneously embody the roles of carer and custodian and that they therefore inevitably take on a custodial identity. This result was also identified in another grounded theory study aimed at exploring "the dual role associated with being both agents of care and agents of social control in correctional environments" (J.-D. Jacob, 2014, p. 47), which included the testimony of a nurse who embodied her custodial identity to such an extent that she identified the correctional officer role as part of her professional role as a nurse. In this context, it is not surprising to read Lyons's (2009) reflection that nurses "become an extension of law enforcement" (p. 54) in forensic environments. In her article, she argued that forensic psychiatric nurses must "maintain neutrality, objectivity, detachment, and an index of suspicion" when providing care to forensic patients (Lyons, 2009, p. 53).

The architecture of forensic psychiatric environments further sustains the separation of the dangerous Other from the suspicious health care providers (Holmes & Murray, 2011; J.-D. Jacob & Holmes, 2011b). When nurses "work with a threatening patient population" (J.-D. Jacob & Holmes, p. 69), cameras provide them with the means to observe and control forensic patients from a distance. Holmes and Murray (2011) described the physical layout of a correctional psychiatric ward: central glassed-in nursing station with a direct line of sight down the corridors. It shared the same observation mechanism as Bentham's panopticon, resulting in "a state of conscious and permanent visibility [of the mentally ill inmate] that assures the automatic functioning of power" (Foucault, 1975/1995, p. 201). Being under the nurses' complete surveillance is believed to entice a self-regulation of deviant behaviours—that is, those who are observed are believed to change their dangerous behaviours to safer, more socially acceptable ones (Perron, 2012), thereby meeting the social protection mandate of forensic institutions.

Although nursing documentation is meant to communicate safe, effective, and ethical care (College of Nurses of Ontario, 2008; Myklebust et al., 2017; Ordre des Infirmières et Infirmiers du Québec, 2002; Saskatchewan Registered Nurses' Association, 2021), in forensic environments it seems to serve a much broader social function: namely, the identification and reform of dangerous thoughts and behaviours (Berring et al., 2015; Perron, 2012; Perron & Holmes, 2011). In their clinical documentation, nurses record the degree to which the behaviours exhibited by forensic psychiatric patients comply with the norms of the institution (Berring et al., 2015; Martin & Street, 2003; Perron, 2012; Perron & Holmes, 2011). For instance, the nurses observe cooperativeness in persons' behaviours and document any transgressions (Martin & Street, 2003; Perron, 2012; Perron & Holmes, 2011). In a critical ethnography of nursing documentation practices in a forensic psychiatric environment, Perron and Holmes (2011)

described how nurses served the institutional mandate of social protection. Nurses identified deviant behaviours, used pharmacological interventions to ensure that their patients' deviant behaviours conformed to the institutional code of conduct, and documented behavioural changes they observed. Similarly, when Martin and Street (2003) studied documentation entries of nurses working in an Australian forensic hospital, they identified that nursing documentation was deprived of information pertaining to the provision of therapeutic interventions—with the rare exception of "as-needed" administration of medications—and rather constituted a surveillance tool to document any transgressions to institutional rules. Combined with the fact that nursing documentation is conceived as giving a true and objective account of a patient's situation (Berring et al., 2015), this dynamic inserts nursing practice and nursing documentation into the realm of the political, having the function of protecting the public from forensic psychiatric patients (Perron et al., 2005).

Chapter 4: Methodology

I selected a critical ethnography methodology to guide the research project. This qualitative approach, rooted in critical theory, allowed for an in-depth look into the structures that sustain RB hearings, produce identities for persons UST or NCRMD, and shape the work of nurses in the forensic psychiatric hospital.

4.1. Ethnography

Ethnography has its foundations in anthropology, the social science discipline concerned with the "study of what makes us human" (American Anthropological Association, 2021). Before being used in anthropology, ethnography was used as a method of documenting the Other, for colonizing purposes (Denzin & Lincoln, 2011). In the mid-19th century, the British Empire provided its missionaries, explorers, and tradespeople with questionnaires to document the intricacies and differences between the Indigenous human and the human of the British Empire (Denzin & Lincoln, 2011; Soyini Madison, 2005). Once completed, the questionnaires were returned to the mainland to be analyzed and interpreted by ethnologists (Soyini Madison, 2005). However, the limited amount of data collected through the predefined questionnaires complicated the ethnologists' analyses, limited their rigorous interpretations, and caused discontent among scholars (Soyini Madison, 2005). At the end of the 19th century, the scholars' dissatisfactions pushed ethnologists to venture off to the colonies on their own, which established the long-term immersion ideal of ethnographic research (Malinowski, 1932; Soyini Madison, 2005).

As opposed to analyzing data collected through predefined questionnaires, long-term immersion in cultural environments enabled scholars to better comprehend the differences between foreign cultures and their own (Denzin & Lincoln, 2011; Soyini Madison, 2005). Long-term immersion data collection techniques were perceived by anthropologists as a humanistic

way to represent and attempt to understand the Other and their culture, thereby moving away from ethnocentrism (Soyini Madison, 2005). Anthropologists' fascination with the technique of long-term immersion as a method of collecting ethnological data collection marked the birth of ethnography as a scientifically accepted methodology to produce knowledge about so-called Other cultures (Creswell, 2013; Soyini Madison, 2005).

4.1.1. Culture

Over time, numerous definitions and interpretations of the concept of *culture*, its origins, its dynamism, its effects, and the way it manifests itself have been proposed. Radcliffe-Brown (1968/1972) defined culture as "le processus par lequel une personne acquiert, savoir, habileté, idées, croyances, goûts, sentiments, au contact d'autres personnes ou d'objets comme les livres ou les œuvres d'art" (a process by which a person acquires knowledge, abilities, ideas, beliefs, tastes, feelings, when in contact with other persons or objects like books or art work; p. 40; my translation). Thomas (1993) considered culture to be "the totality of all learned social behaviour[s] of a given group" (p. 12). Thomas (1993) posited that what he considered social behaviours originated from "material and symbolic artifacts of behaviour—such as belief systems (i.e., religion), conceptual machinery for ordering social arrangements (i.e., ideology), and pre-existing structural (i.e., formal organizations) and material (i.e., tools) attributes" (p. 12). For Thomas, individuals influence and reproduce materials, artifacts, and behaviour merely by belonging to a specific culture. Geertz (1973) also considered culture as a construct that is simultaneously "received" and "produced." He contended that "man is an animal suspended in webs of significance he himself has spun, [and] take[s] culture to be those webs" (Geertz, 1973, p. 5). Similarly, Foucault (1976/1990a) explained that when studying

> the real behaviour of individuals in relation to the rules and values that are recommended to them, . . . one must determine how and with what margins of variation or transgression individuals or groups conduct themselves in reference

> to a prescriptive system that is explicitly or implicitly operative in their culture, and of which they are more or less aware. (pp. 25–26)

Culture, and the prescriptive system/structures inherent in it, must thus be understood as a product of discourses. Culture has the potential to be altered based on the different discourses that co-exist at any particular time. It produces artifacts and practices, and enables a perpetual cycle of discourse formation and embodiment by the individuals being subjected to them.

In keeping with the various understandings of culture mentioned above, and for the purpose of having an operational definition of culture for my own ethnographic work, I define culture as the following: Culture is a product of structures sustained by discourses. It resides in the statements contained within material or symbolic artifacts (e.g., books, guidelines, art) produced through common social practices (i.e., rituals) by persons from different social organizations (e.g., political, household, community). With this definition in mind, I explored the practices and artifacts—hearings and reasons for disposition—that make up the RB culture.

4.1.2. Descriptive Ethnography

Descriptive ethnography was formalized as a methodology when anthropologists first began to adopt the practice of long-term immersion for collecting data at the beginning of the 20th century (Soyini Madison, 2005). The embryonic state of qualitative research at this time is characterized by positivist principles, as were other forms of qualitative methodologies trying to establish themselves within the realm of scientific—i.e., quantitative—research (Denzin & Lincoln, 2011; Guba & Lincoln, 1994).

From an ontological perspective, descriptive ethnographers are realists (Guba & Lincoln, 1994). They believe in the existence of a true culture of a group that can only be accessed, extracted, and described if the utmost level of epistemological objectivity is applied to the methodological process (Creswell, 2013). To find the true culture of a group of people,

descriptive ethnographers seek to incorporate all components of a culture within their analysis (Creswell, 2013; Malinowski, 1932; Soyini Madison, 2005). For example, in describing the importance of fieldwork, Malinowski (1932) wrote:

> Besides the firm outline of tribal constitution and crystalized culture items which form the skeleton, besides the data of daily life and ordinary behaviour, which are, so to speak, its flesh and blood, there is still to be recorded the spirit—the natives' views and opinions and utterances. . . . These ideas, feelings, and impulses are molded and conditioned by the culture, and are therefore an ethnic peculiarity of the given society. An attempt must be made therefore, to study and record them. (p. 22)

Malinowski's way of contrasting the physical "skeleton," "flesh," and "blood" of the culture with its "spirit" helps us understand, from a historical standpoint, the strides qualitative researchers, such as descriptive ethnographers, had to make to gain scientific recognition for their qualitative account of immaterial data such as spirits (Denzin & Lincoln, 2011).

The colossal amount of data required to describe a culture is one of the reasons why descriptive ethnographies are quite laborious and time-consuming to conduct (Creswell, 2013; Koro-Ljungberg & Greckhamer, 2005). Malinowski (1932) depicts the nature of such arduous processes in his ethnography, *The Argonauts of the Western Pacific*:

> The field Ethnographer has seriously and soberly to cover the full extent of the phenomena in each aspect of tribal culture studied, making no difference between what is commonplace, or drab, or ordinary, and what strikes him as astonishing and out-of-the-way. . . . The Ethnographer has in the field, according to what has just been said, the duty before him of drawing up all the rules and regularities of tribal life; all that is permanent and fixed; of giving an anatomy of their culture; of depicting the constitution of their society. (p. 11)

For descriptive ethnographers, the extensive immersion and observations of a group's activity—their actions, behaviours, rituals—enables the discovery of the group's true culture. Malinowski's references to the materiality of the human body in the first quotation above and the juxtaposition of the word *anatomy* with the word *culture* in the second is ontologically

significant. It places the qualitative analysis of culture on the same level as the real, material, quantitative analysis of the human body.

The analogy between culture and anatomy can be transposed to the epistemological underpinnings of the descriptive ethnography methodology. Much like the anatomist who conducts an arm's-length dissection of a corpse so as to avoid the introduction of biases into the data collection, the descriptive ethnographer infiltrates a cultural group, but remains at a distance from it—like being a fly on the wall. By doing so, descriptive ethnographers believe they can objectively discover the true culture of a group of people (Koro-Ljungberg & Greckhamer, 2005).

Descriptive ethnography produces knowledge by relying on long-term immersion methods through which descriptive ethnographers analyze artifacts and observe social practices to produce a report describing the culture studied (Creswell, 2013; Koro-Ljungberg & Greckhamer, 2005). For example, Boas (1895/2002) described the flood legend of the Squamish peoples: "Once it rained for long days and long nights. The sea rose higher and higher and finally covered all the ground. When at last the waters subsided, lakes and rivers remained, and in them the fish" (p. 144). Similar descriptive accounts can be found in Malinowski's (1932) work:

> This somewhat puzzling delay is less incomprehensible, if we reflect that the natives, after having prepared for a distant expedition, now at least for the first time find themselves together, separated from the rest of the villagers. A sort of mustering and review of forces, as a rule associated with a preliminary feast held by the party, is characteristic of all the expeditions or visits in the Trobriands. (p. 207)

Of note is the generalization Malinowski makes to "all the expeditions or visits in the Trobriands" in describing this stop on his journey. The characteristic of the descriptive ethnography methodology to make generalizations is closely related with its realist ontology, in

which studying one of the subgroups of people can, by generalization, uncover the true culture of the overall group (Guba & Lincoln, 1994).

4.1.3. Interpretative Ethnography

Interpretative ethnography emerged as a methodology after the University of Chicago created the School of Ethnography within its Department of Anthropology (Denzin & Lincoln, 2011; Soyini Madison, 2005). This school has influenced social science disciplines including sociology to use ethnography and its methods, such as long-term immersion, to inductively produce knowledge (Creswell, 2013; Denzin & Lincoln, 2011; Koro-Ljungberg & Greckhamer, 2005; Soyini Madison, 2005).

Ontologically, interpretative ethnographers seek to understand the meaning of culture for a societal group rather than searching for an absolute truth governing social practices within that culture (Geertz, 1973). Although interpretative ethnographers accept that truth exists, the trustworthiness of this truth is inevitably influenced by the bias of the individual observer (Koro-Ljungberg & Greckhamer, 2005). Epistemologically, interpretative ethnographers recognize this bias in the production of knowledge. They seek to acknowledge it and put it aside or bracket it as much as possible so as to provide the most accurate account of reality (Guba & Lincoln, 1994; Koro-Ljungberg & Greckhamer, 2005). Any such bias must be identified and removed from the analysis/results. For example, in the preface to *Asylums*, Goffman (1961) wrote: “My immediate object in doing fieldwork at St. Elizabeth’s was to try and learn about the social world of the hospital inmate, as this world is subjectively experienced by him” (p. ix). Goffman acknowledged that a true cultural reality of the hospital’s social world exists, but the reality is modulated according to the person experiencing it. Goffman (1961) further explained:

> I want to warn that my view is probably too much that of a middle-class male; perhaps I suffered vicariously about conditions that lower-class patients handled with little pain. Finally, unlike some patients, I came to the hospital with no great

> respect for the discipline of psychiatry nor for agencies content with its current practices. (p. x)

Similar to descriptive ethnography, interpretative ethnography relies on data-collection methods such as long-term immersion and artifact analysis to produce generalizable results about a culture. However, the aim of these results is very different. Interpretative ethnographers seek to understand the meaning of a culture or a subculture as it is experienced by a group of people. Thus, Geertz (1973) explained that "the analysis of it [culture is] . . . therefore not an experimental science in search of law but an interpretive one in search of meaning" (p. 5). The content of such ethnographies reflects this aim. In Goffman's (1961) ethnography, for example, he explained how, in an attempt to not lose face in front of other patients of the asylum, upon entry a patient may confabulate about the reasons leading to their admission:

> The low position of inmates relative to their station on the outside, established initially through the stripping processes, creates a milieu of personal failure in which one's fall from grace is continuously pressed home. In response, the inmate tends to develop a story, a line, a sad tale—a kind of lamentation and apologia—which he constantly tells to his fellows as a means of accounting for his present low estate. In consequence, the inmate's self may become even more a focus of his conversation and concern than it does on the outside, leading to much self-pity. (pp. 66–67)

4.1.4. Critical Ethnography

Critical ethnography has emerged as a methodology when, in the mid-1980s, qualitative researchers influenced by feminism, critical theory, and epistemologies of color questioned the notions of truth, representation, and knowledge production in order to hear the voice of and advocate for marginalized persons (Denzin & Lincoln, 2011). Critical ethnographers are interested in studying the oppressive features of cultures by describing and understanding the power dynamics inherent in them in an effort to problematize their subjugating effects (Koro-Ljungberg & Greckhamer, 2005; Soyini Madison, 2005; Thomas, 1993).

Although critical ethnography acknowledges the importance of understanding a culture, proponents of this approach explain that this understanding must incite transformation (Baumbusch, 2011). For Brown and Dorbin (2004),

> . . . unlike traditional ethnographic practice, critical ethnography shifts the goal of praxis away from the acquisition of knowledge about the Other (either for its own sake or in the service of the ethnographer's career) to the formation of a dialogic relationship with the Other whose destination is the social transformation of material conditions that immediately oppress, marginalize, or otherwise subjugate the ethnographic participant. (p. 5)

Or, as Thomas (1993) simply put it, "critical ethnography is conventional ethnography with a political purpose" (p. 4). Its general aim is to study a culture to motivate changes in practice—social, political, or professional.

Ontologically, critical ethnographers are historical realists; they posit a single reality (Guba & Lincoln, 1993). This being said, they explain that, depending on a variety of contextual factors—whether political, economic, gendered, or social—a multiplicity of truths can be generated from this reality (Koro-Ljungberg & Greckhamer, 2005). Therefore, truths produced by subjugated discourses and structures may be different from those produced by hegemonic discourses and structures.

From an epistemological perspective, Guba and Lincoln (1994) would classify critical ethnographers as subjectivists. Researchers' values and backgrounds, considered biases in descriptive or interpretative ethnographies, are used as tools of enquiry and analysis by critical ethnographers: "rather than engaging in futile attempts to eliminate the effects of the researcher completely [like it is the case in descriptive and interpretative ethnographies], we should set about understanding them" (Hammersley & Atkinson, 2007, p. 16). Critical ethnographers make use of their subjectivities through an active, constantly self-reflective, and critical process of reflexivity.

4.1.4.1. Reflexivity

Reflexivity is a concrete, active, and productive process of self-examination that pushes critical ethnographers to understand how historical contexts and structures affect knowledge production (C. A. Davies, 1999; D. Davies & Dodd, 2002). It refers to the ethnographer's ability in the research process to profoundly reflect on the role of power dynamics, sociohistorical contexts, and privilege (Baumbusch, 2011; C. A. Davies, 1999; Thomas, 1993). In this practice, "the activities and results of social research are constructed from and reflect both the broader sociohistorical context of researchers and the disciplinary culture to which they belong" (C. A. Davies, 1999, p. 9). Reflexivity is an essential component of the critical ethnography methodology, playing a central role in guiding research (Soyini Madison, 2005). By engaging in reflexivity, critical ethnographers redirect their focus to areas of interest as they arise, whether they be additional data sources, theoretical considerations, or epistemological complexities, and thereby produce valuable knowledge (Hammersley & Atkinson, 2007). In fact, critical ethnographers rely on a constant oscillation between data collection, data analysis, and reflexive practice to produce knowledge. Through their reflexive practices, critical ethnographers become instruments of research (C. A. Davies, 1999; Hammersley & Atkinson, 2007; Soyini Madison, 2005).

Reflexivity is seen to guard against researchers from using critical ethnography as an opportunistic platform for political influence (as opposed to a tool of political change) (Hammersley & Atkinson, 2007). Practices of reflexivity thus increase the integrity of the research process. Researchers examine and reflect on their own political views, so that they will not impose those subjective views on the cultures being studied (Hammersley & Atkinson, 2007). Critical researchers' political views and other subjectivities are used to guide the research process, not to suggest a truer version of reality (Holmes & Gastaldo, 2004).

4.1.4.2. A Four-Process Approach

Methodologically, critical ethnography relies on an approach involving four processes. Although presented successively here, these processes occur simultaneously—researchers often go back and forth between them.

First, data are collected about the culture of a group of persons, to explore the culture's oppressive features (Brown & Dorbin, 2004; Hammersley & Atkinson, 2007). To do so, like descriptive and interpretative ethnographers, critical ethnographers use a combination of data collection methods, including immersion in the milieu, observations, interviews, and analysis of artifacts. However, some data collection modalities differ from those used within descriptive or interpretative ethnographic frameworks. For example, the immersion may be brief or lengthy, and the observation may or may not be named "participant observation." Whatever the case, the methodological goal of producing of one truth among many other truths about a culture, for purposes of structural transformation, is served as long as ample data are rigorously collected (Forsey, 2010; Hammersley & Atkinson, 2007).

Second, throughout this data collection process, critical ethnographers engage in practices of reflexivity. By doing so, they consider the data in the contexts in which they were produced (Brown & Dorbin, 2004; C. A. Davies, 1999; Hammersley & Atkinson, 2007) and, more importantly, understand and critique the structures that allowed for their production (Krzyzanowski, 2011).

Third, these understandings and the data themselves are interpreted using theories that take into account concepts of empowerment, prestige, privilege, inequalities, and power relations. These may include Marxist, critical race, postmodern, and poststructuralist theories, amongst others (Soyini Madison, 2005).

Lastly, critical ethnographers use these interpretations as tools of social change. They leverage their results through various means, such as publications, presentations and activities or advocacy, to promote social transformations (Baumbusch, 2011; Brown & Dorbin, 2004; Creswell, 2013; Soyini Madison, 2005; Thomas, 1993).

4.2. Critical Ethnography and the Research Problem

Critical ethnography was an indispensable tool in the exploration of the subjugating features of the RB culture, namely, the objectification of persons UST or NCRMD. By focusing on the RB hearing as a social practice inherent in the RB culture, critical ethnography helped me explore the relations of power, privilege, and dominance perpetuated in the forensic psychiatric system.

As in any social practice, artifacts are produced in preparation for RB hearings and as a result of them. These artifacts include RB guides and guidelines, the *Criminal Code*, provincial RB websites, case law, and reasons for disposition, all of which perpetuate the hegemony of structures that allow for their production. For this reason, they were essential repositories of data to "describe how a cultural group works and to explore the beliefs, language, behaviours, and issues facing the group, such as power, resistance, and dominance" (Creswell, 2013, p. 94). Indeed, critical ethnography, coupled with my critical discourse analysis method (see 4.2.4), provided me with a set of tools to understand how these data were produced and named as true, and how nurses, as actors in the forensic psychiatric system, participated in this truth-producing machine. The ontological, epistemological, and methodological underpinnings of critical ethnography lent themselves well to the research problem being investigated.

From an ontological perspective, the RB culture offers a structured system that allows for statements about persons UST or NCRMD to be produced and considered true. Various social actors are involved during RB hearings and contribute to the production of these truths, including persons UST or NCRMD, health care professionals, legal professionals, and family members. At

these hearings, statements they have produced about persons UST or NCRMD are presented, discussed, and challenged. At the end of the RB hearing certain statements about persons UST or NCRMD are retained by the RB and concretized in the reasons for disposition.

From an epistemological standpoint, I realized early in the research project that the specific structures in which I was embedded personally, professionally, and academically fundamentally influenced the way I conceptualized the research problem, imagined the data collection, and shaped the data analysis process (Baumbusch, 2011). These influences stemmed from my male sex and gender, French-Canadian cultural background, upper-middle-class socioeconomic status, left-wing political views, and postsecondary education in nursing; my graduate education in nursing was influenced in turn by professors whose research was rooted in critical theory philosophies.

From a methodological perspective, to conduct a rigorous critical ethnography I was bound to immerse myself in the RB culture. As such, I participated in its social activities (RB hearings); conducted interviews with the appropriate social actors (nurses) to answer the research questions; and analyzed artifacts relating to it (reasons for dispositions). During this ethnographic work, I engaged in reflexivity practices, using them as tools to conceive the research protocol, analyze the data, and provide backdrop for further enquiry (Hammersley & Atkinson, 2007). For example, while collecting data, I wrote and dated reflexive entries to think about my position as a researcher retrieving data and to consider the structures that may have produced the data I was collecting (Hammersley & Atkinson, 2007). In this vein, guided in part by my theoretical framework, I systematically considered the structures that allowed for various statements to be construed as true, including the ones in which I was produced as a novice researcher. Like others have done in mental health settings (Bransford, 2006), I reflected on how

various contexts may have influenced the formation of truths about persons UST or NCRMD during RB hearings (Hammersley & Atkinson, 2007; Thomas, 1993).

In summary, the critical exploration of the RB culture as it applies to the identity construction of persons UST or NCRMD required a methodological approach that was flexible, rigorous, and inclusive. Critical ethnography's methodology enabled these requirements to be met and the intersectional nature of the structures permitting the production of identities to be considered. Analysis of the data was conducted with special attention to questions of power, using a theoretical framework rooted in identity construction. This analysis was used as a tool to encourage procedural changes in the RB hearing process and point to possible changes in the practice of forensic psychiatric nurses (Soyini Madison, 2005; Thomas, 1993). (See Chapter 6.)

4.2.1. Research Field

The underlying common characteristic of all ethnographies, independently from their philosophical underpinnings, is the attention they give to the cultural attributes of social entities such as groups of persons, neighbourhoods, and institutions (Denzin & Lincoln, 2011; Hammersley & Atkinson, 2007; Thomas, 1993). In this study, I was interested in studying the cultural attributes of the RB. Unlike most social entities that can be circumscribed in space and in time, such as 1950s asylums or 1960s cities, the RB is nomadic in nature. That is, its existence and common social practices are only sporadically visible, through nomadic social entries (hearings); the artifacts produced to delineate its social practice (*Criminal Code*); and the documents it produces (dispositions and reasons for disposition). Outside of these, the RB is relatively invisible although it remains active through its artifacts.

As such, to study the cultural attributes of the RB and to explore the structures and discourses that produce the identities of persons UST or NCRMD, my primary focus was drawn to the moments where the RB made itself visible. In an effort to explore nurses' contribution to

the identity construction of persons UST or NCRMD, I also directed my attention to the operationalization of the reasons for disposition in the forensic psychiatric hospital. This allowed me to understand the discursive crossovers between the health care and legal systems relating to the construction of identities.

Although the general purpose and functioning of the RB is outlined in Canada's federal legislation, the *Criminal Code* (1985), RBs themselves are organized provincially, not federally. The RB hearings are usually held in the designated forensic psychiatric hospitals responsible for the detention or supervision of persons UST or NCRMD. For my research field I have chosen one of the ten designated forensic psychiatric hospitals in Ontario (Government of Ontario, Ministry of Health and Long Term Care, 2013). This choice was driven by my familiarity with the Ontario RB (ORB) and my geographical proximity to Ontario.

4.2.1.1. Entry into the Research Field

Hammersley and Atkinson (2007) explained that when conducting ethnographic research in formal institutional settings, such as hospitals, it is necessary for researchers to identify the gatekeepers—the persons having the authority to grant or deny access to the setting. The researcher's previous personal experience is essential for securing such access (Hammersley & Atkinson, 2007). As a former clinical nurse manager at one of Ontario's designated forensic psychiatric hospitals, I had built relationships with persons in management positions at other forensic psychiatric hospitals across Ontario, enabling me to understand the leadership structure of the Ontario forensic psychiatry system and made me aware of the procedural functioning of the ORB.

These relationships have been indispensable in navigating the procedural particularity of ORB hearings. This particularity relates to the fact that despite ORB hearings being open to the public (*CC*, 1985), they are held in locations typically considered to harbour the utmost level of

privacy: hospitals. I built and fostered relationships with the leadership team at the forensic psychiatric hospital where the ORB hearings were to be held by keeping my communication channels open through frequent email and phone conversations. Furthermore, I maintained email correspondence with the ORB to inform them about my research project and to secure the initial hearing dates (June, July, and August 2019; see Appendix A). However, as the research process progressed, communication with the ORB proved to be increasingly difficult. Although initial communications were fruitful and information exchange was done without difficulty, in July 2019 the person with whom I had been in contact stopped returning my emails. In order to get the information I needed for my attendance at September, October, and November ORB hearings, I had to rely on the gatekeepers at the hospital where the hearings were being held. That being said, I continued to inform the ORB that I would be present at the hearings so they could inform the board members beforehand (Appendix D). I believe the processes detailed above pertaining to accessing the field of research were "appropriate, ethical, and effective" (Soyini Madison, 2005, p. 22).

4.2.2. Data Sources and Data Collection

In discussing the different data sources that can be used to conduct ethnographies, Hammersley and Atkinson (2007) stated: "There is no need to privilege either participant observation or interviewing as the prime source of data" (p. 170). Having taken these words into account, I relied on three data sources: reasons for disposition, direct observations of RB hearings (immersion), and semistructured interviews with forensic psychiatric nurses. These data sources, in conjunction with contextualizing data sources such as case law and the ORB website, allowed for a thorough exploration and problematization of the production of truths about persons UST or NCRMD.

4.2.2.1. Review Board Hearing Observations

I spent a considerable amount of time in the forensic psychiatric hospital attending RB hearings to describe, understand, and reflect on the hegemonic effects of the RB culture (Hammersley & Atkinson, 2007). I observed six months' worth of public RB hearings between June and November 2019, equivalent to approximately 41 hours of immersion. During this time, because of the strict decorum at RB hearings, according to Conroy (2017) I was an observer as participant. Although I had a right to assist at the RB hearings, the role generally given to viewing participants is one of observation, not participation.

At the beginning of every hearing, when given the opportunity by the board chair, I identified myself to the board members as a PhD student in nursing at the University of Ottawa. By identifying myself as such, I enabled the RB to exclude me from the hearing if it "consider[ed] [the lack of my presence at the hearing] to be in the best interest of the accused and not contrary to the public interest" (*CC*, 1985, s. 672.5(6)). This also allowed for the person UST or NCRMD undergoing the hearing to question my presence. However, this never happened. In fact, more often than not, the board did not ask for me to identify myself.

In an effort to limit disparities in what I felt to be important, from one RB hearing to the next, I used an observation guide based on my research questions, empirical literature, and general principles of observation (Appendix E). There are two types of observation guides: one that serves to spatially and temporally delineate observational data collection; and one that serves to draw the researcher's attention to interactions actors have between themselves and in their environments (Martineau, 2005). The guide I built combines elements of both. For example, I was interested in the physical location of the actors during RB hearings and in the nature of the interactions they had with each other. After the first day of observation and after having

discussed my experience with my supervisor, I added a note to pay particular attention to parallel meetings that occurred between different RB parties before and after the official RB hearing.

My observational data collection commenced as soon as I entered on the hospital grounds where the RB hearing was being held. I made mental notes of the facility's structural details, of actors present in the hallways on my way to the room where RB hearings were being held, and of the conversations I overheard in passing. I paid particular attention to the architectural components of the environment such as the location of the hearing room within the hospital, and the number of locked doors I needed to pass in order to access the room. When seated in the RB conference room, I wrote the information I had mentally stored in my fieldwork journal, according to my observation guide. While in the room, I recorded information pertaining to the persons present, their location in the room, their perceived age, ethnicity, and gender, and the interactions they had. I was particularly interested in the verbal, nonverbal, and paraverbal dynamics between the parties at the hearing—the lawyers (Crown and defence), the attending physician, the members of the RB, and the person UST or NCRMD. The questions that board members asked the parties (Crown or defence lawyers) or expert witnesses (such as psychiatrists) and the responses to these questions were also of interest. Moreover, I recorded any mention of a nurse's involvement, explicit or implicit, with the person UST or NCRMD. When the RB hearing was over, I strategically positioned myself to observe informal hallway conversations and interpersonal dynamics between actors present at the RB hearing.

Following the observational data collection, I reflected on questions of power relations, privilege, and inequalities, and how these factors may have contributed to the formalizing of certain truths about persons UST or NCRMD (Bransford, 2006; Hammersley & Atkinson, 2007; Thomas, 1993). Furthermore, throughout my data collection and analysis processes, I discussed

these factors at length with my dissertation supervisor and co-supervisor in an attempt to understand their role in maintaining structures and discourses in positions of hegemony.

4.2.2.2. Review Board Documentary Artifacts

I accessed a number of RB documentary artifacts. I categorized them as *structural documents* or *produced documents*. Structural documents were all the documents structuring the functioning of the ORB and of the hearing, including the *CC*, Supreme Court decisions (e.g., *R v Swain*, 1991; *Winko v British Columbia*, 1999), the Ontario *Mental Health Act* (1990), the ORB guidelines and the ORB website. These documents are all available through online databases (e.g., Lexis Advance Quicklaw, Canadian Legal Information Institute [CanLII], and governmental or paragovernmental websites). Produced documents were the documents produced following the RB hearing, such as the reasons for disposition. Reasons for disposition are publicly available on the Lexis Advance Quicklaw database.

4.2.2.3. Semistructured Interviews With Nurses

Once research ethics board approval was obtained (Appendices B and C), I conducted semistructured interviews with nurses (see 4.2.3 for recruitment strategy). The aim of these interviews was to yield descriptive and experiential accounts of how nurses contribute to RB hearings and of how the RB guides their clinical practice.

Individual participants were offered their choice of where they wanted their interviews to take place, such as in a private room in the hospital, a room at the University of Ottawa, a municipal library, and even a quiet local coffee shop. I informed the participants that I would travel to meet them wherever they chose. The choice of interview location was important given that the environment can influence the type of data produced and affect the data analysis (Gagnon et al., 2015). Participants had to be comfortable and feel physically and psychologically safe in the location they chose and, for the benefit of me as interviewer, it was best for the

interview location to be relatively quiet and void of interruption. In the end, all participants elected to have the interview conducted in a private office in the hospital.

An interview guide (Appendix F) helped me orient the interviews toward answering the research questions. I built the guide following a review of forensic psychiatric nursing empirical literature, and of identity construction theoretical literature. It was also aligned with methodological considerations of critical ethnography (Sorrell & Redmond, 1995). It had guide had six questions and was estimated to take approximately 60 minutes (S. A. Jacob & Furgerson, 2012). The actual interviews took approximately 30 minutes but the whole interview process, including greeting the participant, reviewing the consent form, conducting the interview, and doing a quick debriefing, lasted 60 minutes.

Five out of six participants gave their consent to have their interviews recorded and transferred onto an encrypted hard drive to be transcribed. Once the interviews were transcribed, and subsequently analyzed, the digital recordings were destroyed. I used Poland's (1995) adapted version of Silverman's (1993) transcription guide to ensure the precision and rigour of transcription. That being said, I acknowledge that transcription is difficult and, in itself, represents an interpretation mediated by the transcriber and their subjectivities (Fairclough, 1992). One participant did not consent to have their interview recorded. Consequently, I took notes during the interview and used these notes as an interpretation of the information shared with me by the nurse during the interview.

4.2.3. Sampling and Selection/Recruitment

My sampling and recruitment strategies differed in accordance with the various data sources used for the study, but they were nonetheless interdependent. I chose artifacts—for example, case law, Supreme Court decisions, and reasons for disposition—based on information I collected during RB hearing observations.

4.2.3.1. Review Board Hearing Observations

For a period of six months (June 2019 to November 2019), I attended every annual RB hearing at the selected Ontario forensic psychiatric hospital. This immersion allowed me to observe 27 cases of persons UST or NCRMD being presented before the ORB. To obtain the ORB hearing schedule and their locations for the selected months and the selected hospital, I communicated with the ORB and with the hospital employee responsible for scheduling ORB hearings through email and phone communications. They both provided me with the ORB hearing schedules.

4.2.3.2. Review Board Documentary Artifacts

Based on the RB hearings I observed, I selected four persons UST or NCRMD and accessed all their reasons for disposition, which were made publicly available through the Lexis Advance Quicklaw legal database. For example, if a person UST or NCRMD had had two RB hearings over the course of two years, I included these two reasons for disposition as artifacts in my analysis. In total, I used 18 reasons for dispositions as data for this critical ethnography. In my study, Person 1 had four reasons for disposition; Person 2 had two reasons for disposition; Person 3 had two reasons for disposition; and Person 4 had 10 reasons for disposition.

Inclusion criteria that guided the selection of these documents were: (a) the person having been found UST or NCRMD for a criminal offence or alleged criminal offence; (b) such person being under an ORB disposition listing the chosen forensic psychiatric hospital as the current detention/supervising hospital; and (c) having the latest annual ORB hearing observed in the context of the present study. Only one exclusion criterion applied, namely the presence of an order restricting publication (*CC*, 1985).

I intended my sample of RB documents to be legally and demographically representative of the population of persons UST or NCRMD. For this, I relied on Creswell (2013), who explained that samples for ethnographic studies should be representative of the entire cultural

entity being studied. Contrary to positivist and postpositivist paradigmatic approaches, having a sample that was representative of the population for my research project was not important for generalizability purposes. Rather, having a sample that represented the Canadian UST or NCRMD population permitted for structures and discourses that sustained the construction of their identities to be thoroughly understood and problematized (Creswell, 2013). Specifically, I wanted my sample of persons UST or NCRMD to include persons accused of different alleged index offences, including nonviolent, sexual, and violent offences; persons of female and male genders; and persons of various ethnocultural backgrounds, including non-White, Indigenous, and White.

Furthermore, a variety of RB structural documents were included as RB documentary artifacts for contextualizing purposes. These included documents that I knew were *a priori* important in the RB hearing, such as the *Criminal Code*, and documents whose importance only became apparent following initial data collection and analysis (e.g., *R v Demers*, 2004; *Winko v British Columbia*, 1999; and the *MHA*, 1990).

4.2.3.3. Semistructured Interviews With Nurses

The sampling of nurses working in designated forensic psychiatric hospitals for interview purposes was primarily to be guided by their willingness to participate. As such, purposive nonprobabilistic sampling methods were privileged (Guest et al., 2006). I recruited nurses through direct contact at team meetings and via email, with the authorization of the hospital administration (Appendix G). The following two inclusion criteria guided the selection of nurses: (a) having worked in forensic psychiatry; and (b) having assisted at one ORB annual hearing at least. There were no exclusion criteria. When nurses contacted me—in person, by phone or by email—after having read my recruitment email or after a team meeting, I explained the objective of the study. I told them that all information shared during interviews would remain confidential.

I emphasized that once the interview was transcribed and the transcription analyzed, the digital recording would be destroyed.

Scientific literature on the number of participants needed for qualitative interviews is not unanimous. For example some qualitative studies have as few as five and as many as 168 participants (Royer et al., 2009). Hennink et al. (2017) raised the concept of saturation as a marker for ending recruitment, and considered code saturation differently from meaning saturation. For a study to achieve code saturation, Hennink et al. (2017) explain that only nine interviews are required, whereas a study would need 16 to 24 interviews to achieve meaning saturation. Guest et al. (2006) proposed that for data saturation, when relying on purposive nonprobabilistic sampling methods, six to 12 interviews need to be analyzed. Beyond the numbers, Hennink et al. (2017) put forth the following parameters for researchers to consider when selecting the number of interviews required: the purpose of the study, population studied, sampling strategy, data quality, type of codes, codebook, and the saturation goal (Hennink et al., 2017). These parameters are in line with the ones proposed by J. M. Morse (2000), namely, the nature of the topic, quality of data, study design, and use of shadowed data.

For the current study, I considered the purpose of the study, the quality of the data, and the study design to be the three parameters most relevant for the selection of the number of nurses needing to be interviewed. Since the purpose of my study lay mainly in exploring structures as materializations of discourse allowing for the production of truths about persons UST or NCRMD, even one nurse participant interview could have been adequate. This is because the information produced during the interview would have been treated as an expression of discursive strategies inherent in the forensic psychiatric system. One could argue that interviewing more than one nurse would be irrelevant, since the structures that shape the

information given by every nurse working in a forensic psychiatric system should be the same. However, considering the importance of various contextual factors in relation to the identity construction of persons UST or NCRMD, it was best that I interview a diverse sample of nurses. I wanted to pay close attention to including participants who identified as being part of, for example, equity-seeking groups such as women, Aboriginal people, persons with a disability, visible minorities, and LGBTQ+ people. Although the main discursive framework guiding the production of statements should have been similar among nurses, I anticipated slight differences with respect to how these take shape. I therefore decided to recruit six nurses.

4.2.4. Data Analysis

Ethnographic research relies on various data sources for providing a description and, depending on its philosophical underpinnings, an understanding of the culture being studied. Although this research project was no different, its paradigmatic orientation, objectives, and research questions called for an emphasis on an analytical process anchored in discourse (Hammersley & Atkinson, 2007). Where typical ethnographic analysis depends on a coding of the data into descriptive or functional categories to identify, compare, and transfer findings relating to a group of people beyond its local context, ethnographic research relying on discourse analysis as its analytical method seeks to "employ relatively small amounts of data and are concerned with local patterns visible within particular data sets" (Hammersley & Atkinson, 2007, p. 210). Discourse analysis methods are paradigmatically congruent with the critical ethnographic methodologies (Krzyzanowski, 2011):

> Discourse-ethnographic research becomes a necessity in order to fully account for the dynamics of construction of "new" institutional cultures and identities which . . . in many cases have very complex political and institutional ontology and draw on many existent/previous models of institutional and organizational practices and behaviour. (Krzyzanowski, 2011, p. 235)

Ethnography and critical discourse analysis have been used together in psychiatric environments as a means of providing a structural and discursive understanding of institutional psychiatric practices such as the initial psychiatric interview (Galasiński, 2011). Such an analytical approach allowed me to explore how public safety and psychiatric discourses, and the structures that perpetuate them—such as the ORB, psychiatry, nursing, and the forensic psychiatric hospital—produce statements about persons UST or NCRMD and fix their identities in networks of writing.

I share Foucault's conceptualizing of discourse, namely that discourses constitute historically circumscribed conditions in which particular statements can be considered as true, thereby allowing for a certain representation of reality. It was therefore necessary for me to employ an analytical method that permitted the identification of statements in the context of the ORB. However, the discourse analysis process that Foucault (1969/2010) described in *The Archeology of Knowledge* and in *The History of Sexuality: An Introduction* (Foucault, 1976/1990a) focuses heavily on the identification of historical discontinuities in the production of statements, in order to describe how various discourses appeared over time. In effect, this is the process Foucault used in his genealogies; see for example, *Discipline and Punish* (Foucault, 1975/1995) and *Madness and Civilization* (Foucault, 1965/1988). Although theoretically robust, Foucault's approach to discourse analysis is complex and did not quite meet my methodological needs. Instead of a process to identify historical discursive discontinuities, I required a method that would assist me in identifying statements produced about the identities of persons UST or NCRMD in order to problematize the structures and discourse(s) that enabled their production. As such, I leveraged Fairclough's (1992) discourse analysis method.

Instead of using Foucault's (1969/2010) concept of *statement*, Fairclough (2001) suggested that the interaction between semiosis and "other elements of social practice," namely "productive activity," "means of production," "social relations," "social identities," "cultural values," and "consciousness" (pp. 122–123) are materializations of discourse. Semiosis is broader than written or verbal language, in that it includes visual images and body language. Somewhat similarly to Foucault, Fairclough (1992) proposed that a discourse

> is shaped and constrained by social structure in the widest senses and at all levels: by class and other social relations at the societal level, by the relations specific to particular institutions such as law or education, by systems of classification, by various norms and conventions of both a discursive and a nondiscursive nature, and so forth. (p. 64)

Furthermore, he specified that discourses "contribute[s] to the constitution of all those dimensions of social structure which directly or indirectly shape and constrain it: its own norms and conventions, as well as the relations, identities and institutions which lie behind them" (Fairclough, 1992, p. 64). Discourse(s) thereby shape(s) the interactions between semiosis and elements of social practice and make up what we consider to be "material social processes"—that is, reality. Therefore, these interactions are events because, much like Foucault's (1969/2010) statement (see Chapter 1), they simultaneously influence and are influenced by social practices and modulate the production of truths:

> Social practices networked in a particular way constitute a social order. . . . The semiotic aspect of a social order is what we can call an order of discourse. It is the way in which diverse genres and discourses are networked together. An order of discourse is a social structuring of semiotic differences. . . . One aspect of this ordering is dominance: some ways of making meaning are dominant or mainstream in a particular order of discourse; others are marginal, or oppositional, or "alternative." (Fairclough, 2001, p. 124)

The structure of semiotic elements, enabled by social practice, permits certain truths to be produced and reality to be represented in a certain way. The aim of Fairclough's critical discourse analysis is to untangle and question this structure by focusing on interactions between

semiosis and social practice in the production of statements. I delved into the semiotic elements constituting the ORB culture to identify, understand, and question the structures inherent in the RB hearing that permitted the production of truths about the identities of persons UST or NCRMD.

Fairclough's (1992) discourse analysis framework assembles this analytical process into three steps: the discursive practice, discourse as text, and discourse as social practice. Fairclough liked this sequence because starting with discursive practice allows researchers to begin analyzing a text from a production and consumption perspective. Then, analyzing discourse as text permits for a deep dive into the intricacies of the text. Finally, finishing with the analysis of the text as a social practice, allows for the analyst to take a step back and consider the structures and discourse(s) sustained by it.

I applied Fairclough's (1992) first two analytical steps to all three of my data sets independently: the interview transcripts (n = 6); my RB hearings observation notes (n = 27); and the four series of reasons for disposition (n = 18). For the reasons for disposition, I analyzed each one of the four profiles as independent texts, composed of the many reasons for disposition (Profile 1: n = 4; Profile 2: n = 2; Profile 3: n = 2; Profile 4: n = 10). Finally, in the discourse as social practice step, I considered my results in their totality. This allowed for a comprehensive understanding of how RB hearings operated as an integral identity-producing ritual to perpetuate the forensic psychiatric system's mandate of preserving public safety.

4.2.4.1. Analysis of Discursive Practice

Fairclough (1992) wrote that the method of analyzing discursive practice entails an analytical process aimed at understanding why texts are produced, for whom, how they are consumed, and what social factors are involved in each of these dimensions. He broke down this analytical step into five substeps, two of which focus on text production (interdiscursivity and manifest

intertextuality); one on text distribution, that is, intertextual chains; one on text consumption or coherence; and one on social aspects of texts.

4.2.4.1.1. Interdiscursivity. For this step, I sought to decipher the interplay of genres during RB hearings, that is to say the various conventions that constrain how actors behave during a social activity (Fairclough, 1992). I problematized how this interplay allowed for certain statements to be made and for a certain "order of discourse" to be maintained. In this same vein, Foucault (1976/1990a) explained that

> . . . to be more precise, we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies. It is this distribution that we must reconstruct. (p. 100)

By focusing on the RB hearing as a social activity, I identified various genres linked, in one way or another, to RB hearings and which allowed for the production of truths about persons UST or NCRMD.

4.2.4.1.2. Intertextuality. When analyzing the different data elements, I paid attention to manifest intertextuality, which occurs when "other texts are overtly drawn upon within a text" (Fairclough, 1992, p. 117). To do this, I identified areas where other texts were mentioned within my data, such as case law mentioned during an RB hearing, and questioned why and how they were used. To make sense of the social activity in which these discursive events were inscribed, I contrasted the genres of the manifested texts, such as journal articles, legal texts, expert reports, or scientific literature, with the genre of the text being analyzed (per Fairclough, 1992). When analyzing the reasons for disposition, for example, I problematized the use of the hospital report as a source of truth in the assessment of the person UST or NCRMD's dangerousness.

4.2.4.1.3. Intertextual Chains. I studied intertextual chains to understand how texts were distributed (Fairclough, 1992). To do this, using the data I collected, I analyzed other texts that

were used in their creation and how they were leveraged. For example, the *Winko v British Columbia* (1999) Supreme Court of Canada decision was often explicitly and implicitly referred to during the RB hearings and in reasons for disposition, so I was interested in understanding how, and why, that decision was used. I also looked into how the data I collected were used within other texts.

4.2.4.1.4. Text Consumption. Fairclough (1992) suggested looking at the different components of a text—its sentences, for example—to pay particular attention to the way they relate to each other and to the text as a whole, and to the way they need to be interpreted by the receiver. He proposed that the analyst consider such specific questions as whether the text was heterogeneous, whether there was ambivalence in the text, and whether any inferential work needed to happen for a receiver to understand it in a coherent way. He gave the following example: "what establishes the coherent link between the two sentences 'She's giving up her job next Wednesday. She's pregnant', is the assumption that women cease to work when they have children" (Fairclough, 1992, p. 84). This process allows for the potentially resistant receivers of the text's interpretation—receivers who would not necessarily make the coherent connection between sentences—to be identified.

4.2.4.1.5. Social Aspects of Texts. Lastly, I considered Fairclough's (1992) fifth step in analyzing discursive practice: the social aspects of the production and consumption of texts. I looked into who produced texts and how they were produced. I also looked at the way they were used.

4.2.4.2. Analysis of Discourse As Text

Next, I took Fairclough's (1992) second step, analyzing discourse as text. Based on Fairclough's background in linguistics, this analytical step is not entirely congruent with Foucault's genealogical or archeological work. However, it provides a good way to observe how structures

function, in networks of writing, to fix truths about persons UST or NCRMD. Fairclough divided this second analytical step into eight substeps, which I present below.

4.2.4.2.1. Interactions Within Texts. Fairclough (1992) suggested that analysts consider "interactional control." I looked at who controlled interactions within the text. I gave importance to the presence of rules and the exchange structure in the text. I delved into how the topics were introduced, how they were developed, how they were established, and by whom. I also considered the content of the information being discussed during RB hearings and if it was policed.

4.2.4.2.2. Cohesion. I paid attention to the cohesion between sentences and clauses, that is, how statements are textually positioned to give a text its ethos and to represent reality in a certain way (Fairclough, 1992). I looked at the way sentences relating to one another by studying how authors framed their deductions, rationalizations, and descriptions (Fairclough, 1992; Foucault, 1969/2010). This analytical step is analogous to Foucault's (1969/2010) rhetorical schemata relative to a group of statements and is inherently important in discourse analysis, since it may evoke the text's discursive construction and "order of discourse."

4.2.4.2.3. Politeness Strategies. Fairclough (1992) said that discourse analysts must analyze politeness strategies used in a text, their purpose, and the different ways they were used depending on the actors using them. He explained that this attention to politeness is crucial because

> . . . particular politeness conventions embody, and their use implicitly acknowledges, particular social and power relations, and in so far as they are drawn upon they must contribute to reproducing those relations. A corollary is that investigating the politeness conventions of a given genre or discourse type is one way of gaining insight into social relations within the practices and institutional domains with which it is associated. (Fairclough, 1992, pp. 162–163)

I identified politeness practices. Some allowed for certain voices to be heard, such as health care professionals, psychiatrists, and RB members. Some allowed for others to be dismissed or silenced, such as persons UST or NCRMD and their families. Taking it a step further, Fairclough explained that he considered the politeness conventions of a discourse to be dialectical. Therefore, by analyzing politeness strategies, one can act in a way to change, alter, and reverse the hegemonic position of certain discourses. This dialectical perspective is not in line with Foucault's epistemological perspective: regardless of the situation, we are always bound by power relations; any actions we take are taken within a certain discursive matrix (McHoul & Grace, 1993). Thus, when we act on politeness conventions within a social practice, we may certainly disrupt the relations of power, but by doing so within another discursive framework we may produce other truths—truths that may replicate the hegemonic system of truth (Fairclough, 1992; Foucault, 1966).

4.2.4.2.4. Ethos of the Text. Interactions between participants allow for social identities to be constructed: "ethos [then] is manifested by the whole body, and not just the voice" (Fairclough, 1992, p. 167). Relying on an example of a doctor-patient interaction, Fairclough (1992) wrote:

> It is not just the way in which doctors talk that signals ethos; it is the cumulative effect of their total bodily disposition—the way they sit, their facial expression, their movements, their ways of responding physically to what is said, their proxemics behaviour. (p. 167)

When analyzing my observations of RB hearings, I paid attention not only to the information that was presented orally, but also to the ways in which the different actors responded to that information.

4.2.4.2.5. Grammar of the Text. The grammar of a text can be examined in three distinct substeps: the ideational function or transitivity, the textual function, and the interpersonal

function of language (Fairclough, 1992). To delve into the ideational function of language, Fairclough asked analysts to take a look at the preference the author(s) gave to certain participants and to certain type of processes such as events, actions, relations, and mental processes. He also suggested they look at whose voice is being represented, and how (in processes of nominalization, expression of causality, and attribution of responsibility). To analyze the textual function of language, he recommended looking at its frequency of themes, the reason behind this frequency, and the assumptions underlying the thematic structure. To decipher the interpersonal function of language, Fairclough urged analysts to look at the frequency of modalities, such as *is*, *may*, *possible*, *definitive*, or *think*, in order to assess the social relations and see how reality is represented.

4.2.4.2.6. Cultural and Social Contextual Meaning. Fairclough (1992) suggested looking at the different meanings of words in their cultural and social contexts. With this step, the analyst may be able to understand if certain power relations support the hegemony of one particular structure or discourse over another—if a struggle or tension between them has been created.

4.2.4.2.7. Theoretical and Ideological Meaning. Analysts must pay attention to the actual wording used in the text being analyzed. Fairclough (1992) suggested looking at the theoretical, cultural, and ideological meaning of certain words, and exploring the differences and similarities of such meanings in other texts. For example, I reflected on the use of the following words and phrases in the texts constitutive of my data set: *privileges*, *antisocial/pro-social behaviours*, and *compliance*.

4.2.4.2.8. Metaphor. Fairclough (1992) suggested taking a deeper look at the use of metaphors within the text. Analysts should focus on their meanings, and on how they have been

used in other texts, if applicable. In my observations, a metaphor used by a psychiatrist describing the constant threat of a person UST or NCRMD's readmission to the forensic psychiatric hospital was a "sword hanging over their heads." This "sword," forcing a person UST or NCRMD to comply with disposition requirements, is particularly evocative of this analytical step and of its importance.

4.2.4.3. Analysis of Discourse As Social Practice

Fairclough's conception of discourse analysis is most aligned with Foucault's in his analysis of discourse as social practice. During this step I made use of my theoretical framework to understand how and why the forensic psychiatric structure produced very distinct identities for persons UST or NCRMD. I looked at the different structures and power relations that constitute RB hearings. In particular, I questioned the effects of structures and their contribution to their own reproduction, maintenance, and transformation. When delving into the analysis of power relations, I was particularly interested in their patterns, distributions, and the strategies by which they took effect at the local level, namely on the bodies and identities of persons UST or NCRMD and on those of forensic psychiatric nurses (Foucault, 1969/2010). Somewhat complementarily, I was also interested in the different patterns, distributions and the strategies by which resistant practices took effect (Foucault, 1969/2010).

By adhering to Fairclough's (1992) three-tiered analytical process to analyze discursive formations in my three data sources, I was not only able to describe and explain the culture that underpinned ORB hearings, but I was also able to engage in a reflexive dialogue with the ethnographic data. This provided me with an understanding of the identity construction processes at play during RB hearings and allowed for a problematization of the role of nurses in this system of subjection. I analyzed the three data sources—nurse interviews, observation of hearings, and reasons for disposition—independently, using Fairclough's first two steps. Then, I

looked at their areas of convergence and divergence using his last analytical step. Out of this analytical process, I was able to understand the instrumental role of forensic psychiatric nurses in maintaining and sustaining RB hearing processes. The process enabled me to follow the construction of "dangerous" identities for persons UST or NCRMD, from the hospital milieu to the RB hearing, and to their formalizing within the reasons for disposition. The analysis culminated in a critique of RBs, and of the overall forensic psychiatric system, as institutions which reinforce an order of discourse by producing persons UST or NCRMD as dangerous individuals.

4.3. Ethical Considerations

All research projects involving humans require some attention to be directed toward procedural ethics (Tracy, 2010). For Tracy (2010), procedural ethics refers to "ethical actions dictated as universally necessary by larger organizations, institutions or governing bodies" (p. 847). Such actions consist of typical research ethics considerations, including research ethics board (REB) approvals, participant consent, and confidentiality of data.

4.3.1. Research Ethics Board Approvals

Once all required REB approvals were obtained (Appendices B and C), I started recruiting nurses for interviews. While awaiting REB approval for the interviews, I commenced some data collection stemming from publicly available sources, namely RB documents and observations of RB hearings.

4.3.2. Participant Consent

In accordance with Article 2.3 of the Tri-Council Policy Statement (TCPS; 2014), collecting and analyzing data pertaining to RB documents and RB observations did not require consent, or REB approval, to be obtained because:

> it does not involve any intervention staged by the researcher, or direct interaction with the individuals or groups;
>
> individuals or groups targeted for observation have no reasonable expectation of privacy; and
>
> any dissemination of research results does not allow identification of specific individuals.

My primary role at RB hearings was as observer. Since RB hearings and RB documents were legally public, persons participating in the RB hearings consequently had no reasonable expectation of privacy (*CC*, 1985).

Conducting semistructured interviews with nurses required REB approval and informed consent to be obtained from the nurses. The consent form I used included the title of the study, an invitation to participate, a description of the purpose of the study, the requirements of participation, risks and benefits associated with participation, confidentiality, anonymity and its limits, modalities of data conservation, an assertion of participation being voluntary, an acceptance statement, and participant and researcher signatures (see Appendix H). The participant's signature signified they understood the information present on the consent form. When providing a consent form to prospective participants, I invited them to take time to reflect on whether they wanted to participate in the study, and to contact me if they had any questions about it. If the participant consented to be interviewed, I asked them to select a venue.

Once the interview venue was selected, I met the participant, answered any residual questions about the study, and proceeded to obtain their signed consent. In line with Article 3.5 of the TCPS (2014), the interview only commenced after consent had been obtained. At the beginning of the interview, I reiterated to the interviewees that their participation was voluntary and reminded them of their right to not answer specific questions, or to terminate the interview at any time without fear of reprisals or need for justification. I also emphasized that I had not

collected or conserved any information allowing me to contact them after the interview, such as their email address or phone number. Thus, I told them that I would not be able to communicate with them after the analysis of the data to share study results. However, I informed them that it they wanted to obtain study results, they could contact me individually.

4.3.3. Risks of Participation

Nurses participating in this study may have felt that the purpose of the interviews was to evaluate their practice. For that reason, I emphasized in the consent form and at the beginning of the interview that the purpose of the study was to explore nursing practices, not to evaluate them. The participants also needed to share information about their professional practice as nurses in forensic psychiatry, which could have caused feelings of emotional and psychological discomfort. Under no circumstance were they required to answer questions that had the potential to cause such feelings. If the nurses were to feel any feelings of anxiety, apprehension, or elevated levels of stress, I would have directed them to their employee assistance program (EAP) to receive appropriate support. If they were to experience these feelings during an interview conducted in a public location, I would have contacted appropriate emergency services (by calling 911). These contingency plans did not need to be used.

4.3.4. Benefits of Participation

Nurses did not directly benefit from participating in this research project, nor did they receive compensation for their participation. However, by participating in this study, they contributed to knowledge development in nursing, and to forensic psychiatric nursing in particular. They were informed that they were part of a project that sought to explore how ORBs, assisted by health care professionals, constructed identities for persons UST or NCRMD.

4.3.5. Confidentiality and Anonymity

In ethnographic research, confidentiality of data extends beyond interview recordings and transcriptions; it applies to all sources of data, such as observations and documentary artifacts in this case. To ensure confidentiality of data and anonymity of participants, all data—including observations, documentary artifacts, interview transcriptions, and related notes—were kept in a secure location in my supervisor's locked office at the University of Ottawa. Access to the raw data was limited to my supervisors and to myself. Moreover, the interview recordings and transcriptions excluded any identifying information, including the hospital name and city in which it was located, and were identified with an alphanumerical code (e.g., N01). Fictitious names will be used in all publications resulting from this research project, to protect the identity of persons UST or NCRMD and of nurses. Hospital names, city names, and detailed descriptions of high-profile crimes were also excluded from transcriptions. However, given the data collection methods involved, there were certain limits to participants' anonymity, given the conduct of interviews and obtaining the nurses' signed consent. First, I knew the identity of the interviewees. Second, I held a master list linking signed consent forms, alpha-numerical codes, and transcripts, all of which were locked in the office of one of my co-supervisors. This list was necessary to uphold the guarantee that participants could withdraw themselves and their contributions from the study at any point, even after the interview was finalized.

4.3.6. Data Conservation

All raw data will be kept for 10 years from the completion of the project in a locked location in the office of one of my two co-supervisors at the University of Ottawa; then it will be destroyed. This exceeds the five-year minimal requirement defined in Article 5.1 of the Internal Guidelines and Procedures of the University of Ottawa Office of Research Ethics and Integrity (University of Ottawa, 2018).

4.4. Rigour Criteria

In her self-proclaimed conceptualization of eight "universal hallmarks for qualitative methods across paradigms," Tracy (2010) suggested that "each criterion of quality [eight of them] can be approached via a variety of paths and crafts, the combination of which depends on the specific researcher, context, theoretical affiliation, and project" (p. 837). The rigour of this research project, from its conception to the production of this dissertation, has been ensured by my commitment to three important criteria of the critical ethnographic methodology: credibility, reflexivity, and aesthetic merit. The work of D. Davies and Dodd (2002) and Richardson (2000), in addition to Tracy's (2010) study, have served as guides to ensure that my research was as rigorous as possible.

4.4.1. Credibility

Credibility can be divided in two elements: auditability and crystallization. Auditability refers to the ability of ethnographers to substantiate their results with detailed descriptions of their analytical process (Baumbusch, 2011); "showing rather than telling" (Tracy, 2010, p. 840). My compliance with this criterion originates in the detailed description and explanation of the inferences I make in the Chapters 5 and 6.

Crystallization refers to the use of multiple sources of data in order to "open up a more complex, in-depth, but still thoroughly partial, understanding of the issue" (Tracy, 2010, p. 844). Crystallization, as opposed to triangulation, is in line with historical realism. Whereas triangulation seeks to have multiple data sources to confirm or challenge a given truth (Baumbusch, 2011; Hammersley & Atkinson, 2007), crystallization seeks to expose the multiplicity of truths and engage with the complexities inherent in various social processes (Tracy, 2010). I achieved this criterion by using three sources of data—RB documents, hearing observations, and interviews—and by selecting discourse analysis as my data analysis strategy.

Furthermore, I used structural data sources, such as the ORB (n.d.) website; *R v Demers* (2004), *R v Swain* (1991) and *Winko v British Columbia* (1999) decisions; and Ontario's *MHA* (1990). These sources historically contextualized the data, enhancing the credibility criterion of rigour since they provided an understanding of the legal and political structures and contexts which the data were produced.

4.4.2. Reflexivity

In critical ethnography, the explicit demonstration of reflexivity practices in the final ethnographic product is an epistemological ethical concern (Richardson, 2000). Critical ethnography, like any other knowledge-production methodology in human sciences, reveals truths about human nature, human potential, and the future of the human condition (McHoul & Grace, 1993). In that sense, despite its dialogic methodological roots, critical ethnography produces knowledge about the Other and, to an extent, produces the Other (C. A. Davies, 1999). While acknowledging that I was somehow contributing to the problem I was attempting to research by engaging in this study, I ensured that my analytical process and my reflexive thoughts were thoroughly detailed. Certain of these reflexive thoughts were also the precursors of analytical problematizations. In line with Richardson's (2000) ideals of reflexive practice, I demonstrated in Chapters 5 and 6 the link between the data and their analysis, my theoretical inclinations, my practices of reflexivity, and the problematizations I proposed.

4.4.3. Aesthetic Merit

Aesthetic merit is a most difficult rigour criterion to achieve, but a crucially important one for critical ethnographers. Considering the fact that the desired outcome of critical ethnography studies is to inspire change and transformation, the textual result of the critical ethnography must be so aesthetically presented as to have enough of an impact on readers to compel them to take action (Richardson, 2000; Tracy, 2010). Tracy (2010) wrote: "Like a good song or a good piece

of pie, a good qualitative report is not boring. It surprises, delights, and tickles something within us" (p. 845). Through the methodical use of Fairclough's discourse analysis, anchoring the results in the data collected and their analysis within a robust theoretical framework, I believe the aesthetic merit criterion has been achieved.

Chapter 5: Results

For this chapter, I chose a structured approach that mirrors data collection sources to present the results of my ethnographic research. The chapter is divided in three sections: nurse interviews (*n* =6); observation of RB hearings (*n* = 27; 41h); and reasons for dispositions (*n* = 18). The results will show the reader how RB hearings operate and help them understand how they produce identities of persons UST or NCRMD as well as those of nurses (see Figure 4).

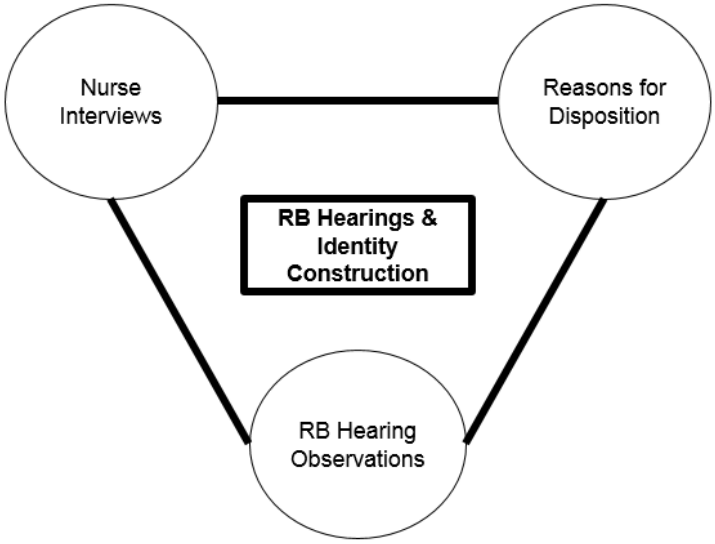

Figure 4. Schematization of major result headings.

5.1. Nurse Interviews

Six semistructured interviews conducted with nurses shed light on various rituals, internal to the forensic psychiatric hospital, that took place alongside RB hearings (see Figure 5).[1] Participants highlighted two main rituals. A process by which health care professionals prepared persons

[1] One of the nurses interviewed, identified as N02 in my results, did not feel comfortable for her interview to be audiorecorded. Therefore, the quotes of nurse N02 presented in this chapter are not verbatim excerpts but rather segments of notes I took while she responded to my interview questions.

UST or NCRMD for RB hearings is detailed in 5.1.1. In 5.1.2, a privilege system that progressively granted liberties to persons UST or NCRMD is described.

Through exploring these rituals, two themes became apparent. The first, reviewed in 5.1.3, relates to the visibility and invisibility of persons UST and NCRMD in the various hearing and hospital processes. As objects of discussion, persons UST or NCRMD were made hypervisible by nurses and forensic psychiatric hospitals, but as subjects capable of discussion, they were invisible. The second theme, presented in 5.1.4, speaks to the identity conflict nurses experienced when trying to locate their professional identities within the custodial aim of the forensic psychiatric hospital. This was named by one nurse as a "dissonance in the natural nursing psyche." Nurses disclosed experiencing feelings of confusion linked to the apparent incongruence between their identity as health care professionals and the custodial identity they embodied as employees of a forensic psychiatric hospital.

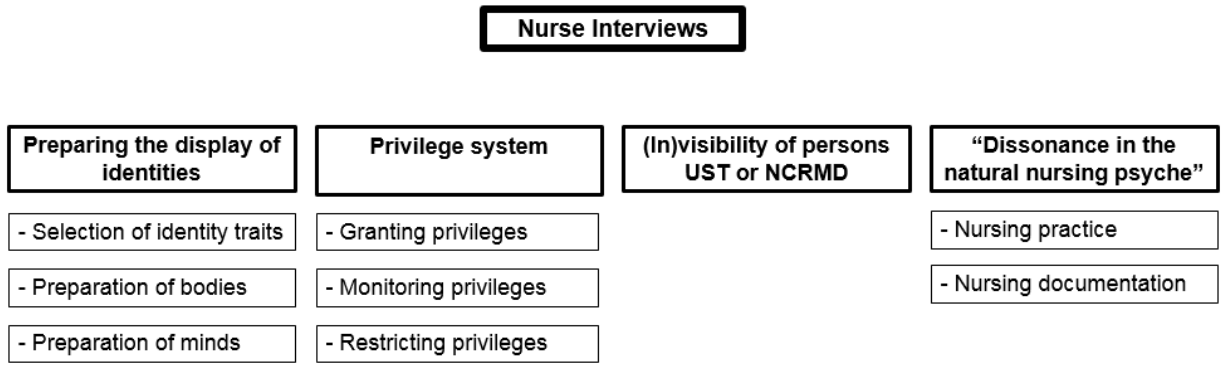

Figure 5. Schematic of results stemming from nurse interviews.

5.1.1. Preparing the Display of Identities

In this study, a continuum of interventions were directed to the bodies and minds of persons UST or NCRMD as they went through the RB process. These included the interprofessional meetings (called "case conferences") where health care professionals prepared how the behaviours and

thoughts of persons UST or NCRMD would be described during RB hearings. Other interventions were those geared toward preparing their bodies and minds on the day of the hearing, and those aimed at managing the outcomes of RB hearings.

5.1.1.1. Selection of Identity Traits

RB hearings are significant events for forensic psychiatric hospitals, their employees, and for persons UST or NCRMD. At annual hearings, RB members evaluate compliance with previous RB decisions and examine ongoing public safety concerns. In anticipation of these hearings, forensic psychiatric nurses, as members of a health care team, participate in the preparation of how persons UST or NCRMD will be presented to the RB.

To do so, the nurses in this study explained that in the weeks prior to RB hearings, hospitals hold "pre-RB conferences." During these conferences, members of the health care team would analyze significant events that characterized the time frame between the previous RB hearing and the day of the conference, such as aggressive episodes, rule breaking, physical health, medical procedures, family involvement, usage of as needed medications, positive urine toxicology screens, and progression within the privilege level process. They would also examine the mental health indicators of persons UST or NCRMD, including their mood level and psychotic episodes; review individual goals; and plan living arrangements for the upcoming year:

> We look back at the notes. We look for incidents, whether they were good or bad. You know, how many times they went out in the community this last six weeks, if they had family involvement in the last six weeks, if they had any medical procedures we would write that down, whether it's the dentist or how many PRNs [as needed medications] they have had, how their mood level was or if they had any psychotic episodes, so we take those and all positives, like, "patient had an increase in privileges," so if you have started out with a "one to four" within that year but you can have up to "independent on the grounds," we will see the increase and we will report that as well and, any bad incident, like, if they were aggressive or like a risk assessment they do at every conference, right? And, so all those are presented and hopefully you see a progression to the positive, right? (N06, lines 84–105)

A variety of discussion items would be brought up by nurses during pre-ORB conferences. However, nurses drew a particular focus on incidents that spoke to the moral character of persons UST or NCRMD, such as their compliance with their treatment plan; their disposition, behavioural expectations, and family involvement. Emphasis was placed on identifying concrete examples suggesting behavioural or cognitive deviancy, that is, "incidents," and not on efforts made by persons UST or NCRMD, through introspection or coping strategies, to overcome these difficult events. This emphasis may have cast a shadow over possible support and counselling interventions provided by nurses to assist their patients through the RB hearing process.

The pre-ORB conferences were not presented as stand-alone team meetings. Rather, they inserted themselves into a larger system of conferences that took place at fixed six-week intervals throughout the year:

> [The nurse] explained that the institution usually meets formally as a team about patients every six weeks and that the information reviewed accounts for the previous six weeks. However, before a review board hearing, the team meets but that the content of the meeting is a cumulative discussion about the previous year. She explained that every member gives input and discusses what the patient wants to get out of the hearing. (N02, lines 24–30)

The nurses described the case conferences as multidisciplinary meetings where various health care professionals gathered information to paint a picture of the progress of persons UST or NCRMD:

> So it's the multidisciplinary team; all the allied staff, the group nurse is in there, psychology, rec staff even you know, everybody that's involved in their care and the doctor of course, and nursing staff. So usually the team lead is in there and then the assigned nurse for that day might be in there as well. (N01, lines 48–53)

Including numerous health care professionals in these meetings validated and legitimized the production of truths about the progress of persons UST or NCRMD. The discussions were presented as being humanistic endeavours seeking to "do what is best for the patient." One nurse

explained that “the hearing was a big discussion looking at all the information and at what the patient wants. With all that information, the team comes to a conclusion about doing what is best for the patient” (N02, lines 56–59). Some nurses spoke of the pre-ORB conference as a cohesive, harmonious, and well-rounded discussion where the team of health care professionals could arrive at a consensus relating to the best course of action for persons UST or NCRMD. Yet the ways in which other nurses spoke about these meetings described hierarchical, ordered conversations in which some people (such as recreation therapists and persons UST or NCRMD) were more or less accessory to the process, while others (such as medical doctors) were indispensable.

Psychiatrists hold a hegemonic position in relation to other professions during pre-ORB conferences and, as such, have the authoritative legitimacy to decide how persons UST or NCRMD are presented during RB hearings. On that topic, one nurse compared psychiatrists to school teachers and said: “teacher[s] could make or break it for you, right? So can doctors” (N06, lines 526–528). I asked her what she meant by this. She responded: “I asked doctor [name of doctor] one time, ‘If we all disagree with something, does the doctor have the last say?’ and he said ‘pretty much’” (N06, lines 547–549). Another nurse explained that the health care team did not have the opportunity to disagree with recommendations formulated by psychiatrists, because its members did not necessarily see the report before it was submitted to the RB:

> I haven’t really seen it where the team disagrees with the doctor’s report or what the doctor’s going to ask because the team really doesn’t see that report. Unless they go into the chart and read it. So they don’t necessarily know what the doctor’s going to recommend. (N04, lines 79–85)

Most of the information produced by nurses and other health care providers about persons UST or NCRMD was unidirectionally reported to the psychiatrist before being presented to the RB:

> Then that [information] is presented at [the conference], that's what the doctor uses for references and, he generally gets a lot of his information from the front line workers because we're with them 24/7, right? And that makes him decide what he wants to present to the board. (N06, lines 67–71)

> 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-and-and have a good understanding. (N05, lines 161–165)

Interestingly, nurses described themselves as simultaneously subjugated by the unidirectional flow of information and as essential components to this process.

5.1.1.2. Preparation of Bodies

Nurses described various activities relating to the preparation of the bodies of persons UST or NCRMD in anticipation of their RB hearings. These activities included coordinating the movement of those persons within the hospital and encouraging their proper physical appearance.

On days where their assigned patients had RB hearings, nurses ensured that institutional requirements relating to the movement of persons UST or NCRMD within the hospital were respected. The following except exemplifies the logistical responsibilities of nurses in this regard:

> I think is, first, it's just basic logistics too, making sure there's enough staff around, especially the ORB week, usually it happens in one week, so there's sort of a blitz of lots of patients having ORB hearings, and so making sure the staff is aware and can accommodate taking people down, there's a bit more circulation on the unit because patients are coming down, one back up, coming down, and, usually they'll often like to have a nurse around as well, at least before and after the hearing. So, I think logistically just making sure proper staffing is available for patient flow and movement. (N05, lines 103–112)

Forensic mental health nurses must possess particular medical and legal knowledge to ensure that persons UST or NCRMD attend their RB hearings, including a legal and procedural understanding of RB hearings. However, in the research interviews they did not describe the

substance of this knowledge. The way they did talk about it, as in “basic logistics,” served to devalue this knowledge.

Nurses were concerned about the physical appearance of persons UST or NCRMD. They explained the need to support, motivate, and assist them in their activities of daily living so that they would be physically presentable at their hearing—that is, to appear as normal as possible to members of the RB—clean, hair combed, shaved, fed, and medicated:

> I think usually checking with the patient, making sure they’re well dressed, ready to go, well groomed, most of them will take the initiative themselves, but still, some still need prompting, like “this is an ORB hearing come on, have your shower that morning, comb your hair back, have a shave,” sometimes the nurses will shave them themselves (laugh) so I think having that supportive nursing approach, a holistic approach of saying look come, present yourself well, . . . but we don’t want to rush it and make it a stressful process either, just come on you got a shower and all this, but I think it’s more very supportive a role. (N05, lines 114–125)

The nursing goal of making the bodies of persons UST or NCRMD look “well groomed,” “shaved,” and “well dressed” for RB hearings demonstrates what nurses considered to be a normal body and, in some way, constituted a reflection of the quality of nursing care received by patients in forensic psychiatric hospitals. Making the bodies of persons UST or NCRMD look normal is ironic in this context, considering that the overall dynamic of the RB hearing, in most cases, seemed directed at justifying the reasons why they were dangerous (see 5.2.2). In addition, this practice underlined the importance given to RB hearings and underscored the subjugated position that the RB placed persons UST or NCRMD.

5.1.1.3. Preparation of Minds

Nurses described palpable changes in their patients’ behaviour as well as in the overall atmosphere of the unit, when RB hearings were about to be held at the hospital:

> You just feel it, or I think it’s more of a feeling where you can sense a lot of patients who have their ORB hearings that week are a bit more nervous, a little bit more reclusive, less talkative. . . . Anxiety can be a way that escalates harmful

> behaviour, so that's certainly when we see people more reclusive. (N05, lines 130–135)

In light of these changes, nurses mentioned they provided support to persons UST or NCRMD in an effort to prepare them for the potential discomfort caused by the RB hearings. This support can be described as on a continuum: pre-hearing, during the hearing, and post-hearing.

Pre-hearing support meant that nurses modified patient assignments, to ensure persons UST or NCRMD who had scheduled RB hearings were assigned to a nurse with whom they had developed rapport:

> And if we can, I guess, [we] work it out between the staff on that day who has the best rapport with the resident, who could actually, you know, be there throughout the process to provide rapport, to provide support I should say, and [it] usually helps if there are challenges for that resident during the day. (N03, lines 28–33)

The relationship developed by nurses and persons UST or NCRMD served a dual purpose. First, persons UST or NCRMD could feel supported as they went through the RB hearing. Second, nurses knew that this privileged relationship ensured a certain level of docility, which helped prevent behavioural challenges in the persons UST or NCRMD during the RB hearing and throughout the day on which it was to take place.

Also included in pre-hearing support was the provision of general reassurance:

> 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 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. (N03, lines 10–16)

Interestingly, one nurse believed that this type of supportive intervention served as a way to align the expectations of persons UST or NCRMD 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. (N05, lines 45–63)

Aligning the expectations of persons UST or NCRMD with the "reality of the RB" seems equivalent to preparing persons UST or NCRMD to agree with the recommendations put forward by the forensic psychiatric hospital.

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 formalize the hospital's recommendations in a disposition:

> Sometimes, there are those interesting moments where [persons UST or NCRMD] are going to request a conditional or absolute discharge, right, and we [the hospital] are not too sure, you know, 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, they [RB hearings] are formalities almost, we go through it, and hope that, they have this sense of importance. (N05, lines 65–72)

The use of the pronoun "we" here indicates that nurses saw themselves as extensions of the forensic psychiatric hospital; their practice was aimed at bringing persons UST or NCRMD to accept and internalize decisions made by the hospital. Strikingly absent from the nurses' descriptions of their role in anticipation of the RB hearing was providing general information to persons UST or NCRMD about the RB hearing procedures, the possible outcomes of the hearing, and their rights throughout the RB hearing process.

Unlike pre-hearing support, support during RB hearings place emphasis on physically accompanying persons UST or NCRMD and managing emerging emotional reactions at RB hearings:

> I've had quite a few occasions where they [persons UST or NCRMD] have asked me specifically "Can you come? Can you be there?" just sort of as a show of support. . . . So whenever I am invited, I try to be there . . . and just to show support for the patient, keep building a therapeutic alliance, and every time I have been to a review hearing, on that the patient asked me to attend, they were quite thankful afterwards. (N05, lines 23–32)

> Not everybody wants somebody with them [during RB hearings]. There's specific patients that don't but generally, the major population does want somebody in there for support and encouragement, basically just there for support. We don't have any say at the review boards but we're like the familiar one, we're the familiar face and sometimes they want coffee (laugh). (N06, lines 15–20)

Persons UST or NCRMD were expected to be present during RB hearings, follow the rules of the RB, and control their reactions while being exposed to information that might be difficult to hear and to decisions that might deprive them from some of their basic human rights, such as freedom of movement. The presence of nurses during RB hearings was meant to help make persons UST or NCRMD feel supported through the stressful process. One focus of the nurses was on the way persons UST or NCRMD reacted to the potentially hurtful information being said about them:

> Then we get into the actual room itself and, it's mostly, the focus is on the resident, how they're reacting to things and, it's not really, the information being discussed in those is, is interesting but it isn't really the primary focus I guess, or we're trying to make sure our person is going to be OK and make it through. (N03, lines 49–54)

Another nurse explained that if persons UST or NCRMD were not "OK," their role would be to remove them from the RB hearing: "[The nurse] mentioned that if she saw the patient become upset [during the RB hearing], she would be the one to take them out of the hearing" (N02, lines 15–18). Although closely monitoring persons UST or NCRMD, providing support, and developing a therapeutic alliance during RB hearings might stem from a professional nursing desire to safeguard patients' emotional well-being, these equally served the function of ensuring

persons UST or NCRMD controlled their emotional reactions during RB hearings and complied with the RB process with docility.

The final form of support is post-hearing support. When persons UST or NCRMD were returned to the inpatient unit after RB hearings, the nurses sought to evaluate, and perhaps mitigate, the harmful effects of the RB hearing:

> So the same scenario, we need two, two nurses usually and security, to move through the building back to the unit, and it's always good to kind of review the day with the resident, to see how they're, how the they're handling things, how they're feeling about it. A bit of a debrief, I guess. (N03, lines 55–60)

> I usually try to talk to them about how they think it went. Usually the patients are a little bit, like they're relieved that it's over, but they don't really know what happened (laugh), because there's no conclusion to it, so they're kind of like "yup, it's over." (N04, lines 22–26)

Conscious of the stress provoked by the RB hearing, nurses would debrief the event with the person UST or NCRMD, discuss their reactions and feelings about the information shared during the hearing, and review coping strategies. As the nurse in the following excerpt explained, it was a time to also work through, support, and relativize the situation until the RB made its decision:

> Well, we could talk about how it [the RB hearing] went well. The last two I've been to have been very positive and good outcomes so far, in the first. Just be supportive and like, you know, it's two weeks later they hear back, so it's a long two weeks for them. (N06, lines 27–31)

In the weeks following the hearing, the hospital would receive the disposition made by the RB and the reasons for this disposition. The hospital was responsible for delivering dispositions to persons UST or NCRMD. This serious, ceremonial procedure is conducted by nurses and other administrative employees of the hospital:

> When [the hospital] receives [the disposition], it's an expectation that it's provided to the patient. So there's two copies . . . I know for sure there's one that goes on the physical chart and one that has to go with the patient. Whether there's a third copy, some of the other administrative staff might have it somewhere else in the building, but definitely there is a process that's taken very seriously that the patient receive a copy of the disposition and made sure to acknowledge that they

> have received it and we'll open the letter and see their disposition. (N05, lines 269–278)

On occasion, part of the ceremony may also involve nurses providing education to persons UST or NCRMD about the content of their disposition. As the nurse in the following excerpt explained, the reasons for disposition may be used as a tool to educate persons UST or NCRMD about the necessity of having a disposition to protect the public from them: "The nurse explained that she reads them [reasons for disposition] because it helps her understand the reasons for the disposition and it also provides a tool when explaining the disposition to the patient" (N02, lines 89–91).

5.1.2. Privilege System

Throughout their interviews, nurses often spoke about the privilege system that operated within forensic psychiatric hospitals and about the role they played in this system. The term *privilege* is psychiatric terminology, relating to the kinds of freedom that psychiatric hospitals allow patients to exercise—such as supervision modalities, geographical location, and personal possessions. In forensic psychiatry, however, privileges and the privilege system take on added dimensions. They are intimately linked with the dispositions issued by RBs and function through the hospital's internal conference system:

> If the disposition has changed, then at the next conference, it's usually brought up because that's also a check and balance, so for example if all of a sudden, there's a patient has been, this is more hypothetical I would say, but if there's a patient that's been doing really well but never had living out in the community prior and also in the disposition they now have . . . living out in the community, well then that comes up in the conference, the next case conference, and then have a team discussion of like… what's the, what's the view now in terms of slowly working them toward discharge or at least discharge into the community or group home or an approved accommodation. (N05, lines 282–294)

> Newly issued dispositions do not immediately translate into an increase in privileges.

Persons UST or NCRMD must wait till the next case conference for the hospital's process to be

initiated in order for them to access any additional privileges. To coordinate this process, forensic psychiatric hospitals have set protocols for granting, monitoring, and restricting privileges, and rely on nurses to enact them.

5.1.2.1. Granting Privileges

The protocol in place at the forensic psychiatric hospital for granting privileges required team members, including nurses, to "support" or "not support" privilege requests made by persons UST or NCRMD during case conferences. Nurses emphasized the necessity for persons UST or NCRMD to be "stable" and "well" in order for their privilege request to be supported. Nurses reported using their expertise, education, and instincts when assessing mental status and wellness to determine if persons UST or NCRMD were to have access to more freedoms:

> Interviewer: How is the determination made that the person is able to go from a 50-kilometre radius to a 100-kilometre radius?
>
> N06**:** Well, their stability. Their mental health, their wellness, I mean sometimes people present well and we have to use our education, our expertise, and our instincts to allow people to have, I mean sometimes when people get closer to freedom, they decompensate because all of a sudden they have been institutionalized and they can't handle the real world. It is scary, even just for somebody who's living in it, like ourselves, and [patient name], when he found out he got his conditional discharge, he was a little scared, and I said "that's what," so it was good what he did, doing it in small steps, he didn't have to report, but he did, he said "I'm going to be out," "and coming back at this time." So increments of freedom are kind of like, a good thing because it's scary out there. (N06, lines 267–287)

This nurse noted how institutionalizing persons UST or NCRMD within forensic psychiatric hospitals caused dependency, to the point where they needed to self-impose additional "checks" ensuring they could function outside the institution—in the "real world." Beyond such individual self-imposed checks, the "increments of freedom" privilege system represented a way for forensic psychiatric hospitals to monitor the transition of persons UST or

NCRMD from their intra-institutional world to the "real world" while mitigating the fear this transition may cause.

When asked to describe what they specifically meant by *stability*, nurses mentioned the absence of aggressive and self-harming behaviours, involvement in care, compliance with medications, and participation in group therapy. The following excerpt illustrates this particularly well:

> So they're more stable, and for a longer period of time there's been no aggression, there's been no self-harm, they're much more involved in their own care, like because if they're attending groups, they have done very well, they have completed their different groups their scoring in that would go from whatever the initial score is increased at the end, how they have showing how they have done and that how much they have understood of it. Their medication compliance, that that sort of thing, their overall stability. (N01, lines 59–68)

The nurse's use of the word *compliance* as it applies to pharmacological treatments in forensic psychiatry deviated from the language used in other domains of health care. Elsewhere in health care, "adherence" is typically used to indicate whether a person is taking their medications as prescribed. Nonadherence to a medication regime can be caused by a plethora of reasons. However, in psychiatry, nonadherence to a medication regime is described as "noncompliance," which places the responsibility—or blame—for nonadherence on the persons UST or NCRMD.

Although nurses suggested that privilege-granting decisions were generally unanimous within health care teams, some occasional disagreements occurred. The following interview excerpt exemplifies a situation where nurses were not in agreement with the health care team's decision to support a privilege requested by the person NCRMD. The nurses' opinion was overlooked by management and a senior nurse had to speak up:

> Well, . . . sometimes [nurses] don't always agree with what the limits are for our patients, so if we have evidence or insight into why we think they shouldn't have. . . . The team of nurses disagreed with a patient in the last year, that had that on his disposition, but we disagreed with the rest of the team because we are front-line workers with him and the manager had the last say. Like at the conference

> everybody has to sign-off on, let's say patient wants to increase his privileges. So, it gets passed around and, denied or accept and it has to be a consensus to agree. But the nurses didn't agree, the nurse in that conference said no, but it got overlooked by management, and so because I'm the speaker (laughing) I'm the bitch, I'm always pushed forward, because I will speak, I'm [age of nurse], I'm going to speak, you know, and I said on behalf of the nurses, which everybody agreed, we don't agree with this. So it got withheld actually. (N06, lines 418–433)

The nurse referred to herself as the "bitch" perhaps because she represented a group of professionals who were disagreement with the decision and assessment made by other members of the health care team. Potentially explaining the interpersonal dynamics described in the previous excerpt, another nurse explained that such disagreements might originate in the extensive involvement of nurses in the daily lives of persons UST or NCRMD:

> Sometimes you develop dysfunctional relationships between the nurses and patients because they have known each other literally for 15 years, 20 years, right. So they see each other day in and day out, and it becomes a power struggle, and so some of these patients who, yeah do have psychopathic traits maybe are not really a risk to the public anymore, but the dynamic is very arduous where they constantly rebel against the authority of the staff and they're deliberately rude, and lie again and again, or constantly play a game in order to not have to concede to certain rules of the unit. It's this power struggle, now does it actually reflect high risk for the public if they were to be discharged, I don't know, not necessarily, but from the day-to-day interactions, it does start to imprint on the brain of the nurse this idea that, if they're constantly lying to me, and they're constantly doing this, what are they going to do in the public? (N05, lines 462–475)

In this instance, rather than upholding public safety, the privilege system operated as a technology of power, reproducing power dynamics between nurses and persons UST or NCRMD. The "game" referred to is particularly evocative of the subjugating effects of the nurse-patient power dynamic, and that of the forensic psychiatric system. If persons UST or NCRMD play the game correctly, they may gain access to additional freedoms. If they do not, or if they bend the rules of the game, their freedoms may be restricted by the rule makers of the game, namely the psychiatrists, nurses, and other members of the health care team. It is worth mentioning that the "gamification" and trivialization of the power dynamics involved in the

privilege-granting process downplays significant real-life effects of these dynamics, namely withholding a person's basic human right to freedom of movement.

5.1.2.2. Monitoring Privileges

Once privileges are granted to persons UST or NCRMD in forensic psychiatric hospitals, nurses are responsible for monitoring their use on a day-to-day basis. For example, every morning during "safety huddles," before persons UST or NCRMD were allowed to leave the inpatient unit, nurses and other members of the health care team evaluated whether the behaviours exhibited by persons UST or NCRMD in the past 12 hours were conducive to the use of these privileges:

> We share [incidents] at safety huddle if we have any concerns of danger or patients unstable or decompensating, or whatever, so the whole team is aware, so every morning at nine o'clock, on our unit, and earlier upstairs, they discuss the night's events, the last 12 hours or something, so we're all aware of "OK, well, so-and-so is not well today," or "we all think so and so should be able to go out," you know he's proved himself or herself and they can, we're going to give them a little more freedom, right. (N06, lines 296–303)

This day-to-day modality of surveillance was an additional component of the overarching risk-management system comprising the case-conference process and the RB-hearing process, reportedly serving to ensure that persons UST or NCRMD proved that they could conform to social, moral, and institutional rules.

Once persons UST or NCRMD had been given permission to use their privileges by the health care team at the daily "safety huddle," nurses ensured that they knew how they needed to behave when exercising their privileges: "so [nurses] discuss [the rules] with [persons UST or NCRMD] and how they go about [using their privileges] and what's expected" (N01, lines 93–94). Persons UST or NCRMD must therefore abide by two sets of rules when using their privileges: the ones ordered by the RB in the disposition, and the ones imposed by nurses. For example, one nurse mentioned that when caring for patients found UST or NCRMD for crimes

of a sexual nature, some nurses implemented interventions additional to the ones listed in the disposition, based on the reasons for disposition and out of their own volition:

> So say sex-related [crimes], you're going be a bit more careful. We used to get a lot of them in say from [city name] that would be gender specific. And then in the reason[s for disposition] there would be why, you'd see why, that doesn't happen as often anymore, but we still right now assume they're gender-specific until it's written otherwise. But certainly if there's a sexual offence or anything pedophilia any of that stuff we're going to watch to make sure they're not brought around any children once we have them out, that sort of thing, so that, the reasons of the disposition tell us a lot of, you know, what we could maybe look for too in their history. (N01, lines 118–129)

The first set of rules (that is, the disposition) to which persons UST or NCRMD must comply dictates where they may go, while the second dictates how they must behave. Among other things, this second set of rules may prevent persons UST or NCRMD from contacting certain "at-risk" subgroups of society, such as children, elderly people, members of a religious group, and persons identifying with specific genders.

The hospital's protocol for monitoring the use of privileges might require nurses to ensure that persons UST or NCRMD are located where they said they would be in the community: "so let's say in the community, like just in [city name], for community checks, [nurses] are checking them to make sure, every two hours if they're gone for more than two hours, we'd go and we have a visual check" (N04, lines 126–129). If nurses are not capable of locating persons UST or NCRMD, they may rely on local law enforcement services to assist them in their search:

> Well [nurses], whoever's on the door [makes sure persons UST or NCRMD come back to the hospital]. That's their responsibility. For two hours we sit on the door. So we, OK, "so-and-so went out at 9 o'clock" so at 09:30 if she's not there we start paying attention. . . . So sometimes, we'll give them five minutes because if the [site specific attraction] is here, so then it's, you know a little longer, someone's [going to] go outside and look and then, if they aren't visible, if they're not there, then were going a little further, and then we might, alert upstairs [another unit], and we'll start spreading out, we'll go in a car, we'll look, and then we call the police if it's too far. (N06, lines 312–324)

Nurses hold a central role in monitoring the persons UST or NCRMDs' use of privileges. They are responsible for ensuring that persons UST or NCRMD are aware of behavioural norms to follow while in the community and, with the occasional help of law enforcement agencies, that persons UST or NCRMD comply with the geographical parameters set out in their disposition.

5.1.2.3. Restricting Privileges

When persons UST or NCRMD violate the behavioural expectations set out for them, nurses may choose, or be obligated by institutional protocols, to restrict previously granted privileges and notify the RB:

> They're often, or I guess consistently, their privileges are held, whatever they may be, so someone who might be, say in the community under a disposition would come to us for assessment, see what needs to be done, whether there's, is this a "one-off," or something, that needs more looking into. Sometimes residents are with us for quite some time after a breach, medications adjusted, but sometimes they'll be here a couple days and back to life as it was. (N03, lines 172–180)

> If there's a breach in the disposition, so [nurses] take care of the situation acutely and then once things are settled, we notify the ORB coordinator and she lets the board know that there was a breach in the disposition. (N04, lines 134–137)

Breaking the rules set out by forensic psychiatric hospitals and by the disposition legitimizes a temporary restriction of liberties for the purpose of assessment. The length of this privilege restriction varies, based on the assessments conducted by health care professionals and the level of risk to the public posed by the persons UST or NCRMD:

> Interviewer: And what determines that length of time of privilege reduction?
>
> N03: Yeah, so definitely a resident's, has there a noticeable change in their mental state from a recent assessment. Are they cooperative with us, or are they combative, or threatening. Yeah, so basically if they're, we're kind of reassessing their risk to the public if there's a breach. So they may have to start and work toward those higher privileges again if, if it seems like they are higher risk then they were before the breach" (N03, lines 181–190).

Despite the variety of reasons that can explain why a breach in disposition occurs, which can range from a deterioration of the person's mental state to a purposeful breaking of rules, the

importance given to “cooperation” relegates the responsibility of this rule-breaking behaviour to persons UST or NCRMD. Consequently, to regain access to the privileges they once held—that is, their basic human right of freedom of movement——persons UST or NCRMD are required to comply with the rules of the game and work on themselves.

5.1.2.3.1. Urine Collection/Analysis System. When discussing processes relating to the granting, monitoring, and, especially, restricting privileges, nurses emphasized the role they played in the collection of urine samples for purposes of toxicological analysis. The RB frequently included conditions in dispositions ordering forensic psychiatric hospitals to randomly test the urine of persons UST or NCRMD for the presence of alcohol and drug metabolites. The wording of the dispositions gave carte blanche to forensic psychiatric hospitals to decide the frequency with which they would conduct urine toxicology screens. To illustrate this, one nurse compared the practices of two institutions:

> I’ve worked in another facility where that was quite systematically dealt with, like we’d have, at the beginning of a month, say a random date was chosen that [incomprehensible], residents with that note would have a urine taken. Just, we understood that so. But around, in this facility it tends to be a little different, it’s cultural change, I guess, where it’s just, the practice when there’s suspicion that there’s been a substance taken there that, that we, we know we have that ability to go ahead. (N03, lines 152–160)

Notwithstanding interinstitutional differences, nurses seemed to identify three different situations that could prompt them to collect urine samples for toxicology analysis. In each of these situations, the justification supporting collecting urine samples was external to the medical domain, but rather stemmed from a requirement for persons UST or NCRMD to comply with the legal parameters of their disposition.

First, nurses could randomly request urine samples from persons UST or NCRMD. This process was a well-orchestrated monthly ritual: “[nurses] usually do it like monthly randoms so we’ll have a list and we go, so it’ll be, we have everything ready in the morning, and usually

there is a group of them that are due that day, so we do it like that" (N01, lines 103–106). The ceremonial nature of the random urine collection process constituted a surveillance mechanism to ensure that persons UST or NCRMD complied with the abstinence requirement of their disposition.

Second, nurses might collect urine samples for toxicology screening whenever they believed the behaviours of persons UST or NCRMD were suspicious or "off":

> If we suspect any illicit drugs, anything like that, they're off a little bit, we can pull a urine on them to see if there's anything. (N01, lines 106–108)

> We can do random urine anytime, we can do one today and one in the afternoon if we want. (N06, lines 380–381)

In this case, the expertise of nurses in mental health care, and their clinical skills at conducting mental status assessments in particular, was leveraged to decide if the behaviours or thoughts of persons UST or NCRMD had deviated from the usual. Although the trigger for collecting urine could stem from a clinical assessment of a person UST's or NCRMD's mental status, the underlying authority permitting such a collection and analysis resided in the RB's disposition. If a person UST or NCRMD refused to provide a sample of urine, nurses could restrict their privileges until it was provided: "many times, like a lot of times we'll hold [persons UST or NCRMD] in [the hospital] until they give that urine [sample] if it's suspect that we think that they're not well enough to go out or you know that sort of thing, you know sometimes it's just that feeling" (N01, lines 109–111). Collecting and analyzing urine was thereby a way for nurses to validate their suspicion about a person UST or NCRMD's unusual behavioural presentation, since it allowed them to find out if that person had used substances, thereby violating their legal requirement of remaining abstinent.

The third situation which might prompt nurses to collect urine samples was if persons UST or NCRMD violated any condition ordered in their disposition—any violent incident or

unauthorized leave, for example. When this took place, nurses relied on institutional protocols requiring a restriction of freedom, a relocation of the persons UST or NCRMD to a more secure unit, the collection of a urine sample, and an examination by their psychiatrist:

> Usually, they might go to the most secure area for the time, because they would be confined, depending on the reasoning, had they gone out and used [drugs or alcohol] or whatever, they might be not very stable so they would be in our most secure area for a time being, they have to be seen by their doctor, we would monitor closely, and that's again we would pull a urine, all that stuff that we typically do. (N01, lines 169–175)

If the breaches in disposition related specifically to the use of psychoactive substances, the institutional protocol required nurses to confine persons UST or NCRMD until toxicology results demonstrated that the drug or alcohol metabolites were no longer present in their urine:

> Our protocol is that we confine the individual until there is a negative [urine] drug screen. So we confine them to the unit, notify their family doctor, try to figure out what they took, where they got it, if they're in any distress from it. And then in follow-up from that we try to offer some support with the program nurses for addictions. (N04, lines 142–148)

This emphasis on abstinence raises certain questions. Does such a focus prohibit nurses from providing alternative, effective interventions such as harm reduction? If a person UST or NCRMD breached their disposition due to the use of substances, did this automatically mean they wished to engage in treatment? The nurse above mentioned that they would offer support to persons UST or NCRMD by potentially referring them to the program nurses for addictions. However, considering the constraints imposed by the abstinence requirement of the disposition, I wonder if the forensic psychiatric hospital would nevertheless allow the program nurse to offer services such as psychosocial support, harm reduction, or pharmacology.

In this case, confinement and treatment for use of substances appeared to serve as a punishment aimed at educating persons UST or NCRMD in remaining abstinent. By enacting institutional protocols, nurses restricted the freedoms of persons UST or NCRMD and inserted

them in treatment regimens with little regard to therapeutic need or interest; a process that caused some amount of confusion in some nurses:

> Interviewer: I asked what happens when the disposition is breached.
>
> N02: The nurse said that this confuses her. For example, the disposition says patients must remain abstinent, but then when patients have a positive urine, she said, all that happens is that they are confined for 24 hours and reassessed. What is confusing is that this is considered . . . [to be] taking action. (N02, lines 81–86)

The confusion stems from the conflation of a punitive approach aimed at enforcing the disposition and a therapeutic approach aimed at assisting persons UST or NCRMD with substance use disorders.

The sole presence of drug or alcohol metabolites in the urine of persons UST or NCRMD warranted their continued restriction of privileges, whereas a urine sample free from drug or alcohol metabolites constituted a key to freedom. This dynamic instilled a state of vigilance and apprehension in persons UST or NCRMD, supported by a lingering threat of privilege restriction. Regaining access to freedom was thereby dependent on obtaining a urine sample free of substances; and, conversely, a refusal to provide a urine sample could result in the deployment of additional penalties such as the restriction of privileges or coerced treatment.

5.1.3. Visibility of Persons UST or NCRMD

I explored the privilege system inherent in the forensic psychiatric hospital and the process by which the identities, bodies and minds of persons UST or NCRMD were prepared in anticipation for RB hearings. In doing so, something became strikingly apparent: despite being about persons UST or NCRMD, these procedures rarely considered the patients' perspective. For example, although being described as multidisciplinary and considered to give a "snapshot of the [person UST or NCRMD]'s whole year" (N01, line 33), key conversations that occurred during pre-ORB case conferences took place without the active involvement of those persons UST or NCRMD.

One nurse explained that the involvement of persons UST or NCRMD was limited to them "check[ing]-in" at the end of the meeting: "The nurse said that 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" (N02, lines 51–53). Persons UST or NCRMD were only permitted to "speak for themselves" after the multidisciplinary health care team had already had a discussion about them and their treatment plans:

> 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 or NCRMD] 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. The, 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. (N06, lines 114–132)

Involving persons UST or NCRMD at the end of case conferences gave an appearance of including them. Their actual exclusion from key conversations seemed to cause this nurse discomfort. She uncovered an irony in this process—if the conferences were about the persons UST or NCRMD and their progress, they should be able to participate in key discussions about their treatment plan and be given whatever amount of time they needed to say what they had to say. The apparent lack of discussion between the health care team and persons UST or NCRMD during pre-ORB conferences demonstrated their true, objectifying purpose: their ultimate aim was to protect the public from persons UST or NCRMD.

A related concern was that during the interviews, nurses repeatedly alluded to the necessity of rendering persons UST or NCRMD hypervisible in order to protect the public. Nurses did this through various means, such as:

- placing the reasons for disposition in the medical files of persons UST or NCRMD;
- using observation techniques when persons UST or NCRMD engaged in possibly risky activities, such as speaking with their defence counsel in a closed room, or being accompanied off the unit to their RB hearing;
- documenting their behaviours and thoughts; and
- photographing persons UST of NCRMD, depicting their male or female gender characteristics.

5.1.3.1 Placing Reasons for Disposition in Medical Files

Nurses placed reasons for disposition in the patients' medical file so that their colleagues could have rapid access to their information: "[The reasons for disposition] is on the chart for anybody to look at" (N04, line 166). The reasons for disposition seemed to provide a repertoire of historical information that nurses could use to modulate the way they interacted with persons UST or NCRMD for the purpose of safety:

> Say early on meeting someone, [the reasons for disposition] is a useful, I guess bit of history when were first admitting someone, or transferring someone. In these cases, we want to know as quickly as possible how carefully we should be carrying ourselves around them and so, we'd be using it as a bit of history. We often don't get very good histories. The hospitals all have their own health records kind of sequestered from each other and it takes time for us to get records to us. So it can be a bit of extra information about risk level basically. (N03, lines 196–207)

Making the reasons for disposition visible on the medical chart of persons UST or NCRMD amounts to an efficient adjunct observation system for the nurses and their colleagues. Such clinical use of a legal document makes me question the impact the document may have on interactions of care between nurses and persons UST or NCRMD.

5.1.3.2 Observation Techniques Used to Safeguard Others

Nurses also used observation techniques specifically directed to protect visitors and employees from persons UST or NCRMD. For example, a nurse working on an acute care forensic psychiatric unit explained that nurses might be asked to participate in certain legal meetings for security reasons. Although they might be physically present, they usually stayed out of the room. They would position themselves in such a way as to constantly observe persons UST or NCRMD while they were meeting with their lawyer:

> We try to make sure there's a private thing, . . . it's a touchy thing basically, so there have been scenarios where we've had agreement from all parties including resident, lawyer, that we could, we could be in the room during those meetings, but mostly we're able to just have line of sight, door closed and that can happen. (N03, lines 35–49)

The private nature of such meetings was something nurses valued and, as such, they sought to ensure the safety of the lawyer at those meetings by keeping the persons UST or NCRMD within their line of sight:

> I work with mostly assessment residents, but there are folks with us with an NCR status, but they tend to be with us because they have had some difficulties while they have been here, so line of sight is often important, we ought to make sure we're, we're able to continually assess how they're handling situations, so providing that privacy with a lawyer but kind of weighting that against us being able to step in if something goes wrong, if they become emotional. (N03, lines 37–44)

If, while observing unwell persons UST or NCRMD through the window, the nurse identified that the person was unable to suppress their emotional expression, they might intervene to contain that emotional reaction.

Such observation techniques were amplified when persons UST or NCRMD were unwell or considered to be at a higher risk of harming others. For example, if they were considered less risky, they might be allowed to attend their RB hearing supervised by only one nurse; but those

who were considered a higher risk might need to be accompanied by three staff members—one of whom being from security personnel:

> I think there'd be residents that would be kind of considered higher risk on other units that would have like a similar need, because they're basically they, they may cause harm to somebody while they're in transit so we want more people around, but almost always from, from the assessment unit here, we'd have two staff, one security. (N03, lines 70–76)

5.1.3.3 Documenting Behaviours and Thoughts

Nurses also rendered persons UST or NCRMD visible by documenting their behaviours and thoughts. Nurses observed them and evaluated the effects of various interventions on their bodies and minds. Nurses compiled these observations in a central location, namely, the medical file, rendering behaviours and thoughts visible (and true):

> We are the front line workers and we get treated good or bad by the patients and we think of it, "this is how you treat us in here, how are you going to treat the public, the vulnerable public," right? So we have to . . . a big thing is charting, you have to chart everything, good or bad because that's what they [the psychiatrist] go by, if it's not charted it didn't happen. So it's really important to chart incidents if those are incidents that you think might protect, harm the public and sometimes it goes on deaf ears and depends on how bad you want to advocate. (N06, lines 421–430)

Through documenting incidents that are contrary to public safety ideals, nurses participated in the forensic psychiatric institution's objective of protecting the public. Nursing documentation provided evidence for the psychiatrist (and the RB) to justify ordering restrictive disposition orders for persons UST or NCRMD. Therefore, this documentation served as a truth-producing tool, making the deviant bodies and minds of persons UST or NCRMD visible for purposes of discipline, including increased surveillance and restriction of freedom, and for legitimizing detention/surveillance decisions.

In preparation for pre-ORB conferences and RB hearings, nurses explained that they were responsible for reviewing the medical file of persons UST or NCRMD, analyzing the

nursing documentation for the previous year, and preparing a comprehensive summarizing piece of nursing documentation:

> So prior to the patient having an ORB, there's a pre-ORB conference, so all of the team members that are involved with that patient would prepare a report that they would give to the doctor and put on their patient's chart, it would explain like the past year's progress or incidents, also how they're doing with their mental illness, if they're medication compliant, any incidents, like I said, that they had, what privileges that they had, if they used them, what family contacts that they had. So the nursing pre-ORB note is quite extensive. It talks about, you know, their behaviour on the unit, how they get along with others, and, so then at that pre-ORB conference, the team kind of talks about the patient's progress. (N04, lines 32–43)

Nurses prepared a nursing note for the psychiatrist before RB hearings. When asked how these notes were used by the psychiatrist, they said that their documentation was used to demonstrate to members of the RB the various ways in which persons UST or NCRMD deviated from or conformed to behaviour expectations:

> The nurse explained that the note is prepared before the meeting and includes 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]. Furthermore, the nurses 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 also any other significant incidents such as an elopement. The note would also include the patient's participation in groups. At the end of the note, the nurse would give their overall nursing opinion regarding the patient (i.e., if the patient is stable or has decompensated). (N02, lines 35–49)

> I've seen some report they have written and tends to be kind of get right down to the point of it, like they take dates, time, what happened, and then, I guess they focus on the most objective stuff that they can find and from that form their opinion about things but there's no real topic that it's limited to. It doesn't seem that they favour reporting on you know incidents of harm or to self or others versus, um, say, like a health crisis that the resident is going though. (N03, lines 108–116)

By writing down their observations of behaviours, nurses objectivized the bodies and minds of persons UST or NCRMD, producing truths about persons UST or NCRMD that could subsequently be used as evidence by psychiatrists during RB hearings. Again, strikingly absent from the piece of nursing documentation were episodes of nursing care provided to persons UST or NCRMD—any type of emotional support, education about coping strategies, or guidance about interpersonal relationships. The role of nurses in this instance appeared to be limited to passive observation.

5.1.3.4 Photographing Persons UST or NCRMD

Nurses explained that on occasion they ensured forensic psychiatric hospitals render visible the bodies of persons UST or NCRMD through the production of pictures. For example, one nurse explained that it was her duty to ensure that the hospital would take pictures of a transgender person UST or NCRMD's face, showing both their female and male gender identity expressions, should they eventually need to be located by police:

> I know one day that we were, there was a patient that, gender identity was kind of in like wasn't sure what they wanted do, they had a couple of different identities. . . . And when they were going out we need pictures of both male and female of themselves. . . . Anyway so I called down to say, "by the way, do you have," because we need to know what they look like if were, if have to, for some reason, to call the police if there's been an issue. (N01, lines 197–207)

In this situation, photographing constituted an observation technique conducted with the sole anticipatory purpose of aiding law enforcement to locate the person UST or NCRMD, should they run off.

In brief, nurses actively participated in activities that made the persons UST or NCRMD visible and objectified them. These activities, which were justified for a number of reasons (e.g., maintaining the safety of the public, documentation of clinically relevant behavioural changes, ensuring the safety of colleagues), revealed an incongruence inherent in the forensic psychiatric

system: persons UST or NCRMD were rendered hypervisible objects of observation for the purpose of protecting the public; yet they were invisible subjects in discussions about their care.

5.1.4. "Dissonance in the Natural Nursing Psyche"

A second theme apparent in the nurses' interviews was the stated incongruence between their professional identity as health care professionals and the identity they embodied as employees of a forensic psychiatric hospital. Throughout the interviews, the nurses said that prioritizing interventions aimed at protecting the public, over interventions aimed at enhancing the quality of life of persons UST or NCRMD, provoked a sort of identity crisis in them. One nurse referred to this as a "dissonance in the natural nursing psyche," linked to her being required to take on a "correctional officer" identity while maintaining her "supportive" and "caring" roles:

> The nursing role in forensic is tricky because you're expected to be caring and kind and supportive and you're expected to be almost like a correctional officer at the same time. So I think that creates a bit of a dissonance in the natural nursing psyche, not to get too deep about it (*giggles*), but I think it's something that's interesting about forensic nursing in particular is that, you kind of get that split pole where you have to maintain safety of the public by allowing people to come in and out of the door, making sure the privileges request, if there's a patient missing, you got to find them, de-escalating patients when they start to show risky behaviours, but at the same time you want to be supportive and caring and so on and so forth. (N05, lines 446–457)

This identity crisis emerged when nursing knowledge and skills were used for the security and public safety purposes of protecting the public against persons UST or NCRMD.

Another nurse mentioned that using nursing expertise in this way was paternalistic and lacked harmony with the ideals espoused in the academic nursing curriculum:

> It's a bit paternalistic, but if one is going to go out and harm somebody, then it's probably not good for them either, so yeah like the thing you come out of school with, or that I came out of school with was definitely skill and interest in providing care to the person, but with some, not huge amounts of forensic experience, the other thing [protecting the public] starts to make more sense, becomes more important, (*pause*) so yeah, I don't think professionally there's really (*pause*) a lot of harmony there, but (*pause*) yeah just case by case I guess is my answer case by case and deciding do we have time, is risk low enough that we

> can focus on, making this person's life better or is the risk so high that our priority needs to be making sure that they're not going to harm somebody. I guess it's just, you know, an ongoing debate within the team. (N03, lines 217–230)

Providing care to persons UST or NCRMD for the purpose of making their "life better" was in constant conflict with, if not secondary to, the protection of the public.

Sometimes, nurses acknowledged having been required to intervene with persons UST or NCRMD in ways that made their lives worse, if it meant that the public would benefit from enhanced safety:

> They're found not criminally responsible, but we still treat them like criminals, so that's something that is a challenge because obviously due to their history . . . we always have to err on the side of caution, but sometimes to the extent that we want to restrict, restrict, restrict instead of, give, give, give. Sometimes it's easier to just to restrict, and that actually makes it even worse. (N04, lines 216–224)

Implementing restrictions detrimental to the lives of persons UST or NCRMD—for example, increasing the restrictions on their bodies rather than altering the environment—was seen as a more efficient way to control problematic behaviour:

> If [the breach] is something bigger, like, let's say they [persons UST or NCRMD] had a restraining order, they're not supposed to call somebody, then, we ensure that, so let's say they're on a unit where there's a telephone and they're have access to it, then we remove the threat to the other individual, so we'd have to move him to another ward, where the phone isn't so accessible without staff knowing kind of thing. (N04, lines 148–154)

By moving the person UST or NCRMD to a more restrictive unit where a phone was not readily available, the nurse "removed the threat" to the public by restricting the person's freedom.

Nevertheless, making persons UST or NCRMD out to be threatening caused ambivalence in some nurses who felt they were losing sight of the needs of their patients:

> When we're dealing with like the disposition and we have these set orders, we're so focused on maintaining and keeping everybody in line, that we lose sight of that individual. What does he really need? Like instead of "what do we have to follow," everybody's good at what we have to follow, but sometimes we lose sight of what the patient actually needs. (N04, lines 226–232)

This apparent lack of professional harmony was described by one nurse as a juggling act: “it’s difficult because, from a security point of view, it’s all [metal detector] wands and locked doors and, you know (*pause*), custodial-type things, but then there are also nurses who are trying to be therapeutic so it’s a really, it’s a juggling act sometimes” (N04, lines 190–193). Although the term “juggling act” may figuratively demonstrate how nurses experienced the care-and-custody dichotomy, it suggests that interventions of care and interventions aimed at maintaining custody were mutually exclusive. However, in some situations, the lines between care and custody were blurred and dichotomizing these aims was impossible.

5.1.4.1. Nursing Practice

Using clinical nursing interventions to protect the public from persons UST or NCRMD exemplifies the impossibility of distinguishing the caring role from the custodial role of nurses working in forensic psychiatric hospitals. When specifically asked how they consolidated their responsibility of providing care for patients with the institutional responsibility of protecting the public, one nurse quickly responded “care and custody” (N01, line 143) and then proceeded to explain how nurses practised this philosophy. She rooted her description of it in the limits imposed by the disposition and used this description to justify the firmness of her approach with persons UST or NCRMD: “my philosophy basically is fair but firm” (N01, line 144). She also underlined the importance of the nurse’s advocacy role by explaining how it was used to limit, control, and monitor the movements and behaviours of persons UST or NCRMD:

> I mean they have to abide by the rules. We’re obligated to have them abide by the rules, but also when they do well, [we] advocate for them, they have done well, they have done this, they have done that, we’re advocating for them to go on the next step on their disposition what else they can achieve at their next conference is typically what we do. (N01, lines 146–151)

The advocacy role of nurses in forensic psychiatry has little to do with assisting persons UST or NCRMD attain their individual health goals. Rather, the role is leveraged to help patients progress through the forensic psychiatric system (i.e., the "steps" on their dispositions).

Nurses also suggested that they consolidated their two roles by mobilizing their knowledge, professional skill sets, and therapeutic alliances with persons UST or NCRMD for the purpose of protecting the public. The following testimonial exemplifies this particularly well:

> Whenever I explain to people the job that we do here, I'm always talking about care and custody. So, in one point, we're providing mental health nursing and we're providing care to patient, and in the other, we're ensuring the safety of the public by having custody (*pause*). Me, personally, I always make sure that whatever, (*pause*), I think from a team's perspective whenever we do a conference, we're also doing a risk assessment, so consolidating the two is we're using our nursing judgement and our assessment skills to then evaluate what the risk is to increasing someone's privileges or allowing this to happen, what's the risk, to the community or if there is one, or is it low, medium, high, so I think by using risk assessments, using a team approach, definitely getting everybody's input into a situation, and then putting in (*pause*), like if we're increasing privileges or, or, you know, doing an approved person, then we're following all the checks and balances of what we're supposed to do and it's a team decision moving forward for increasing that little bit of freedom. (N04, lines 172–189)

The professional skill set of nurses was being deployed as a means to protect the public from persons UST or NCRMD, thereby rendering difficult the differentiation of caring interventions from custodial interventions. Indeed, nursing care in forensic psychiatry seems to be defined by the security rituals in which nurses participate.

One nurse took this position to the extreme by proposing that without a detention order, the care provided to a person UST or NCRMD by nurses was "quite minimal." The nurse explained that once the freedoms of persons UST or NCRMD were no longer restricted by a detention order, they were merely "housed" by the forensic psychiatric hospital until a place of residence was found for them:

> We've recently had a patient who told us he would ask for a discharge, absolute, and the team said it wouldn't support it and he got a conditional discharge, so now

> he's just being housed by us, so that means, so we still had a case conference, but it was a very interesting one because now (*laugh*) we're kind of still overseeing him, but we're not. So he's just trying to look for apartment building or setting up his community situation in the meantime. (N05, lines 302–209)

When I asked that nurse what specific nursing care was provided to persons UST or NCRMD who had received conditional discharges, the answer seemed to be that nurses assisted the social worker in coordinating the discharge and in ensuring that persons UST or NCRMD were not disruptive to hospital rules, routines, and general functioning:

> Yeah, I mean, as a nurse, it's, to be honest, it's quite minimal, it's just to be, make sure they [persons UST or NCRMD] are not disruptive to the other clients really. That there's some basic rules, that are more hospital rules, not because it's on the disposition, but because just out of respect that, there still, if they're going to be part, we also want to be compassionate, we don't want to put them out on the street, right. . . . So, but then, it's a two-way street, if they're going to be in the hospital, we still, we don't want to chase them, try to find out where they are at nine o'clock, at eleven o'clock at night. So, we still make sure they abide by basic rules. Although the rules will change for them compared to other patients. They don't need to go fill out itineraries, or sign in and sign out, so that really changes but I think it's more making sure that things are progressing for their community placement or wherever there going, community accommodation. . . . Our team leader nurse will often help coordinate, make sure the social worker's involved, and then, it's more the, being cautious that they're not disruptive to the other clients now that they have more freedom and they, you know, let's say leaving, and buying cigarettes and selling them, we house them, but at the same time they be respectful to keeping the status quo on the unit. (N05, lines 314–338)

The data suggested that some nurses working in forensic psychiatry were able to conceptualize providing nursing care only to persons involuntarily detained. Indeed, without the presence of dispositions forcefully detaining persons UST or NCRMD within the forensic psychiatric hospital, nurses appeared to lose the beacons that typically structure the care they provide. The disposition provided forensic mental health nurses with a framework that governed their professional caring practice.

5.1.4.2. Nursing Documentation

The use of nursing documentation as evidence during RB hearings also exemplifies the impossibility of separating the caring role from the custodial role of nurses working in forensic psychiatric hospitals. Although the purpose of nursing documentation in mental health care is to capture the care provided by nurses, it is used by hospital psychiatrists for another purpose: as evidence to demonstrate a person UST or NCRMD's "deviancy," "normalcy," and "dangerousness" during RB hearings and other ceremonies at their periphery, such as the pre-ORB conference (see 5.2.2.1):

> So from all of those mini-reports [from various team members] that come in, the doctor makes a final report and that's submitted to the review board. (N04, lines 50–52)

> I guess you can hear some of what's been used in your [nursing] report explained by the psychiatrist while they're being cross examined [during RB hearings], for example the number of incidences, a severe problem with their hygiene, interpersonal conflict with other co-patients on the unit . . . that comes out during the hearing. . . and that's what we want, right? (N05, lines 236–243)

Using health care information for this purpose provoked mixed feelings in the nurses interviewed. Some of them saw information they compiled being used by psychiatrists as evidence during RB hearings as a kind of professional validation:

> So it's actually kind of nice to see when something that you know you put into your [nursing] report is said at the hearing, but usually it's pretty typical yeah, it'll be yeah the number of incidences that the nurse went through and counted out yeah. (N05, lines 249–253)

> What we do is a note for the whole year based on the nursing notes for the whole year. Anything that's gone on, so it's our perspective and that's given to the doctor and that's part of his, what he presents in the ORB. (N01, lines 74–77)

These nurses considered the use of nursing documentation by psychiatrists as a way to share the nursing "perspective" about persons UST or NCRMD with RB members—as a perspective different from that of others, particularly that of the psychiatrist. Nevertheless, the nursing

perspective could not be deciphered as such, since it was now part of the psychiatric perspective that contributed to the same institutional goal: the production of truths about persons UST or NCRMD for purposes of public safety and individual reform.

One nurse described feeling uncomfortable with the idea of clinical information being used by lawyers to defend their respective agendas:

> That [RB hearings] can be kind of an ugly thing to sit through, it's our documentation that I've sat through, you know the lawyers using those to basically fight with each other over points of disagreements, so yeah, we're the ones recording incidents, we're usually the ones witnessing them, so those will be used by someone, say fighting for a more restrictive disposition, more restrictive disposition, they'll use our, basically what we recorded as a means to getting them less rights I suppose, so that's it's usually not what we hope will happen with our documentation (*small laugh*). (N03, lines 121–131)

By referring to their experience as "ugly" and by explaining that "it's usually not what we hope will happen with our documentation," this nurse underlined the ethical irregularity of such practice and the sentiment of professional incongruence it might cause.

5.2. Observations of Review Board Hearings

The RB hearings were held within the forensic psychiatric hospital. To get to the conference room where the RB hearings took place, attendees had to go through four heavy metal doors, two of which were locked and needed to be unlocked by security personnel. There were no signs to direct visitors to the location of public RB hearings within the hospital.

The conference room was quite large. It contained three windows. At the long table in the centre were five chairs on one side of the table, where members of the RB sat, and four more on the other side for the other parties at the hearing—the Crown attorney, the hospital psychiatrist, the defence counsel, and the person UST or NCRMD. One person, who recorded information discussed at the hearing, sat in a chair at the head of the table. In one corner of the room was a

table with refreshments—coffee and water. Along one wall, chairs were aligned for observers (Figure 6).

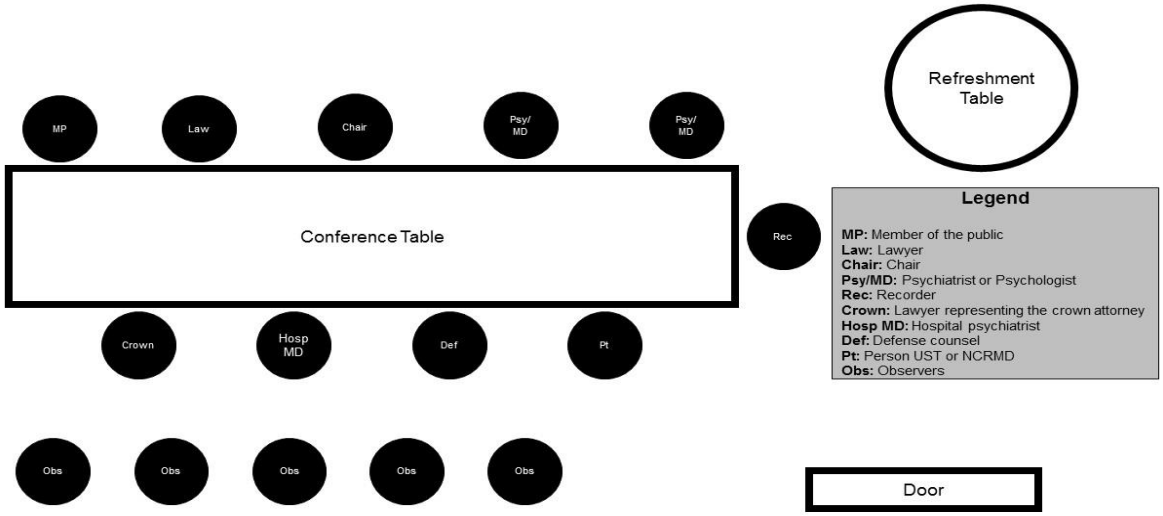

Figure 6. Review board room disposition of bodies/objects.

I observed 27 RB hearings, an attendance totalling over 41 hours. This gave me first-hand knowledge of how various medico-legal practices, processes, and rituals converged in a ceremonial examination to produce identities for persons UST or NCRMD rooted in notions of risk and dangerousness. I came to understand that RB hearings had three properties or functions (see Figure 7): they followed a structured, ritualistic process; they served as instruments of normalization, to produce deviant individuals and ensure their reform; and they offered a rare opportunity for the public to hear about the rehabilitating ability of forensic psychiatric hospitals.

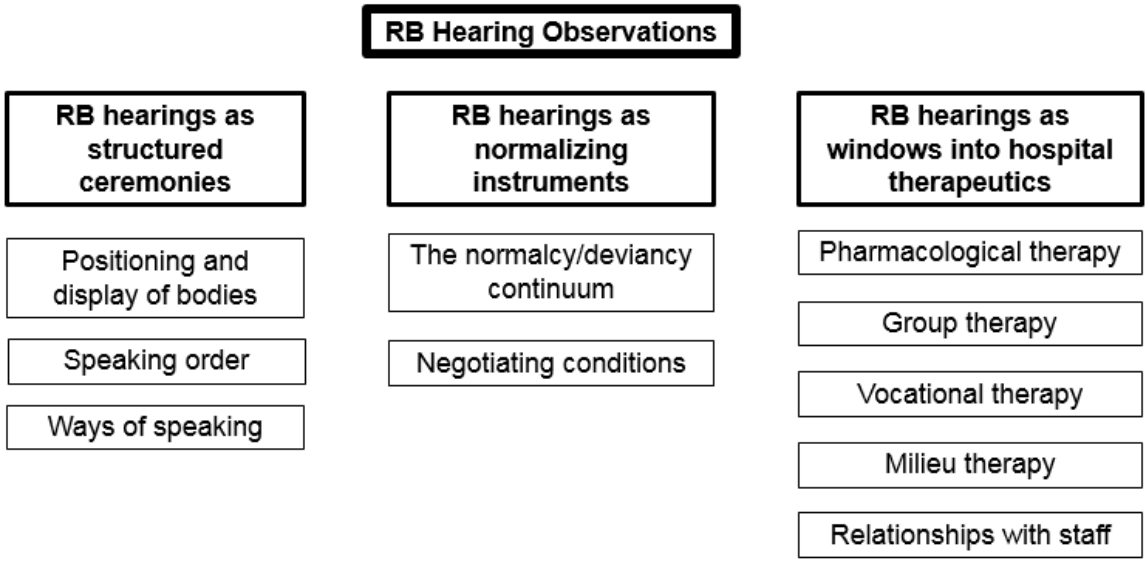

Figure 7. Schematic of results stemming from RB hearing observations.

5.2.1. Review Board Hearings as Structured Ceremonies

Observations of RB hearings revealed that they were structured ceremonies. Although no publicly available formal rules governed the unfolding of RB hearings, each actor had a predetermined place to be and role to play. When they deviated from these unwritten rules, RB actors were reminded of them and were required to conform to the established order of things.

5.2.1.1. Positioning and Display of Bodies

No written guidelines dictated the way RB actors had to be positioned at the RB hearing table. The precise spatial distribution of actors stemmed from an implicit rule of etiquette inherent in the RB culture, rather than from any legal requirement. The composition of the RB and the positioning of actors during the RB hearing rarely changed. 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

6). The other parties at the hearing, were similarly seated, on the other side of the table, in this particular order: the Crown attorney, the hospital psychiatrist, the defence counsel, and the person UST or NCRMD. Anybody observing the RB hearing was required to sit along the wall behind the person UST or NCRMD.

This very precise positioning of bodies only changed twice. Once, a psychologist RB member was sick and could not attend the hearing. On that day, the RB only had three members, namely the member of the public, the chair and the psychiatrist:

> There were only three members of the board because one member was sick and there needs to be an odd number of board members as decisions are made by majority. This is what the chair explained to the patient and the other parties at the table [at the beginning of the hearing]. (OB7, lines 27–30)

The chair asked the other legal member to not take part in the hearing, since the board's decisions were made by majority (*CC*, 1985), and hence the need for an odd number of RB members. The other time, an interpreter was required at the hearing:

> The patient before the board had an interpreter accompany him. The hearing was slow, as everything was translated for the patient. To assist with translation, some typical physical placements were altered. Specifically, when the hospital psychiatrist was giving his evidence, he swapped positions with the defence counsel (to be closer to the interpreter and the patient). (OB19, lines 48–53)

In this instance, to facilitate the work of the interpreter, the hospital psychiatrist changed positions with the defence counsel when he was providing his oral testimony.

When the positioning of the participants deviated from this meticulous order, RB hearing attendees were reminded of the rules and conformed 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 where the observers sat. (OB2, lines 34–36)

> When the Crown entered the room, she sat in the chair that the doctor had been sitting in during the previous hearing. She said "Oh, I am sitting in the doctor's chair." (OB9, lines 85–87)

In addition to the spatial distribution of RB actors, their bodies were methodically prepared in anticipation of the RB hearing. Throughout my observations, I saw that all the actors were well dressed, clean, and well groomed when attending RB hearings. See, for example, my field notes from OB12:

> *Member of the public*: White man approx. 60 years old. Wearing a suit, tie & blazer. He also wore glasses.
>
> *Lawyer member of the board*: White man approx. 70 years old. Wearing a suit.
>
> *Chair*: White man approx. 50 years old. Wearing dress pants and a dress shirt (…)
>
> *Board psychiatrist no. 1*: White man approx. 60 years old. Wearing dress pants and a dress shirt (…)
>
> *Board psychiatrist no. 2*: Black man approx. 45 years old. Very formally . . . dressed. Fitted suit with matching tie, pocket piece, and shoes.
>
> *Recorder*: White woman approx. 45 years old. Well but casually dressed.
>
> *Crown*: White woman approx. 45 years old. Well but casually dressed.
>
> *Psychiatrist*: White man approx. 50 years old. . . . Well dressed and groomed. Wearing a dress shirt and a blazer without a tie.
>
> *Patient*: Black Somali man approx. 30 years old. Well dressed and groomed. Wearing a black dress shirt. (OB12, lines 76–97)

Although it may be common for legal and medical professionals to pay attention to their physical appearance, such attention to appearance was extraordinary for persons UST or NCRMD. Before one of the hearings, a Crown attorney and a social worker student made a remark regarding the presentation of a person NCRMD:

> The social worker student called the patient by a nickname and commented positively on the way the patient was dressed. The Crown overheard and said "you clean up well." At that point everyone in the hallways including the patient laughed. (OB12, lines 43–47)

The reaction of the social worker student and of the Crown attorney to the groomed presentation of the person NCRMD suggested that the patient's "cleaned-up" physical display was different from the way they typically presented themselves.

5.2.1.2. Speaking Order

As the RB hearings unfolded, a formal pattern became discernable relating to the order in which the various actors spoke, reminiscent of criminal tribunals. I identified 10 successive steps in this pattern:

1. Introductions—during this period the chair spoke directly to the patient.
2. Confirms the list of exhibits—these always include most recent reasons and disposition, and a report submitted by the hospital.
3. Initial positions of the parties.
4. Highlights the psychiatrist wants to make about his report and the progress of the patient.
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 patient and informs them that a decision would be rendered within one week and that the reasons would follow. (OB16, lines 26–39)

Actors 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). He 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’” (OB14, lines 156–159). The psychiatrist’s intervention demonstrated the internalization of the RB’s order of speaking, ensuring that the correct order of speaking was maintained.

Similarly, when persons UST or NCRMD deviated from this speaking order, by reacting to the things said about them, for instance, they were either ignored or reminded to remain silent until they were given the right to speak. My fieldwork journal documented a couple of occasions, like this one, where a person NCRMD 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. (OB10, lines 138–146)

> The board psychiatrist no. 2 asked if the cannabis use occurred during the patient’s privileges to the hospital ground. The psychiatrist said “yes.” The patient interjected, saying “I only used once.” The patient’s intervention was ignored by the board. (OB10, lines 212–215)

Although persons UST or NCRMD were generally ignored when they sought to interrupt dialogue between other parties at their RB hearings, on some occasions their defence counsel actively asked them to remain quiet:

> The patient then made some verbalizations. The defence counsel told the patient to “wait your turn.” (OB11, lines 227–228)

> 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.” (OB10, lines 118–124)

Defence counsel most likely silenced their clients because they feared such interjections might substantiate claims suggesting lack 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 as proof of their impulsivity. Despite the underlying reason for the person NCRMD's interjection—to clarify the veracity of the information being shared about him—precedence was given to respecting the order of speaking during RB hearing—he was ignored by the RB.

When more subtle ways—such as ignoring the person or subtly reminding them to remain quiet—failed, the RB chair would intervene to lay out the rules of the hearing and re-establish the order of speaking:

> The board psychiatrist no. 2 asked if there was any clinical relevance to the cannabis use. The psychiatrist said that there were no extra incidents, but maybe more verbal clinical relevance. The board psychiatrist no. 2 asked the doctor to give context around the "July 21 incident." The patient said out loud: "He was touching my crotch." The chair intervened, addressing the patient: "I've been nice now, but I need to set the ground rules, one person at a time. Write things down and we will get to it later." The psychiatrist explained that the patient was on the couch, that there was an argument over the remote and the patient kicked another patient in the face. The board psychiatrist no. 2 asked the psychiatrist if there were any other arguments. The psychiatrist said "yes, arguing with staff" and added that the other individual which received the kick in the face also had an intellectual disability. (OB10, lines 218–233)

By intervening publicly, the RB chair asserted his authority as the person responsible for maintaining the RB hearing rules. That being said, the rules guiding the order of speaking during RB hearings seemed to only be applied to persons UST or NCRMD. In all of my observations, persons UST or NCRMD 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.

Thus, persons UST or NCRMD were expected to be docile and remain quiet when hospital psychiatrists presented evidence about them—even if this evidence was difficult to hear and strewn with inaccuracies. This was particularly apparent during one defence counsel's interjection at the end of a RB hearing: "The defence said the [person NCRMD] 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'" (OB18, lines 322–324). By adhering to the hospital's interpretation of their character, persons UST of NCRMD refrain from "rock[ing] the boat" out of fear that the RB will be more stringent if they contradict the hospital's recommendation.

5.2.1.3. Ways of Speaking

During the rare hearings where persons UST or NCRMD were allowed to speak and provide evidence to the RB, the chair ensured they spoke in very constrained ways. Over the course of the 27 hearings I observed, persons UST or NCRMD only provided evidence on two occasions.

On the first, the person NCRMD was asked by the chair to modify the way they were presenting their evidence as it was judged that they were "leading the delivery of evidence" as opposed to answering questions 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 that he sees benefits to it. 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, that he is on the patient council, that he presented at the "corporate welcome," he attends numerous alcoholic anonymous meetings, he has a sponsor, he sees the psychologist, he volunteers at Alcoholics Anonymous and in the community on a regular basis, he goes to the YMCA, he has job prospects. He further explained that he wanted to stay in the present city emphasizing that he did not want to return to the city or the facility where he was transferred from, explaining that he has made good progress in this present city. The chair interrupted telling the patient to "let the counsel lead, she will ask you questions." (OB4, lines 452–468)

On this rare occasion, the RB hearing served as a public venue for the person NCRMD to internalize his deviancy, showcase the efforts he made to offset it, and highlight the changed, docile individual he had become:

> The defence asked the patient about the Haldol and the decrease request [he made to his psychiatrist]. The patient explained that he felt good on Haldol and that he requested for a decrease because he felt fatigued. The defence asked: "What did you learn about the bumps in the past?" The patient said "I have a personality disorder of narcissism, so I disengage when I get discharged from the hospital; so I do a day-to-day routine to protect me" before re-listing his protective factors. . . . .The defence asked the patient if he would return to the hospital upon request of his psychiatrist. The patient said "I've always agreed, as the evidence shows." The defence asked the patient how he was maintaining sobriety. The patient explained that the Alcoholics' Anonymous groups, his sponsor, his volunteering and therapeutic groups all contribute to balancing his mental health and his life. . . . The defence then asked the patient which factors were the most protective. . . . Medications, the MDO group and . . . he then continued his listing and added exercise and diet. . . . The patient added that he was happy with his current physician. Explaining that he was mad at his physician at the previous facility, he said that he has realized in his psychotherapy that he and his previous psychiatrist were both oppositional, so, he said "I stuck my heels in." He continued: "What the board needs to know is that I am doing my damndest to show that I've made changes and I hope we can all come out of this as winners." (OB4, lines 472–519)

The use of phrases such as "I disengage when I get discharged" or "the evidence shows" is consistent with the medico-legal words used by other parties and indicates that the person NCRMD took on some sort of professional role during his hearing. By publicly explaining to RB members that he was deviant and that he had offset his deviancy by working on himself through therapeutic groups offered by the hospital, the person NCRMD built his case for RB members to acknowledge his efforts.

On the second occasion when a person NCRMD was authorized to speak during my observation of RB hearings, he seemed to be ignored by RB members and other parties in the conference room:

> 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." **Nurse and other staff laughing while patient speaks**. The patient says: "The doctor is telling lies and 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 test and perfect condition for 15 years. I want to live in [name of city] 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 speaks**. (OB26, lines 201–223)

In my ethnographic field notes for this observation, I wrote: "when the patient gave his testimony, all the parties at the board, except the defence [counsel], were writing and not paying conscious attention to the patient speaking . . . in striking contrast to when any other of the parties speak, such as the psychiatrist" (OB26, lines 260–262, 263). Although the language of the person NCRMD's testimony did not contain the typical wording of psychiatrist expert testimonies, the truths it conveyed, namely that he felt that the psychiatrist was punishing him and that the staff members were threatening him, 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 unwritten RB hearing "rules."

5.2.2. Review Board Hearings As Normalizing Instruments

RB hearings were instrumentalized as ceremonies, permitting the negotiation of key identity parameters for persons UST or NCRMD, namely their deviancy and normalcy. Through establishing these identity parameters, the RB could determine whether or not the person UST or NCRMD was dangerous—that is, a significant threat to the safety of the public.

5.2.2.1. The Normalcy/Deviancy Continuum

RB hearings provided a venue for parties to explain why the behaviours of persons UST or NCRMD should be considered normal or deviant. Deviancy and normalcy as concepts were not presented as static, but rather as dynamic descriptors of behaviours and thoughts exhibited or

shared by persons UST or NCRMD. From this perspective, every person's behaviours and thoughts can be considered as having some degree of deviancy or normalcy, whether under the RB or not. For this reason, normalcy and deviancy can be seen to exist on a continuum with no clear starting point or end point (see Figure 8). During RB hearings, the role of parties such as Crown attorneys, hospital representatives, and persons UST or NCRMD is to present evidence to demonstrate where persons UST of NCRMD are to be positioned on this continuum. For their part, the role of RB members is to situate, somewhere on this continuum, a threshold identifying the cut-off point for "dangerousness." If persons UST or NCRMD are situated on the deviant side of the dangerousness threshold, the RB produces a disposition in order to protect the public against them. On the contrary, if they are situated on the normalcy side of the dangerousness threshold, they are absolutely discharged from the RB.

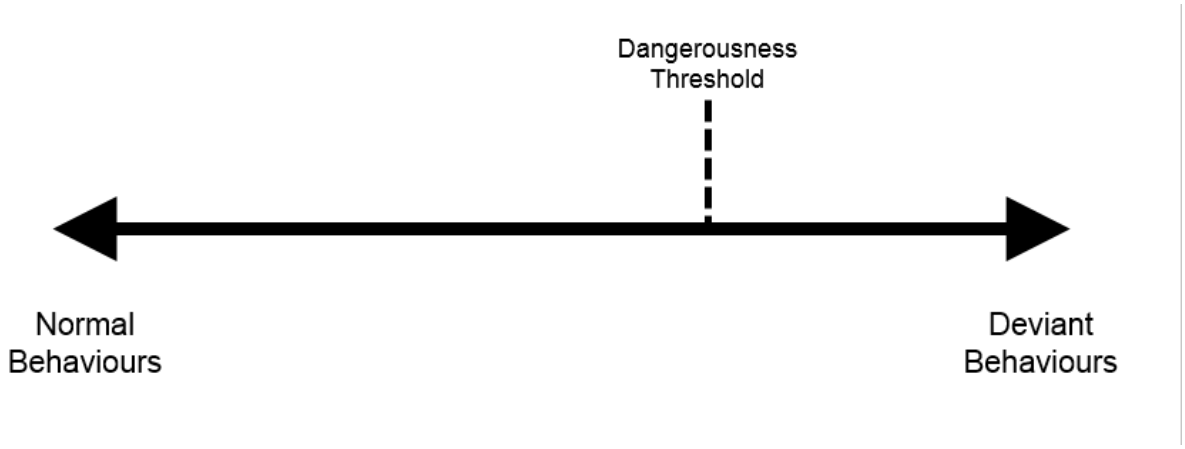

Figure 8. Normalcy/deviancy continuum.

5.2.2.1.1. Establishing Deviancy. Thoughts and behaviours of persons UST or NCRMD were examined extensively during RB hearings. These thoughts and behaviours were examined for how they deviated from social values, rules, and hospital directives. Attributes of deviancy revolved around three key themes: criminal deviancy, mental status, and rule breaking.

5.2.2.1.1.1. Criminal Deviancy. The RB members can request almost unlimited amounts of information about the life of persons UST or NCRMD. Everything in the life of these persons, including confessions they may have made while under care, can be subjected to RB enquiries and used to anchor their identities as deviant. For example, during the hearing of a person NCRMD who had been in the forensic psychiatric system for over 40 years, the chair asked the hospital psychiatrist and the Crown attorney for information regarding two unsolved murders for which the person NCRMD allegedly claimed responsibility during a conversation with a social worker:

> The chair asked for clarifications regarding two additional murders the patient had admitted to, but that the police never investigated because the file was closed. The psychiatrist said that when speaking to the social worker, the patient recanted this confession. The chair asked if the hospital had any additional information regarding this. The psychiatrist said no. The chair asked the Crown to maybe look into this. The Crown said they were "familiar with this particular gentleman" and asked the chair what she wanted. The chair answered she wanted information regarding the two potential women that were murdered, their age, why their murders were just crossed off the books. The Crown said he would do what he could. (OB7, lines 68–81)

By asking the Crown attorney to look into the unsolved murders of these two women, the chair was seeking to clarify the criminal past of the person NCRMD for the purpose of redefining his deviant identity. The person NCRMD's defence counsel enquired about the relevance of such an exercise, given the length of time involved and the fact that, over the years, RB members had never asked for clarifications in this regard:

> The defence said it had been 40 years [since the alleged murders had taken place] and questioned why this was just arising. The chair answered she wanted to know if the confessions were valid. The defence answered that this hadn't been of interest to the board for 40 years. The chair responded "Well, you have a curious board." (OB7, lines 82–88)

Similarly, during another RB hearing, when comparing the person NCRMD's criminal history described in the hospital report with offences listed in the Canadian Police Information

Centre (CPIC), the chair sought to ascertain that alleged sexual assault charges had not been included in the hospital report:

> The chair, comparing p. 4 of the hospital report and the CPIC submitted as exhibit no. 2 confirmed with the psychiatrist that the report did not take into account the alleged sexual assaults of nieces and nephews. The psychiatrist said "no sir." The chair said "yes, OK, I get it." (OB21, lines 241–245)

By introducing alleged sexual assaults as a potential piece of evidence in the RB hearing, the chair rendered them true. The person had been found NCRMD for a relatively benign index offence—indecent exposure. In an apparent attempt to emphasize the deviant character of the person NCRMD, during his final submission, the Crown attorney brought forward the person's alleged sexual assaults, suggesting that he remained a significant threat to the safety of the public: "The Crown summarizes that although 'the index offence is minor, other offences in the 80s are violent' referring to the alleged sexual assaults" (OB21, lines 259–261). Every demonstration of criminality having occurred throughout the life of persons UST or NCRMD, even alleged offences and those that had occurred prior to the index offence, can be marshalled to demonstrate the persons' deviant character.

5.2.2.1.1.2. Mental Status. Identity parameters relating to the mental status of persons UST or NCRMD were also used during hearings to demonstrate the persons' deviancy. These persons' UST or NCRMD mental status was frequently used as evidence to suggest they had altered perceptions of reality:

> The psychiatrist said that the [person NCRMD] has exhibited an increase in his vocalizations about the devil while in hospital. The patient also exhibited some homosexual thoughts when he said "I will kill him" about a co-patient he thought was infatuated by him. (OB11, lines 110–113)

> [The psychiatrist] explains the patient is "settling" and regaining some privileges and is more compliant. The attending psychiatrist says the patient continues to be psychotic evidenced by grandiose and paranoid delusions regarding unlawful detention. . . . The attending psychiatrist explains the patient lacks insight. (OB26, lines 120–125)

Information relating to the mental status of persons UST or NCRMD most likely stemmed from assessments conducted and documented by nurses (see 5.1.1.1) and other health care professionals.

A person's delusional thought contents were particularly advanced as evidence of deviancy. For example, a psychiatrist used delusional information disclosed by a person NCRMD during a case conference to suggest that his mental status resembled the mental status he exhibited at the time of the index offence, thereby rendering him deviant and possibly dangerous:

> The patient had denied psychotic symptoms and the team hadn't seen any psychotic symptoms during the past year. However during the pre-ORB case conference, the patient disclosed delusional thoughts to the whole team: he killed and executed many people in [country] between [year] and [year]. He also disclosed that he had supernatural powers to knock everyone off the planet and that he will inherit trillions of dollars. The psychiatrist continued and said the patient described his family as being "fried" and his current legal situation as a "hostage situation." . . . The psychiatrist said the patient believes people can read his mind and that he can have conversations with people on other planets. The psychiatrist said that the team's concern is that the patient's delusional thoughts are consistent with his mental state at the time of the offence. The psychiatrist said the team continue to encourage the patient to share his thoughts. The patient denies any thoughts to harm other people. When the patient disclosed this to the psychiatrist that he had delusions, the psychiatrist told the patient he would need to disclose everything to the board. (OB21, lines 89–111)

The overt disclosure of delusional thoughts in a pre-ORB case conference caused the health care team to worry about the person NCRMD's potential for dangerous action and prompted the psychiatrist to disclose this information during RB hearings. By being open about his thoughts, the person NCRMD provided the health care team, and the psychiatrist, with evidence to support his deviancy.

Information disclosed by persons UST or NCRMD during mental status examinations can be used beyond the confidential context of the "carer-cared for" interaction, for the purpose of establishing their deviancy and their need for continued supervision or detention. This was the

only time I observed an explicit statement suggesting that information provided by persons UST or NCRMD during interactions with health care professionals would be shared with the RB. Although in this case the psychiatrist informed the person NCRMD that he would share the disclosed delusional information with the RB, it is worth questioning the extent to which health care professionals examining the mental status of persons UST or NCRMD on a daily basis warn them about the ramifications of their disclosure.

5.2.2.1.1.3. Breaking the Rules. The various ways in which persons UST or NCRMD broke rules were also adduced by parties at RB hearings as a demonstration of those persons' deviancy. These included rule violations relating to social norms, RB dispositions, hospital rules, and various other rules established by health care professionals.

5.2.2.1.1.3.1. Rule Violations Relating to Social Norms. Evidence would be presented to RB members illustrating how persons UST or NCRMD violated social norms. For example, as a demonstration of repeated deviancy, incidents combining sexual motivated behaviour, "antisocial" behaviour, and threatening a nurse were leveraged during an RB hearing:

> The psychiatrist acknowledged that some incidents occurred over the past year, but that these were managed with support, advice, and supervision. The psychiatrist said that in [date], the patient made a threat to shoot the community nurse, but that with persuasion, he calmed down. The psychiatrist said the patient apologized afterward. The psychiatrist said that with numerous transitions, [the person NCRMD] missed the Lupron [injection], so this medication was added. The psychiatrist said the patient was seen in the vicinity of schools and was advised to stay away from schools. The psychiatrist explained that another incident was that he picked up a tampon on the side of the road to satisfy sexual urges; urges that have reduced with the addition of Lupron. The psychiatrist said that the patient took cigarettes from staff and equated this behaviour to antisocial behaviours. (OB27, lines 62–76)

By collating various single social norm violations, the psychiatrist was able to establish that the person NCRMD had engaged in a pattern of deviant behaviours. Nevertheless, the psychiatrist explained that with the help of health care professionals—including their support,

advice, persuasion, medication administration, and supervision—the person NCRMD was able to modify some of his deviant behaviours. To support this affirmation, the psychiatrist highlighted how the patient apologized after the incident where he threatened to shoot the nurse. Emphasis put on the act of apologizing was relevant because it represented a custom whereby a person identifies their behaviour as being contrary to social norms and should be condemned. Apologizing demonstrates that a person has partially reformed. Failure to apologize and show remorse following a socially deviant act may demonstrate a failed embodiment of social norms. For example, the lack of remorse expressed by a person NCRMD when he barricaded a staff member in her house was used by a psychiatrist to illustrate the person's deviancy: "The defence counsel asked if the patient had any remorse for the act he had done. The psychiatrist said the patient had no remorse for the staff member, he even denied barricading her" (OB26, lines 183–185).

5.2.2.1.1.3.2. Review Board Dispositions. Deviations from disposition orders were also used as illustrations of deviancy. For example, a hospital psychiatrist explained that health care providers were "quick to point out" occasions where a person NCRMD violated the conditions listed in his disposition. Specifically, he explained that, almost in a targeted way, staff acutely monitored the behaviour of this particular person NCRMD in an effort to identify and document any deviations. Although the behaviours exhibited by that person might not have been clear-cut disposition violations, they could be documented as such by staff members:

> The psychiatrist said that the patient hadn't violated his conditions. He hadn't had bad or suspicious behaviours. The patient provides a detailed itinerary when he goes into town with his scooter. He added that when the itinerary needs to be clarified, he calls in. The psychiatrist explained that the "staff is split about him." He said that the patient has staff he really likes and others he doesn't. The psychiatrist said that some staff don't like him and are quick to point out what he does wrong. (OB7, lines 89–95)

Despite using the word “staff” to designate employees that penalize the person NCRMD, we know that these staff members are nurses (see 5.1.2.2 and 5.1.2.3). By choosing what shortcomings to point out and to document about persons UST or NCRMD, nurses render certain behaviours visible and true, providing evidence to substantiate claims of deviancy.

5.2.2.1.1.3.3. Hospital Rules. Behaviours contrary to rules established by the forensic psychiatric hospital exhibited by persons UST or NCRMD were used to substantiate claims of deviancy. For example, the fact that a person NCRMD was found with prohibited items in his room was used to establish that his behaviour was deviant:

> The board psychiatrist no. 2 enquired about a comment made in the report suggesting contraband was found in the patient’s room—he asked the psychiatrist if he knew what the contraband was. The psychiatrist responded it was “something he shouldn’t have had.” Then the doctor turned toward the patient and said “Maybe [patient’s name] might know”? The chair intervened and said “no, we won’t ask other people.” The answer is “I don’t know.” (OB10, lines 205–211)

Although the hospital psychiatrist was not initially able to identify what the contraband item(s) found in the person NCRMD’s room was, the mere fact that it was found (most likely by a nurse conducting a room search) was offered as an event demonstrating his noncompliance with hospital rules. The psychiatrist later confirmed that the contraband item was “rubber gloves”: “The psychiatrist then said without prompting that the contraband was rubber gloves (I had seen him make phone calls during the break)” (OB10, lines 271–272). By having rubber gloves, a prohibited item, in his room, the person NCRMD was construed as deviant.

Illicit drugs were also considered contraband. Their use was also presented during RB hearings as being contrary to hospital rules:

> The board psychiatrist then commented on the amount of cocaine the patient brought to the unit. He confirmed that the amount found on the patient was 3.5. ounces; and he then commented on the high monetary value of such cocaine—which is about $4,000. Immediately the psychiatrist said “Whoa!” and then said well, that is what I got from the nursing notes. The psychiatrist then explained that

> the patient had mentioned the cocaine was for a patient with whom he was involved romantically. (OB15, lines 223–228)

That being said, not all breaches of hospital rules relating to drug use were considered equivalent: "Furthermore, the psychiatrist admitted that the patient had used recreational drugs, and 'it was not like marijuana or alcohol', it was a 'serious drug'—methamphetamines" (OB25, lines 68–70). There is some sort of a hierarchy regarding drug-related rule violations whereby breaches following the use of cannabis or alcohol were considered to be less important than breaches involving other more "serious" substances like methamphetamines. In this case, despite the fact that the person NCRMD violated the rules of the hospital regarding abstinence, when being questioned by the Crown attorney, the psychiatrist did not seem to consider the patient's drug use to be relevant to his medico-legal profile:

> The Crown mentioned he was worried about the methamphetamines. He explained that it wasn't as insignificant as marijuana or alcohol. Specifically, he explained he was worried about the network the [person NCRMD] needed to be close to in order to access the drugs. The Crown asked the psychiatrist if he was concerned. The psychiatrist conceded that methamphetamines are very addictive, but pointed out that the patient only used twice in eight months. (OB25, lines 102–108)

The person NCRMD in this case was from a White ethnocultural background. Interestingly, for the Crown attorney, it was not the effects of methamphetamines on the person's mental status that were particularly significant, but rather the "network" of people with whom he needed to interact in order to access these drugs. This comment was significant in a context where associations had been established between racialized communities and drug-related policing and prosecutions (Vitale, 2018).

Arguments between persons UST or NCRMD living in inpatient units were also considered contrary to hospital rules and used to establish their deviancy:

> The chair asked if the attending psychiatrist saw any changes in behaviour. The psychiatrist reported he did not as the patient just came out of seclusion on Friday

> [date], but that there were no reported concerns. The chair confirmed that the patient was in seclusion from the Wednesday [date] to the Friday [date] following an altercation with another patient. The psychiatrist said yes, and mentioned that both patients were secluded. The attending psychiatrist then mentioned the patient was doing well. That she would be given privileges and transferred to the less restricted ward. Crown asked "how long will she need to stay out of trouble" to be transferred. The psychiatrist explained that this decision would be taken as an interprofessional team and that it would be discussed at a "case conference" that occurs every 6 weeks. (OB9, lines 112–125)

> The psychiatrist explained that on [date] there was an incident where the patient kicked another patient in the midst of a disagreement about the television. The psychiatrist did point out there was a positive outcome of this altercation which was that at the end of the incident, the patient accepted psychotherapy and participation in an anger management group. (OB10, lines 113–117)

These rule-breaking incidents, witnessed and documented by nurses (see 5.1.1.1 and 5.1.4.2), were exploited as evidence of deviancy. The violations triggered the deployment of various treatment modalities for the patients—individual psychotherapy and anger management group therapy—in an effort to render their bodies and behaviours docile; to encourage them to "stay out of trouble."

5.2.2.1.1.3.4. Other Rules. Various parties referenced certain other benign behaviours prohibited by hospital employees to demonstrate the deviancy of persons UST or NCRMD. The following excerpt exemplifies one of these deviant behaviours, namely a person NCRMD not cleaning his room:

> The defence asked if these behaviours are addressed significantly. The psychiatrist said yes, when the patient is more occupied, he would engage less in "negative behaviours.". . . The psychiatrist explained that "yesterday the patient didn't follow nursing rules to clean his room, but it certainly isn't as bad as last year." (OB14, lines 136–143)

These acts of disobedience with the expectations established by nurses were used to substantiate claims that persons UST or NCRMD were deviant.

5.2.2.1.2. Re-establishing Normalcy. Beyond providing a venue to substantiate claims of deviancy, RB hearings were ceremonies where the normalcy of persons UST or NCRMD

could be re-established and where discussion took place relating to the ways in which they moved toward the normal-behaviours side of the normalcy/deviancy continuum (Figure 8). Among other things, parties used the reduction in frequency and intensity of aggressive incidents as evidence demonstrative of normalcy:

> He said there was a significant improvement with the patient. . . . The psychiatrist attributed the improvement to the work of the behaviour therapist. He explains that there has been less incidents although there was still some as listed on page 76 of the report. (OB5, lines 89–95)

> There were some level of progress. "Good year because of the involvement of the behavioural therapist and the nursing staff who followed elements of the plan." (OB14, lines 102–104)

Occasionally, as in the above excerpts, the intervention of health care providers, such as behavioural therapists and nurses, was highlighted as having facilitated the displacement of persons UST or NCRMD along the continuum.

The movement toward "normalcy" was figuratively referred to as a puzzle by a hospital psychiatrist, suggesting that successfully placing a puzzle piece represented neutralizing a risk factor deemed to increase the potential for dangerousness action:

> The Crown asked if the [person NCRMD] had insight into his mental illness. The psychiatrist responded yes. The Crown asked if the patient had insight into the need of taking medication. The psychiatrist said yes. The Crown asked if the patient was still using marijuana. The psychiatrist said "yes, it is the last piece of the puzzle." The Crown asked the psychiatrist how he intended to address this. The psychiatrist responded he would address the problematic marijuana use through psychoeducation. (OB20, lines 101–110)

The "pharmacological treatment" and "insight" risk factors having already been neutralized, the psychiatrist reported that the person NCRMD's "marijuana use" was the last deviant piece of the normalcy puzzle needing to be successfully positioned—addressed through psychoeducation—before they could make it past the "dangerousness" threshold.

Although the hospital psychiatrist in the above example mentioned that specific risk factors needed to be fixed for the "puzzle" to be assembled, a variety of other risk factors were used for the same purpose throughout the dozens of hearings I observed. The following excerpt provides an example of the way these were presented:

> The psychiatrist explained that he took over the care for the patient in [month] and that the patient had an "uneventful year" and that he was presently living on his own. The patient has been on a conditional discharge for the past two years. He is capable for treatment and finances. The psychiatrist said the patient was "settled" during the "reporting period." The patient is employed. He does not like his current living arrangement because of his roommate but he is [refusing] every bachelor apartment suggested to him. The psychiatrist describes the patient as being "pleasant and polite." (OB21, lines 80–88)

By privileging factors relating to the finance and treatment competency status of persons UST or NCRMD, as well as their employment status, moves toward reintegration into the community, and relationship with health care providers, among others things, hospital psychiatrists subtly suggested that "progress toward normalcy" was intimately linked to autonomy, docility, and social reintegration.

Defence counsel, somewhat similarly, leveraged ways in which their clients (persons UST or NCRMD) conformed to social norms as a means of demonstrating their progress toward normalcy. First, attention was given to social norms in managing stressful situations. The following excerpt illustrates how a defence counsel used his client's appropriate reaction to a real-life stressor to highlight the normalcy of his behaviour:

> The defence said he wanted to clarify about the YMCA incident; where someone said the [person NCRMD] was a sex offender and where the manager took it upon himself to report it to other patrons. The defence explained that, since then, the patient put in a complaint with the human rights commission. The psychiatrist explained the YMCA incident according to his version of the facts. The defence confirmed with the psychiatrist that the patient pursued the issues appropriately. The psychiatrist said yes comparing the patient's appropriate behaviour with the potential behaviour of other patients who would have contacted and harassed the manager until a police intervention would incur. (OB23, lines 81–92)

By comparing the way in which their patient reacted to the way "other patients" would have reacted in a similar situation, the hospital psychiatrist, after being questioned by the defence counsel, qualified the reaction as being "appropriate."

Second, defence counsel would demonstrate ways in which persons UST or NCRMD complied with the implicit social expectation that members of a society must be financially productive in order to support their normalcy:

> The defence mentioned he would be submitting three [exhibits]. The first was a hospital newspaper where the patient was interviewed. The second was a WHMIS Global System certificate ([date])—a course certification to get a job. The third was a food handler certification that was recognized across Canada. The defence explained the patient acquired these certifications in anticipation of a job at A & W. (OB18, lines 103–111)

> The defence mentioned that, in the past, the patient has spent long chunks of time working for the same company (two five-year-long employment). He said that this demonstrates the patient is a pro-social individual that would work if he were to find work. The psychiatrist said yes. (OB25, lines 159–163)

The action of working, or the willingness to work, was included as evidence demonstrative that the behaviours of persons UST or NCRMD were in line with social norms.

5.2.2.1.3. Determining the Dangerousness Threshold. Identifying key identity parameters suggesting deviancy ultimately served to establish whether persons UST or NCRMD were dangerous—that is, a significant threat to the safety of the public. To achieve this end, statements made during RB hearings emphasized the dangerous nature of deviant thoughts and behaviours. These statements were grouped around three distinct themes: incidents of aggression, use of substances, and formal assessments of risk.

5.2.2.1.3.1. Aggressive Incidents. Information regarding the presence or absence of aggressive behaviours exhibited by persons UST or NCRMD over the course of the previous year was offered many times during RB hearings. Nevertheless, in most of the hearings

observed, persons UST or NCRMD had not engaged in recent behaviours indicative of aggression. See the following two excerpts from my fieldwork journal as examples:

> The psychiatrist explained that on the positive side, the patient hadn't been involved in physical aggression or threatened any violence. (OB15, lines 95–96)

> [The psychiatrist] explained that there was no change with the patient and that he hasn't been physically violent. (OB17, lines 98–99)

In situations where persons UST or NCRMD had engaged in aggressive behaviours over the course of the previous year, the incidents were used during the RB hearing to demonstrate dangerousness:

> The psychiatrist listed that on [date] the patient made angry comments out of frustration directed toward women staff members—saying that they would be going to hell. On [date] he had an episode of agitation and an outburst. In [month], the patient was irritable after a call with his mother. (OB11, lines 105–109)

> The Crown asked, in regards to significant risk, for the psychiatrist to describe some incidents that occurred at the other facility. The psychiatrist listed two. P. 49 of the report. [Month, year]: Yelling and threatening stance, slapped someone beside the head and put them in a "choke hold." [Date]—Staff observation: Patient lunged at the recreational staff when he needed to be restrained. The psychiatrist specified that these two incidents took place at the other institution the patient was at before being transferred at the present institution. The Crown added, that on page 53 it says that the patient smashed windows. She then said "violence is directed essentially to anyone that is around when he loses it." The psychiatrist agreed to this. (OB15, lines 114–125)

As evidenced in the last excerpt, when listing such aggressive incidents and misconducts, hospital psychiatrists were occasionally questioned by other parties.

When confronted with the fact that persons NCRMD did not exhibit aggressive behaviours or engage in misconducts in the preceding year, parties at the RB hearing sometimes used historical incidents to support the position that these persons remained dangerous. For example, in the following excerpts from my field notes of OB18, incidents that took place decades previously were used to suggest a person NCRMD was dangerous:

> The board psychiatrist no. 1, from the hospital report, identified a couple of incidents and listed them. 1995—fist fight with black eye; 2005—shoving match; 2009—verbal threats. He then asked the psychiatrist if he was aware of any other incidents. He asked the psychiatrist if he had any other evidence of significant risk. The psychiatrist said no. (OB18, lines 248–252)

> The Crown asked the psychiatrist if the patient has a history and a criminal record full of violence. The psychiatrist said yes. The Crown mentioned the patient was found NCR in [year—2 decades ago] and she listed all the assault charges that had occurred prior to [year] before saying "drugs + community = violence." (OB18, lines 280–284)

In brief, all the historical incidents of aggression in which a person UST or NCRMD was implicated, even those having taken place before a finding of UST or NCRMD, can be used in addition to the ones from the year preceding the RB hearing to illustrate the dangerousness of a person UST or NCRMD.

5.2.2.1.3.2. Use of Substances. In RB hearings, dangerousness also seemed to be determined based on persons UST or NCRMD's use of illicit drugs. While this was prevalent in a number of hearings, the following two examples exemplify it particularly well:

> The defence reflected to the psychiatrist his assessment of the patient's violence "he may use, so he may be violent?" The psychiatrist said yes, use of substances but so far it hasn't been linked to violence because we catch it early on, plus the access to drugs is limited. The psychiatrist said the patient told him that when the episodes of violence occurred at the previous hospital he was using steroids. (OB15, lines 195–199)

> The psychiatrist acknowledged that the [person NCRMD] had tested positive for substances and that his mental status had been altered by the drugs which led him to be moved to the most restrictive unit between [date] and [date].The psychiatrist explained that while on the most restrictive unit, the patient misused another patient's medication. (OB24, lines 59–65)

Beyond the mere use of substances however, the RB was interested in understanding, beyond speculation, how the use of substances altered the mental status of persons UST or NCRMD to the extent that their behaviours could become threatening for the public:

> The chair asked what substance the patient tested positive to in May. The psychiatrist said it was amphetamines. The chair wanted the psychiatrist to

> confirm what mental status changes were apparent when the patient took the amphetamines. The psychiatrist mentioned that the patient was nervous and agitated but that he went voluntarily to the most restrictive unit. (OB24, lines 81–86)

> The chair, referring to page 36 of the hospital report, enquired about the drug use and the subsequent community visit by the outreach nurse and the psychiatrist and the conclusion that there was no change in [the person NCRMD]'s mental status. The chair asked if this meant the effects of the drugs had worn off. The psychiatrist said yes and clarified that there were no sustained changes to the patient's mental status. The chair confirmed that there hadn't been any reports of abnormal behaviours by members of the community or the police. The psychiatrist confirmed. (OB25, lines 194–203)

Persons UST or NCRMD whose mental status was altered by the use of substances were deemed to be dangerous. Control mechanisms, such as relocating to a more restrictive unit, then became necessary. Conversely, persons UST or NCRMD whose mental status was not lastingly affected by their use of substances were considered less dangerous. As explicitly stated in the last excerpt above, the responsibility of examining the effects of drug use on the mental status of persons UST or NCRMD was partially that of the nursing staff. Nurses were also responsible for enacting the necessary control measures relating to the prohibited use of drugs.

5.2.2.1.3.3. Assessment of Risk. At RB hearings, the dangerousness of persons UST or NCRMD was also determined based on the formal assessments of risk contained in the hospital reports submitted as evidence to the RB. At the end of their oral testimony, psychiatrists frequently listed the various risk factors, originating in various risk assessment tools used in their expert report (i.e., HCR-20 v.3), to substantiate their claims of dangerousness and the need for control measures:

> The psychiatrist then listed the [person NCRMD]'s risk factors. He explained that the patient's historical risk factors were that he has a history of violence, a major mental disorder, a brain injury (occurred in [date]) resulting in a personality change, past treatment failure, relapse in substance use (marijuana) requiring hospitalization, lack of insight and the presence of psychiatric symptoms. He explained the "risk management" risk factors were the presence of stressors such as the patient's living situation, his limited personal and family support. The

> psychiatrist concluded by saying that any changes to the current disposition would lead to symptoms appearing, substance misuse which would cause decompensation and relapse. . . . The psychiatrist ended his presentation by saying he believed the current disposition was the most appropriate and least onerous. (OB21, lines 117–133)

When presented in this fashion, risk factors seemed to be listed simply as a means of supporting the recommendation made by the hospital regarding a particular disposition order. They were removed from the context in which they materialized. For example, the substance use risk factor of a person with a substance use disorder who was engaged in a treatment program might be presented in the testimonies and reports without mention of the treatment program. Presented in this way, risk factors seemed to simply serve as support for the hospital's position regarding dangerousness.

During one of the hearings, a defence counsel interrogated the psychiatrist about the risk factors that were contributing to an increase in a person NCRMD's dangerousness. The counsel questioned that, since all the identified risk factors were static and could never really change, this meant that the person NCRMD would perpetually be a threat to the public:

> The defence reflected to the psychiatrist that when he listed all the [person NCRMD]'s risk factors, he only listed static factors; factors that won't change. The psychiatrist clarified that his concern is that the patient has a "low key personality" and is a man of few words, even when he was living in the [name of country], despite being hospitalized and treated. The psychiatrist stated that the most recent hospitalization allowed for the patient to talk, but only to familiar staff. He said that while the risk factors listed are static, they remain relevant and that dynamic risk factors including psychiatric symptoms and stress are also a concern for potential relapse. (OB19, lines 216–226)

The psychiatrist defended his assessment by noting two dynamic factors: psychiatric symptoms and stress. He also suggested that the communication issues between health care staff and the person NCRMD rendered the assessment of risk difficult, thereby increasing the person's potential dangerousness. Also alluded to in the above excerpt was the fact that a person UST or NCRMD may not be able to actively participate in assessments of risk, because of underlying

language barriers. In itself this may be considered a factor which contributes to the determination of dangerousness.

When there was a disagreement about the dangerousness of a person UST or NCRMD, the hospital's assessment of risk was closely examined by the parties at the hearing. The following example demonstrates a situation where the person NCRMD disagreed with the psychiatrist. The hospital psychiatrist was of the opinion that the person NCRMD represented a moderate risk of violence and of "relapse" and, as such, should reside in a controlled environment in order for the public to be protected:

> With regards to risk, the psychiatrist says the patient represents a moderate risk of violence and lists the risk factors: history of substance use, mental disorder, antisocial personality, no insight, no personal support, no response to therapy, exposure to destabilizers. The psychiatrist continued and explained that the current controlled environment has managed his risk of violence. The psychiatrist explained that in the absence of structure, the risk to the public would be higher. If the patient would be out of the hospital, he would be at a moderate risk for relapse. . . . For all these reasons, the psychiatrist says, the patient is considered a significant threat to the safety of the public and a detention order is the least onerous, restrictive and most appropriate. (OB4, lines 173–188)

The hospital psychiatrist's assessment seemed to be based on the fact that the person NCRMD became violent when he used substances.

Not satisfied with the hospital psychiatrist's assessment, the defence counsel questioned him so as to understand the way in which her client's "moderate risk for relapse" presented a significant threat to the safety of the public. The defence counsel also questioned the psychiatrist about his determination that a detention order, as opposed to a conditional discharge, was necessary to protect the public:

> The defence asked the psychiatrist what would happen to the patient if he were to use substances. The psychiatrist said "violence, they contributed to the index offence." The defence asked what the risk difference would be as it relates to the use of substances if the patient was on a conditional discharge as opposed to a detention order. The psychiatrist said "none." The defence asked the psychiatrist about the likelihood of violence should the patient use substances. The

> psychiatrist said there would be a high risk given the impact drugs have on his mental status. The defence asked the psychiatrist how the violence manifests itself. The psychiatrist said it was impulsive and in reaction to stress. The defence askes the psychiatrist in what way would the patient be violent. He said "Would it be directed at object? At persons?" The psychiatrist said "both" and explained it depended what and who was in close proximity if he is impulsive. The defence asked what would be the criminal offence. The psychiatrist said "if he assaulted someone." The defence asked who would be the victim. Questioning if it would be a domestic concern. The psychiatrist said "yes, and others." (OB4, lines 291–311)

The chair presiding over the RB hearing was also unconvinced of the hospital psychiatrist's assessment of dangerousness. He asked the psychiatrist what would be the criminal nature of the act resulting from the person NCRMD's use of substances:

> The chair asked what would happen if the substance use affected the mental status of the patient. The psychiatrist pointed the chair to p. 5 of the report—he mentioned the patient would be paranoid. The chair asked the psychiatrist to provide examples of significant risk. The psychiatrist responded by saying the patient would be elated, agitated, disorganized, verbally aggressive, and experience sleep disturbances. The chair then said: "which would culminate in what?" The psychiatrist said he would be brought back to hospital. The chair said: "But that isn't a criminal act." The psychiatrist said: "Maybe that is because he is brought back into the hospital." (OB4, lines 407–419)

The chair's line of questioning was intended to decipher whether the hospital psychiatrist's determination of "significant threat to the safety of the public" conformed to the Supreme Court of Canada's interpretation as detailed in the *Winko v British Columbia* (1999). Correspondingly, when presenting her closing argument, the defence counsel emphasized to RB members that the legal test related to the "real risk" of harm, and not mere inconvenience to the hospital should the person NCRMD require an admission:

> The defence then presented her position. She said that it is easy to focus on the past and not on the present when people are in the system for so long. She emphasized that the patient had no substance use since [year]. She explained that the board must focus on the risk difference between a detention order and a conditional discharge. She continued saying the patient is consenting to treatment, his plan is to return to hospital if needed. She said that "inconvenience [in regards to readmissions] isn't the test; it is about the real risk." (OB4, lines 629–636)

The inconvenience to which the defence counsel was referring most likely related to the added administrative burden associated with using the *Mental Health Act* (*MHA*) as a legal authority to involuntarily detain persons NCRMD under conditional discharge orders—a practice that is not necessary when RBs issue detention orders.

Occasionally, instead of relying an assessment of risk justifying that persons UST or NCRMD were dangerous and therefore in need of a disposition order, certain parties took an opposite approach. They identified events that could hypothetically transpire if the RB were to order an absolute discharge and then use these as justification of dangerousness:

> The Crown, referring to p. 70 of the hospital report asked the psychiatrist how the Invega Sustenna medication was administered. The psychiatrist responded that it was administered by injection. The Crown asked what would happen to the [person NCRMD] if he refused to receive this injection. The psychiatrist said that patient would relapse and have an increase in his psychotic symptoms. The Crown asked if, in the event the patient would receive an absolute discharge, he would need to be compliant to the injection. The psychiatrist said no. The Crown asked if, in the event the patient would receive an absolute discharge, he would remain compliant with any structure. The psychiatrist responded that without the disposition, the patient would disengage, take off and leave the city, possibly even the country to [name of country], which he did in the past. The psychiatrist also added that medication compliance would also be an issue. . . . The psychiatrist continued by saying that boredom was also a factor. He said that without a conditional discharge, the team wouldn't be able to support. . . . The Crown asked, in the event of an absolute discharge, what is the expectation for the patient from a financial perspective. The psychiatrist mentioned this was a significant concern as the patient can't make decisions without support. The Crown summarized that the patient was capable for finances, but barely so. The psychiatrist said correct. (OB21, lines 134–169)

The Crown attorney and the hospital psychiatrist emphasized the person NCRMD's lack of autonomy in various aspects of his life—his medication adherence, leisure activities, and finances. They thereby suggested that if the RB ordered an absolute discharge his mental health could decompensate and that he could potentially leave the country. Dangerousness, in this situation, was therefore established by speculating about the consequences of ordering an absolute discharge, rather than through a formal assessment of risk based on "tangible" factors.

5.2.2.2. Negotiating Conditions

In situations where persons UST or NCRMD were determined to be dangerous, the RB issued disposition orders with various conditions in order to protect the public and to guide the path toward normalcy. On occasion, parties at RB hearings were consulted about the specific conditions to be included in the disposition orders. Although the nature of these conditions could vary, the examples presented in the following paragraphs illustrate the negotiation of conditions about potential places of residency for persons UST or NCRMD, the necessity for them to take a pharmacological treatment, and the need for them to refrain from being in contact with certain subgroups of society.

The following excerpt shows an interaction between the lawyer representing the Crown attorney and the hospital psychiatrist. They agreed that a condition obliging the person NCRMD to reside in a supervised setting needed to be applied so that the public could be protected:

> The Crown asked the psychiatrist if he would consider a 24h supervised accommodation instead of an approved accommodation [for the person NCRMD]. The psychiatrist said he was unsure given the patient's higher level of functioning. The Crown confirmed that the psychiatrist would consider the 24h supervised accommodation. The psychiatrist responded yes, maybe 24h to 8h supervised accommodation, maybe a coop and approved accommodation. The Crown asked if the psychiatrist will bypass the 24 hour supervised accommodation. The psychiatrist said he would maybe bypass it, it would depend on the discussion with the team. The Crown confirmed that if the privileges were granted, the hospital would monitor the patient. The psychiatrist confirmed. (OB24, lines 121–133)

When the Crown asked the psychiatrist about the potential course of action in this specific hypothetical situation, he suggested that decisions relating to appropriate discharge locations were taken as a team. However, in light of the data gathered from interviews with nurses, we understand that consultation does take place but decision-making is very much hierarchical; the psychiatrist makes the final decision (see 5.1.1.1).

During another hearing, the chair of the RB asked the psychiatrist if it was worth adding a condition to a conditional discharge order requiring the person NCRMD, with his consent, to take a pharmacological treatment:

> The chair asked the psychiatrist about adding within the conditional discharge disposition as requirement for the [person NCRMD] to take medication if he consents to it. The psychiatrist explains this isn't important anymore considering that the patient understands the importance of medications in maintaining wellness. (OB20, 95–100)

The psychiatrist, not believing such a condition to be necessary, opposed its inclusion in the conditional discharge order. Including conditions about pharmacological treatment in disposition orders is futile as they have no clout. Provided that persons UST or NCRMD remain capable of consenting to treatment (*Health Care Consent Act*, 1996), they could always retract their consent. One therefore wonders about the purpose of including of such a condition in their dispositions. Does it mainly serve a symbolic function, to re-establish the moral authority of the RB over the lives of persons UST or NCRMD? Is it solely a disciplinary technology aimed at evaluating whether persons UST or NCRMD comply with certain ordered conditions?

Conditions requiring persons UST or NCRMD to refrain from contacting particular subgroups of society were also negotiated during RB hearings. For example, during the hearing of a person found NCRMD on violent sexual charges against a minor, the chair of the board enquired about the relevance of including a no-contact clause for minors under the age of 16:

> The chair . . . asked [the psychiatrist] that given the index offence, should the board include a clause for the patient not to be in contact with minors under the age of 16. She directly asked the psychiatrist if he would have a problem with this. The psychiatrist answered he wouldn't have a problem with this, but that it wouldn't make a difference. The chair asked if its inclusion would prevent the patient finding children. The psychiatrist said that this wasn't an issue. The chair continued and said "But if you put temptation at a distance, it would be less likely to happen." The psychiatrist responded that it wouldn't be "necessary." (OB7, lines 268–278)

Despite the psychiatrist not believing this clause would be necessary to prevent harm, the chair insisted on its potential relevance in that it would prohibit the person NCRMD from approaching children, thereby "put[ting] temptation at a distance." The defence counsel for the person NCRMD also opposed the inclusion of such a clause in the disposition, stating that it was not necessary for protecting the public and that it would just make the RB feel like they were "doing something":

> He urged the board not to add a condition relating to noncontact with minors explaining that the last sexual offence was at the index offence or around the time of the index offence [more than 40 years ago]. Furthermore he said that the patient had access to potential victims throughout the year, without recidivism. The chair asked if the parties would consider a clause about not having contact with minors under the age of 12 unless supervised by an adult. The defence explained that his objection was relating to the necessity of such a condition. He said that he questioned the public being any more protected by this condition or if it would just make us feel like we are doing something. He ended by saying the evidence doesn't suggest this is an issue. (OB7, lines 333–344)

It appears as though the RB felt morally compelled, to include a clause in the disposition restricting the person NCRMD from having access to "temptation" (i.e., children) despite the evidence provided by the hospital psychiatrist suggesting that such a condition was not necessary to protect the public.

5.2.3. Review Board Hearings As Windows into Hospital Therapeutics

RB hearings present a rare opportunity for the public to hear about the therapeutic rehabilitative activities that take place within forensic psychiatric hospitals. These include pharmacological treatment modalities, group therapy, vocational therapy, milieu therapy, and interpersonal relationship with staff.

5.2.3.1. Pharmacological Therapy

In explaining their treatment decisions to the RB and answering questions that arise, hospital psychiatrists publicly expose the pharmacological profiles of persons UST or NCRMD and the

side effects of these treatments. This information is typically considered highly confidential in hospital settings. Yet, when it is transposed from the hospital setting and used in RB hearings, it becomes available for the public to hear.

At RB hearings, the pharmacological profiles of persons UST or NCRMD were put on display. This was accomplished by having hospital psychiatrists explain and justify the specific pharmacological treatment plans of persons UST or NCRMD. The following excerpts from my field notes serve as examples for the numerous occasions this took place:

> The board psychiatrist commented that the [person NCRMD] was only on 60 mg of Latuda and that this dose was decreased. The hospital psychiatrist confirmed that the current dose of Latuda was 40mg. The board psychiatrist asked if the reduction was due to restlessness and akathisia. The hospital psychiatrist confirmed and mentioned that he added Cogentin, and Epival "for insomnia." (OB20, lines 143–148)

> The chair asked if the patient was on Clozapine now. The psychiatrist referred the board to page 4 of the hospital report. He explained that the dose of Clozapine was currently at 250 mg, but it had been at 275mg. The dose had had to be reduced because the patient experienced urinary incontinence at night, a common side effect of clozapine. The chair asked what medications the [person NCRMD] had been on prior to Clozapine. The psychiatrist said a long-acting injection of Clopixol and Haloperidol. The psychiatrist explained the Clozapine initiation protocol to the board. The chair asked if the patient was at his optimal level of Clozapine. The psychiatrist said the patient was doing quite well. (OB24, lines 87–99)

Information relating to the ways in which pharmacological treatments were administered and monitored was also discussed during RB hearings:

> The Crown asked the psychiatrist [if] . . . the patient [would] continue to take his medication should a conditional discharge be ordered. The psychiatrist said the patient was on an injection and explained that if he was released, an outreach nurse would be able to provide him with his injection at his house. (OB15, lines 163–166)

> The board psychiatrist asked the psychiatrist if he was going to change any antipsychotic medications. The psychiatrist said no, given the length of time the patient has been on the medications. He said "we will provide support and closely monitor." The board psychiatrist asked if the "dosette" was checked to monitor compliance. The psychiatrist said yes, and added that the patient used to call the

> unit to confirm he was taking his medication, but he is no longer required to do this as "we have given him more liberty." (OB21, lines 219–226)

Whether persons UST or NCRMD are provided with intramuscular long-acting injections or have their consumption of psychotropic medications closely monitored, health care professionals—most likely nurses—ensure these persons comply with their pharmacological treatments. In the last excerpt above, the hospital psychiatrist explained that the treatment team gradually reduced the level at which they supervised the person NCRMD's medication consumption. This gradual reduction of surveillance was an approach aimed at ensuring persons UST or NCRMD eventually consume their medications autonomously without requiring support, prompting, or monitoring.

The mere possibility that a person UST or NCRMD might eventually become noncompliant with their pharmacological treatment was construed as an indication of dangerousness: "The psychiatrist reports that the patient said that if he is discharged from the forensic system, he would stop his medications . . . which led the psychiatrist to say that the patient represents a significant threat to the safety of the public" (OB16, lines 77–79). Somewhat ironically, by confessing that he would stop his medication if he were absolutely discharged from the RB, the person NCRMD provided information to the hospital psychiatrist that was subsequently used as evidence to demonstrate that he still required ongoing supervision.

5.2.3.2. Group Therapy

RB hearings also served as a window into the functioning of group-based therapy within forensic psychiatric hospitals. They specifically allowed for an understanding of the types of group therapies provided, their effects, and the role of health care professionals in their delivery. Although a variety of group-based therapies were offered at the forensic psychiatric hospital, a

couple of them were particularly highlighted during RB hearings: those aimed at reforming behaviours relating to substance misuse and unhealthy social relationships:

> The psychiatrist member of the board asked if the patient will be involved in substance misuse rehabilitation. The attending psychiatrist acquiesced. . . . The board psychiatrist asked if this type of program was available at the hospital. The attended psychiatrist said yes and specified that individual and group therapy both are available. (OB9, lines 153–158)

> The psychiatrist said the patient was involved in numerous activities including Alcoholics Anonymous, substance group, but he denied attending the healthy relationships group after having taken offence that he wasn't able to attend at the moment when he wanted to. . . . The psychiatrist continued to list the activities the patient was involved in: gym, patient-run café, lawn care with the outreach team, hospital patient counsel representative. (OB4, lines 139–148)

This last excerpt demonstrates that, for the participation of persons UST or NCRMD in these group-based therapies to be recognized and reported to the RB as satisfactory, their participation must be done as instructed by the health care team.

When the person NCRMD above testified at his RB hearing, he explained that his refusal to partake in the "healthy relationships" group was based on a suggestion made by the health care professional responsible for the group, who told him that his relationship needs would be better addressed through individual therapy: "The [person NCRMD] . . . specified that the group moderator for the healthy relationships group told him that this group was not for him and said 1:1 psychotherapy would be better suited for him" (OB4, lines 497–500). The hospital appeared to be more concerned with the person NCRMD not obeying the instructions and process laid out by the health care team, than with his participation in a therapy designed to improve the nature of his relationships as the outcome.

The prescriptive nature of group therapies within the forensic psychiatric hospital is highlighted by the vocabulary used to designate the ensemble of groups that persons UST or

NCRMD must attend. During various RB hearings, this ensemble was referred to as a "functional prescription" or as a "script program":

> The patient would be entered into a new "script program" aimed at structuring therapeutic group involvement. (OB4, lines 255–256)

> Psychiatrist then explained that the patient would be soon initiating what he called a "functional prescription" which is some sort of structure to his day-to-day activities. (OB10, lines 125–127)

Persons UST or NCRMD had to comply with pharmacological prescriptions to ensure the "rehabilitation" of their mental health. They also had to comply with functional prescriptions to ensure that their lives were structured in such a way as to functionally "rehabilitate" themselves:

> The psychiatrist then added that the patient would be on a "functional prescription" before explaining that at the hospital every person that wants to be discharged needs to do certain things such as "getting up in the morning, participate in activities." He mentioned the functional prescriptions were client specific. (OB1, lines 196–201)

> [The hospital psychiatrist] mentioned that the patient presents well, he is happy at the residential treatment centre and with the current disposition. He said that the patient seems insightful since the events having led to the last restriction of liberties. The psychiatrist reiterated that the patient is doing quite well and that the patient is highly motivated and eager to comply. The psychiatrist said that at the next conference, hopefully the team can help the patient move forward. (OB18, lines 131–138)

Failure to comply with functional prescriptions could be considered as a lack of functional "rehabilitation" and might cause delays for persons UST or NCRMD to "move forward" and be discharged from the hospital into the community.

Persons UST or NCRMD had to participate in various group-based therapies. They also had to demonstrate that they had been able to transpose the principles learned in these groups outside the group setting:

> The defence asked about an "emotional awareness and social skills" group the patient was involved in. The psychiatrist explained that the patient doesn't miss any group sessions. However, part of the problem with the patient is the

> application of the skills learned outside of the group. "How to use those tools in-vivo." (OB14, lines 144–148)

The successful "functional rehabilitation" of persons UST or NCRMD was seen to materialize itself in a two-step process: attending groups "prescribed" by the health care team, and embodying the concepts taught in those groups. Emphasis was placed on the latter. For example, when RB chairs addressed persons UST or NCRMD at the end of RB hearings, they regularly attributed the progress made by those persons to the efforts made in working on themselves:

> The chair then addressed the [person NCRMD] and told him that the hearing was finished. She thanked him for having a good year and said "keep up the good work." (OB19, lines 290–292)

> The chair addressed the [person NCRMD] and said "You've done well and we commend you." (OB20, lines 190–191)

Doing "good work" or "doing well" appears to be a synonym for embodying the public safety aims of the hospital—the "work" consisted of modifying one's self.

However, when the rehabilitation of persons UST or NCRMD seemed to happen too quickly, parties at RB hearings might become suspicious about whether changes had really occurred. The following excerpt describes an interaction between a Crown attorney and the hospital psychiatrist about the unusually rapid and "remarkable" rehabilitation of a person NCRMD, relating to his misuse of substances:

> The Crown reflected that the concern with the patient was his drug use. He reflected that the patient hasn't tested positive for drugs since the day of the index offence. The Crown asked "what is the change? It seems to be a remarkable turnaround." The psychiatrist explained that when the incident happened, the patient took it on board that drug use was an issue. Now, he says that without drugs he feels better. The Crown said "all I am saying is that I am surprised about this success. It doesn't happen often." . . . The Crown asked the psychiatrist if without the review board, the patient would backslide. The psychiatrist said that if he continues his behaviours, maybe he will get in trouble, but that at this point, it is up to him. (OB6, lines 81–93)

Persons UST or NCRMD were therefore placed in a paradoxical position: they cannot be too normal because this raises suspicion from parties at annual hearings, nor can they be too deviant as this may position them too close to the dangerousness threshold (Figure 8).

5.2.3.3. Vocational Therapy

The participation of persons UST or NCRMD in various vocational therapies—activities aimed at ensuring their productive participation in society such as volunteering, getting an education, working—also constituted information conveyed by hospital psychiatrists during RB hearings. The productivity of persons UST or NCRMD in society's functioning was presented at the RB hearings in a positive light. The following example demonstrates this particularly well:

> The Crown asked the psychiatrist if the patient's goal to attend college was a reasonable one. The psychiatrist said yes. The Crown asked the psychiatrist about the patient's employment. The psychiatrist confirmed the patient worked at a café. The Crown asked the psychiatrist where the college the patient was planning on attending was. The psychiatrist responded with the name of the college. (OB20, lines 114–120)

Vocational activities were conceived as beneficial because they offered a "structure" to the day of persons UST or NCRMD:

> The chair asked what activities the patient would be doing. The psychiatrist answered that he would continue vocational activities at the hospitals such as lawn work and shovelling. . . . The chair said that it would be important for the patient to have structure in his life. The group home staff explained the structure provided by the group home. (OB27, lines 132–139)

Although vocational activities were encouraged, they needed to be conducted with the approval of the health care team. Participation in vocational endeavours seemed to be of secondary importance to the involvement of persons UST or NCRMD in other group-based therapies offered at the forensic psychiatric hospital: "The psychiatrist then said 'While we encourage employment, we want to privilege therapeutic groups to reduce risks'" (OB4, lines 207–208). Furthermore, persons UST or NCRMD who wished to undertake vocational

endeavours had to do so in accordance with hospital processes, which might include the forced disclosure of their UST or NCRMD status:

> The psychiatrist said that the patient's latest employment opportunity at local stables "fell through." [The psychiatrist said that] the patient wasn't happy to inform employer about being an inpatient and that "the hospital has duty of care to the public, so we would have to inform the employer." (OB4, lines 167–170)

Despite being supportive in assisting persons UST or NCRMD in their vocational undertakings, forensic psychiatric hospitals consider these must be done within strict parameters. In the previous excerpt, the psychiatrist explained that the hospital needed to notify employers of the person UST or NCRMD's inpatient status in order to protect the public. However, this notification was not a condition in the person NCRMD's disposition, nor was it a legal requirement in Ontario. The hospital's motives for proceeding with such a notification therefore remains unclear. Even though the hospital presented the deviant behaviour of the person NCRMD as being the cause for his employment "falling through," it is worth questioning to what extent the hospital itself constituted a barrier to the patient's vocational endeavour since it was the one who disclosed the person NCRMD's inpatient status to his employer.

5.2.3.4. Milieu Therapy

The RB hearings provide an opportunity for the public to learn how the architecture and processes inherent in the forensic psychiatric system operate, namely, the ways in which the forensic psychiatric milieu rehabilitates and protects persons UST or NCRMD, and the ways in which it protects the public.

5.2.3.4.1. Rehabilitating Persons UST or NCRMD. The rehabilitative function of the forensic psychiatric hospital operated in a tier-like process where persons UST or NCRMD "geographically" progressed from restrictive units within forensic psychiatric hospitals to community living milieus:

> The chair asked about the "geographical progress" the psychiatrist was referring to. He said "take me through the sequence." The psychiatrist said the patients start on the admission unit. He explained that this is where patients on assessment orders and unwell patients reside. He explained that some patients "getting their medications titrated" would also be there. He added patients in "seclusion suites." He explained that this unit fostered "relational stability." He said the unit had higher staff-to-patient ratios and that patients would need to be stable for weeks, perhaps for months there before being transferred. The chair interjected and said "Stop, just take me through the progression." The psychiatrist said "Well, all forensic hospitals function like this." (OB10, lines 236–246)

> The psychiatrist explained that the patient is currently on the second unit and would remain there for several months. He further explained that the next steps would be a transition to the other units where he would be expected to participate in activities, activities of daily living before he could be transferred to a group home. The Crown emphasized that this would be a slow process. The psychiatrist said yes. (OB11, lines 142–148)

Each unit of the forensic psychiatric hospital and each community living milieu had a specific purpose, such as assessment, seclusion, stabilization, community reintegration, and community living. They also displayed characteristics such as nurse/patient ratios and therapeutic group offerings.

For persons UST or NCRMD to be transferred from one unit to the next and then into the community, they needed to meet certain milestones such as being "stable relationally" or as having their medications "titrated." One psychiatrist referred to this step-by-step process as a "rehabilitative process," underlining its "rehabilitative" function:

> The psychologist asked the psychiatrist what his plan was. The psychiatrist responded "carry on with the rehabilitative process. . . . Move forwards." He continued by saying that the patient need to "carry on the activities on the ward. They need to give the evidence that he used the privileges and participated in the activities on the ward." (OB1, lines 186–190)

As highlighted in this excerpt, for the "rehabilitative" effect of this process to materialize itself, persons UST or NCRMD needed to be actively involved in the in the "therapeutics" of the hospital—that is to say, they must participate in the activities offered to them on each unit.

For persons UST or NCRMD to transition from one unit to the next, they had to demonstrate how they had improved their "selves" by embodying the notions learned during the offered activities: "The defence confirmed that for community access to be granted, the patient would need to demonstrate a self-improvement. The psychiatrist confirmed" (OB24, lines 159–161). The determination of whether a person UST or NCRMD had modified their selves satisfactorily was contingent on the information reported by nurses to hospital psychiatrists:

> The board psychiatrist no. 1 asked if the hospital would give the patient the privileges to have indirectly supervised passes to Walmart. To which the psychiatrist said it would depend on the progress and if the reports from the nursing staff is good. (OB10, lines 199–202)

The observations nurses made and documented thus had a central role in the rehabilitative functioning of the hospital.

By reducing the structures imposed on persons UST or NCRMD while maintaining an adequate level of supervision, health care providers were able to assess the degree to which the various treatment modalities had transformed deviant persons UST or NCRMD. That is, they assessed whether these persons had become more normal, and responded to environmental stressors in a more normal way:

> The psychiatrist explained that the [person NCRMD] was doing well. He said the patient was out since 2016 and that his risk is diminished. He explained that over the past year, the team saw the patient's response to stressors, and although his response was disproportionate, the result was appropriate. The psychiatrist said that this was comforting for the future. He then said that he wasn't asking for an absolute because the patient isn't asking for it. The patient said he wants to remain under the structure of the ORB. (OB23, lines 69–77)

Nevertheless, this excerpt describes the paradoxical effect of the hospital structure on the person NCRMD's autonomy. The progress through the forensic psychiatric system appears to have caused the person NCRMD to find comfort in being supervised by the ORB and the hospital. This sense of comfort was the only reason why the hospital did not recommend the RB to

absolutely discharge the person NCRMD: “The psychologist asked the psychiatrist if the only reason why he was not asking for an absolute discharge was because the [person NCRMD] wants a conditional discharge. The psychiatrist said this was correct” (OB23, lines 100–102). The forensic psychiatric system in itself may thereby present a barrier for the community reintegration of persons UST or NCRMD—they become dependent upon the structure it provides.

5.2.3.4.2. Protecting the Public. The forensic psychiatric system and the supervisory structure inherent in the forensic psychiatric hospital were displayed during RB hearings. These were institutions that, in themselves, protected the public:

> The psychiatrist said that the patient has managed because of the structure and because of the staff. Without the structure, he said, the patient would lack in self-care, be malodorous and, if he was med noncompliant, his symptoms would increase, he would use alcohol which can lead to an increased chance to “act out.” (OB17, lines 177–181)

> The psychiatrist then explained that without the structure and conditions listed in the disposition, any significant changes at the present to the disposition would lead to an increase in the [person NCRMD]’s level of stress and to a worsening of symptoms. The psychiatrist mentioned that the risk to other is currently low and that the patient’s risk of imminent violence is also low, but this is due to supervision and support. For these reasons, the psychiatrist explained that a detention order was the necessary, least restrictive, least onerous and most appropriate way of managing the patient’s risk. (OB19, lines 153–162)

The forensic psychiatric hospital provided walls, locked doors, procedures, and personnel to supervise and control the behaviour and thoughts of persons UST or NCRMD, which purportedly reduced the threat they posed to the public. The protection provided by the architecture of the forensic psychiatric system functioned through a tiered system, like the one described in 5.2.3.4.2, where persons UST or NCRMD were gradually reintegrated into community settings while being monitored by hospital employees:

> The member of the public asked the psychiatrist to walk the board through the typical steps that would be taken for a person that has the same privileges as the

> patient before getting a conditional discharge. The psychiatrist said "that's a good question." And proceeded to list the steps. First, he said, the patient would get accompanied privileges, first to the hospital grounds, then to the community. He would be monitored for drug use and violence. Second, the patient would get indirect privileges, first to the hospital grounds, then to the community. He would be monitored for drug use and violence. Third, we would try a community placement. He would be monitored for drug use and violence. Finally, we would then recommend a conditional discharge. The member of the public asked what would a timeline for such a progression. The psychiatrist said "If he puts his mind to it, 6 months; but it is up to him." (OB15, lines 249–259)

The gradual increase in freedoms given to persons UST or NCRMD allowed for the forensic psychiatric hospital to closely monitor them and ensure that the public is protected from them. Although the psychiatrist used the word "we," it is important to note that in light of the interviews conducted (see 5.1.2.2), "we" most likely refers to nurses. Nurses were the hospital employees who monitored persons UST or NCRMD when they exercised their privileges and reformed any deviant behaviours previously exhibited.

Specifically, the tiered progress from more restrictive milieus to less restrictive milieus allowed for a gradual decrease in supervisory modalities, thereby offering occasions for persons UST or NCRMD to demonstrate their lack of dangerousness when not supervised by the hospital and the RB. In that vein, the following excerpt illustrates a long dialogue between a hospital psychiatrist and a chair negotiating what conditions should be kept on a disposition for a person NCRMD and what conditions should be dropped to uphold this gradual reintegration principle:

> The chair looking at last year's disposition mentioned it required the [person NCRMD] to submit samples [of urine]. She then said "I wonder what conditions are really necessary." Asking the psychiatrist she asked if he thought it was really necessary for the patient to submit samples [of urine]. The psychiatrist rationalizing the situation said that the consequences of taking this condition out would be that the patient could say no, so he told the board they could remove the condition. The chair asked about the condition that requires the patient to report once every two weeks. The psychiatrist said that the board could change that condition, but it wouldn't really make a practical difference but that it would "loosen the net." The chair said "So you don't need it?" The psychiatrist said no. The chair asked about "1.B."—submit sample. The psychiatrist said the board could remove the sample clause. He explained that taking it out the clause would

> be a good test for next year. The chair asked about 1.A.—to participate in a rehabilitation program. The psychiatrist said the patient does this voluntarily. He is involved with the vocational therapy and he sees his nurses. The chair asked if it was appropriate for the condition to remain. The psychiatrist said no. The chair asked about "1.D.—to notify the hospital if he changes his addresses," but then said "we will leave that in." The psychiatrist said yes. The chair mentioned the F and G conditions are standard. The chair asked about the 2a—rehabilitation program conditions to be offered by the hospital. The psychiatrist said they would offer the program regardless. The chair asked about 2b—for the hospital to take samples. The psychiatrist said they could remove that one too. (OB23, lines 107–139)

By removing various conditions with which the person NCRMD must comply, the RB provided him with more liberties, which "loosens the [supervisory] net."

The tiered-like "rehabilitative process" of the forensic psychiatric milieu therefore permitted forensic psychiatric hospitals to test persons UST or NCRMD in controlled environments:

> The Crown noted that the patient scored as moderate risk in HCR-20 and in the 9th percentile in the VRAG. The psychiatrist answered that the only way to reduce risk is to give the patient an opportunity to make a mistake, and for him not to do it. (OB7, lines 172–175)

> The board psychiatrist asked what the psychiatrist meant when he said "make a mistake." The psychiatrist explained that this meant that the patient needs to be in a situation where he could reoffend but that he doesn't. (OB7, 248–251)

Despite the potential for endangering the public, the hospital psychiatrist in these excerpts suggested that to evaluate and reduce the risk posed to the public by the person NCRMD, he had to be inserted into an environment where he could behave in ways contrary to what was wanted. This would provide the hospital an opportunity to test whether the person NCRMD was able to govern himself independently. This gradual access to more freedom was even identified by a defence counsel as the motivating factor for the person NCRMD to follow the rules imposed upon him: "The defence explained that the hospital would gradually implement the privileges in

a step-by-step fashion with risk assessments at every stage. He added that this would leave the patient well motivated" (OB24, lines 387–390).

Somewhat similarly, in another hearing, the testimony of a psychiatrist suggesting that the forensic psychiatric system's ability to threaten the person NCRMD with a rehospitalization is the modus operandi by which it keeps the public safe:

> The member of the public asked the psychiatrist why the patient was a significant threat to the safety of the public. The psychiatrist explained that despite the lack of incident, there has not been a full rehabilitation. . . . The member of the public asked for a likely scenario that would pose a significant risk. The psychiatrist said that they couldn't predict but a likely scenario would be that the patient would use recreational drugs "without the ORB legal sword hanging over his head" which would lead to a mental state destabilization which would escalate the threat. (OB18, lines 180–190)

The psychiatrist described the ORB as a "sword" hanging over the person's head like a lingering threat preventing him from using substances. The combination of the increase in liberty, the ongoing supervision of the hospital, and the omnipresent threat of readmission ensures that persons UST or NCRMD conform to the rules of the forensic psychiatric hospital, and that society is protected.

Community reintegration does not mean a complete lack of supervision. Community settings into which persons UST or NCRMD were discharged might replicate many restrictive characteristics of the forensic psychiatric hospital:

> The defence asked if the 24 hour supervised residence would have staff 24/day. The psychiatrist confirmed. The defence asked how big the residence was. . . . The defence asked if the residence was locked at night. The psychiatrist said he thought so, but that he wasn't 100 percent certain, but confirmed that the doors are monitored. The defence asked if the patient would be required to submit an itinerary when he left the residence. The psychiatrist denied but said that residents are required to sign in and out at the residence. The defence asked if there was a curfew at the residence. The psychiatrist said yes. The defence asked if the hospital would be contacted if the patient didn't return to the residence. The psychiatrist confirmed. (OB7, lines 192–210)

Similarities in supervision structures between forensic psychiatric hospitals and 24-hour-supervised residences can include, but are not limited to, 24-hour supervision, locked doors, monitored sign in/sign out entries and exits, supervised medication administration, and curfews.

Furthermore, community discharges of persons UST or NCRMD may be accompanied by other supervisory modalities such as randomized urine testing for drug metabolites: “The defence asked if there was any substance use. The psychiatrist said no and that monitoring will continue by collecting urine samples. The defence asked if all the urines had been ‘clean’. The psychiatrist said yes” (OB18, lines 168–172). The hospital, by proxy of its nurses (see 5.1.2.3.1), randomly analyzed the urine of persons UST or NCRMD for drug metabolites in order to ensure they were complying with a disposition that required them to be abstinent.

In the community, family members of persons UST or NCRMD might also be required to supervise their loved ones with regards to the use of substances:

> The defence asked the mother if she could control “drug use” within her house. The mother said yes. The defence asked how she would manage her son. She said she would have “behavioural contracts” and jobs. She further said that she had “contacts in the community.” The defence asked the mother if she had access to a car for her son to partake in the mandatory drug tests. The mom said yes. The defence asked the mother if she thought her son would comply. She said yes. (OB15, lines 337–342)

Surveillance may thereby extends outside the traditional health care team to the person NCRMD’s family, which constitutes an added level of control to maintain abstinence.

The necessity of proceeding with a tiered approach to reintegrate persons UST or NCRMD within the community was so deeply anchored in the RB culture that any deviation was seen as abnormal. The following excerpt illustrates the case of an RB psychiatrist trying to understand why a gradual approach to community reintegration was not attempted by the hospital before requesting an absolute discharge for a person NCRMD:

> The board psychiatrist referring to the patient's current detention order 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 community placement given that long-term care is what was identified. The board psychiatrist mentioned that the previous placement in 2017 was in a long-term care facility and that it didn't work out and, as a result, the patient was readmitted. He pointed out that the patient didn't need an absolute discharge to try placement. The psychiatrist explained the hospital didn't move forward given medical concerns. The board psychiatrist pointed out that "adjustment to community facility" hasn't been tested. The patient said "I was actually assaulted." The board psychiatrist to the psychiatrist said "With the current detention order, you could have tried, but you didn't." (OB22, lines 221–236)

The RB psychiatrist would have seemingly preferred a tiered approach with a gradual reduction of supervisory modalities. He scolded the hospital psychiatrist for not having tested the person NCRMD in a long-term care facility while she was on a detention order before requesting an absolute discharge.

5.2.3.4.3. Protecting Persons UST or NCRMD. The forensic psychiatric milieu was also depicted during RB hearings as a setting that protected persons UST or NCRMD. Hospital psychiatrists explained that the forensic hospital protected these persons from themselves. For example, in one RB hearing, the hospital's ability to detain a person UST was construed as protecting him against the possibility he might be "hit by traffic":

> The psychiatrist explained that there had been progress over the previous year. However, the staff remain worried about the patient's safety when he accesses the community indirectly supervised. The staff are worried that the patient will get hit by traffic because he wears headphones. As a result, the patient is limited to take the bus to one specific store in the local community and to walk to another store in the community. The psychiatrist mentioned that the team would be worried if the patient had a wide range of privileges so they are proceeding gradually. (OB1, lines 98–107)

In this scenario, the health care team was not using restrictions imposed by the disposition to protect the public; rather, they were using these restrictions as a custodial modality to protect the person UST against potential harm he might cause to himself.

In another hearing, it was the vulnerability of the person NCRMD to being sexually exploited that provided justification for the restriction of her freedom:

> The psychiatrist explained that the patient wasn't able to exercise much of her indirectly supervised privileges because when she did utilize them, she was sexually exploited by other residents, so the hospital limited her indirectly supervised privileges. The psychiatrist said this was done to protect the patient. He continued by explaining that now she only goes out monitored by staff because when she goes out alone, she is sexually exploited. He said "our job is to protect her." (OB5, lines 96–102)

Because she was sexually exploited by other residents, her freedom had to be restricted for her own protection. Her access to the hospital grounds was restricted to once daily and her access to the community was restricted to once weekly. Both privileges were exercised under the supervision of hospital employees, most likely nurses:

> The psychologist questioned the psychiatrist about the frequency of [the person NCRMD]'s accompanied privileges with staff considering that her indirectly supervised privileges were limited given her victimization. The psychiatrist tried to answer the question generally by giving the overall procedure for the unit. The psychologist interrupted the psychiatrist and asked "what about hers." The psychiatrist responded "once a day" for ground privileges and "once a week" for privileges "further away." (OB5, lines 183–193)

Instead of intervening at the source of the sexual exploitation, namely the perpetrators, the forensic psychiatric hospital imposed custodial measures on the person NCRMD.

During a third RB hearing, the restriction of a person UST's privileges was justified by the hospital psychiatrist as a necessary step to prevent the patient from exhibiting aggressive behaviours that reportedly increased his quality of life:

> The psychiatrist explained the patient had a history of physical aggression when staff were conducting searches on him. So to manage this, the patient is now only allowed to have privileges "accompanied" with staff which means, he does not smoke when he goes outside and doesn't need to be searched when he re-enters the unit. The psychiatrist explained that the patient's quality of life has increased. (OB3, lines 89–94)

Although the hospital's invasive practices such as searches were at the root of the person UST's aggressive behaviours, the responsibility for these behaviours was attributed solely to the person UST. This permitted the hospital to impose additional restrictive measures—namely, removing his freedom to go outside without being supervised by health care professionals—in order to prevent searches from being conducted. Instead of modifying invasive search practices to adapt to the person's clinical presentation, the hospital imposed additional restrictions on his freedom.

In other areas of psychiatry, such legal circumstances—namely, where persons are detained involuntarily—would permit persons to contest their involuntary status before a Consent and Capacity Board (CCB): "An involuntary patient, or any person on his or her behalf, may apply to the Board in the approved form to enquire into whether or not the prerequisites set out in this Act for admission or continuation as an involuntary patient are met" (*MHA*, 1990, s. 39(1)). However, to protect the physical well-being of persons UST or NCRMD, forensic psychiatric hospitals leverage the RB hearing and the restrictions permitted in the dispositions to restrict their freedoms. Persons UST or NCRMD are denied access to provisions in the Ontario *MHA* that would otherwise allow them to contest such restrictions.

Interestingly, the forensic psychiatric hospital's capacity of protecting persons UST or NCRMD was put into question by defence counsel during RB hearings. They proposed that the forensic psychiatric hospital milieu itself may be the cause of the development of "antisocial" behaviours in their clients:

> Defence counsel brought up a concern about the fact that the supervised (institutional) setting was the cause of antisocial behaviours. To which the psychiatrist responded yes, and emphasized that the hospital needed to see if these behaviours persist as the patient transitioned into the community. (OB10, lines 153–157)

> The defence asked if the antisocial behaviour was linked to hospitalization. The psychiatrist said it was possible. (OB15, lines 186–187)

The mother of a person NCRMD also suggested that the hospital setting might be a petri dish in which "antisocial behaviours" develop:

> The chair speaking to the mother said: "We heard from the psychiatrist that your son isn't ready to live in the community. What are your thoughts about that?" The mother explained that all the violent incidents took place while her son was in the hospital; none of them took place in the community. She then said: "All I can say is that environment plays a part in one's behaviour. Home is a safe place." She then explained that her son was heavily bullied as a child. She said that there is a lot of stress inside an institution. Hypothetically speaking she said: "I don't know how I would manage in the system. I don't know how any normal person can come out of this system normal." (OB15, lines 398–405)

Instead of being portrayed as an environment that protects persons UST or NCRMD, the forensic psychiatric institution is sometimes described as an environment that would make any "normal person" abnormal. Although it may be conceived as being a milieu that protects persons UST or NCRMD, the forensic psychiatric system is also a milieu that can contribute to the development of behaviours that are incongruent with social/institutional norms.

5.2.3.5. Relationship With Staff

The degree to which persons UST or NCRMD engaged in "good working relationships" with members of the health care team was also deemed important information to be shared during the RB hearing:

> The defence, referencing p. 105 of the hospital report, confirmed that there was a good working relationship between [the person NCRMD], the hospital staff, and the staff of the residential treatment centre. The psychiatrist said yes and confirmed that this relationship has been helpful. (OB18, lines 163–167)

> To conduct his day-to-day activities, the patient relies on support from the group home staff. The psychiatrist said the patient was "a man of few words, despite the presence of an interpreter" and explained that due to this, he needs to be with staff that are familiar with him and that can identify when he is in distress or when he needs support. (OB19, lines 136–141)

Although one can suppose that a "supportive" or "good" relationship may be synonymous with the development and maintenance of a therapeutic relationship, this type of relationship—one

where persons UST or NCRMD are docile and open about their thoughts with members of the health care team—allows for evidence of deviancy/normalcy, and possible dangerousness, to be compiled and documented by health care providers:

> The chair, referring to page 43 of the hospital report, . . . said that the [person NCRMD] had a troubled childhood and had numerous factors that would increase his risk of violence, but confirmed that the patient was transparent with his difficulties. The psychiatrist said that the patient wasn't only transparent with him, but also with the nursing staff and all the staff. (OB24, lines 310–315)

The necessity for the person NCRMD to openly disclose their thoughts to the health care team was even positively highlighted by the chair at the end of this RB hearing: "The chair thanked the [person NCRMD] and acknowledged the discomfort in hearing people speak about you. She added 'It's all to the good that you discuss things with the doctor and the treatment team'" (OB24, lines 393–395). What the RB chair omitted to tell the person NCRMD was that the "things" they told their health care team, in the context of treatment, constituted the evidence that could equally be used to justify their dangerousness, and legitimize their surveillance and detention.

5.3. Reasons for Dispositions of Persons UST or NCRMD

Reasons for disposition constitute a legal document that serves to provide the various reasons supporting the RB's need to issue a disposition in order to keep the public safe. Its legal purpose renders its format and content uniform. My analysis of 18 reasons for disposition permitted me to understand how identities of persons UST or NCRMD negotiated during RB hearings were fixed in writing.

The first section of such a document contains identifying information: the date of the hearing, the names of the RB members and parties at the hearing, the case-file number, the forensic psychiatric hospital responsible for the person UST or NCRMD's detention/supervision, the nature of any previous disposition order, the index offence(s) for which the person was found

UST or NCRMD and the list of exhibits for the hearing. The second section describes the written and oral evidence presented at the hearing. The last section comprises the RB's analysis of the case and its decision.

Notwithstanding its legal purpose, reasons for disposition documents allow for an understanding of how, over time, persons UST or NCRMD are constructed as psychiatrically and legally deviant, and therefore dangerous. The four following profiles of persons UST or NCRMD illustrate the identity constructing and concretizing process as displayed in RB decisions over time (Figure 9). I intentionally chose to showcase the profiles in this dissertation in such a way as to (a) be transparent with respect to risk factors and identity parameters inductively produced in my analysis, and (b) highlight the complexity with which these various risk factors and identity parameters interacted and intersected with each other to construct dangerousness. While the choice to showcase the profiles this way gives persons UST or NCRMD an inherent substance, arguably providing some sort of permanency to their dangerous identities, it was an essential step toward discussing and problematizing the medico-legal processes constructing these identities. Despite possibly appearing as a philosophical incongruity, my decision to present the results generated from the analysis of reasons for disposition in four distinct profiles was deliberate, analytically relevant, and upheld the credibility and rigour criteria of qualitative research.

For esthetic and pragmatic reasons, I attributed pseudonyms to the four persons UST or NCRMD for whom the reasons for disposition were produced—"Nathan," "Diego," "Jeremy," and "Anna." While I employed these pseudonyms in the text I wrote, I left the generic, neutral, and anonymized "person UST" or "person NCRMD" designations in the excerpts used to substantiate my claims. I did not make this choice lightly. Although giving fictitious names to

these persons has the consequence of humanizing an identity construction practice that is, as you will read, inherently dehumanizing, this stylistic choice was made to provide clarity to the reader, and to distinguish specific claims about each subject from general claims about the identity construction process of persons UST or NCRMD. I thought it was important to highlight and explain this apparent dissonance before I delved into each of the four profiles.

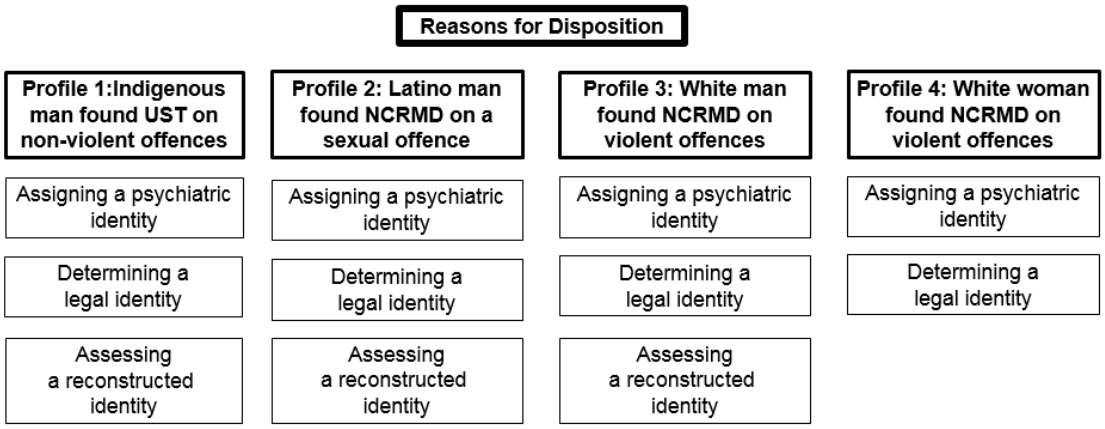

Figure 9. Schematization of results stemming from reasons for disposition.

5.3.1. Profile 1: Indigenous Man Found UST on Nonviolent Index Offences

The first profile is of an Indigenous man, "Nathan," found UST on charges of mischief under $5,000, break and enter, and failure to comply with undertaking; all nonviolent offences. At the time of the analysis, Nathan was starting his fourth year under the detention and supervision of the Ontario forensic psychiatric system. He had had four RB hearings and, as such, his "dangerous" identity had been inscribed in reasons for disposition on four occasions (RfD1, RfD2, RfD3, and RfD4). The RB gave importance to three specific identity parameters—what I have called *psychiatric identity*, *legal identity*, and *reconstructed identity*. The first two seem self-explanatory. The last refers to how the forensic psychiatric hospital worked to move Nathan from the "deviant" area of the "normalcy/deviancy continuum" to the "normal" area (Figure 8).

5.3.1.1. Assigning a Psychiatric Identity

In this case, Nathan's psychiatric identity had three specific components: intellectual and cognitive disability, psychosis, and substance use. These parameters were marshalled to illustrate his deviancy.

5.3.1.1.1. Intellectual and Cognitive Disability. Producing Nathan's psychiatric identity as one tainted by an intellectual and cognitive disability was achieved by using various pieces of information originating from different sources. Faced with the inexistence of medical records prior to his index offences, the RB was constrained to rely on information provided by collateral sources:

> Little was available to the treatment team with respect to [the person UST]'s past psychiatric history. Despite serving a number of local medical and mental health resources, there appeared to be no record of [the person UST]'s involvement with any mental health resources, apart from [name of agency]. As such, elements of [the person UST]'s psychiatric history were inferred from collateral sources as well as serial observations of [the person UST] while he has been admitted to the [hospital]. (RfD1, lines 257–261)

Much of this collateral information was provided by Nathan's mother. Whether or not she was aware that the information she gave the treatment team concerning her son would be used by the hospital as proof of deviancy, and perhaps dangerousness, is unknown. The information she provided was used to demonstrate his deviant physical movements and his deviant social interactions. The information about the former stemmed from his youth:

> According to [the mother], her son would exhibit "happy and joyful feelings" in the home. She explained that he would also use his arms to exhibit happiness and would often "flap them like a bird" when he got excited. [The mother] stated that he flapped his arms in this manner until he was 14 years old. (RfD1, lines 222–224)

By using collateral information about the way he would "flap [his arms] like a bird" until age 14, the RB acknowledged the historicity of Nathan's psychiatric deviancy.

The RB also used information provided by Nathan's mother to establish that his interactions with peers had been deviant in the years preceding the alleged index offences:

> He has been even more reclusive and less willing to interact with others than before [in the past four or five years]. As such, [the person UST]'s mother raised the suspicion that he has been dealing with deterioration in his mental status for at least the past three or four years. (RfD1, lines 270–272)

To corroborate the mother's observations of her son's reclusiveness, the RB explained that hospital staff members had also identified his reclusive behaviours: "[The person UST] has been continuously observed during his stay at the [hospital]. By and large, he has been observed to be quite reclusive" (RfD1, lines 274–275). Although the interviews conducted with nurses established that they were the health care professionals who would make these observations, nurses remained anonymous within the reasons for disposition.

With the information provided by Nathan's mother, the RB was able to establish the pervasiveness of his deviant intellectual and cognitive psychiatric profile:

> As reported by his mother, [the person UST] has struggled significantly in several domains, including independent living, social functioning, as well as academic process. Moreover, in [year], it was reported that [the person UST] suffered from at minimum, a moderate intellectual disability, with impairment in multiple domains. As such, it seemed to be fairly well established that [the person UST] has dealt with cognitive disabilities for most of his life. (RfD1, lines 263–266)

Despite the lack of clarity about the source of the determination that Nathan had a "moderate intellectual disability," by using the collateral information provided by his mother about her son's cognitive and intellectual disability, the RB established historicity for his psychiatric identity.

During the second year he was detained at the hospital, Nathan underwent a neuropsychological assessment which confirmed the presence of an intellectual disability:

> [The person UST] participated in a formal neuropsychological assessment in [year]. The report raises concerns about [the person UST]'s capacity for language and his executive functioning. The results were consistent with, at least, a mild

> intellectual disability. The report went on to note that his difficulty in communicating verbally could underestimate his overall functioning as he shows "well preserved perceptual reasoning abilities as well as an ability to learn new information." (RfD3, lines 201–205)

This diagnostic confirmation legitimized the production of truths about Nathan and offered some sense of optimism regarding the permanency of his unfitness. The neuropsychological assessment changed the RB's reliance on collateral information provided by the mother. In effect, the inclusion of information stemming from his mother in the third reasons for disposition was limited to her account of his academic progress:

> According to [the person UST]'s mother, from Kindergarten to Grade 6, [the person UST] was not able to speak properly and had difficulty comprehending and remembering words. He had a difficult time understanding his school lessons and following course material. As a result, he began to fall behind in school. [The person UST]'s mother explained that he was assessed when in elementary school and found to be born with a "mental delay and mental retardation." He was also diagnosed as being hyperactive. She stated that [the person UST] would leave the classroom if he was frustrated. He was eventually expelled at the age of 17, as a result of this behaviour. [The mother] also stated that her son had difficulty socializing with other students. (RfD3, lines 160–167)

This marked the last time that information provided by the mother was used to substantiate a claim of intellectual disability in the reasons for disposition.

In the fourth reasons for disposition (RfD4), after three full years in the forensic psychiatric hospital and after the formal neuropsychological assessment, the historical information about Nathan's intellectual disability, previously presented as a mere report from his mother, was construed as true facts by the RB:

> At a young age [the person UST] was unable to speak properly. He was described as having difficulty in comprehending and remembering words. He began to fall behind in school and was assessed as having developmental delay. He was also diagnosed as being hyperactive. He had difficulty socializing with other students. (RfD4, lines 218–221)

> Nonetheless, [the person UST] has suffered from life-long developmental and cognitive disability. He has struggled with independent living, social functioning, and academic progress. (RfD4, lines 242–243)

The neuropsychology diagnostic confirmation legitimized the transformation of "hearsay information" from the mother to the production of (expert) "truths" about Nathan.

5.3.1.1.2. Psychosis. In addition to having characterized Nathan's psychiatric identity as being "intellectually and cognitively disabled," the reasons for disposition also labelled it as being "psychotic." This "psychotic" identity is multifaceted and supported by numerous sources of information, namely Nathan's mother and the observations and assessments of health care professionals.

The information provided by Nathan's mother to the RB was used in the reasons for disposition to demonstrate the historicity of her son's unusual and behaviours later construed as psychotic:

> His mother reports bizarre and disorganized behaviour for some four or five years prior to the index offences. In [month, year], she became concerned about her son after witnessing him having a "weird conversation with himself" for about four hours. She described his language as "gibberish." When she asked her son about his behaviour, he had no recollection of it. (RfD3, lines 192–195)

> His mother stated that she became concerned with his mental health, in [year], when he started to describe that he was "noticing and seeing things." He would often see a person who would tell him to hurt himself, according to his mother. (RfD4, lines 226–228)

This information established that Nathan exhibited psychotic behaviours prior to the alleged index offences.

The RB also included information in the reasons for disposition to establish Nathan's ongoing psychotic presentation. Such information originated from various observations and assessments conducted by health care professionals:

> [The person UST]'s treatment team has made a number of observations about his day-to-day mental status. First, [the person UST]'s presentation is quite variable. On some days, he can be quiet, cooperative, and exhibit no distress at all; on other days, he seems to be reacting to internal stimuli. Specifically, the treatment team has noted that [the person UST] will break out in some laughter, seemingly without any cues from his environment. When asked, [the person UST] has either

> declined to describe the source of his humor, or has talked about something inside him making him laugh. In addition, at times [the person UST] will answer questions appropriately, albeit with typically short and nonelaborated responses, at other times, he has seemed quite perplexed and unable to answer even simple questions. (RfD1, lines 279–285)

To illustrate variability in Nathan's psychotic symptoms, the RB contrasted behaviours evocative of positive psychotic symptoms, such as reacting to "internal stimuli," with behaviours not indicative of psychosis, such as behaving quietly, cooperatively, and not showing distress. But being "quiet" or "cooperative" does not necessarily indicate a lack of psychosis; it may be indicative of the presence of other symptoms of schizophrenia such as apathy and anhedonia. Indeed, the types of behaviours being contrasted in the previous excerpt may perhaps be more indicative of disruptive behaviours (noncompliance) and nondisruptive behaviours (compliance), rather than of psychotic behaviours and nonpsychotic behaviours.

5.3.1.1.3. Substance Use. As the years progressed, the RB gave more and more attention to Nathan's substance use. His use of substances was barely mentioned in the first and second reasons for disposition, but this fact became important in the third and the fourth. In the first and second reasons for disposition, the only allusions to his use of substances were made when the RB listed his diagnoses. The RB textually included the psychiatrist's risk of violence assessment, mentioning his substance use, in the first reasons for disposition:

> The hospital's overall risk is set out at page 17 of the hospital report and can be summarized as follows: "At the time of the preparation of this report, while in hospital [the person UST] appeared to be at low risk for both imminent and long term aggression as well as reoffending. [The person UST]'s risk would likely increase significantly in the event that he is in a situation characterized by a lack of supervision, a lack of supports, and increased opportunity to access substances." (RfD1, lines 334–339)

The inclusion of "increased opportunity to access substances" as a factor that would increase the risk of aggression of reoffending seemed out of place, considering it was not mentioned elsewhere in the reasons for disposition.

In the third and fourth reasons for disposition, however, an increased amount of attention was given to Nathan's substance use. This may have originated from the fact that a toxicology analysis of his urine identified the presence of cocaine and cannabis metabolites on a couple of occasions during the years preceding the respective RB hearings:

> [The person UST] has progressed to indirect privileges on hospital grounds, although these were suspended following a positive urine drug screen (for cocaine) on [date]. (RfD3, lines 225–226)

> A random urine sample tested positive for cocaine . . . [The person UST] also used cannabis in the previous year, while on indirect grounds privileges. (RfD4, lines 263–265)

In addition to being substantiated by urinalysis procedures inherent in the forensic psychiatric hospital, Nathan's substance use was also corroborated by his mother. Consequently, the RB was able to establish that his substance use started in his early teens:

> [The person UST] has had significant involvement with the use of nonprescribed drugs, since he was 13 years of age. His mother has described that he has used cannabis and likely cocaine and codeine. [The person UST] himself has admitted to a history of substance use including the use of cannabis, cocaine, and speed. (RfD4, lines 236–238)

By admitting to health care professionals that he had used substances in the past, Nathan provided evidence for the hospital and the RB to construct part of his psychiatric identity as including his use of substances. This psychiatric identity was used by the RB in the third and fourth reasons for disposition to substantiate claims that Nathan might be at risk of mentally decompensating and, as a result, represented a "risk of violent conduct":

> In relation to Future Risk Management, the Hospital Report states that it is highly likely that [the person UST] would quickly resort to illicit substance use if and when at large. Such relapse will quickly worsen his mental state and escalate his risk of violent conduct. (RfD3, lines 256–258)

> [The psychiatrist] confirmed that [the person UST] continued to experience positive symptoms of his mental illness but not to as debilitating a degree as in the past. However, this is exacerbated by substance use. He noted [the person UST]'s

> poor insight into the relationship between his use of drugs and his continuing psychosis. (RfD3, lines 294–300)

Because a random urine sample of Nathan tested positive for the presence of cocaine metabolites, the RB now relied on Nathan's use of substances in the past to demonstrate that he still posed a significant threat to the safety of the public.

5.3.1.2. Determining a Legal Identity

Nathan's legal identity was characterized by three themes: delinquency, fitness, and establishing and managing dangerousness. These themes were marshalled to substantiate the person's dangerousness.

5.3.1.2.1. Delinquency. When people allegedly commit index offences and are subsequently found UST, they are forced into an institutional process that produces them as delinquents. Their entry into the forensic psychiatric system nevertheless publicly attaches their names to offences for which they have not been tried, and for which they have little recourse to unattach themselves. This practice allows for a meticulous scrutiny of their past and present behaviours. Thus, the forensic psychiatric hospital conducts a biographical work that then builds the entire life of Nathan within a delinquency framework. The hospital report submitted to the RB provides evidence of unfitness and dangerousness, permitting delinquency to be introduced into the reasons for disposition.

In this case, the fitness assessment order by the courts legitimized the examination of Nathan's life through a "biopsychosocial" assessment: "Background information was pulled from a biopsychosocial assessment dated [15 days before the UST finding]" (RfD3, line 160). In addition to containing information relating to the onset of psychiatric and developmental symptoms, the biopsychosocial assessment yielded numerous pieces of information relating to Nathan's family and to his youth. Most of this information was provided by his mother.

Information contained within the reasons for disposition about his family related to parental figures and siblings. For example, his biological father was presented as being absent, thus allowing for his mother's boyfriend to take on a fatherly role:

> [The mother] was involved in a relationship with an individual named [name of mother's boyfriend], for a period of 14 years. [The mother] explained that [her boyfriend] was a father figure to her son. [She] and [her boyfriend] separated in [year]. According to the mother, [the person UST] was relieved when she separated from [her boyfriend] as [the person UST] had heard rumours that [her boyfriend] was being unfaithful to her. (RfD1, lines 208–212)

The details about his mother's conjugal relationships and their effects on Nathan allowed the RB to problematize the lack of a stable father figure in his life. In doing so, the RB produced truths about these father figures, including their full names and rumours relating to their infidelity.

Truths about Nathan's siblings were also included in the reasons for disposition:

> [The person UST] is the eldest in a sib line of three. His sister is 20 years old and lives in [Canadian province]. She receives government financial support after being diagnosed with ADHD and dyslexia. He also has two younger half-siblings, a maternal half-sister, and a maternal half-brother. (RfD1, lines 204–206)

Information that would be considered confidential in any other setting, such as Nathan's sister's diagnoses of dyslexia and attention deficit and hyperactivity disorder, were publicly exposed in the reasons for disposition. Nathan's mother also fell victim such a public revelation of her personal information. Her "transient" nature in Nathan's life and the fact that she was financially supported by social assistance was included in the reasons for disposition:

> To date, [the person UST]'s mother has been unreachable. Further, [the psychiatrist] described her presence as only temporal, or short lived, in her son's life. The Board heard from [the defence counsel] that his client's mother is transient and supported by social assistance. However, [the person UST]'s mother does contact [the defence counsel] about once a week, usually by via email. She was present in Court the day her son was found unfit to stand trial. (RfD1, lines 321–325)

The mere fact of having a brother or a son that had been found UST placed items of the mother's and sister's personal health and social information in the public domain.

The RB also included information about the interaction between Nathan and his childhood friends in the reasons for disposition. By including them in the reasons for disposition, the RB linked socially deviant youth behaviours to the index offence, positioning Nathan as a delinquent:

> From the ages of 14–17 years old, his mother stated that [the person UST] became involved with a group of friends that were a negative influence on him. She stated that [the person UST] was easily influenced by this peer group and got involved in antisocial behaviours such as throwing rocks at cars. His mother stated that she would follow [the person UST] around at night in order to ensure that he was not engaging in antisocial behaviours with this peer group. She stated that she would have to restrain [the person UST] on occasion when he would try to leave the residence. She stated that he was never violent with her; however, he would occasionally "wrestle" with her and with his stepfather if they were trying to restrain him. She stated that he can occasionally become verbally aggressive with her and has caused property damage in the house when upset. (RfD1, lines 224–232)

Through evidence provided by Nathan's mother, the RB construed the identity of Nathan as lacking agency—being constantly vulnerable to peers and needing external agents, such as his mother, to provide him with surveillance, protection, and containment. The RB's use of the word "antisocial" in the previous excerpt is interesting, considering the medico-legal context in which it is presented and in light of the fact that the term is loaded in legal and psychiatric fields. "Antisocial" behaviours can be presented in psychiatry as evidence of a diagnosis of an antisocial personality disorder. However, the RB used the term more broadly to designate behaviours that were contrary to the moral and legal codes of society such as throwing rocks at cars.

The entry of Nathan into the forensic psychiatric system also allowed for his criminal history to be inspected and subsequently exposed, enhancing the construction of his delinquent identity:

> Exhibit 4, introduced into evidence by [name of Crown attorney] on behalf the Crown Attorney's Office is an [date] Information and Arrest Warrant in which

> [name of police officer], a [name of jurisdiction] Police Officer states he has reasonable grounds to believe that:
>
> On or about [date], [the person UST] committed an assault on his sister with the use of a weapon, punishable on summary conviction pursuant to section 267(a) of the *Criminal Code*.
>
> On or about [date], [the person UST] knowingly uttered a threat to cause death or bodily harm to his sister, punishable on summary conviction pursuant to section 264.1(1)(a)(2)(b) of the *Criminal Code*. (RfD1, lines 236–245)

The criminal history of this person, relating to charges incurred in another jurisdiction prior to the alleged index offences, was used to establish a pattern of alleged criminal behaviours.

Because he was deemed UST, his life underwent a meticulous screening to find various behavioural deviances that would explain his current mental presentation and the reasons why he was unfit to stand trial. The profile built as a result of this examination was solidified when it was inscribed in the reasons for disposition, construing his *entire* life as the life of a delinquent despite the alleged index offences having taken place in a specific point in time.

5.3.1.2.2. Fitness. The RB hearings held for Nathan necessitated a review of the evidence substantiating his ongoing unfitness. The RB achieved this by copying passages of the hospital report into the reasons for disposition or by paraphrasing the verbal testimony of the psychiatrist.

In the initial reasons for disposition (RfD1), the psychiatrist's assessment of fitness was not laid out as a stand-alone assessment. Rather, it was presented as a question-answer interaction between members of the RB and the psychiatrist:

> The Board questioned [the psychiatrist] as to whether a lawyer could muster any type of defence for [the person UST] considering he may never recall the index offences, let alone have the capacity to instruct counsel. [The psychiatrist] responded that to date the combination of [the person UST]'s psychosis and intellectual challenges have left him unable to recall what occurred at the time of the index offences or to organize his thoughts to a degree that would permit instruction of counsel. (RfD1, lines 327–331)

Nathan's inability to communicate with his defence counsel as a result of his "psychosis" and "intellectual challenges" was then identified as the specific factor that rendered him UST.

In the second and fourth reasons for disposition (RfD2, RfD4), the RB proceeded differently: they textually used the psychiatrist's assessment provided in the hospital report as evidence of Nathan's unfitness:

> With respect to the issue of fitness the Report states: "Overall, compared to [the person UST]'s initial assessment, he seemed better able to provide relevant responses. That said his responses were at best inconsistent times [the person UST] provided meaningless responses or simply did not respond at all; at other times and especially with more guided questions, he could provide somewhat more relevant responses. That said [the person UST] seems to provide responses consistent only with a superficial understanding of his situation. This was particularly of the case when he was describing the role of the principal actors in the court, namely the judge. In addition research provided inconsistent responses about his understanding of the consequences and his ability to construct counsel." (RfD2, lines 281–289)

By copying and pasting the psychiatrist's fitness assessment from the report to the reasons for disposition, the RB silenced any discussions or questions relating to this assessment of fitness that might have been asked during the RB hearing by other parties. By allowing only one perspective—the psychiatrist's assessment—to be inscribed within the reasons for disposition and rendered true, it is worth questioning whether the RB was legitimizing and sustaining the hegemonic position of psychiatry within the forensic psychiatric system.

In the third reasons for disposition (RfD3), the RB partly textually copied the fitness assessment documented in the hospital report and partly paraphrased it:

> [The person UST] was examined, with respect to fitness, on [date] by [the psychiatrist], his attending psychiatrist. [The person UST] was unable to identify the difference between pleading guilty or not guilty, had difficulty explaining the role of various personnel present in court or why it was important to tell the truth. [The psychiatrist] concluded that [the person UST] remains unfit to stand trial as, owing to his mental disorder, namely intellectual disability, [the person UST] does not understand the nature and object of the proceedings against him including the roles of the judge and the counsel. It is unlikely that he will be able to follow court proceedings and is currently not capable of instructing or effectively communicate with his counsel, to aid his own defence. (RfD3, lines 215–221)

As part of a fitness assessment, the psychiatrist asks Nathan numerous questions relating to court proceedings. The object of these questions is to assess Nathan's capacity to prepare a proper defence, such as understanding the consequences inherent in various pleas, and the importance of telling the truth. If the RB finds that Nathan is able to conduct a proper defence and is therefore fit to stand trial, it may transfer the person to the criminal justice system for the remainder of their legal proceedings. However, if the RB finds that Nathan remains unfit to stand trial, it will issue a disposition for Nathan and relegate him to the forensic psychiatric hospital until the next annual RB hearing or until such time he becomes "fit."

5.3.1.2.3. Establishing and Managing Dangerousness. The RB established Nathan's dangerousness in the reasons for disposition by referring to the psychiatric and legal identities it had created for him. It subsequently used this "dangerous" profile to justify the various disposition conditions imposed on him.

In the first and second reasons for disposition, the vulnerability caused by Nathan's intellectually and cognitively deviant psychiatric identity was used to determine that he represented a threat to the safety of the public. A passage in the second reasons for disposition illustrates this particularly well:

> With respect to the issue of appropriate disposition the Report stated: "There are a number of things to consider in recommending a disposition for [the person UST]. Certainly has done well in the hospital and in this milieu he has seemed to be at low risk for reoffending or committing an aggressive act. At the same time, it was recognized that this risk would increase significantly if [the person UST] were to return to the community without access to support monitoring. Moreover it was less than clear to what extent [the person UST] would be able to incorporate suggestions around treatment and support. Given that [the person UST] has a persistent cognitive delay, he seems to have evidence of a serious mental illness and that appropriate supports are not yet in place for [the person UST] and that is low risk is currently best attributed to his current milieu." (RfD2, lines 293–302)

Nathan's legal identity as a delinquent was also highlighted as an additional element establishing dangerousness and substantiating the necessity of issuing a detention order, as

opposed to a conditional discharge, to protect the public: “The psychiatrist indicated that a Detention Order with scope for privileges was appropriate. He added that the Information and Arrest Warrant entered as Exhibit 4 further contribute to the appropriateness of the Detention Order” (RfD1, lines 310–312). The arrest warrant entered as Exhibit 4 detailed charges of assault and uttering death threats with which Nathan had been charged in another jurisdiction. The combination of the patient’s deviant psychiatric identity and his delinquent legal identity legitimized the enactment of restrictive conditions.

In the third reasons for disposition, the psychiatrist’s assessment of the person’s risk of violence, using HCR-20 V3, was used to determine dangerousness:

> The Hospital Report under Risk Considerations notes [the person UST]’s risk was reviewed using the HCR-20 V3. Clinical Risk Factors included his intellectual impairment and his continuing to experience psychotic symptoms on occasion despite optimal treatment. His insight remains poor and he has poor compliance with directions and supervision. . . . The long-term plan is for him to be transferred to a supported accommodation. However, he would need to remain compliant with privileges and improve his insight to enable the team to have some confidence that he would benefit from such a transfer without the plan quickly breaking down with the reduced personal support and supervision he would get upon such community placement. (RfD3, lines 253–262)

No culture-related caveat was included in the presentation of the HCR-20 V3 scores, despite Nathan’s Indigenous cultural ancestry.

Various factors were contained in the psychiatrist’s assessment of risk of violence. Nevertheless, to establish Nathan’s dangerousness the RB emphasized the psychiatric character as someone who used substances, as opposed to emphasizing his intellectual and cognitive deviance:

> The Board agrees with the joint submission of the parties that [the person UST] remains a significant threat to the safety of the public. His clinical picture has contributions from both a psychosis of unknown certain etiology as well as profound developmental difficulties expressed primarily as cognitive delay. While there have been no violent or aggressive incidents in the year under review and [the person UST] has remained relatively stable on the ward, he occasionally

> reports continuing auditory hallucinations. Of greater concern is his lack of insight into the effect that his continued drug use has on psychosis. A positive urine screen, as recently as [date], is of concern given that his substance use exacerbates the positive symptoms of his mental illness. (RfD3, lines 341–347)

This excerpt demonstrates the way in which the RB linked numerous facets of Nathan's identity to assert that they were dangerous. First, by including the occasional self-disclosed reports of persistent auditory hallucinations in the same sentence as the determination that there had been no violent or aggressive incidents during the year, the RB insidiously linked auditory hallucinations with violence and aggression. Second, the RB identified that Nathan's psychosis was exacerbated when he used substances, thus also associating the use of substances with violence and aggression. Finally, alluding to the fact that Nathan used substances over the course of the previous year, the RB was able to establish the realistic possibility that Nathan might become violent—and this despite the fact that when Nathan used while in hospital, no violence occurred.

In the fourth reasons for disposition, the RB did not explain why Nathan represented a threat to the safety of the public. Regardless, it still affirmed the need of the public to be protected from him, through a detention order:

> The Board unanimously finds that the necessary and appropriate Disposition is to continue the current Disposition. [The person UST] is currently on a trajectory to progress through to the next level at the hospital. He resides on [name of unit] and in time, will likely move to [name of less restrictive unit]. Plans will then be made for him to reside in the community. The current Disposition permits him the privilege to live in the community, in accommodation approved by the person in charge. It also permits him hospital and grounds privileges, indirectly supervised and the privilege to enter the community of [name of city], indirectly supervised. There is a good deal of flexibility available to him and to the hospital, all of which are necessary and appropriate. In making this decision the Board has considered the need to protect the public from dangerous persons, [the person UST]'s current mental condition, his other needs and his reintegration into society. (RfD4, lines 382–392)

In their explanation, the RB emphasized the therapeutic nature of the forensic psychiatric hospital's functioning. They explained that by moving Nathan from one unit to the next, and eventually to the community, he would "progress" and the community would be protected.

5.3.1.3. Assessing a Reconstructed Identity

The RB hearings provided an opportunity for the RB to assess the degree to which Nathan had reconstructed his identity in accordance with various social norms and institutional expectations. The results of this assessment were included in the reasons for disposition and were related to Nathan's thoughts and behaviours (his individual reconstruction), and to social interactions (his social reconstruction).

5.3.1.3.1. Individual Reconstruction. Throughout the four reasons for disposition, the RB highlighted the various ways the forensic psychiatric hospital engaged Nathan in processes aimed at reforming his thoughts and behaviours. First, the reasons mentioned that hospital routines ensured that Nathan conducted his activities of daily living complying with directions given by hospital staff and respecting the general rules of the ward:

> [The person UST] will abide by ward routine in terms of taking his meals with others, respecting rules around access to common resources, but for the most part, he has had few to no interactions with his co-patients. (RfD1, lines 275–277)

> Despite his frequently perplexed facial expression, it has always been reported that [the person UST] has accepted direction, has been cooperative with ward routine and expectations, and there have been no concerns about any aggressive behaviour toward himself or anyone else. (RfD2, lines 265–267)

When Nathan violated rules or behavioural expectations, health care professionals intervened to ensure that the rules of the institution would be complied with. Rituals inherent in the forensic psychiatric hospital, such as unit searches, seek to identify violators of these rules. For example, during one room search, Nathan was found to have been diverting medication for other uses:

> [The person UST] also admitted that he had been secreting his medication, which he would eventually crush and snort. Since the discovery of this, after a random room search in [month, year], his medication has been crushed and put in jam. (RfD3, lines 226—228)

Upon discovering the diverted medications and obtaining the patient's admission of guilt, hospital employees, most likely nurses, altered the way Nathan was provided with his medication—crushing them, and mixing them with jam. They implemented this intervention to align the behaviour of Nathan with the expectations of the institution—in this case, appropriate administration and consumption of medications.

Secondly, interventions aimed to normalize Nathan's mind were of interest to the RB. The RB was specifically interested in means taken by the hospital to restore his fitness:

> [The psychiatrist] confirmed that [the person UST] has attended sessions of the Fitness Restoration program where, given [the person UST]'s cognitive difficulties, the fitness issues were presented in a visual fashion. However, this had little or no effect on his ability to address the fitness issues. (RfD3, lines 272—274)

The hospital modified their fitness restoration program to align it with Nathan's cognitive and intellectual abilities. Nevertheless, their effort to normalize his mind when it came to fitness was unsuccessful; he remained unfit.

5.3.1.3.2. Social Reconstruction. The RB was also interested in the normalcy of Nathan's interpersonal interactions, including the ones he had with his peers, family, and cultural community. Given that he was initially described as reclusive, the RB seemed to consider socialization as a step in the direction of normalcy:

> [The person UST] has enjoyed regular visits from his mother, grandmother, and other family members. He has enjoyed the exercise group on the unit as well as a fishing group in the community. He attends the [recreation room] to play pool and socialize. (RfD3, lines 237–243)

The hospital recommended that Nathan attend a group aimed at aiding socialization skills—namely, the healthy relationships group—with the intended effect of enabling autonomy in setting boundaries with peers:

> He has been involved in groups while in the hospital, including the healthy relationships group, which he began in [month, year] and completed in [month, year]. The report states: "[The person UST]'s insight remains suboptimal as does his motivation to make change. Ongoing support would be encouraged as [the person UST] continues to experience (as per him) some interpersonal difficulties with his peers, such as peer pressure and exploitation that cause him stress. Improved skills will allow him to engage in assertive communication and boundary setting would be helpful." (RfD4, lines 252–260)

By stating that his motivation to make change was "suboptimal," the hospital seemed to indicate that Nathan was capable of making such changes—a position not congruent with his psychiatric identity. In fact the hospital simultaneously used his intellectually and cognitively deviant psychiatric identity as the reason why he needed a "healthy relationships" therapeutic group, and also as the reason why he was not successful in completing this group. This had the potential to keep Nathan in a perpetual position of deviancy and dependency, and thus of dangerousness and detention.

The RB was also interested in Nathan's development of relationships with members of his Indigenous community. In the second reasons for disposition (RfD2), the psychiatrist representing the hospital was questioned during the RB hearing about whether or not lines of communication had been established between Nathan and members of his Indigenous community:

> [The psychiatrist] was questioned both by counsel for [the person UST] and by Board members about what efforts had been made to set up any lines of communication with [Indigenous community] Nation in order to see if any support was available for [the person UST]. Unfortunately [the psychiatrist] had only been at hospital for some six weeks and [the person UST]'s regular treating physician was away for an extended period of time due to a family emergency. Therefore he was unable to provide any specific details with respect to

> communication with [Indigenous community] although he believed that the social workers at the hospital had made some attempts. (RfD2, lines 310–315)

During the third yearly RB hearing, the RB followed up with the hospital to ensure relationships between Nathan and his Indigenous community had been developed:

> [The psychiatrist] was asked about the cultural opportunities made available to [the person UST]. [The person UST]'s defence counsel] pointed out that [name of person], a social worker with the [Indigenous community] Nation, has made best efforts in that regard and, in particular, [the person UST]'s attendance at drum ceremonies was appreciated. (RfD3, lines 285–288)

By relying on an external agency, the hospital was able to facilitate the participation of the person UST in drum ceremonies. However, his participation was short-lived. The fourth reasons for disposition (RfD4) indicated that the hospital had not made arrangements to facilitate his participation in ongoing culturally relevant activities:

> The Doctor confirmed that [the person UST] had not been permitted, or, at least no arrangements had been made for [the person UST] to attend with his family at [name of Indigenous community] and that no arrangements were made for him to attend the powwow, which recently occurred. The Doctor acknowledged that connection with the [Indigenous community] nation and his ancestry is important and agreed that arrangements should and could be made for [the person UST] to participate more with the [Indigenous community] Nation. (RfD4, lines 307–311)

There is somewhat of an incongruence between the psychiatrist's verbal commitment to making arrangements for Nathan to access culturally relevant services and the lack of arrangements actually made. In light of the hospital's lack of engagement in providing him access to his Indigenous community, the RB dedicated an entire section in the fourth reasons for disposition to cultural activities and emphasized that more should be done by the hospital to assist him:

> Evidence and submissions in this matter led the panel to conclude that nothing has been done over the course of the past year to assist [the person UST] to participate in culturally appropriate activities. The panel heard from counsel that [the person UST] would like to participate in such activities at [name of city], but that opportunity had not been made available to him. [The psychiatrist] was unable to explain why that was the case. . . . This panel of the ORB expects to see progress on this issue over the course of the next reporting year. In *R v Sim* 2005 CanLII 37586. (Ont. C.A.), the Ontario Court of Appeal held that the unique

> circumstances and background of an accused should be considered in making a Disposition. Clearly, this was done in past years, since an appropriate privilege is already part of [the person UST]'s Disposition. We believe that more should be done by the Hospital to assist [the person UST] to engage with his ancestry and his roots, given that he has a desire to do so—as expressed by his counsel at this hearing. We expect that a plan should be put in place to deal with this issue, subject to [the person UST]'s mental status and his continued desire to so participate. (RfD4, lines 353–378)

In this instance, the RB's attention shifted from Nathan to the hospital. By inscribing such information in the reasons for disposition, the RB publicly examined the services the hospital provided to Nathan and scolded the psychiatrist for not providing services it judged adequate for the protection of the public and for the rehabilitation of Nathan. This calls into question the role of the RB, in taking on an advocacy role for Nathan and a disciplinary role for the forensic psychiatric hospital.

5.3.2. Profile 2: Latino Man Found NCRMD on a Sexual Index Offence

The second profile is that of a Latino man, "Diego," found NCRMD on a charge of sexual assault. At the time of the analysis, Diego had been under the supervision of the Ontario forensic psychiatric system for two years. He had had two RB hearings (RfD5, RfD6). At the end of the second hearing, the RB established that he had reconstructed his identity in line with social norms relating to public safety, and ordered an absolute discharge. The analysis of this profile suggested that the RB gave importance to three specific parameters to characterize his identity: *psychiatric identity*, *legal identity*, and *reconstructed identity*.

5.3.2.1. Assigning a Psychiatric Identity

In this profile, the psychiatrist conducting the risk assessment for the RB had a different diagnostic impression than the psychiatrist who had conducted the assessment during the trial that led to the NCRMD finding. The latter believed that Diego's index offence, sexual assault, was caused by a parasomnia, namely, sexsomnia. The former, however, came to the conclusion

that Diego simply suffered from a substance use disorder which contributed, in part, to him committing the index offence. The two reasons for dispositions analyzed in this profile (RfD5, RfD6) simultaneously deconstruct Diego's "sexsomnia" psychiatric identity and construct his problematic "substance use" identity.

5.3.2.1.1. Sexsomnia. Given the novelty of the sexsomnia diagnosis, the first reasons for disposition (RfD5) relied on the diagnostic impressions formulated by the trial psychiatrist:

> The information on which the novel, for the Board panel at least, diagnosis of sexsomnia on which [name of person NCRMD] was found NCR raised significant concern for the Board. The Court based its NCR decision on the evidence presented by [name of trial psychiatrist]. This included his oral testimony and his written report found at Exhibit 12. (RfD5, lines 237–245)

The presence of the sexsomnia diagnosis was concerning for the RB, most likely because of its novelty, but also because of its symptomatology. The RB members listed the symptoms of sexsomnia to demonstrate Diego's dangerousness:

> These findings, including "walking almost daily during the night, symptoms of depression, he has many symptoms of paranoia" and especially the fact that "he has nightmares and believes that he has initiated sexual activity in his sleep" raise very significant concerns. [Name of person NCRMD]'s condition will need to be monitored and the course of assessment and treatment required will need to be determined. Information in this regard should be provided to the Board at the time of the next annual review, or earlier if deemed necessary. (RfD5, lines 288–292)

The symptoms of parasomnia raised "very significant concerns" for members of the RB, which rendered supervision by the hospital inevitable. However, according to RB members, the hospital had not created a supervision plan for these symptoms that was sufficiently robust to protect the public.

In the second reasons for disposition, however, although the paragraph summarizing the diagnostic impressions of the trial psychiatrist was included (RfD6, lines 169–176), it was merely used by members of the RB as the groundwork to substantiate the claims of the hospital psychiatrist suggesting that the trial psychiatrist erred with his diagnosis of sexsomnia:

> [The hospital psychiatrist] does not concur with the trial diagnosis of parasomnia. His diagnosis is different. Notwithstanding this difference in opinion, the [hospital] Doctor finds no evidence which he could offer for this Panel of the ORB to make a finding that [name of person NCRMD] constitutes a significant threat to the safety of the public. (RfD6, lines 239–241)

> He does not suffer from a major mental illness, which warrants treatment. He is not prescribed and is not taking medication for a mental illness. His mental state is stable. (RfD6, lines 248–249)

The hospital psychiatrist believed that Diego's main diagnosis was substance use disorder. This diagnosis was the only one listed in each of the reasons for disposition:

> Mental and Behavioural Disorders due to multiple drug use and use of other psychosocial substances—active dependence. (International Classification of Mental And Behavioural Disorders). (RfD5, lines 149–150)

> His current diagnosis is as follows, as set out on page one of the hospital report: F19.24, ICD—10—Mental and Behavioural Disorders due to multiple drug use and use of other psychoactive substances, currently abstinent. (International Classification of Mental and Behavioural Disorders, 10th Edition. (ICD -- 10) World Health Organization, 1993. (RfD6, lines 135–140)

The hospital psychiatrist refused to adhere to the psychiatric identity created for Diego by the trial psychiatrist and built one of his own, rooted in a substance use disorder.

5.3.2.1.2. Substance Use. Although both reasons for disposition list substance use disorder as the main diagnosis for Diego, in the initial hearing the RB members were more concerned with the sexsomnia diagnosis given at the trial. Substance use was only mentioned once throughout the first reasons for disposition (RfD5), and that was to establish chronicity: Diego did not have a prior history of psychiatric assessment or treatment. On the other hand, "he has a significant history of substance abuse dating back to his teens" (RfD5, lines 144–145). The relatively minor reference to substance use disorder in the first reasons for disposition is in stark contrast to the central place it takes in the second reasons for disposition (RfD6).

The second reasons for disposition presented Diego as a heavy consumer of psychoactive substances since his teen years:

> [The person NCRMD] has a substantial substance abuse history. He first smoked marijuana at age 14. He stated that when he did use it caused him to trip. He started using Ketamine (a horse tranquilizer) about 14 years ago. He had been using Ketamine weekly. He stated he would have used it more often, but he could not afford it. He has a history of using LSD, GHB, magic mushrooms and MDMA. (RfD6, lines 158–161)

RB members decided to include a detailed description of Diego's drug use in the reasons for disposition, thereby rooting Diego's psychiatric identity in his history of consuming various psychoactive substances. By framing Diego's psychiatric identity in such a way, RB members were able to contextualize the hospital psychiatrist's finding that Diego no longer represented a significant threat to the safety of the public because he had remained abstinent from "illicit substances and/or alcohol":

> [The hospital psychiatrist] is unable to provide any positive evidence in support of a finding that [the person NCRMD] constitutes a significant threat to the safety of the public. [The person NCRMD] does not suffer from a major mental illness which warrants treatment. (RfD6, lines 230–232)
>
> There is no evidence over the past few years that he has used illicit substances and/or alcohol. (RfD6, lines 252–253)

By emphasizing the hospital psychiatrist's opinion, according to which Diego did not have a major mental illness, RB members dismissed the sexsomnia psychiatric identity and formalized a new psychiatric identity for Diego rooted in his use of substances. This psychiatric identity subsequently permitted the hospital psychiatrist and RB members to determine that Diego no longer represented a significant threat to the safety of the public, since he had not used illicit substances or alcohol over the past few years.

5.3.2.2. Determining a Legal Identity

Diego's legal identity was built by RB members in the reasons for disposition around two main axes. First, his delinquency was established by relying on information from his past, including

the index offence. Secondly, in the first reasons for disposition, by relying mainly on psychological testing, RB members were able to assess and manage Diego's dangerousness.

5.3.2.2.1. Delinquency. The reasons for disposition demonstrated that Diego's identity, and his legal identity in particular, had been deviant prior to the commission of the index offence. To establish deviancy, the reasons for disposition delved into various aspects of Diego's life, namely his family history, his previous criminal records, and, his employment and financial instability.

Diego's childhood and family history, and particularly his immigration history, was marshalled by the RB to demonstrate delinquency:

> [The person NCRMD] was born in [name of South American capital city] where he grew up with his parents and two siblings, an older brother and a younger sister. He reportedly met his milestones at appropriate ages and did not present any problems at home or at school. He indicated that he had enjoyed a large extended family. His family left [Country] because of threats from the guerillas and initially lived in the USA before moving to Canada in [year]. (RfD5, lines 114–117)

Although Diego benefited from some normality in his family life and educational milestones, the fact that he and his family had left their hometown out of fear of violence was used as a demonstration of childhood instability.

Diego's criminal record, for previous crimes that had occurred in another country, were also used by the RB in the reasons for disposition to establish delinquency:

> He has a criminal record, in [country], which includes shoplifting on two counts in [year—2 decades ago], and larceny on two other occasions in [year—2 decades ago]. He was charged for trespassing in [Month, year—2 decades ago] and on [date—2 decades ago] he entered a guilty plea of drugs-traffic. He advised that he spent six months in jail for that offence. (RfD6, lines 144–146)

By listing his previous offences, ones that had occurred 15 years prior to the index offence, the RB integrated his index offence into a pattern of other offences. Although mentioned in both reasons for disposition, these historical offences were never referenced as analytical items

considered as part of the assessment of risk. Their inclusion in the reasons for disposition merely established a pattern of deviant behaviours prior to the index offence.

In addition to his family history and to his criminal record, Diego's financial and education stability were reviewed by the RB:

> After migrating to Canada, he commenced a diploma program in Travel and Tourism at [name of school] in [name of town] but had to leave the program because of lack of funding. He started working at the age of 16 in [country] and has worked in several jobs mostly in restaurants. In Canada, he worked in general labour jobs and indicated that for the last six years prior to the index offence, he had only managed to obtain odd jobs, making very little money. At the time of the preparation of the hospital report (Exhibit 1), he was receiving social benefits and was using the Food Banks on a weekly basis. He had been living in the same apartment in [name of city] for four years with no concerns. (RfD5, lines 120–130)

Despite Diego's relative stability, the RB emphasized Diego's failed attempts at obtaining education and work. The RB discredited the effort that he had made to attend postsecondary education and to work by including the phrases "but had to leave the program because of lack of funding," "he had only managed to obtain odd jobs, making very little money" and "he was receiving social benefits and was using the Food Banks on a weekly basis." The emphasis placed on these phrases also classified persons who did not have high-paying, stable jobs as deviant members of society. Diego's money problems, especially those that would require the use of social benefits and food banks, contributed to that determination.

The instability in Diego's relationships was also used by the RB to construe his identity as delinquent:

> [The person NCRMD] has been involved in some relationships before meeting the mother of his only offspring in [year]. They cohabitated for seven years and were in an "on-and-off" relationship for another two years. His daughter, who is six years old lives with her mother in [city]. At the time of the index offence, [the person NCRMD] was returning from an attempted visit with his daughter. (RfD5, lines 133–136)

Despite the fact that Diego's relationships were generally stable in nature and in time, the RB chose to emphasize the aspects that rendered them deviant: the two years of "on-and-off" relationship with the mother of his child, and the fact that the index offence had occurred after an "attempted" visit with his daughter.

In brief, the reasons for disposition highlight the deviances in Diego's life. By emphasizing the deviant aspects of his family history, his previous behaviours and criminal record, and his employment and financial situation, the RB was able to establish that beyond the index offence Diego had led a life characterized by a pattern of deviancy and delinquency. This lifestyle was seen to partially explain the reason for the index offence.

5.3.2.2.2. Establishing and Managing Dangerousness. The first reasons for disposition (RfD5) supported a finding that Diego represented a significant threat to the safety of the public, necessitating a conditional discharge disposition. The second reasons for disposition (RfD6), on the other hand, supported a finding that Diego no longer represented a significant threat to the safety of the public and therefore needed to be absolutely discharged. The goal of the first reasons for disposition was to establish dangerousness; the second reasons for disposition aimed to demonstrate the lack of such dangerousness.

To establish dangerousness and justify the need for a conditional discharge, the RB focused on the psychological assessment report completed following a request made during a pre-RB hearing:

> At a Pre-Hearing Conference on [date], the Board issued an out-of-custody assessment order in relation to [person NCRMD]. [The person NCRMD] attended at the Outpatient Clinic of the [hospital] on [date] and [date] for interviews with [hospital psychiatrist] who subsequently authored the hospital report which was filed as Exhibit 1. This report basically provided all the evidence that was presented to the Board. [The person NCRMD] had also met [the psychologist], a clinical psychologist at the [name of hospital] for a psychological assessment using the MMPI-2 (the Minnesota Multiphasic Personality Inventory), which is a

> standardized psychometric test of adult personality and psychopathology. (RfD5, lines 166–171)

The concluding section of the psychological assessment was included in the reasons for disposition, word for word:

> The hospital report includes a summary of [person NCRMD]'s psychological and risk assessments which concluded as follows at page 13–14 of the report: "[person NCRMD]'s risk to reoffend was evaluated using the RSVP [Risk for Sexual Violence Protocol]. It should be noted that no collateral file information was available for the present and the findings are therefore largely based on [person NCRMD]'s self-report. Thus, the opinions are limited by the accuracy of the information he provided. A consideration of the RSVP guidelines suggests that [person NCRMD]'s risk for future sexual violence is relatively moderate. According to his self-report, many factors that were relevant in the past (e.g., problems with substance use, stress or coping, and with intimate relationships) have improved since the index offence. However, his responses in the clinical interview suggest that his self-awareness into the motivations for his sexual behaviour is limited and he also tends to minimize his responsibility in problematic behaviours more generally. As such, it is unclear whether these problems have genuinely improved or whether [person NCRMD] fails to appreciate the extent to which they contributed to the incident. (RfD5, lines 185–197)

The information provided during the assessment rendered the psychologist leery of Diego's self-awareness in relation to the sexual behaviours for which he had been found NCRMD. The psychologist posited that Diego "tends to minimize his responsibility in problematic behaviours."

Recommendations for developing a risk management plan for Diego were included at the end of the psychologist's assessment. They were directed toward Diego's minimization of sexual violence, and treatment for his problems with stress and coping, substance use, intimate relationships, and employment:

> Risk factors that seem particularly relevant with regard to future monitoring treatment, and supervision for [person NCRMD] include the minimization of his sexual violence, problems with stress and coping, problems with substance abuse and problems with intimate relationships. Only one risk factor was rated to be present more recently: problems with employment. However, this item was deemed to be only partially relevant for his offending behaviour in the future. (RfD5, lines 199–203)

In light of the risk assessment suggested by the psychologist, the hospital proposed the following management plan:

> The report recommended that [the person NCRMD] participate in psychological treatment to address various issues and that he attend monthly appointments with a psychiatrist to review his mental state, his medication compliance (if any) and his abstinence from substances. (RfD5, lines 205–209)

The hospital's plan had a dual purpose: treatment and surveillance. The aim of the treatment was to address the issues at the origin of Diego's dangerousness; the aim of the surveillance was to ensure that he complied with the treatment plan.

Nevertheless, the RB was not satisfied with the hospital's proposed management plan. According to them, the plan was not sufficiently detailed. In effect, RB members considered the plan's lack of thoroughness to be, in itself, a risk factor for future offending:

> Apart from the information provided in [trial psychiatrist]'s report that [person NCRMD] is employed full-time (which is contrary to the information provided to [hospital psychiatrist]), basically no information was provided regarding his living arrangement, social life, and personal issues. [The person NCRMD] indicated that he plans to move to [another city], but no details were provided regarding those plans. It will be important that the hospital obtain information on [person NCRMD]'s current life and future plans at the earliest possible time and that he report to his psychiatrist on a monthly basis to monitor his mental condition and his living arrangements. The index offence was significant, and the hospital should assure that the symptoms that led to this offence are monitored and managed to avoid a repetition of such behaviour. (RfD5, lines 297–308)

RB members publicly denounced the hospital for their lack of comprehensiveness in the reasons for disposition while urging it to develop a precise risk management plan based on detailed information as soon as possible. They were particularly concerned about the seriousness of the index offence and the person NCRMD's risk for reoffending.

In brief, the reasons for disposition identified three specific factors that made the RB determine that Diego represented a significant threat to the safety of the public: "the index offence [sexual assault]" (RfD5, line 230); "the diagnosis that led to the NCR finding

[sexsomnia]" (RfD5, line 236); and "the lack of information regarding [the person NCRMD]'s current and planned living arrangements" (RfD5, line 295). Consequently, the RB ordered a conditional discharge and listed the conditions in the reasons for disposition:

> The Board nevertheless finds that a conditional discharge should allow for adequate protection of the community. Accordingly, taking into consideration the four factors set out in section 672.54 of the *Criminal Code* of Canada, the Board is of the unanimous view that the disposition that is necessary and appropriate, as well as the disposition that is the least onerous in the circumstances, is that [the person NCRMD] be discharged with the following conditions:
>
> > Reside within 250 km of the hospital in [name of province] or [name of province].
> >
> > Report to the person in charge of the facility, or his or her designate as directed, not less than once per month.
> >
> > Abstain absolutely from the nonmedical use of alcohol or drugs or any other intoxicant.
> >
> > Submit samples of his urine and/or breath to the person in charge of the [hospital] for the purpose of analyzing whether the accused has ingested alcohol, drugs or any other intoxicant.
> >
> > Advise the person in charge, or his or her designate, in advance, of any absence from his residence of 24 hours or more.
> >
> > Participate in the rehabilitation program created for him by the person in charge of his/her designate.
> >
> > Refrain from contact or communication, direct or indirect, with [name of victim]. (RfD5, lines 310–334)

Most of these conditions were in relation to various supervision modalities ensured by the hospital. It is worth noting that the full name of the victim was exposed and treated as a piece of publicly available information in this excerpt.

When justifying the use of a conditional discharge to keep the public safe, the RB leveraged "the four factors set out in section 672.54 of the *Criminal Code* of Canada" and used vocabulary specifically attributable to the *Winko v British Columbia* (1999) Supreme Court judgement, namely the sentence referring to the disposition as being "necessary and appropriate,

as well as [it being] the least onerous in the circumstances." Yet, the way in which the disposition was to comply with these criteria was not detailed. The use of this legal vocabulary therefore seems tokenistic in that its inclusion did not add substantive content to the reasons for disposition; it merely gave legal importance to what was already contained in the document.

5.3.2.3. Assessing a Reconstructed Identity

The objective of the first reasons for disposition (RfD5) was to justify measures to keep the public safe. The aim of the second reasons for disposition was to justify why Diego no longer represented a significant threat to the safety of the public, by seeking to establish ways in which Diego complied with various social norms. The evidence to support this position was presented by the hospital psychiatrist during the RB hearing; this evidence convinced the Crown attorney:

> Both at the beginning and at the end of the hearing, [hospital psychiatrist] on behalf of the hospital and [defence counsel] on behalf of his client, took the position that [the person NCRMD] no longer constituted a significant threat to the safety of the public and accordingly should be absolutely discharged. At the commencement of the hearing the Crown reserved his position but at the end of the hearing, joined in the joint submission that [the person NCRMD] did not constitute a significant threat and accordingly should be absolutely discharged. (RfD6, lines 70–74)

The arguments presented by the hospital contributed to the RB's establishment of Diego's lack of dangerousness. The psychiatrist mainly relied on a risk assessment conducted using the HCR-20 V3:

> In September [the hospital psychiatrist] completed a risk assessment which is set out at page 17 of the hospital report as follows: "[The person NCRMD]'s current risk was reviewed using the HCR-20-v3 (K. S. Douglas, 2014). His historical risk factors include history of substance misuse, as well as relationship and employment difficulties. However in relation to his clinical or current risk factors, [the person NCRMD] does not currently suffer from a major mental disorder (and did not appear to be suffering from any such major mental disorder even at the time of his index offence), he is not on any medication for any mental disorder, has no violent ideation or intent and has an improved insight, particularly in relation to his substance misuse, which, in my view, contributed significantly to his index offence. He has been abstinent since his last ORB hearing following a condition that he refrains drug and alcohol use. All the random urine screening for

> drugs and alcohol during the reporting period have been negative. Regarding future risk management, [the person NCRMD] continues to reside in [another province] with no concerns. He is in employment and reported that he intends to continue to refrain from substance misuse whether he is granted an absolute discharge or not. Because of the offence, he is also required to be on the sex-offender register for ten years, which he reports he has been fully compliant with." (RfD6, lines 200–216)

The first risk assessment conducted was the RSVP, to give an indication regarding the risk of Diego committing sexual violence (RfD5). For the second RB hearing, the psychiatrist decided to assess Diego's risk using the HCR-20 V3 tool. The results of the RSVP suggested that Diego was at a moderate risk for sexual violence, but the results of the HCR-20 V3 the following year suggested that he was at low risk for violence. Of note is the change in diagnostic impression that occurred over the course of the year. At the first hearing, the RB was more concerned with the diagnosis given by the trial psychiatrist, sexsomnia. At the second hearing, the RB considered the hospital psychiatrist's opinion that Diego had a substance use disorder. The arguments put forward by the hospital psychiatrist to explain that Diego no longer represented a significant threat to the safety of the public, which the RB subsequently used, revolved around two axes: the way in which he had changed as a person (i.e., his individual reconstruction) and the way in which he contributed to society (i.e., his vocational reconstruction). Both axes reflected his docility and his abstinence. The sexual component of the risk he posed was absent from the justification.

5.3.2.3.1. Individual Reconstruction. To establish Diego's safeness in the reasons for disposition (RfD6), the RB relied on his docility, abstinence from drugs, and lack of negative incidents. Diego's docility was demonstrated by comparing his behaviour over the previous year to the conditions imposed upon him in the conditional discharge order. These conditions, the ones relating to living arrangements, frequency of reporting to the hospital, compliance with the treatment plan, and stability of his mental status, were scrutinized by the RB:

> Over the course of the past year [the person NCRMD] has complied with the terms of his Ontario Review Board disposition. Despite living in [name of city], he has attended monthly appointments in [name of city] always on time. At each of these meetings he was noted to be mentally stable. (RfD6, lines 181–184)
>
> Whenever [the person NCRMD] moved during the year, he provided his address to the Hospital. (RfD6, lines 190–191)
>
> He has been fully cooperative with the treatment team. (RfD6, lines 197–198)
>
> [The person NCRMD] is not prescribed any medication and is accordingly, not taking any. His mental state continues to be stable. (RfD6, lines 222–224)

Diego's identity was presented as reconstructed into an identity that could be considered "normal" in that he now conformed to the conditions listed in the conditional discharge and to the treatment plan proposed by the health care team. Diego had therefore managed to move beyond the "dangerousness" threshold of the normalcy/deviancy continuum (Figure 8) toward the "normal" section.

His treatment plan included participating in a treatment program aimed to address his substance use disorder: "[The person NCRMD] has engaged in his own [substance use] program to deal with his addictions and in [month] joined a combined program of Alcoholics Anonymous and Narcotics Anonymous. He has been attending meetings" (RfD6, lines 251–252). The degree to which Diego's behaviour was modified as a result of his involvement with Alcoholics Anonymous and Narcotics Anonymous was then noted by the RB: "While [the person NCRMD] has been subject to the jurisdiction of the Ontario Review Board there is no evidence that he has used any street drugs, or alcohol. He has not tested positive for any" (RfD6, lines 224–225). His abstinence from drugs and alcohol was presented as key to ensuring the safety of the public. Confirming this determination is the fact that there had been no other reported incidents involving Diego during the four years he had been living in the community: "There are no reports of issues that have arisen regarding [the person NCRMD]'s behaviour, during the four

years that he has been residing in the community since the index offence occurred" (RfD6, lines 258–259). Diego's willingness to work on himself was also presented as a factor suggestive of his safeness: "During the last year, [the person NCRMD] has been reflective on his life and has indicated that he wants to change his life" (RfD6, line 194). In brief, Diego's docility in relation to the various conditions imposed upon him and his internalization of these conditions were presented in the reasons for disposition as factors that contributed to the reconstruction of his identity into an identity that was no longer threatening to the public.

5.3.2.3.2. Vocational Reconstruction. Diego's capacity to be a productive member of society was used to demonstrate what I call his vocational reconstruction. Lacking employment was initially used to justify Diego's "dangerousness" (5.3.2.2), but his current employment stability was presented as a factor determining his safeness:

> During this period, [the person NCRMD] has maintained employment, usually in restaurants and occasionally in the construction industry. (RfD6, lines 187–188)
>
> [The person NCRMD] has been employed in the community, at various jobs, for the past 4 years. (RfD6, line 255)

In summary, the combination of Diego's individual and vocational identity reconstructions allowed the RB to determine that he no longer represented a significant threat to the safety of the public:

> In accordance with *Winko v British Columbia* (*Forensic Psychiatric Institute*), [1999] 2 S.C.R. 625 and *R v Ferguson*, 2010 ONCA 810, 264 C.C.C. 451, we conclude that the evidence before us does not support a finding that [the person NCRMD] represents a significant threat to the safety of the public. We find that he does not represent a foreseeable and substantial risk of physical, or, psychological harm to members of the public, that is serious and beyond trivial, or, annoying. The evidence does not support a finding that he is likely to commit a serious criminal offence, if he is not subject to a Disposition of the ORB. Indeed, [the person NCRMD]'s behaviour over the past four years, since the index offence occurred, can be described as pro-social. (RfD6, lines 263–269)

Instead of referencing the potential risk posed to the public by Diego's behaviours, the RB members referred to the "pro-socialness" of his behaviours to establish his lack of dangerousness. This raises questions about the definition of "pro-social" behaviours and the way in which they relate to the various factors evaluated in risk assessments.

5.3.3. Profile 3: White Man Found NCRMD on Violent Index Offences

This profile is of a White man, "Jeremy," found NCRMD on charges of attempted murder, possession of a weapon for dangerous purposes, and resisting a peace officer; all offences considered to be violent or for violent purposes. At the time of the analysis, Jeremy had been detained under the Ontario forensic psychiatric system for two years. He had had two RB hearings, and a "dangerous" identity had been assigned to him in the two reasons for disposition (RfD7, RfD8). The analysis of this profile suggests that the RB found three specific parameters important in characterizing his "dangerous" identity: *psychiatric identity*, *legal identity*, and *reconstructed identity*.

5.3.3.1. Assigning a Psychiatric Identity

Two expert psychiatrists presented contradicting initial diagnostic impressions relating to the major mental illness affecting Jeremy. The RB constructed and assigned a specific psychiatric identity for Jeremy, characterized by a major mental illness diagnosis that was ambiguous, and by Jeremy's use of substances.

5.3.3.1.1. Major Mental Illness Diagnostic Ambiguity. In both reasons for disposition, a detailed description of events leading up to the index offence spearheaded determining a psychiatric identity for Jeremy. The description went deeply into Jeremy's religious and erotomanic delusional system. The following passage provides an excerpt of this description:

> The circumstances giving rise to the index offence are set out in the case file synopsis/agreed statement of facts, as follows: On Wednesday, [date], at 0700 hours, I [name of police officer] along with [name of police officer] were

> dispatched to attend the Canadian Tire Gas Bar at [address] in response to a suspicious incident. Information obtained prior to our arrival was that a male is on scene with mental health issues talking about ISIS and that he is scaring staff. I arrived on scene at 0715 hours and met the male in front of the store, he was identified as [name of person NCRMD] ([date of birth]). He stated that he was in a relationship with a female coworker named [name of coworker], she works with him at Tim Hortons across the street, and she is trying to get him to join ISIS. He added that she is an ISIS supporter and that she works with them closely and is trying her best to have him join them. . . . He learned that Muslim women seduce men, convert them to Islam and entice them to join ISIS and commit acts of terrorism. He believes [name of victim] is doing this exact thing and he wants to bring this to Police attention because he believes her to be a threat to national security. . . . I asked if he has spoken to a doctor or professional about his mental state, he said he never visited a doctor about this and that he isn't taking medication/or prescribed mental health medication. (RfD7, lines 116–145)

Although presented as a legally irrefutable "agreed statement of facts." the case synopsis was written by the police officer/police officers who responded to the event and represents only one side of the story. This synopsis was then included in the hospital report submitted to the RB and, subsequently, in the reasons for disposition. The repeated inclusion of the description of Jeremy's mental state and delusional system at the time of the index offence in various documents (i.e., case synopsis, hospital report, reasons for disposition) rendered them true and moulded Jeremy's psychiatric identity.

However, the etiology of Jeremy's reality-altering illness remains ambiguous. While the psychiatrist who produced the expert report on behalf of the hospital suggested Jeremy suffered from some sort of a psychotic disorder, another psychiatrist who treated Jeremy between the time he had committed the index offence and the time of his inaugural RB hearing believed his symptoms to be more congruent with a bipolar type 1 disorder:

> Current Diagnoses:
>
> Psychotic Disorder (around time of index offence -- No Further significant symptoms or signs reported or observed post index offence) -- currently under treatment
>
> Depressive Disorder (by more recent history) -- currently under treatment

> Substance Use Disorder. (Cannabis) -- mild, but currently abstinent
>
> [Other psychiatrist] opined that [person NCRMD] has Bipolar 1 Disorder and not a Psychotic Disorder. (RfD7, lines 91–101)

After establishing her expertise in forensic psychiatry and her significant involvement with Jeremy, the "other psychiatrist" explained that her different diagnostic impression was based on various factors, including Jeremy's response to pharmacotherapy:

> [The other psychiatrist] testified as follows: She has been treating [the person NCRMD] from [date] until today. She is a forensic psychiatrist, and she worked full-time in the Forensic Psychiatry Department at the [name of hospital], from [year] to [year]. . . . [The person NCRMD] sought her help, as he was unable to get interim psychiatric support when he was released on bail, despite his best efforts. She saw [The person NCRMD] on [date] and on nine additional occasions since, most recently [date], after his release on bail. It is her opinion that [the person NCRMD] suffers from Bipolar 1 Disorder. This diagnosis is based on his history, previous presentation, response to his medications and the symptoms he has presented with. (RfD7, lines 225–248)

Following the testimony of this "other psychiatrist," the treating psychiatrist agreed that Jeremy's symptomatic presentation might be more in line with a mood disorder such as bipolar 1 disorder than with a psychotic disorder: "[The treating psychiatrist] does support [the other psychiatrist]'s diagnosis of Bipolar 1 Disorder, as [the person NCRMD]'s symptoms are consistent with that" (RfD7, lines 306–307). He mentioned that fine-tuning diagnostic impressions and treatment modalities was still necessary: "The hospital is still fine-tuning [the person NCRMD]'s treatment and diagnosis" (RfD7, line 324).

Despite this acknowledgement in the first reasons for disposition (RfD7), the diagnostic ambiguity regarding the etiology still remained one year later:

> [The person NCRMD]'s current diagnoses are: Psychotic Disorder versus Bipolar 1 Disorder with Psychotic Symptoms; Depressive Disorder; Cannabis Use Disorder mild (currently in remission). (RfD8, lines 228–235)

The second reasons for disposition (RfD8) included an excerpt of the hospital report detailing Jeremy's psychiatric history. It clearly identified that the symptoms leading to the

commission of the index offence were novel. It also presented Jeremy's perspective on the evolution of his illness:

> [The person NCRMD]'s psychiatric history is set out in the hospital report and is summarized as follows: During this assessment [person NCRMD] reconfirmed that his only admission to a mental health unit was the admission for NCR assessment at [name of hospital] between [date] and [date]. He had reported that he saw a counsellor during the first year of university as he was feeling "out of place" at the time. He explained that he was prescribed Paxil (Paroxetine, an antidepressant) during this time period, but only took it for about two weeks. He also reported that he started struggling with his mental health leading up to his arrest. (RfD7, lines 201–210)

Jeremy's disclosure to a member of a health care team, that he had seen a counsellor when he was in university after feeling "out of it," was presented as a precursor to the mental health problems leading to his arrest. However, the link between all these episodic mental health "struggles" was only made a posteriori—after the crime had been committed.

The excerpt of the hospital report included in the reasons for disposition also presented Jeremy's mother's perspective on the evolution of her son's mental illness. She emphasized that her son had had long-standing self-esteem issues, and said he was not the only person in the family to have a major mental illness:

> His mother had stated that she has always been worried about [the person NCRMD]'s perceptions about his self-worth. She explained that he has always been too hard on himself, and is affected by things others say about him. She explained that he has suffered with depression and anxiety through different periods in his life. . . . The mother stated that [the person NCRMD] would also do "a lot of ruminating" on issues when he would become depressed after perceiving himself as a "loser." She also believes that [the person NCRMD] has poor perceptions of himself, and has felt depressed over not moving forward in life. His mother stated that [the person NCRMD] also had poor body image, and that he lost a significant amount of weight toward the end of his High school years. . . Regarding a familial history of mental health, [the person NCRMD]'s mother said that she has suffered from periods of depression during her own life. She stated that one of her brothers has been diagnosed with Post Traumatic Stress Disorder [PTSD] with suicidal tendencies, and that she has another brother who has had a "manic episode" with "hallucinations." (RfD7, lines 211–228)

Although Jeremy's self-esteem and self-worth issues might have been significant when experienced, they only became clinically and legally relevant because the crime was committed as a result of mental illness. In effect, Jeremy's self-esteem and self-worth issues were presented as being chronologically linked to his mental illness at the time of the index offence. Of note, the mother's perspective on the evolution of her son's mental illness exposed confidential personal health information relating to other members of her family—her own (depression) and her brother's (PTSD, manic episode, and hallucinations).

In brief, as early as the initial phone call was made to the police days prior to the commission of the index offence, the psychiatric identity of Jeremy was constructed with statements that clearly identified a disconnection from reality. Both psychiatrists (the treating psychiatrist and the "other psychiatrist") confirmed such a disconnection from reality and attributed it to two possible major mental illnesses, namely bipolar 1 disorder or a psychotic disorder. By including this symptomatic presentation of Jeremy in various documents, the forensic psychiatric system—comprising courts, hospitals, and RBs—concretized this as a true, chronological representation of Jeremy's psychiatric identity.

5.3.3.1.2. Substance Use. Another truth produced in the reasons for disposition as a characteristic of Jeremy's psychiatric identity related to his use of substances. As demonstrated in the previous section, in the list of diagnoses provided by psychiatrists to the RB, cannabis use disorder was listed as a psychiatric diagnosis in both reasons for disposition.

In both reasons for disposition, the effects of the Jeremy's cannabis use disorder were vaguely examined:

> [The person NCRMD]'s substance abuse disorder is very problematic and can have negative effects on him. (RfD7, line 301)

> The evidence is not clear as to the impact of the use of cannabis on [the person NCRMD]'s mental stability but it is reported that [the person NCRMD]'s

> consumption of cannabis was significant up to two weeks before the index offences, and would likely still have been in his system. (RfD8, lines 336–338)

Despite the lack of clarity linking Jeremy's cannabis consumption with the exacerbation of his major mental illness, the RB considered the substance use disorder to be problematic and needing to be addressed.

5.3.3.2. Determining a Legal Identity

Jeremy's legal identity was characterized by two themes: delinquency, and establishing and managing dangerousness. These themes were marshalled to demonstrate the threat that Jeremy posed to the public.

5.3.3.2.1. Delinquency. In contrast to all the other reasons for disposition analyzed for the purpose of this study, the RfD7 was the only one that did not include a section on background information about the person UST or NCRMD. Typically, in this background section the various behaviours exhibited by the person UST or NCRMD (or their close relatives) throughout their lifetime would be detailed, to establish somewhat of a pattern of deviant behaviours. In this case, the RB decided instead to go directly into a detailed description of the index offence.

A background section was however included in the second reasons for disposition (RfD8). A close look at this section revealed that Jeremy did not have either a criminal history or a history of deviant behaviours: "[The psychiatrist] and counsel for the Crown both confirmed that [the person NCRMD] has no prior criminal record" (RfD8, line 296). Both his parents had stable employment and his brother was completing a university degree: "Briefly summarized, [the person NCRMD] is 26 years old and is the eldest of two children. His younger brother is studying economics at university. His mother is a teacher and his father is a [name of city]

Councillor" (RfD8, lines 170–172). Jeremy himself held a university degree and had had plans to continue his education:

> [The person NCRMD] reportedly did well in school, attended university, and completed a bachelor's degree in English. Prior to the index offence, he had planned to start a professional writing course at [name of college], but had to defer his enrolment due to his legal circumstances. (RfD8, lines 189–191)

The index offence was construed as having been a barrier to the completion of his "professional writing course." Typically, the background of persons UST or NCRMD are presented as being precursors to index offence. In this situation however, there was a significant shift: the index offence was construed as being a barrier to Jeremy's life.

Delinquency, that is to say a pattern of deviant behaviours or deviant biographical conditions culminating in the index offence, was not established by the RB. Jeremy was presented as having had a normal and uneventful upbringing. His family life was quite stable and he, himself, was on route to become a successful and productive member of society. These statements about the legal identity of Jeremy were construed as true when they were determined in the second reasons for disposition (RfD8). Perhaps this lack of "delinquency" as a characteristic was a contributing factor to the RB's unusual decision to order a conditional discharge at the first RB hearing, despite the severity of the index offence:

> These are still early days, and as [the psychiatrist] indicated in her report, while a Conditional Discharge is unusual in an index offence of this magnitude, it is justified by the evidence and in the circumstance as set out in these reasons. Similarly, the conditions imposed, and agreed to by all of the parties, provide for the safety of the public and for the safe reintegration of [the person NCRMD] into the community, as well as for his other needs. (RfD7, lines 394–397)

With the evidence provided to the RB by the psychiatrists, it was determined that although Jeremy represented a significant threat to the safety of the public, his level of threat was manageable with a conditional discharge.

5.3.3.2.2. Establishing and Managing Dangerousness. Jeremy's dangerousness was mainly established by bringing into evidence the severity of the index offence, his mental illness, and his problematic substance use. Both reasons for disposition described in detail the events that took place immediately surrounding the commission of the index offence:

> The accused was triaged at the [name of hospital] located at [address] in [name of town] by a nurse. . . . The accused waited for about 30 seconds and got up from the stretcher and walked toward the Triage room where he picked up a pair of scissors he had seen while in triage inside the room on the desk and bolted at the Reception Clerk. The Clerk immediately got up seeing the accused running toward her and at the same time the accused began in a stabbing motion striking the Clerk on the top of her head. . . . Police who were there at the time ran toward the accused and held him down as the clerk was pulled out of harm's way by fellow staff members. . . . Police attempted to handcuff the accused who was resisting police by pulling his arms away and preventing him from being handcuffed. . . . Police informed the accused he was being charged with assault and weapons dangerous. . . . Police spoke to the clerk who had suffered four lacerations to her head and defensive cuts on her hands and arms. She said she believed that the accused would not have stopped his assault on her if police were not there and believed he would have killed her. . . . At 0356 hours the accused provided a video statement. He advised he believed his co-worker who he believes is radicalized made him attack the Clerk. . . . He said he wanted to stab the clerk to death. (RfD7, lines 181–214)

This detailed description of the index offence motivated by a delusional system emphasized Jeremy's intent to kill the hospital clerk. The seriousness of the crime was highlighted by the RB as a factor justifying the significance of Jeremy's dangerousness:

> Having considered all of the evidence tendered at the hearing, and the joint submissions of the parties, the Board finds that [the person NCRMD] does pose a significant threat to the safety of the public as defined in s. 672.5401 of the *Criminal Code* of Canada, and as further defined in the *Winko* decision. [The person NCRMD] was quite psychotic at the time of the index offence which involved serious violence against a stranger. [The person NCRMD] also has a history of difficulty interpreting social situations and was endorsing delusions in relation to a female co-worker. (RfD8, lines 379–383)

Considering the significance that Jeremy's mental illness contributed to the commission of the index offence, it is not surprising that the RB considered it a supporting factor for the argument that he represented a significant threat to the safety of the public: "[The person

NCRMD] main risk factors are his mental illness and his diagnosis of substance use disorder" (RfD7, line 265). One of the testifying psychiatrists in the first RB hearing reminded the RB that "at the time of the index offence, [the person NCRMD] was not on any medication" (RfD7, line 277), which was not the case at the time of the hearing. Jeremy was presented in the reasons for disposition as having been stable for an extensive period of time due to his treatment adherence and to his "exceptional cooperation":

> In [the psychiatrist]'s opinion, [the person NCRMD] has been completely stable psychiatrically over the past five to six months. The medication prescribed by [the psychiatrist] is the same medication being prescribed by the hospital. [The person NCRMD] is exceptionally cooperative. (RfD7, 253–257)

Furthermore, the psychiatrist believed that Jeremy would not decompensate rapidly even if he were not to take his prescribed medication: "When not on his medication and unwell [the person NCRMD] decompensated over a one-month period. Accordingly, she does not anticipate him to decompensate rapidly should his behaviour be monitored" (RfD7, lines 283–285). Given this stability, it was the psychiatrist's opinion, and that of the RB, that a conditional discharge was sufficient to protect the public against Jeremy:

> [The person NCRMD] has indicated that he is willing to continue living with his mother. His mother has good insight into his mental illness and would be able to recognize same should he decompensate. The evidence is that, while being monitored at least once per week by the forensic outpatient team, [the person NCRMD] would not decompensate rapidly. Therefore, a detention order is not necessary. [The person NCRMD] is very willing to work with the treatment team and has sought treatment on his own. (RfD7, lines 397–402)

Jeremy's willingness to work with the treatment team and to voluntarily return to the hospital —that is, comply with the treatment team's direction—should his mental illness decompensate constituted factors alleviating his level of dangerousness and contributed to the RB's ordering of a conditional discharge with minimal conditions: "The evidence is quite clear that [the person NCRMD] would voluntarily return to the hospital should it be necessary, and as

such the *Mental Health Act* would be applicable" (RfD7, lines 390–391). In ordering a conditional discharge, the RB attributed importance to Jeremy's willingness to "voluntarily" return to the hospital should decompensation occur, at which point the *MHA* could be used to involuntarily admit Jeremy to the forensic psychiatric hospital.

Although the use of substances was also identified as a diagnosis and a risk factor for Jeremy, the way that it directly affected the level of threat he posed to the public was not explained:

> In response to questions posed to him by members of the panel, [the psychiatrist] acknowledged that the treatment team has not had an opportunity to assess whether cannabis has an actual impact on [the person NCRMD]'s mental condition. The concerns arise, in part, because [the person NCRMD] acknowledged having been chronically using cannabis up to two weeks before the index offences, and cannabis can remain in the system for some time. (RfD8, lines 287–290)

Nevertheless, the psychiatrists and the RB suggested that Jeremy should be monitored for the use of substances and that he should actively participate in treatment to maintain abstinence:

> [The psychiatrist] agreed that [the person NCRMD] should not have easy access to drugs or alcohol. (RfD7, line 279)

> While his prognosis is good, [the person NCRMD] still needs counselling with respect to substance abuse, a comprehensive relapse prevention program, and insight into his social interactions. (RfD7, lines 287–288)

Despite not having a clear link between the use of cannabis and the potential increased threat posed by Jeremy to the public, the RB included in their decision a clause for Jeremy to be monitored for the use of substances.

5.3.3.3. Assessing a Reconstructed Identity

The RB hearings provided an opportunity for the RB to assess the degree to which Jeremy had reconstructed his identity in accordance with various social norms and institutional expectations. The results of these various assessments, determined in the reasons for disposition, related to

Jeremy's thinking, behaviour (individual reconstruction), and productivity as a member of society (vocational reconstruction).

5.3.3.3.1. Individual Reconstruction. Considering that the psychiatric identity constructed for Jeremy revolved around his major mental illness and his substance use disorder, it is not surprising to see that the reconstruction of his deviant identity also revolved around these themes. In various places throughout the reasons for disposition, Jeremy's compliance with his pharmacological regime was highlighted:

> [The psychiatrist] indicated that the severity of the index offence is not relevant to [the person NCRMD]'s progress; he has responded well to treatment and shows good insight into his mental illness, need for medication and concern about the well-being of others. (RfD7, lines 291–293)

> [The person NCRMD]'s insight into the need to continue taking medication is good. He understands and accepts that his stability is reliant on continued treatment. (RfD8, lines 253–256)

Beyond the actual consumption of medication and the compliance with the medication regime, the fact that Jeremy understood the need for such a treatment was also deemed important. Although both components were presented in tandem, there is a difference between a person UST or NCRMD's willingness to comply with a certain treatment and a person UST or NCRMD's acknowledgement that they need a certain treatment. The former refers to the docility of their body whereas the latter refers to a reconstruction of their mind.

Whereas Jeremy's psychiatric identity as it related to his major mental illness was presented as being reconstructed, the reconstruction of his psychiatric identity relating to his substance use was presented as a work in progress. This reconstruction was being achieved through dual mechanisms, namely efforts aimed reconstructing Jeremy's mind, through psychoeducation, cognitive behavioural therapy, and dynamic interpretation; and efforts aimed at

ensuring his compliance with the abstinence condition of his disposition order (i.e., testing for substances):

> [The person NCRMD] requires ongoing psychoeducational treatment to address this issue [substance use]. [The psychiatrist] indicated that the plan for the next year is to continue with treatment (medication and psychoeducation) in an effort to assist [the person NCRMD] in understanding the effects of cannabis on the brain and on his mental stability. [The psychiatrist] believes it to be important to continue with testing for substances as well as a prohibition on the use of substances. (RfD8, lines 259–262)

Although the psychiatrist mentioned that he was the one who would conduct the various interventions aimed at making Jeremy understand the impact of cannabis use on his mental health, the health care professional responsible for testing for the use of substances was not explicitly named. Yet, we know from our ethnographic interviews that nurses are the health care professionals responsible for collecting urine from persons NCRMD for the purpose of analyzing it for drug metabolites (see 5.1.2.3.1).

5.3.3.3.2. Vocational Reconstruction. The RB also gave importance to the various ways Jeremy's identity had been reconstructed from a vocational perspective. In both reasons for disposition, the board placed emphasis on how Jeremy contributed, or planned to contribute, to society:

> [The person NCRMD]'s future plans include going back to College and getting work. His priority is to remain stable, and [the psychiatrist] believes he will live with his mother, as the hospital recommends. (RfD7, lines 279–281)

> [The person NCRMD] is currently employed at a café in [name of city]. There are no reports of any issues at work. His goal is to apply to College for [date], and according to [the psychiatrist], this is a realistic goal given that [the person NCRMD]'s cognition is intact. (RfD8, lines 264–266)

Being employed and having the intent of returning to school was presented positively by the hospital.

Jeremy's life choices to achieve this vocational normality were supported by the forensic psychiatric hospital, and by the RB:

> [The person NCRMD] would like to move out of his mother's home in the next year. He intends on moving closer to [city] in order to facilitate his attendance at college next year. (RfD8, lines 268–269)

> [The person NCRMD] intends to move out of his mother's home in order to be closer to college for next year. . . . The Board has no issue with the removal of the residence specification. (RfD8, lines 340–342)

The potential effects of achieving this vocational normality—returning to work—on the assessment of risk was not explored in the reasons for disposition.

5.3.4. Profile 4: White Woman Found NCRMD on Violent Index Offences

The fourth profile comprised 10 reasons for disposition documents describing how a White woman, "Anna," found NCRMD on various assault charges was a significant threat to the safety of the public (RfD9 through RfD18). The analysis illustrates some salient elements relating to ways in which the RB hearing, as a social practice, constructed a deviant psychiatric and legal identity for Anna. The construction of this identity was marked by numerous discontinuities relating to the relation between mental illnesses and risk to the public, and to the arguments supporting findings of significant threat to the safety of the public. Furthermore, the analysis of this profile also painted a picture of how RBs establish their authority as medico-legal institutions.

5.3.4.1. Assigning a Psychiatric Identity

Anna's psychiatric identity was assigned by relying mainly on the duality of her major mental disorder (schizophrenia) and her comorbid mental disorders (seizure disorder, mental retardation, and impulse control disorder). In the crossfires of arguments justifying the dangerousness attributable to Anna's psychiatric identity, the RB also included information relating to her other medical diagnoses:

> Background: [The person NCRMD]'s current diagnoses include the following:
>
> AXIS I: Chronic Paranoid Schizophrenia, Impulse Control Disorder
>
> AXIS II: Mental Retardation? Personality Disorder, Not Otherwise Specified
>
> AXIS III: Head Injury, Seizure Disorder, Diabetes Mellitus, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Chronic Arthritis
>
> AXIS IV: Moderate to severe psychosocial stress resulting from problem with primary support, employment, education, access to health care and recurrent conflict with the law.
>
> AXIS V: GAF score over past year = 50, GAF score (current) = 55. (RfD9, lines 180–233)

Under the subtitle "AXIS III," the hospital psychiatrist, using the multiaxial system of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000; *DSM-4-TR*), listed other medical diagnoses believed to contribute to Anna's mental disorder or to managing that disorder. Although this was the specific intention of AXIS III, we can observe that with time, the hospital added all sorts of diagnoses to the six initially identified (head injury, seizure disorder, diabetes mellitus, hypothyroidism, chronic obstructive pulmonary disease, chronic arthritis):

> AXIS III: Diabetes Mellitus, Remote Traumatic Brain Injuries, Seizure Disorder, History of Septicemia, Hypothyroidism, Hyperlipidemia, Mild Chronic Obstructive Pulmonary Disease, Chronic Osteoarthritis with Left Knee Instability, Left Hip Fracture, Scoliosis, Osteoporosis, Upper Jaw Edentia, Tardive Oral-Buccal Dyskinesia, Gastroesophageal Reflux Disease. (RfD14, lines 213–239)

Even when psychiatry moved away from the multiaxial system by adopting the *DSM-5*, physical diagnoses kept on appearing in the list transposed by the RB from the hospital report to the reasons for disposition:

> Current Diagnoses: Schizophrenia, Impulse Control Disorder, Intellectual Disability -- moderate severity, Personality Disorder, Not Otherwise Specified with Borderline Features, Diabetes Mellitus, Remote Traumatic Brain Injuries, Seizure Disorder, History of Septicemia, Hypothyroidism, Hyperlipidemia, Mild Chronic Obstructive Pulmonary Disease, Chronic Osteoarthritis with left knee

> instability, Left Hip Fracture, Scoliosis, Osteoporosis, Upper Jaw Edentia, Tardive Oral-Buccal Dyskinesia, Gastroesophageal Reflex Disease, Obesity. (RfD18, lines 76–115)

Although there may be clinical relevance in knowing that Anna had no teeth on her upper jaw or that she suffered from scoliosis, this information was out of place in the reasons for disposition. Beyond the fact that this highly confidential information was included in a public document, including this extensive list of diagnoses in all the reasons for disposition redefined Anna's identity as infused by physical deviancy on a yearly basis. Furthermore, the information contained within the reasons for disposition formalized her identity as a mentally deviant person. The construction of Anna's psychiatric identity focused on her major mental disorder, her seizure disorder, and on her need for a slow and gradual reintegration into the community.

5.3.4.1.1. Major Mental Disorder. Anna had various mental disorders listed in her diagnostic profile: schizophrenia, impulse control disorder, personality disorder, and intellectual disability. Most of the reasons for disposition identified that Anna's mental disorders had origins that preceded her entry into the forensic psychiatric system. Anna's involvement with the mental health care system dated back to her adolescence:

> [The person NCRMD] has a very extensive history of contacts with psychiatric services starting at the age of 16. This has included multiple hospitalizations for psychosis and aggressive behaviour. The hospital lists a very significant number of admissions to hospital between [year] and [year]. (RfD12, lines 147–149)

Before the commission of the index offence and the finding of NCRMD, Anna had already been assessed and treated for her mental disorders.

In the first reasons for disposition, the severe nature of Anna's mental illnesses and the fact that she tended to decompensate quickly was used to substantiate the significant threat to the safety of the public that she represented:

> In [the hospital psychiatrist]'s opinion, [the person NCRMD] continues to be a significant threat to the safety of the public. He drew attention to the fact that she

> suffers from multiple mental illnesses and when untreated she rapidly deteriorates into disorganized behaviour. (RfD9, lines 262–264)
>
> On the basis of the evidence before us, the Board unanimously finds that [the person NCRMD] remains a significant threat to the safety of the public. She suffers from several major mental illnesses. (RfD9, lines 328–329)

Pharmacotherapy and Anna's compliance with it were presented in the first reasons for disposition as being vital to treat her major mental disorder and to protect the public:

> However, [the hospital psychiatrist] has observed that since [the person NCRMD] has been in the hospital and has been treated, she has become less preoccupied and less paranoid. On the unit she has not been assaultive. In addition, her use of PRN medication has been reduced considerably. (RfD9, lines 276–278)

All of Anna's major mental illnesses were regrouped and presented as one area of concern that could be managed by pharmacological therapy. This amalgamation of major mental illnesses was dissected two years later, when RB members questioned the link between Anna's seizure disorder and her diagnosis of schizophrenia:

> [The hospital psychiatrist] advised that she is extremely concerned about [the person NCRMD]'s seizure disorder. [The hospital psychiatrist] put it that the seizure disorder may have "fallen out of control." [The RB members] were advised that [the person NCRMD] had three seizures on one day, including one in which [the person NCRMD] turned blue. We were advised that these seizures lasted less than two minutes. It is not clear to the panel the effect, if any, that the seizures have on [the person NCRMD]'s psychotic illness. (RfD11, lines 166–170)

Dissatisfied with the lack of clarity in the hospital psychiatrist's testimony about the link between Anna's seizure disorder and the diagnosis of schizophrenia, and the lack of urgency with which the hospital was addressing this issue, the RB urged the hospital administration to get involved:

> The Board was advised that prior to this seizure activity the hospital had arranged for [the person NCRMD] to see a neurologist in [name of city]. That appointment is scheduled for [Date 3 months later]. The Board is extremely concerned about the late date of this appointment considering [the person NCRMD]'s current condition. The Board is extremely concerned whether [the person NCRMD] has had a series of strokes. The Board is obliged to consider "the other needs" of [the

> person NCRMD]. [The person NCRMD] has an immediate other need, and that is for an immediate neurological assessment that can clarify the many issues concerning [the person NCRMD]'s physical and mental stability. This is an issue that should not be dealt with simply by [the hospital psychiatrist] and her clinical team. This is an issue which must, in this panel's opinion, be dealt with by the head of this hospital on an urgent basis. (RfD11, lines 200–215)

This excerpt exposes two important power relations. First, by publicly denouncing the hospital psychiatrist's inefficiency and by recommending that the head of the hospital should be involved "on an urgent basis," the RB was taking a position regarding the lack of care provided to Anna and asserting itself as an institution responsible for the welfare of persons UST or NCRMD. By explaining that the "board is obliged to consider the 'other needs' of [the person NCRMD]," the RB placed these "other needs" in relation to other parameters within the *Criminal Code*, namely the paramount consideration of the safety of the public, the mental condition of the accused, and the accused's reintegration into the community. In the 18 reasons for disposition I analyzed, this is the only time "other needs" were explicitly cited, which somewhat attests to the rarity of this occurrence.

The following year, there was no mention of the neurological testing included in the reasons for disposition (RfD12). Rather, Anna's illnesses, and their effects, were further dissected. Whereas Anna's "serious mental illness[es]," namely schizophrenia and impulse control disorder, were identified as the cause of her dangerousness, her seizure disorder was identified as the cause for her disorganization and confusion:

> [The hospital psychiatric] submitted that [the person NCRMD] continues to present as a significant risk to the community because she suffers from a serious mental illness of which she continues to present active symptoms. Her seizures disorder leads her to become disorganized and confused. (RfD11, lines 277–279)

Contrastingly, in the reasons for disposition the year after (RfD13), the cause-effect logic between mental illnesses and behaviours was reversed. Whereas Anna's major mental disorder was previously identified as the cause of her dangerousness in RfD12, in RfD13 her comorbid

illnesses, and particularly her seizure disorder, were identified as the source of her dangerousness:

> She is fragile in terms of her diabetes and seizure disorder in particular and requires significant monitoring and nursing support. Acute medical illness has a direct causative role in [the person NCRMD]'s aggressive acting out and has resulted in very grave outcomes with violence toward health care personnel on multiple occasions in different hospitals. Fortunately, good control of her seizure disorder with Divalproex Sodium has likely avoided many more incidents of violence this past year as she has been seizure free since [date]. (RfD13, lines 235–243)

Nevertheless, from the information contained in the hospital report, the RB was able to demonstrate that with an adequate pharmacological regimen including an anticonvulsant, and with monitoring and support from nurses, the risk posed to the public by Anna's seizure disorder was diminished.

In brief, the major mental disorder component of Anna's psychiatric identity was marked by its chronicity and discontinuities. These two attributes were also apparent in the "community reintegration" component of Anna's psychiatric identity.

5.3.4.1.2. Community Reintegration. The difficulties inherent in Anna's reintegration into the community also defined her psychiatric identity. Beyond the complexity of Anna's mental illnesses and their chronicity, her path toward community reintegration was characterized by discontinuities intrinsic to hospital processes. In most of the 10 reasons for disposition, the RB included a segment suggesting that Anna should be able to reintegrate and function in the community, such as the following:

> [The person NCRMD] has also had problems in residential placements due to escalating aggressive behaviour. It is noted that [the person NCRMD] had a relatively stable period between [year] and [year] when she was living at the [name of group home] in [name of city]. (RfD10, lines 129–132)

Although the RB acknowledged the difficulties relating to the residential placement of Anna in their first sentence, by emphasizing that she had a relatively stable period of four years while living in the community, the RB considered community reintegration as an attainable goal.

That being said, in the first reasons for disposition of the profile, the RB, by way of the hospital report, clearly identified that Anna's access to more freedom had to be given in a very slow and methodical way:

> In terms of the timetable for implementation of the privileges, [the hospital psychiatrist] suggested that in the next two to three months [the hospital] would implement staff accompanied hospital grounds privileges. If that goes well then they will implement, for two to three months, for longer staff accompanied activities in the community. If that also goes well then they will consider indirect access to the community. (RfD9, lines 280–283)

In the reasons for disposition of the following year (RfD10), the RB attested to the fact that Anna was given her privileges as described and that she had had no episodes of aggression when using her privileges:

> [The person NCRMD] has exercised her privileges well. Although she is allowed indirectly supervised grounds privileges she prefers to be on the grounds with staff to avoid being bugged by other patients. She has gone in the community accompanied by staff and the visits have all gone well. (RfD10, lines 235–241)

In light of the way in which Anna reacted to the increase in freedom, the RB questioned the psychiatrist about the hospital's plans for Anna's reintegration into the community. The psychiatrist responded that the health care team was exploring various residential options and said they would work with Anna to achieve a community discharge:

> In reply to questions by Board members, [the hospital psychiatrist] indicated that the hospital is looking for a community placement for [the person NCRMD]. This could be in the form of a group home or in a halfway accommodation (…). [The hospital psychiatrist] added that the hospital will work with [the person NCRMD] to attempt to have her go out more in the community. (RfD10, lines 248–251)

Four years later, this goal had not been achieved. Anna was still in the hospital. The hospital psychiatrist said that a "psychological assessment" and a "behavioural plan" was needed prior to any community reintegration:

> When questioned by the Board, [the hospital psychiatrist] acknowledged an updated psychological assessment that would include personality and IQ testing to address how [the person NCRMD]'s needs, particularly with respect to aggressiveness could be addressed. (…). [The hospital psychiatrist] acknowledged that [the person NCRMD] required significant supports, but said there was a "possibility" that she might be placed in an appropriate supervised accommodation over the upcoming year. . . . He confirmed that a move to the community was dependent on the outcome of [the person NCRMD]'s successful implementation of the Behavioural Plan. (RfD14, lines 165–172)

The psychological assessment and the behavioural plan were presented as the key to adequately manage Anna's aggressiveness and impulsivity in the community, and ultimately to protect the public. The way in which Anna complied with the behavioural plan, that is to say the way her identity was reconstructed by it, was also a crucial element of her community reintegration.

In the reasons for disposition for the following year, beyond identifying that the consistent application of the behavioural plan reduced the severity of Anna's aggressive behaviours, the RB ascertained, through the hospital psychiatrist's report, that a psychological assessment had been completed, allowing the hospital to secure additional funds to help with Anna's reintegration into the community:

> Consisten[t] behaviour modification therapy over the past year has achieved a significant reduction in the severity of [the person NCRMD]'s physical aggressive behaviour. Her presentation is much improved and the treatment team will continue to work with her to achieve further improvements and transition her to a suitable community environment. Toward that objective a neuropsychological assessment has been completed so as to apply for special funding that will enable her successful transition to a group home on a recovery based manner. (RfD15, lines 284–288)

By saying that "the treatment team will continue to work with her to achieve further improvements and transition her to a suitable community environment," the RB noted that Anna

was not ready for community reintegration and had to continue to improve her problematic behaviours before being discharged from the hospital.

Two years later, Anna was still on a detention order and still resided in the forensic psychiatric hospital. The RB clearly indicated in the reasons for disposition that they were concerned with the slow progress of Anna's reintegration into the community: "[RB members] hope that [the person NCRMD]'s progress of reintegration into the community will proceed much more quickly than it has in the past" (RfD17, lines 298–299). Ten years after the initial reasons for disposition, the RB concluded that Anna's community reintegration process was at a standstill and shared their dissatisfaction with the hospital:

> The issue of community living was discussed at length at this hearing and the Board explored the circumstances that have led to the current state of affairs wherein [the person NCRMD] is still on a waiting list for admission to a transitional group home. The Board is very unhappy with the current state of affairs in that there appears to have only been one avenue explored for [the person NCRMD] to be able to live in the community, which is to live at the Dual Diagnosis group home in [name of city]. (RfD18, lines 373–377)

> The Board finds this disconcerting, given the delay in the decision-making process, and perhaps the lack of follow-up by the hospital in this regard. The Board wishes this process to be moved along much more quickly than the current state of affairs. (RfD18, lines 383–385)

The RB used the RB hearing, and subsequently the reasons for disposition, as venues to denounce the inadequate community reintegration process for this person NCRMD. By doing this, the RB took on an adjunct role of advocate for Anna's welfare.

In order to ensure that the hospital made progress with Anna's transition into the community, the RB listed numerous "comments and observations" in the reasons for disposition relating to the way the hospital should spend the special funding given to Anna and to the way the hospital should transition Anna into the community:

> As well, the Board wishes the hospital to explore other community living options, other than the Dual Diagnosis group home, and makes the following comments and observations:
>
> The hospital should look into further . . . funding for [the person NCRMD] to allow her the ability to use her indirectly supervised and supervised privileges on hospital grounds and outside of the hospital grounds to a greater extent.
>
> . . . other routes to community living, especially given the availability of . . . funding to [the person NCRMD], which could replicate the supervision and rehabilitation that is usually present in transitional group home settings, should be explored.
>
> (…)
>
> The Board notes, as well, that forensic outpatient services would continue to be involved with [the person NCRMD] once she is discharged from hospital. They can assist in providing supervision, rehabilitation and other services to [the person NCRMD] that may not be replicated in a normal group home setting. . .
>
> The Board is also ordering a six-month review and recommending that a pre-hearing conference be conducted prior to the next hearing to determine the issues of placement and/or the commitment to placement, as addressed above.
>
> As, well, if there is not significant movement in terms of placement of [the person NCRMD] in the community in the near future, The Board recommends that a future Board should consider hearing from a representative from the Ministry of Community and Social Services to explore what other services and housing may be available to [the person NCRMD]. (RfD18, lines 385–425)

The RB used their annual hearing as a platform from which to publicly denounce the hospital's inadequacies, and presented measures by which it expected the hospital to remediate them. To ensure progress was made, the RB increased the hospital's visibility by "ordering a six-month review" to assess if "the issues of placement and/or the commitment to placement" had been rectified.

The community reintegration component of Anna's psychiatric identity was marked by the chronicity of her mental illnesses and community reintegration attempts, and by the objectifying stance taken by the hospital when discussing community reintegration strategies. In the process of attaching truths to the community reintegration component of Anna's psychiatric

identity, the RB similarly attached truths to the forensic hospital as an inadequate institution at reintegrating persons UST or NCRMD into the community.

5.3.4.2. Determining a Legal Identity

Anna's legal identity as inscribed in the reasons for disposition revolved around two themes. The first, delinquency, demonstrated the longitudinal character of Anna's deviant legal identity. As well as being deviant because of the index offence, Anna was deviant before the index offence ever occurred. The second, establishing and managing dangerousness, forged Anna's deviant legal identity in the present and for the foreseeable future, that is to say until the next RB hearing. It also identified ways in which this legal identity could be reformed.

5.3.4.2.1. Delinquency. The RB established that Anna's delinquency went beyond the commission of the index offence. First, it suggested that the index offence was not a stand-alone incident in Anna's life; it could be explained by her deviant upbringing. Secondly, as in most reasons for disposition, specific incidents of aggression that occurred in the year in review were brought forward to illustrate Anna's continuing delinquency.

Anna's upbringing was framed as being deviant throughout the various reasons for disposition. The reasons emphasized that the early years of Anna's were characterized by the dysfunctionality of her family and by physical and sexual abuse:

> [The person NCRMD] has had a very difficult life. Little information is provided in the hospital report in regards to [the person NCRMD]'s early years except to indicate that she was brought up in a dysfunctional family characterized by physical and sexual abuse. Both her parents are deceased and she has had very little contact with members of her family in recent years. [The person NCRMD] has been involved with social services as well as the mental health system since she was approximately sixteen years of age. (RfD16, lines 117–125)

The reasons for disposition also emphasised Anna's family history of mental illness: "There is an extensive family history of mental disorder in the form of bipolar disorder

complicated by alcohol abuse. [The person NCRMD]'s mother reportedly suffered from Schizophrenia" (RfD16, lines 127–128).

In presenting Anna's upbringing and early adulthood, the RB also gave importance to her deviant academic progress, employment status, and interpersonal relationships: "[The person NCRMD] reported having had difficulties in school both academically and in her interpersonal relationships. She has no work history" (RfD16, lines 131–132). The RB focused on Anna's history of romantic relationships:

> [The person NCRMD] was involved in a common law relationship from which she reportedly had a child which died at birth. She had other brief relationships and was often taken advantage of by men. The relationships are reported to have always been chaotic and associated with physical aggression. (RfD16, lines 132–134)

In brief, by describing Anna's upbringing and early adulthood as being deviant from different normative standpoints such as family life, academic life, employment, and relationships, the RB inserted the index offence in a pattern of deviancy.

In every reasons for disposition, the index offence was presented, either at length or in a summarized format. This description of the index offence inscribed in the reasons for disposition was extracted from the hospital report:

> The nature of the allegations giving rise to the index offences is described at length in the hospital report and can be summarized as follows: . . . [The RB members] do note the following concerning the index offence: "On [date], the [name of city] Police were called at the [name of hospital] in regard to a patient who was attempting to leave hospital. The police attended at the Emergency Department of the Hospital where the accused [name of the person NCRMD] was sitting on a stretcher speaking with nursing staff. Upon seeing police, [the person NCRMD] indicated that she was leaving. When told by a police officer that she could not leave, [the person NCRMD] hit the police officer in the face with an open hand. With police assistance, the staff proceeded to restrain [the person NCRMD]. After the incident, hospital staff informed the police that several nurses had been assaulted by [the person NCRMD] and wanted her charged. . . . As a result of the incidents, [the person NCRMD] was charged with two counts of assault and one count of assaulting a police officer. On [date], police were dispatched to a location in the [name of city] after receiving a report that an

> assault was in progress on a city transit. One of the police officers entered the bus and attempted to detain [the person NCRMD] who was out of control. She actively resisted a first police officer who was assisted by a second officer. The officers were able to handcuff [the person NCRMD] and place her in a police car. [The person NCRMD] then began slamming her head on the plexiglass divider in the police car extremely hard. As [the person NCRMD] was refusing to stop hitting her head, an ambulance was called to assist with restraining [the person NCRMD] who was eventually transferred to the [name of hospital]. Further investigation revealed that [the person NCRMD] had punched another female passenger on the transit bus several times. As the police officer was speaking with the bus driver to determine what had occurred, [the person NCRMD] left her seat and struck the bus driver in the head knocking his glasses off his face. When the officer attempted to intervene, [the person NCRMD] struck the police officer in the head. (RfD16, lines 59–106)

This long excerpt presents only one version of the index offence(s), namely the one captured by the police officers responding to the calls. It justified the actions posed by police officers—charging Anna with certain crimes, restraining her—as opposed to providing a well-rounded description of the incident. Thus, truths produced in their written report by police officers on the date of the index offence were mobilized, year after year, in the hospital report and in the reasons for disposition to construct Anna's identity. Anna's own perspective was not included in this description of events, which exposes an irony in the title attached to the description of the index offence(s) in the first reasons for disposition: "Official Account of the Alleged Charges" (RfD9, line 63). The official account of the index offence(s) was the one retrieved by the police officers from the victims and witnesses of the incident, thus silencing any other truths about the incident that might have been provided by Anna. The official account of the index offence(s) excluded Anna. The emphasis placed by the RB on these "official police accounts" presented a static portrait of Anna, reflecting of the latent risk to which the public was exposed.

In addition to detailing the index offence(s) and providing a chronological component to Anna's deviancy, the RB re-established her delinquency year after year by bringing forward

incidents of violence and aggressiveness to substantiate that Anna remains a threat to the safety of the public:

> A significant incident occurred in [month] when in the course of attempting to leave the [name of hospital] where she had been transferred, [the person NCRMD] assaulted a nurse who suffered a broken arm in the incident. She had also pushed a nurse and punched her in the face. She required pharmacological restraint at the time. In [month], [the person NCRMD] again required pharmacological restraint and locked seclusion because of significant behavioural problems. (RfD12, lines 210–215)

> Over the past year, [the person NCRMD] has exhibited disruptive behaviour that included physical violence, multiple episodes of verbal aggression and rule violation. (RfD13, lines 132–133)

While these incidents in themselves were stand-alones, their association with one another, with the index offence, and with Anna's difficult upbringing, reaffirmed Anna's delinquency. In addition to being identified as victims in certain incidents, nurses were the professionals observing and documenting these incidents in the medical record, thereby making them true and available for use in the hospital report and in the reasons for disposition.

5.3.4.2.2. Establishing and Managing Dangerousness. Further to determining that Anna was a delinquent, the RB established that she was dangerous and needed a plan to manage this dangerousness. The RB justified this decision by marshalling various assessments of risk conducted by the hospital. The plan to manage Anna's dangerousness was marked by a reliance on the structure of the hospital and of its processes, and her pharmacological and behavioural treatment.

Risk assessments conducted by the hospital were leveraged by the RB to determine that Anna was a significant threat to the safety of the public. In their assessments, most psychiatrists noted that they used the HCR-20 risk assessment tool. The following excerpt illustrates how this was presented in the reasons for disposition:

> The hospital's risk assessment is set out in the hospital report at page 54 and summarized as follows: "Using the HCR-20 (v3), [the person NCRMD]'s historical risk factors include history of problems with violence (at least as an adult), other antisocial behaviours (all her life), relationships (intimate and nonintimate), employment, mental disorder, personality disorder, traumatic experiences in the form of victimization, violent attitude, treatment and supervise response including multiple failed previous community placements. On the same risk assessment tool, significant clinical risk factors include recent problems with insight both into her mental disorder and violence risk, violent intent, affective and behaviour instability, responsiveness and compliance with pharmacological intervention, e.g., behaviour modification. In regards to risk management for the future, significant factors include future problems with professional services or plans, living situation, personal support, and treatment or supervision responsiveness and compliance. There are also future problems with stress associated with living in a communal environment. Based on the above, it is the opinion of the Treatment Team that [the person NCRMD] continues to constitute a significant threat to the safety of the public." (RfD15, lines 300–319)

The excerpt presents the assessment of risk as being a unanimous decision made by the treatment team. In the reasons for disposition, the RB also listed the factors of risk Anna needs to reform:

> As the Hospital Report indicates, there are significant risk management factors. Risks include problems dealing with professionals in both community settings and living situations and problems coping with stress, especially stress associated with financial difficulties, resulting in inappropriate sexual interaction. (RfD17, 301–304)

In this passage, the RB identified Anna's sexual conduct as inappropriate and noted that it stemmed from her financial difficulties.

Midway into Anna's transit through the forensic psychiatric system, it was established that she was incapable of managing her finances:

> [The hospital psychiatrist] testified at the hearing and advised the Board [that the person NCRMD] had experienced difficulties in managing her finances over the past year, but said the hospital had recently received permission from the Public Trustee to assist her in this regard. (RfD14, lines 152–154)

Three years after this determination, Anna's incapacity to manage her finances was linked to her becoming vulnerable to sexual exploitation: "She becomes sexually exploited when she needs money. . . . [The person NCRMD] will perform sexual favours in order to obtain money while on

hospital grounds" (RfD16, lines 257–260). In the following years, the hospital psychiatrist used the connection between Anna's financial vulnerability and sexual exploitation as an element of justification for imposing restrictions on her liberties:

> [The hospital psychiatrist] cautioned that [the person NCRMD] is not exercising many of her indirectly supervised privileges due to her sexual vulnerability from other patients. This concern requires her to be watched by a staff member whenever she exercises her indirectly supervised privileges on the hospital grounds. (RfD18, lines 244–246)

Because she was vulnerable to sexual exploitation, the hospital deployed measures to restrict her freedoms and to increase her supervision. Interestingly, although the reasons for disposition remains vague by mentioning that "hospital staff" would be conducting Anna's monitoring, we can assume, based on the interviews conducted with nurses, that this monitoring was carried out by nurses (see 5.1.2.2).

With Anna's dangerousness established, by way of the hospital psychiatrist's report, the RB determined various modalities by which Anna's deviant legal identity should be normalized. The hospital psychiatrist stated that a structured environment and a behavioural management plan could assist in making Anna's identity less deviant, and arguably less dangerous:

> The Board agrees that a detention order is still required as [the person NCRMD] will continue to require living in a very structured environment as provided by the hospital. (RfD12, lines 311–312)

> Because of her persistent and chronic behavioural difficulties, [the person NCRMD] was seen by a behavioural therapist, approximately two weeks ago. The therapist has been conducting baseline studies, to understand the triggers for [the person NCRMD]'s behaviour. The intent is to develop a program to target those behaviours that are causing [the person NCRMD]'s problems and to provide her adaptive behaviours. The therapist hopes to complete this program, and fully implement it, by the spring of [year]. (RfD17, lines 266–272)

Regardless of the treatment modality identified to normalize Anna's behaviours—structure, pharmacological treatment, behaviour modification program—the intent was always to modify her deviant behaviours. Strikingly, nurses were not rendered visible in the various

excerpts as the professionals who would administer these normalizing treatments. Nonetheless, they were the ones who administered the pharmacological treatments, implemented the structure ensured by hospital protocols, and enabled a consistent approach to behaviour modification programs.

Chapter 6: Discussion

The results generated from this critical ethnography shed light on the involvement of nurses in medico-legal practices that occur during RB hearings and at their periphery. To my knowledge, this is the first time a study has taken the RB hearing as an object of enquiry with the goal of exploring the role of nurses in the subjection of persons UST or NCRMD. In broad terms, my findings suggest that nurses are key actors in the collection of information about the deviant nature of persons UST or NCRMD, in the production of their dangerous identity, and in carrying out interventions aimed at protecting the public from them. In this chapter, I expand on these results. I discuss them in relation to relevant theoretical and empirical literature. I then discuss various limitations associated with this research project. Finally, I reflect on my study's implications for future nursing research, nursing practice, and nurses' education.

6.1. Assigning and Reconstructing Dangerous Identities

Forensic psychiatric hospitals and RBs are institutions that define which persons UST or NCRMD are dangerous and how their behaviours and thoughts must be reformed to keep the public safe. In keeping with these findings, I turn to Foucault's concept of *disciplinary power* to build on discussions currently taking place in forensic psychiatric nursing, and to expand on the role of the forensic psychiatric system in identifying and managing dangerous individuals. Although disciplinary power in the context of forensic psychiatric nursing is well discussed in the literature (Holmes & Murray, 2011; J.-D. Jacob & Holmes, 2011a; Perron & Holmes, 2011), it is less well discussed in relation to RB hearings and the role nurses play in these hearings.

Relying on Bentham's metaphor of the panopticon, Foucault (1975/1995) explained that, in disciplinary institutions, persons are positioned in ways that ensure their permanent visibility. This allows supervisors to efficiently observe and document their thoughts, movements, and behaviours: "the Panopticon [provides] an efficient technique for distributing individuals,

knowing them [and] ordering them along a graded scale in any of a number of institutional settings" (Dreyfus & Rabinow, 1982, p. 193). Compiling information about persons simultaneously produces them as objects of knowledge and provides a backdrop against which each individual person can be codified, classified, and differentiated. It thereby produces them as subjects with their own individualities or identities. In this chapter, I engage with this concept of identity construction by reflecting on the production of dangerous identities for persons UST or NCRMD (see 6.1.1 and 6.1.2). In 6.1.3, I make sense of the therapeutic practices which are said to reduce dangerousness.

6.1.1. The Forensic Psychiatric Network of Observation and Documentation

Forensic psychiatric hospitals and the RB are disciplinary institutions comprising a broad network of observation and documentation procedures that produce truths about persons UST or NCRMD (Figure 10).

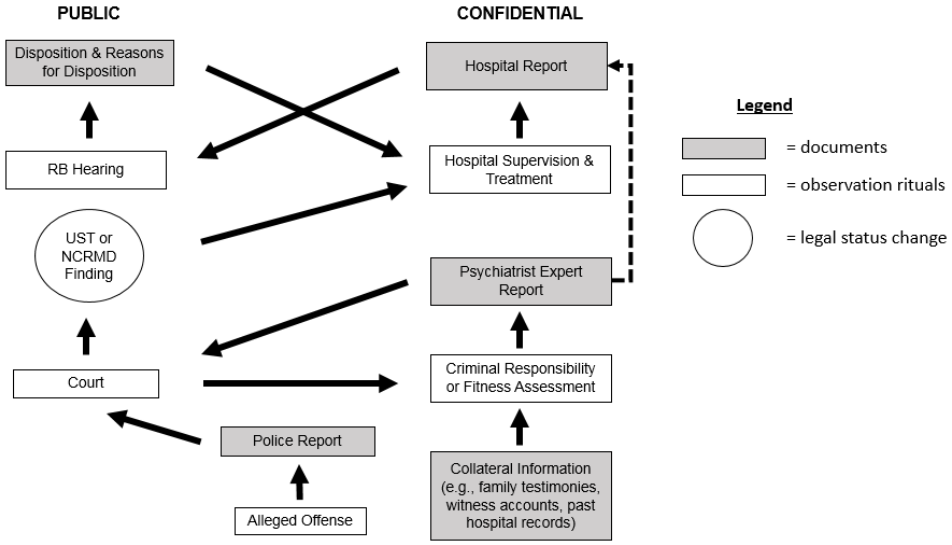

Figure 10. Forensic psychiatric network of observation and documentation.

My findings demonstrate that from the moment persons UST or NCRMD are arrested by police officers to the moment they obtain their absolute discharge, their behaviours are observed,

documented, and compiled in various legal and medical records. As they progress through the system, a broad and permanent corpus of medical and legal information about them is created. Year after year, this corpus is relied upon, during RB hearings, to re-establish their dangerousness and their need for reform.

Criminal responsibility assessments ordered by judges give forensic psychiatric hospitals the authority to research the lives of individuals in order to provide explanations for their crimes and for the circumstances in which they were committed. My results demonstrate that this biographical work involves conducting in-depth psychiatric interviews with those patients/accused persons, collecting collateral information from family members and friends, and consulting clinical records from other psychiatric facilities where they sought previous treatment. All of these procedures culminate in the production of expert psychiatrist reports. On this topic, Foucault (1975/1995) wrote:

> As the biography of the criminal duplicates in penal practice the analysis of circumstances used in gauging the crime, so one sees penal discourse and psychiatric discourse crossing each other's frontiers; and there, at their point of junction, is formed the notion of "dangerous" individual, which makes it possible to draw up a network of causality in terms of an entire biography and to present a verdict of punishment-correction. (p. 252)

Such biographical work allows for the entire lives of criminals to be "linked [to their crimes] by a whole bundle of complex threads (instincts, drives, tendencies, characters)" (Foucault, 1975/1995, p. 253). Conceptually, this introduces an interesting and important development; it establishes deviancy—and, arguably, dangerousness—after a crime has been committed, but also *before* it is committed.

To prevent the possible recurrence of dangerous acts, the deviant "instincts, drives, tendencies, and characters" of persons UST or NCRMD become subject to the disciplinary gaze of the forensic psychiatric system. Indeed, my findings suggest that all thoughts of persons UST

or NCRMD, all their behaviours, and all the plans they make for the future or lack thereof may be observed, analyzed, and documented in clinical records as identity parameters and potential precursors for dangerous acts. Much like Goffman (1961) suggested, the purpose of the clinical record in forensic psychiatry appears to be aimed at

> . . . show[ing] the ways in which the patient is "sick" and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had "symptomatic" significance. (pp. 153–154)

"Sickness" and "symptomatic significance" being intimately linked with the notion of dangerousness in forensic psychiatry, the content of clinical and legal documents produced as part of the "forensic psychiatric network of observation and documentation" is therefore associated with the need to justify why persons UST or NCRMD are dangerous or not, and why they need to be detained and supervised. To produce such a justification, the forensic psychiatric hospital introduces various sets of rules and rituals that allow for the deviant instincts, drives, tendencies, and characters of persons UST or NCRMD to materialize and then be inscribed within the medico-legal record. Rules include nursing rules, unit rules, and dispositions; rituals include nursing notes, safety huddles, and case conferences; and the medico-legal record, of course, comprises the patient report, hospital report, and reasons for disposition. Consequently, day after day, week after week, month after month, and year after year, the biography of persons UST or NCRMD is rewritten within a scheme that considers every rule transgression, regardless of how trifling such a transgression may be—such as not cleaning one's room—as a demonstration of deviancy, a potential for dangerousness, and therefore as a reason for further supervision and detention.

From a nursing perspective, this disciplinary dynamic raises questions regarding the purpose of clinical interventions and nursing documentation in forensic psychiatry. The

delineation between therapy and security is unclear. Similar to Martin and Street's (2003) findings, my results show that by documenting their patients' transgressions of institutional rules, forensic psychiatric nurses produce evidence about the deviant instincts, drives, tendencies, and characters of persons UST or NCRMD. This evidence is subsequently brought forward as proof of dangerousness by psychiatrists during RB hearings and legitimizes imposing modalities of freedom restriction including surveillance, detention, and urine toxicology screens. In that sense, far from being a judgement-free, objective, and relatively neutral process (Berring et al., 2015; College of Nurses of Ontario, 2008; Myklebust et al., 2017; Ordre des Infirmières et Infirmiers du Québec, 2002; Saskatchewan Registered Nurses Association, 2021), the nursing act of documentation in forensic psychiatry is an integral part of a structure that reproduces the "dangerous" identities of persons UST or NCRMD and justifies the need for their reform and rehabilitation.

The seemingly harmonious unilateral direction by which information is collected and delivered to the psychiatrist in preparation for RB hearings formalizes the "nursing perspective" (N01) as an essential component of the psychiatrist's perspective, and that of the forensic psychiatric hospital. The practice of forensic psychiatric nurses thereby establishes the hegemony of psychiatry as the expert discipline about human behaviour, and psychiatrists as the sovereigns of the health care team.

In this context, it is impetrative that we question the way in which this use of clinical information violates nurses' responsibility for nonmaleficence, since transferring personal health information about persons UST or NCRMD from the clinical setting to the legal setting renders it available for the public to hear and see. Relatedly, we must also ask what room, if any, is left

in the medical record for documenting nursing interventions aimed at supporting persons through the ebbs and flows of their recovery process, and to what extent these are used in RB hearings.

Indeed, this hegemonic order of discourse seems to prevent emerging trends in risk assessment, such as strengths-based approaches and consideration of protective factors, and alternative practices of care, such as harm reduction approaches and trauma informed care, to be applied or even considered in forensic psychiatry. From a risk assessment and management perspective, using strengths-based models such as positive criminology (Ronel & Segev, 2014) or the Good-Lives model (Barnao, Robertson & Ward, 2010) would place emphasis on "how the positive qualities of persons found NCRMD [or UST] could foster personal growth and crime desistance, rather than concentrating principally on their negative characteristics and how they need to be fixed" (Livingston et al., 2016, p.181). From a perspective of care, trauma-informed and strength-based approaches, namely approaches that recognize the impact of trauma experiences on emotional and relational aspects of an individual's life and that focus on the strengths and positive coping strategies of individuals, could help build stronger therapeutic nurse-patient relationships, avoid trauma triggers, and prevent incidents of aggression (Maguire & Taylor, 2019). The implementation and evaluation of these approaches requires a strong institutional commitment and an allocation of resources, particularly related to personnel training, on the part of the forensic psychiatric system (Livingston et al., 2016; Maguire & Taylor, 2019).

6.1.2. Dangerousness, Risk, and Morality

In *Winko v British Columbia* (1999), the Supreme Court of Canada (SCC) made it clear that by *dangerousness*, it meant "significant threat to the safety of the public" (para 50). The SCC further specified:

> The threat must [also] be "significant," both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. (*Winko v British Columbia*, 1999, para 57)

Notwithstanding the irony inherent in the notion of "real risk"—risk being, by its very definition, something that is immaterial and intangible—in the excerpt above the SCC explained that the task set out for RBs is an assessment of risk instead of a determination of dangerousness; or rather, an assessment of risk for the purpose of establishing dangerousness. This conceptual overlap is important, since dangerousness is the only factor that legitimizes the custodial and security-based care provided within forensic psychiatric hospitals (*CC*, 1985). Without a finding of dangerousness, *Winko v British Columbia* (1999) indicates that the RB must absolutely discharge the person from the supervisory purview of the RB.

In an attempt to further understand the conceptual link between risk and dangerousness, I turned to Robert Castel's (1981/2011) reflections in *La gestion des risques*. He explained that dangerousness is a descriptive attribute that can only be affixed to a person after they have engaged in a behaviour that caused some sort of harm. A murderer can only be deemed dangerous after they have murdered an individual. Contrastingly, the notion of risk does not necessarily originate from a specific dangerous act. It rather stems from the relation between a series of factors—antisocial associates, substance use, history of criminal behaviour, to list a few—that are found to be predictive of an undesirable action such as violence or aggression.

In forensic psychiatry, and as demonstrated in the results of my study, various structured risk assessment tools such as the HCR-20, VRAG, and RSVP assist clinicians in evaluating the risk posed by persons UST or NCRMD (K. S. Douglas, 2014; Harris et al., 2015). Although their use is said to increase transparency, objectivity, and capacity to predict the occurrence of negative outcomes (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015; Levin et al., 2018),

significant problems remain with respect to the predictive capability (Fazel et al., 2012), validity (Siontis et al., 2015), and cultural applicability (Shepherd, 2016; Shepherd & Anthony, 2018) of risk assessment tools. My results add an additional level of complexity to these problems: they highlight an overlap between the concepts of risk and dangerousness, and suggest that the operationalization of risk assessment tools exposes a new form of governance rooted in moral and subjective imperatives.

The use of risk assessment tools to identify factors of risk in persons UST or NCRMD is evident throughout my results. In general, the information presented during RB hearings, and included in reasons for disposition, amounted to descriptions of factors such as substance use, recent rule transgressions, social network, leisure activities, and antisocial attitudes. When considered together, these provided some alleged indication about whether or not the persons UST or NCRMD would engage in conduct amounting to a significant threat to the safety of the public. Persons UST or NCRMD had actually engaged in recent behaviours indicative of dangerousness on very few occasions. Psychiatrists and RB members often listed these risk factors at the end of their verbal testimonies, or at the end of reasons for disposition, and they would conclude with sentences such as: “Based on the above [risk assessment], it is the opinion of the Treatment Team that [the person NCRMD] continues to constitute a significant threat to the safety of the public” (RfD15). If we keep in mind that the SCC ruled that dangerousness was synonymous to significant threat to the safety of the public, my results then highlight a theoretical expansion in the clinical operationalization of risk—where being risky is synonymous with being dangerous.

On their own, the assessments of risk conducted as part of the RB hearing process, and included in the reasons for disposition, appear to be scientific and objective endeavours to the

extent that the factors used to establish riskiness generally stem from widely accepted, empirically validated tools and reports of factual events (Crocker, Nicholls, Seto, Côté, Charette, et al., 2015). However, if we take a chronological look at these risk assessments, as I did in my analysis of the four profiles, the objectivity espoused by these assessments becomes less compelling, since risk is an impalpable target that moves with time. In effect, my findings highlight that, depending on the day, month, or year of assessment, different elements ranging from mental illness to interpersonal relationships, financial instability, and sexual vulnerability, are relied upon in very fluid, interchangeable, and discretionary ways to build the risk profiles of persons UST or NCRMD, to justify their dangerousness and to legitimize restrictions on their freedoms.

Perhaps this volatility can be explained by the fact that information pertaining to the risk profiles of persons UST or NCRMD is compiled by a plethora of health and legal professionals, each with different conceptions about what constitutes a factor indicative of risk. My findings suggest that decisions made by health and legal professionals about which instincts, drives, tendencies and characters merit being reported to the psychiatrist and documented, and which ones do not, may not solely be driven by disciplinary structures, but also influenced by conceptions of morality.

In one of his later works, Foucault (1984/1990b) explained:

> By "morality," one means a set of values and rules of action that are recommended to individuals through the intermediary of various prescriptive agencies such as the family, educational institutions, churches, and so forth. [These rules and values] are transmitted in a diffuse manner, so that, far from constituting a systematic ensemble, they form a complex interplay of elements that counterbalance and correct one another, and cancel each other out on certain points, thus providing for compromises and loopholes. With these qualifications taken into account, we can call this prescriptive ensemble a "moral code." (p. 25)

My results demonstrate that a health or legal professional's decision to consider a person UST or NCRMD's thought or behaviour as a factor of risk was, partly at least, based on the values and rules that comprised their "moral codes." In that sense, factors stemming from the realm of morality, such as financial stability, employment quality, and sexual vulnerability, were included in clinical/legal records and considered as factors of risk. While my study generated many specific examples of such, two of them are particularly evocative of these morality-infused risk factors.

First, it was not sufficient for members of the RB that persons UST or NCRMD were employed; employment had to be stable and well remunerated. Second, in one of my RB hearing observations, a Crown attorney alluded to the fact that the risk associated with various illicit substances could be hierarchized in a way that rendered certain drugs (e.g., crack cocaine, methamphetamines) more risky than others (e.g., alcohol, cannabis, cocaine). In this case, the Crown attorney specified that such a risk resided in the network of people with whom the person NCRMD, who was from a White ethnoracial background, would have had to be in contact to obtain these substances. This comment was significant in a context where associations had been established between these riskier substances, drug-related prosecutions, and racialized groups (Jones et al., 2020; Vitale, 2018). Consequently, it is worth reflecting on whether the rules and values constituting this Crown attorney's moral code, and perhaps that of others, may have concealed a racially based hierarchy of persons behind which lay the risk hierarchy of substances. At the very least, such a reflection introduces the notion of racial stigmatization and discrimination to the boundaries that exist for the forensic psychiatric hospital and the RB between dangerous substances, dangerous persons, and policed communities.

In brief, RB hearings are depicted in my results as ceremonies where concepts of morality, risk, and dangerousness intersect and merge into a truth-producing matrix that sustains and perpetuates the notion that persons UST or NCRMD are morally deviant individuals, and by definition risky. Further, this riskiness establishes their dangerousness, and legitimizes their supervision, detention, and reform. One could consider this overlap to be caused by biases or morally tainted factors negatively interfering with a true and objective assessment of risk. However, my findings suggest this epistemological tension between realist and strong constructionist approaches to risk is a necessary precondition for the forensic psychiatric system to scientifically govern the morally deviant conduct of individuals (Lupton, 1999; O'Byrne, 2008).

Relying on Castel's (1981/2011) work on dangerousness and risk, it is difficult to assert that dangerousness—as it is mobilized in RB hearings—meets the criterion of a significant threat to the safety of the public as established by the SCC. Nevertheless, by identifying factors indicative of risk, RBs, using forensic psychiatric hospitals' testimony, may act pre-emptively in an effort to prevent certain morally deviant actions from occurring. To this effect, Castel (1981/2011) explained, in order to prevent the emergence of dangerous behaviours, factors indicative of risk may be subjected to observation and intervention:

> [Les nouvelles politiques préventives] déconstruisent ainsi le sujet concret de l'intervention pour le recomposer à partir d'une configuration d'éléments hétérogènes. Ainsi peut-on moins parler d'une surveillance qui, même à distance, se donne toujours des cibles précises et matérielles, que de construction d'une combinatoire systématique de tous les groupements possibles susceptibles de produire du risque. Il s'agit moins d'affronter une situation déjà dangereuse que d'anticiper toutes les figures possibles de l'irruption du danger. ([The new preventative politics] thereby deconstruct the concrete subject from the intervention, in that it reconstructs it from a configuration of heterogeneous elements. Thus, we can talk less of a surveillance that, even at distance, always gives itself precise and tangible targets, than of the construction of a systematic combination of all possible groupings that are susceptible of producing risk. It is

> less about facing an already dangerous situation than anticipating all the possible materializations of danger.) (Castel, 1981/2011, p. 143–144; my translation)

In a context where the assessment of risk is intimately linked with the rules and values making up the moral codes of the assessors, it is worth reflecting on the way that RBs target the morality of persons UST or NCRMD for purposes of moral reform. It is also worth questioning how the forensic psychiatric system constructs the perception of immorality through a loosely associated interpretation of meanings (and possibly race-based classifications) in a narrative presented as objective and science based.

To further explore this process of moral reform, I turn to Garfinkel's (1956) concept of degradation ceremonies. I rely on the association of RB hearings and degradation ceremonies (see Domingue, Jacob, et al., 2020) for providing a good framework to understand how processes inherent in RB hearings ensure persons UST or NCRMD reform their immoral behaviours. Garfinkel (1956; and see Chapter 2) explained that a degradation ceremony consists of a person being degraded by another person in front of witnesses in order to justify their social exclusion. The ceremony is meant to instill in that person a feeling of moral indignation and to propel them into an identity reconstruction process.

Contrary to feelings of shame and guilt that simply lead to social exclusion (Lepore et al., 2017), moral indignation generates in degraded persons a willingness to reconstruct their selves in line with the moral codes of the societies that have excluded them. Understood in this way, degradation is not an unwanted or undesirable effect of RB hearings; rather, degradation is the modus operandi in which RB hearings function. My results highlight that during RB hearings, the moral codes violated by persons UST or NCRMD are identified, and these violations serve as grounds for degradation. When these rule and value violations are subsequently inscribed within the reasons for disposition, they provide persons UST or NCRMD, and the forensic psychiatric

hospital responsible for their rehabilitation, with somewhat of a recipe to follow to target their risk factors and reduce their dangerousness. The immoral thoughts and behaviours of persons UST or NCRMD, which are at the origin of these rule and value violations, thereby become the targets of hospital, and nursing, therapeutic interventions.

6.1.3. Hospital "Therapeutics" and the Reconstruction of Dangerous Identities

Similar to other studies of how psychiatric hospitals reform the conduct of their patients (Foucault, 1965/1988; Goffman, 1961; Holmes & Murray, 2011; J.-D. Jacob & Holmes, 2011a, 2011b), my findings suggest that the therapeutic functioning of the forensic psychiatric hospital is operationalized through its disciplinary architecture. By being concretized in a network of writing through intricate practices of observation, risk assessment, and documentation, the morality-infused factors of risk of persons UST or NCRMD become objects on which forensic psychiatric hospitals can intervene therapeutically. In a cyclical way, the degree to which these therapeutic practices mitigate factors of risk is stringently observed, documented, and set out in the medico-legal record. This cycle operates until RBs, by way of the evidence compiled in hospital reports, find that persons UST or NCRMD no longer represent significant threats to the safety of the public.

In this section, I turn to Foucault's (1975/1995) work on discipline and to Goffman's (1961) work on mortification to discuss how my results depict the therapeutic functioning of the forensic psychiatric system and to understand the role of nurses in the provision of these therapies.

Various therapeutic modalities, such as pharmacotherapies and psychotherapies, were mentioned in my findings. However, crucial emphasis was placed on the therapeutic function of the disciplinary architecture of the forensic psychiatric system in reducing the dangerousness of persons UST or NCRMD. Foucault (1975/1995) explained that, coupled with their observation

and documentation structures, disciplinary institutions deploy intricate systems of punishment-gratification to train, correct, and normalize the movements and behaviours of deviant individuals. For Goffman (1961), these punishments serve to achieve the mortification of inmates by shaping their moral career as they progress through the institution. Goffman explained that institutions use mortification when they enact interventions and rituals, such as admission procedures, showers, searches, and random drug screens, aimed at disconnecting inmates or patients from the roles they previously had in society. Mortification processes are coupled with interventions, such as therapeutic groups and gratification-punishment systems, which are designed to reform inmates or patients in ways consistent with the aims of the institution—public safety, for instance.

My findings highlighted two core therapeutic processes enabled by the disciplinary architecture of the forensic psychiatric system, both of which mortify persons UST or NCRMD: the "privilege system" and the "rehabilitative and/or geographical progress." These therapeutic processes were presented as efficient ways to rehabilitate and protect dangerous persons UST or NCRMD, and as ways to protect the public from them. Through these processes, persons UST or NCRMD were taken along a rigorously supervised progress through distinct, identifiable steps—from restrictive inpatient units, to less restrictive ones, to community settings. Each step had a specific purpose, including assessment, stabilization, rehabilitation, and transition; specific activities, including medication titration, emotional stabilization, and functional rehabilitation; and specific supervisory structures and specific freedom restrictions. They served a single end goal: social reintegration. In Goffman's (1961) words:

> The ward system is a kind of social hothouse in which patients start as social infants and end up, within the year, on convalescent wards as resocialized adults. . . . This resocialization perspective tends to overstress the extent to which those on the worst wards are incapable of socialized conduct and the extent to

> which those on the best wards are ready and willing to play the social game. (p. 163)

Thus, to move from the worst wards to the best and into the community, the person UST or NCRMD must play the social game by internalizing the institutional ideals into their ways of being and behaving.

My results demonstrate that for persons UST or NCRMD to move to less restrictive wards or for them to gain more privileges, they had to participate in the various therapeutic activities made available to them, such as the substance use group or the healthy relationship group. They then had to apply their educational gains outside the group setting—that is, on the unit or in the community. Persons UST or NCRMD also had to comply with directions given to them by the health care team and with unit routines targeting their functioning as members of society, such as getting up in the morning, cleaning their room, and attending to their personal hygiene. These were called "functional prescriptions."

Compliance with rules, routines, and treatments possibly indicated that persons UST or NCRMD had mitigated factors constituting their risk profiles, and therefore might be ready for additional freedoms, such as a less restrictive ward or more privileges. Noncompliance suggested that they needed to be subjected to punishments in the form of further restrictions on their freedom. Indeed, Goffman (1961) said, "for disobeying the pervasive house rules, the inmate will receive stringent punishments expressed in terms of loss of privilege; for obedience he will eventually be allowed to reacquire some of the minor satisfaction he took for granted" (p. 148). Similarly, Foucault (1975/1995) wrote that "by way of punishment, a whole series of subtle procedures [are] used, from light physical punishments to minor deprivations and petty humiliations. . . . The slightest departure from correct behaviour [is] subject to punishment" (p. 178). Congruent with these theoretical explanations, my results indicate that the lingering fear of

having their freedom reduced, in a context where the disciplinary gaze was permanent, was thought to compel persons UST or NCRMD to comply with the rules and treatments imposed upon them, and to internalize institutional discourses relating to public safety.

Furthermore, my findings suggest that this disciplinary functioning and supervisory structure extended beyond the walls of the institution. Various administrative mechanisms and processes existed to supervise persons UST or NCRMD while in the community, and threatened them with the omnipresent possibility of a hospital readmission. While some of these mechanisms, such as curfew or staff supervision, were directly integrated within the architecture of community residences, other processes operationalized by forensic psychiatric hospitals included taking pictures of persons UST or NCRMD in case they eloped or absconded, randomly checking up on them in the community, and counting on their family members to report any behavioural deviancy. The words used in disposition orders, such as "enter the community indirectly supervised" or "hospital grounds escorted/accompanied by staff" further legitimized the deployment of these community-based supervisory measures (ORB, 1995).

In brief, the central function of the forensic psychiatric system's therapeutic architecture, whether in the hospital or based in the community, was seen to operate on punitive principles of coercion, rooted in the omnipresent threat of the restriction of freedom. Throughout my results, nurses were identified as integral actors in both the privilege system and in the rehabilitation/geographical progress system. They had key roles in observing and documenting deviant behaviours and thoughts of persons UST or NCRMD, and in operationalizing gratification/punishment systems. Thus, my findings add to knowledge now emerging which problematizes psychiatric nurses' contribution and active involvement in a system that is

structurally and inherently coercive (Jager & Perron, 2018; Paradis-Gagné, Pariseau-Legault, et al., 2021; Pariseau-Legault, Vallée-Ouimet, et al., 2020).

Nurses' role in the process of collecting and analyzing urine is probably the most striking depiction of their involvement in such systems. Although RB dispositions broadly provided forensic psychiatric hospitals with the authority and responsibility to randomly collect and analyze the urine of persons UST or NCRMD, nurses were the health care professionals responsible for urine collection. My results clearly showed that they could (and did) autonomously compel persons UST or NCRMD to provide urine samples. If these persons refused to provide a urine sample, or if the sample were found to be positive, they could enact punishments in the form of restricting freedoms—confining those persons to the unit or transferring them to more secure wards, or coercing participation in group therapies. Thus, in this context, the therapeutic benefit of urine toxicology screens and substance use treatments took on a new meaning: their outcome was geared toward achieving the abstinence requirement of the disposition, without regard to the actual desire of persons UST or NCRMD to remain abstinent.

As disciplinary interventions, these practices of urine collection and analysis constituted an added supervision tool used to identify deviant behaviours, legitimize the enactment of punishments and gratifications, and thereby mortify persons UST or NCRMD. The primary goal of such screening was thus to ensure that persons UST or NCRMD complied with the abstinence provision of their dispositions. In Lyons' (2009) words, forensic psychiatric nurses "become an extension of law enforcement" (p. 54). These findings, problematizing the therapeutic benefit of such a vast system of drug screening, complement those of Penney et al. (2020).

Nurses' role in urine collecting also demonstrates what many scholars (e.g., Holmes, 2002; Holmes, 2005; J.-D. Jacob, 2014; Lyons, 2009) have noted: when nurses spend time

working in forensic psychiatric hospitals, they seem to merge their professional identity with that of the custodial forensic psychiatric system. In my study, such a reconstruction of nurses' professional identities seemed to materialize through RB dispositions becoming a framework for nursing care. The extensive use of the pronoun "we" when nurses spoke about the forensic psychiatric hospital during my interviews was a testament to the reconstruction of their identity as a collective endeavour.

Previous scholars have explored the role of nurses in evidence-collection practices in the context of sexual assault medical forensic exams (J. Morse, 2019; Mulla, 2014). The results of my study partly corroborate theirs, in how they problematize the role of nurses in collecting urine for toxicology screens. The practice seems to be geared toward "evaluating clinical findings [of deviancy] . . . at the expense of compassionate care" (J. Morse, 2019, p. 332), and, arguably, of care in general.

However, nurses in my study considered the enactment of custodial requirements dictated to the hospital by the RB dispositions as interventions of care. In effect, nurses who participated in the various supervisory practices and gratification/punishment activities mentioned above considered these to be therapeutic in nature—an integral part of their nursing role. In that sense, my findings align with those of others who have identified that assessing and mitigating safety risks are central components to the role of forensic psychiatric nurses (Byrt et al., 2018; Mason, 2002; Timmons, 2010). However, my results also establish that the caring practices of these nurses operate on inherently disciplinary imperatives, which are no different from the ones used in prisons, schools, or military environments. As Foucault (2003) mentioned, it is only because such disciplinary technologies operate within a medical environment, with a psychiatrist as its head, that they are considered as interventions of care at all.

That being said, the incorporation of disciplinary tasks within nursing's professional role was not without consequence. Some nurses fully embraced their custodial identity, but others had difficulty with this. They found that their professional responsibility for providing mental health care to persons UST or NCRMD was incompatible with their responsibility for enforcing disposition conditions and institutional security protocols. The nurses' self-reflections can be seen as exemplars of micro practices of resistance—resistance being very difficult and complex in regimented structures like the forensic psychiatric system. One nurse, reflecting on their caring role in the forensic psychiatric environment, called it a "dissonance in the natural nursing psyche." The natural nursing psyche, in this case, was the capacity to develop a therapeutic relationship with their patients built on trust, mutual respect, and compassion (Eckroth-Bucher, 2001; Laskowski, 2001; Peplau, 1952, 1997). The dissonant element was the dangerousness of persons UST or NCRMD and the need to protect the public from them (J.-D. Jacob, Gagnon & Holmes, 2009; Holmes, Perron & O'Byrne, 2006; Peternelj-Taylor, 2004).

These findings agree with those of many other scholars. The care-and-custody dichotomy seems inherent in the provision of nursing care in custodial environments (Burrows, 1993; Dhaliwal et al., 2021; Doyle et al., 2017; Martin, 2001; Niskala, 1986; Peternelj-Taylor, 1998). On that subject, J.-D. Jacob (2012) said:

> For nurses working in corrections, decreasing cognitive dissonance may be achieved in two different ways: by reconceptualising the way nurses provide care in order to align disciplinary/punitive interventions within a rational medical framework; and reconceptualising how they view patients to justify punitive interventions within a correctional framework (pp. 181–182)

My results highlight that forensic psychiatric nurses conceptualized therapeutic interventions such as advocacy, mental status assessments, professional advice, support, and accompaniment, as essential components of the forensic psychiatric system's disciplinary structure—the case conferences, privilege system, and RB hearings. For example, nurses considered their expertise

in conducting mental status assessments as integral to the risk of violence assessment processes. They also described their role of advocacy in forensic psychiatry as associated with helping persons UST or NCRMD progress through the legal steps inscribed within their dispositions. In a somewhat cyclical way, to justify and rationalize their roles in these punitive and coercive procedures, nurses (such as N04) reconceptualized their patients as threats to the public that needed to be neutralized. However, my results go one step further. They suggest that, in forensic psychiatry, nursing care can never be free from coercion and punishment, since every interaction, every therapeutic intervention, and every piece of nursing documentation can be used to objectify persons UST or NCRMD during RB hearings, and to justify their ongoing detention, supervision, and reform.

In summary, the role of nurses in forensic psychiatric hospitals is orchestrated by means of surveillance, documentation, and systems of gratification-punishment. It takes refuge in the public safety aims espoused by the RB in its dispositions. In that sense, dispositions constitute the framework for nursing care within the forensic psychiatric system. With their involvement in disciplinary processes inherent in forensic psychiatric hospitals, nurses participate in the reproduction of dangerous identities for persons UST or NCRMD, and in the reconstruction of their identities in line with moral codes of society.

Once a year, the RB evaluates whether the identity reconstruction of persons UST or NCRMD has been successful, and if so, allows them to be discharged from the supervisory architecture of the RB. The rituals inherent in the RB hearing and the social functions of the RB are the focus of my discussion in the next section.

6.2. Institutional Displays, Procedural Justice, and Biopolitical Efficiency

Throughout the process of collecting and analyzing data, I frequently turned to legal and theoretical texts to make sense of the nature, purpose, and effects of RB hearings. These

reflections led me to conceive of RB hearings as well-orchestrated ceremonies that serve three main purposes: reforming persons UST or NCRMD by targeting factors suggestive of risk; legitimizing psychiatrists as the scientific experts in identifying and reforming dangerous individuals; and protecting the public.

First, to complement the reflection I proposed earlier regarding degradation ceremonies, I explore the RB hearing procedure by using Goffman's (1961) work on institutional ceremonies. I conceptualize them as theatrical venues that reaffirm psychiatrists as the experts of human behaviour and human nature. Then, I problematize the function of procedural justice in RB hearing proceedings inasmuch as it serves as a political tool by efficiently enticing persons UST or NCRMD to work on their selves for the benefit of society. Lastly, I further reflect on the social function of the forensic psychiatric system, using Foucault's (1997, 2007) concept of biopolitics. This sets the stage for problematizing the caring rhetoric, behind which rests the biopolitical role of forensic psychiatric nurses.

As a total institution in Goffman's (1961) sense, the forensic psychiatric hospital segregates persons UST or NCRMD from the outside world. It does this by creating an intra-institutional world where every aspect of life, and every activity of daily living and leisure, is conducted in close proximity to other persons and under the close scrutiny of hospital staff. Built-in security mechanisms and policies abound, ensuring the segregation of persons UST or NCRMD: walls, locked doors, controlled and supervised outings to the community, visiting policies, supervisory policies, and privilege processes. Also thereby ensured is a heavy regulating and sanitizing of information coming into and going out of the institution.

Heavy information regulation takes place when visitors—such as RB members, in this case—enter a total institution. As Goffman (1961) explained, staff members carefully plan which

areas of the institution are to be visited, what information about inmates is to be shared and, in the case of psychiatric hospitals, which therapeutic activities are to be highlighted. Goffman (1961) dedicated a whole section of his first essay to these visitations, which he named "institutional ceremonies" (p. 93). They are theatrical performances, serving as opportunities to display total institutions in their best light. In preparation for such visits, institutions engage in activities such as vigorous cleaning efforts, enhancement of food offerings, and glamorous portrayals of modern treatment modalities for mental illnesses "such as psychodrama or dance therapy" (Goffman, 1961, p. 102). Keeping this precise framework in mind, I have come to consider RB hearings as institutional ceremonies.

My findings suggest that in preparation for RB hearings, the forensic psychiatric hospital in my study meticulously selected what information to present to the RB, and how to present it. The hospital orchestrated a series of activities that aimed to present only certain information about itself and about persons UST or NCRMD. Such activities related to the space in which RB hearing was to take place, and to the characters, bodies, and minds of the persons UST or NCRMD. This preparatory work was essential because, beyond protecting the public from persons UST or NCRMD, RB hearings re-establish psychiatry as the medical discipline with the expertise to define and reform dangerous individuals (Foucault, 1975/1995). On this subject, Foucault (2003) described a procedure at psychiatric hospitals for presenting mentally ill patients—complete with their life histories and clinical progression—before an audience comprising the patient, students, and other clinicians. In such presentations, he wrote, "le médecin se constitue comme maître de la vérité" (doctors constitute themselves as masters of the truth) (Foucault, 2003, p. 185; my translation). Because of this mastery of truth, psychiatrists can "exercer à l'intérieur de l'asile un sur-pouvoir absolu, de s'identifier finalement au corps asilaire,

[de sorte que] l'asile [se constitue] comme un corps médical qui guérit par ses yeux, ses oreilles, ses paroles [et] ses gestes." (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.) (Foucault, 2003, p. 185; my translation). By providing testimonies about the lives and clinical progress of persons UST or NCRMD during RB hearings, forensic psychiatrists establish themselves as experts and masters in the identification and reform of dangerous individuals, and likewise establish forensic psychiatric hospitals as institutions responsible for the treatment of dangerousness.

If psychiatrists were to err when giving their testimony, or if their professional opinions were to be scrutinized by RB members, their expertise could be put into question, as could the forensic psychiatric hospital's legitimacy for treating dangerousness. Activities and documentation that prepare and assist psychiatrists for delivering their testimony, such as case conferences, nursing notes, chart reviews, and biopsychosocial assessments, are therefore essential. They serve to limit the potential for error during the written or viva voce presentation of evidence, and protect forensic psychiatry and forensic psychiatrists against threats to their discursive hegemony.

My results show that RB hearings are rituals during which the effectiveness of forensic psychiatrists and forensic psychiatric hospitals at treating dangerousness is examined and evaluated. Much like the normalizing interventions applied to deviant persons UST or NCRMD, if forensic psychiatric hospitals were deemed to be inefficient and ineffective in this matter, RBs could prescribe corrective actions to ensure their reform, such as more frequent RB hearings, or public censure. To prevent the imposition of such corrective measures and to protect the hegemony of forensic psychiatry, forensic psychiatric hospitals orchestrate institutional

ceremonies limiting what information about persons UST or NCRMD, and about themselves, becomes available during RB hearings (Goffman, 1961). Consequently, RB members are only exposed to certain truths about persons UST or NCRMD and about forensic psychiatric hospitals. This ensures control over the narratives about the forensic psychiatric system and the representation of persons UST or NCRMD.

In some sense, RB hearings, and the rooms in which they take place, are reminiscent of Foucault's (2009; Pariseau-Legault, Bernheim, et al., 2021) concept of *heterotopia*. Foucault contrasted this concept with that of *utopia*. Whereas the latter refers to an unreal, imaginary, dream-like space, the former constitutes a materialized utopia. Heterotopias are real, geographically defined spaces that serve as overt contestations of ignominious societal realities. Foucault explained that they dissipate reality, serving as "contestations" of society. They are denunciations of societies' illusory "perfect," "meticulous," and "well-organized" views of themselves. As such, they serve as paradoxical representations of these "disorganized and poorly arranged" societies (Foucault, 2009, p. 34).

The RB hearings theoretically give persons UST or NCRMD a chance to contradict and question the expertise of psychiatrists. However, such opportunity for refutation seems to be illusory: Crocker, Charette, et al. (2015), for example, have found that in Ontario, 92 percent of the recommendations put forth by forensic psychiatric hospitals are upheld during RB hearings. On that note, one nurse I interviewed even recognized RB hearings as "formalities" (N05, lines 67–70). Despite this, nurses appear to make sure that persons UST or NCRMD participate in opportunities built into the forensic psychiatric system, such as case conferences or meetings with their lawyers, which allow for the murmured voices of those patients to be somewhat considered, albeit in very constrained ways. Perhaps these opportunities for refutation contribute

to the notion that procedures involved in RB hearings are just, in that they give the illusion of placing persons UST or NCRMD, and the truths they produce, on an equal footing with psychiatrists and their truths (Livingston, Crocker, et al., 2016; Tyler, 2003).

In reality, my findings suggest that the ritualistic way in which RB hearings take place, including their illusory opportunity to question the expertise of psychiatrists, is not arbitrary. As many scholars have recently demonstrated in the context of mental health tribunals (Canada & Hiday, 2014; Kopelovich et al., 2013; Pratt et al., 2013), if individuals believe the process by which they are subjugated is just, they are more likely to comply with the outcomes of this process. The principle of procedural justice that underpins RB hearings thus appears to entice persons UST or NCRMD to actively engage, obediently, in various disciplinary activities. If such persons perceive the RB hearing process as procedurally just (per Livingston, Crocker, et al., 2016), then one can infer that they are more likely to comply with the conditions listed in their dispositions and with the treatments offered to them by forensic psychiatric hospitals. Procedural justice, whether actual or illusory, may thereby serve to engage persons UST or NCRMD in therapeutic activities to reduce their dangerousness. In that sense, procedural justice can be termed a technology of biopower, since it contributes to the protection of society by rendering persons UST or NCRMD docile and compliant with processes aimed at reconstructing their identities.

Biopower can be broken down into two interdependent components, namely anatomopolitics and biopolitics (Foucault, 1997; Perron et al., 2005). Whereas the aim of anatomopolitics is the surveillance and reform of deviant individuals, biopolitics operates at a societal level through population regulation processes of such things as birth rate, death rate, epidemic surveillance, growth domestic profit, and school enrollment rate (Gros, 1996). In

relation to biopower, Foucault (1997) specified: “Nous sommes donc dans un pouvoir qui a pris en charge et le corps et la vie, ou qui as pris, si vous voulez, la vie en général en charge avec le pôle du côté du corps et le pôle du côté de la population.” (We are thus under a power that has taken charge of body and life, or has taken . . . charge of life in general, with the body at one pole, and the population at the other.) (p. 226; my translation). My results demonstrate that the forensic psychiatric system can be conceptualized as a security apparatus (*dispositif*) of biopower. Its anatomopolitical branch, which has been discussed at length in this chapter (see 6.1), targets the individual and operates within the forensic psychiatric hospital, using mechanisms such as surveillance, punishment-gratifications, and identity reconstruction. Its biopolitical branch operates in part through the RB as a representation of the collective that is to be kept safe from dangerous persons UST or NCRMD.

From a biopolitical perspective, my results demonstrate that during hearings, RB members ensured a regulation of the population in two separate and successive steps. First, based on the information contained in the hospital report and in the viva voce testimony of the psychiatrist, RB members decided if persons UST or NCRMD represented a significant threat to the safety of the public. If so, their second step was to formulate a disposition order compelling dangerous persons UST or NCRMD to follow various conditions to protect the public, such as detention, supervision, and rehabilitation. That is, they protected the population from dangerous persons UST or NCRMD by deciding who was considered dangerous and in need of detention, supervision, and reform. In forensic psychiatry the two axes of biopower are intertwined: the biopolitical management of persons UST or NCRMD cannot be accomplished without anatomopolitics; and the only legitimization for anatomopolitics is biopolitical efficiency. The anatomopolitical processes and procedures that operate within forensic psychiatric hospitals—

namely those aimed at correcting, reforming, and training persons UST or NCRMD—converge at RB hearings, where dangerousness is established and managed. However, my findings suggest that the biopolitical reach of the RB extends beyond public protection. It is also concerned with the way in which persons UST or NCRMD comply with the moral codes of society, particularly in terms of social profitability, including activities such as employment, leisure activities, education, and volunteer work. In the same vein as Holmes and Murray (2011), my study shows that, in keeping with neoliberal ideology, processes and procedures inherent in the forensic psychiatric system direct the accountability for self-improvement to persons UST or NCRMD, freeing itself from this responsibility.

What my results ultimately have established is that, in forensic psychiatry, there is a single patient, which is the public. Nursing practice in these settings is inherently geared toward the detention, supervision, and reform of dangerous persons UST or NCRMD for the benefit of the population at large, thereby problematizing the humanistic rhetoric of nursing care. By evaluating, treating, and monitoring persons UST or NCRMD, nurses provide a form of preventative and protective care to the general public. Persons UST or NCRMD constitute a threat nurses must intervene in.

The role of nurses in the domain of forensic psychiatry very closely resembles the role of nurses in other domains such as public health. To protect the public from the transmission of contagious illnesses, public health nurses administer treatments such as pre-exposure prophylaxis and antituberculosis agents, and enforce custodial-type interventions, such as monitoring, isolation, masking, and social distancing. To protect the public from physical or psychological harm, forensic psychiatric nurses administer various forms of treatments, such as psychotropic medications, punishments/gratifications, emotional support, and custodial-type interventions,

including unit/room searches and urine drug screens. The nursing work with the individual is for the safety of the public. Therefore, contrary to others who have suggested that nursing care in forensic psychiatry is constrained by the custodial environments in which the care is dispensed (Burrows, 1993; Doyle et al., 2017; Peternelj-Taylor & Johnson, 1995), my findings suggest that the care provided by nurses is integral to the custodial function of the forensic psychiatric system. Consequently, by their very nature, interventions conducted by forensic psychiatric nurses, such as collecting urine, operationalizing the privilege system or conducting "community checks", can be considered punitive and/or coercive to the extent that they may have harmful repercussions on the social lives and trajectories of persons UST or NCRMD including prolonged in-hospital detention or RB supervision.

Similar work in nursing has problematized the role of nurses in the domain of HIV care, since their clinical documentation can be used in legal processes intended to criminally prosecute patients for HIV nondisclosure and transmission (O'Byrne, 2011; O'Byrne & Gagnon, 2012; Phillips et al., 2013; Sanders, 2014). Contrary to the results of my study, however, in the context of HIV criminalization, the purpose of documentation seems to remain in the clinical domain—that is, teaching safe(r) sex practices or monitoring of viral load. My results, on the other hand, highlight that some nursing practices in forensic psychiatry are intended to demonstrate transgressions and to construct of the risk profile of persons UST or NCRMD. Thus, through therapeutic practices and processes such as the privilege system, the assessment of mental status, or the provision of assistance with activities of daily living, nurses ensure that dangerous persons UST or NCRMD are produced and reformed in accordance with the moral codes of society.

Notwithstanding the humanistic intents of nurses who engage in therapeutic practices, their effects transcend the nurse-patient relationship and contribute to the biopolitical

management of populations. As with Perron et al. (2005) and O'Byrne (2008), I contend that reflecting upon the political implications of nursing care is necessary since, by actively engaging in practices deemed therapeutic, nurses act as agents of the state and contribute to maintaining certain systems of thought about what is and is not a risk in a position of hegemony.

6.3. The Limits of the Study

Despite having adhered to stringent criteria of rigorousness (outlined in Chapter 4) and conducted my analytical process with the utmost thoroughness, my study has certain limitations that must be considered. The areas to which I draw the reader's attention relate to an ontological reflection and three methodological concerns.

The goal of the study was to understand and problematize how forensic psychiatric structures and practices constructed the identities of persons UST or NCRMD as dangerous. Relatedly, the very focus of my theoretical framework is a critique of various subjection processes that take place within society. Yet, by observing, analyzing, and writing, I also ontologize persons UST or NCRMD and forensic psychiatric nurses by assigning a truth about them in a network of writing. By composing this dissertation, I engage in the very issue I critique. Although I believe my study was necessary to understand the complex social processes at play in forensic psychiatry and forensic psychiatric nursing, I acknowledge its ontologizing effect as a limitation to the extent that I believe this dissertation should be considered as one truth among many others.

The second limitation of this study relates to three methodological concerns. The first concern originates from the data collection and analysis sequence. The recruitment of my nurse participants took place very rapidly and interviews were conducted in a short time frame. This prevented me from starting the analysis of the interview data as other data were being collected. Having more time for reflection would have been beneficial since it would have allowed me to

ask clarification questions in future interviews. Despite the rich nature of the interviews I did conduct, I think additional reflection time might have allowed for additional rituals, beliefs, and practices inherent in the forensic psychiatric culture—such as unit searches, room searches, community checks—to be better understood.

Secondly, nurse participants knew that I, their interviewer, was a registered nurse with an expertise in forensic psychiatry. This may have modified the ways in which they responded to my questions. For example, they may have provided less-detailed answers to questions pertaining to certain subjects, such as nursing practices or security protocols, because they assumed I was familiar with them. Nurse participants may have also modified their responses out of a concern for social desirability. I mentioned explicitly in the consent form and before starting the interviews that the study did not constitute an assessment of nursing practices in forensic psychiatry, but rather an exploration of these practices. Nevertheless, nurses may have adjusted their responses to highlight what they believed to be desirable nursing practices or to underline injustices in the forensic psychiatric system.

The final methodological concern relates to the data sources used for my ethnographic analysis. When I wrote the protocol for this study, I made a calculated choice to use reasons for disposition as documentary sources and RB hearings as rituals to observe. I made this choice because I was concerned about their public nature. Having now completed my dissertation, I believe other documents, such as nursing notes, hospital reports and internal RB documents detailing procedures, and other rituals, like case conferences and safety huddles, could have been relevant to include as data sources. They would have allowed me to have a better understanding of the flow of information about persons UST or NCRMD from the clinical setting to the RB hearing, and of the way such information is used to make disposition orders.

6.4. Implications for Nursing Research, Education, and Practice

The results of this study expand on the corpus of nursing knowledge in the domain of forensic psychiatry by positioning the discipline of nursing within social, political, legal, and moral structures. The theoretical framework I have used has allowed me to grasp and comprehend the political magnitude of nursing practice within the forensic psychiatric system and to propose that, beyond stemming from caring intentions, the work of nurses has deep-rooted political functions, such as public protection and sociomoral sanitization. Forensic psychiatric nursing care cannot be dissociated from the moralistic, coercive, and punitive functioning of the forensic psychiatric system; this nursing care actually supports the system and enables its sustainability. Considering this, I pose the following question: Is it even possible to envision a nursing practice exempt from coercion and punishment in the domain of forensic psychiatry without radically transforming the system at multiple legislative and procedural levels? I would answer no, given that I consider a major paradigmatic shift would be needed for relationships between nurses and patients in forensic psychiatry to be infused with trust and transparency, and be truly rooted in principles of nonmaleficence. I acknowledge, from a pragmatic perspective, that my dissertation will probably not engender such a change. Nevertheless, in line with the transformation aim of critical ethnographies, in the following paragraphs I propose a pragmatic discussion and reflection about the implications of my study for nursing research, the practice of nurses, and their education.

From a research and knowledge production perspective, the study exposes various areas of enquiry that deserve attention and that are relevant to the discipline of nursing. I focus on three in particular: the replication of colonial dynamics in RB hearing processes; family as an extension of medico-legal structures; and the transferability of the methodology I used to other domains of nursing where medico-legal structures intersect.

Colonial dynamics are replicated in RB hearing procedures and in the larger forensic psychiatric system. Profile 1 paints a picture of an Indigenous person UST being confronted with a health care institution that did not seem ready to provide him with well-rounded holistic and culturally competent care. Regardless of the reasons offered in this specific case by the forensic psychiatric hospital for delaying or restricting access to culturally relevant activities, this situation exemplifies structural barriers to which Indigenous persons UST or NCRMD are confronted when trying to access health care services. Indigenous persons spend a disproportionate amount of time under the purview of the RB (Crocker, Nicholls, Seto, Charette, Côté, et al., 2015; Latimer & Lawrence, 2006). Thus, additional qualitative inquiries using postcolonial approaches could be beneficial for better understanding the effect of forensic psychiatric structures—such as RB hearings, assessments of risk, identity reconstruction activities, and detention/supervision modalities—on Indigenous persons, and on their health and social trajectories.

Secondly, the influence and importance of families to RB hearing processes is evident throughout my results. Family members provided health care professionals with a wealth of information regarding the medical and social histories of their loved one. Furthermore, their own medical and social histories were leveraged as risk factors during RB hearings and within reasons for disposition as evidence that their loved ones did or did not represent significant threats to the safety of the public. From a perspective of behaviour management, families were considered as an extension of the disciplinary structure of the hospital: they needed to report any deviant behaviour committed by their loved one to the health care team. Building on Paradis-Gagné and Holmes's (2019) work on the experience of family members living with a loved one exhibiting violent behaviours, an enquiry specifically targeting the meeting place of family

members and RB hearings (and perhaps other parajudicial tribunals, such as mental health tribunals and consent and capacity boards) would shed light on roles held by them within the forensic psychiatric system, and other systems at the junction of health care and social control.

The third item I would like to mention here is not a specific domain of enquiry; instead, it relates to the methodology used for this study and its transferability to other medico-legal structures in which nurses are involved. The use of a critical ethnography methodology coupled with a discourse analysis framework allowed for a deep understanding of the ways in which psychiatric and public safety discourses shaped the rituals, beliefs, and practices inherent in the RB hearing process (Krzyzanowski, 2011). With this methodology, I was able to not only identify the roles of nurses in these practices, but also to problematize their contribution; they were part of the system that maintained the hegemonic position of psychiatric and public safety discourses. I believe the methodology used in this study could be successfully transferred to explore and problematize the involvement of nurses and other health care professionals in other structures on the medico-legal borderland, such as health and safety committee meetings, labour management meetings, consent and capacity boards, and research ethics boards, to name a few.

From a nursing practice perspective, the results of my study raise questions regarding the ethical responsibilities of nurses with regard to the confidentiality of personal health information. During RB hearings, the medical progress and social histories of persons UST or NCRMD are publicly examined with the intent of establishing robust plans to manage those persons' dangerousness. When clinical information compiled by nurses is used outside the therapeutic environment of the forensic psychiatric hospital, such as when it is submitted during public RB hearings, it cancels persons UST or NCRMD's right to confidentiality (see Figure 10).

Very few guidelines regulate why and how clinical information can be transferred from clinical settings to legal settings (and back) without the consent of persons UST or NCRMD or their family members. Although the Ontario *Mental Health Act* (1990, article 35(2)) provides the legal authorization for such a use of clinical information, this legislative framework is problematic. When such information become public, it is available to every member of society. The publication of the reasons for disposition thus violates the dignity of persons UST or NCRMD and that of their families (Gustafsson et al., 2014), and raises significant concerns relating to the ethical responsibilities of nurses for "maintaining privacy and confidentiality" and at "honouring [the] dignity" of their patients (Canadian Nurses Association, 2017). In Québec, RBs seem to have partially alleviated this issue by anonymizing the reasons for disposition they publish for public consumption—a solution the ORB should consider.

When personal health information of persons UST or NCRMD crosses hospital/RB or confidential/public thresholds, my results highlight that an intricate work of translation occurs. When personal health information is collected as evidence to support the psychiatrist's expert opinion before an RB hearing, it is decontextualized, becoming merely an amalgam of factors that may predict the possible emergence of undesirable violent behaviour. Conversely, when legal documents such as police reports, expert psychiatrist reports, and reasons for disposition are used in the clinical domain, their production is likewise decontextualized. They become de facto clinical documents from which nursing care plans are developed.

Forensic psychiatric nurses do not control the way in which the law is written or the way that forensic psychiatric institutions regulate when and how personal health information can be used in clinical/legal settings. However, as street-level bureaucrats, they have a great deal of discretion and autonomy with respect to the way in which they apply and comply with

regulations such as community checks, urine toxicology screens, and documentation of incidents (Lipsky, 2010). On the subject of street-level bureaucracies, Lipsky (2010) said:

> Public service agencies that employ a significant number of street-level bureaucrats in proportion to their work force are called *street-level bureaucracies*. Typical street-level bureaucrats are teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health workers, and many other public employees who grant access to government programs and provide services within them. (p. 4)

Lipsky (2010) added that, because of the discretion and autonomy street-level bureaucrats have in delivering public services, they assert a certain level of influence and control over society, particularly over recipients of those services. That being said, such an influence and control is limited to the extent that

> . . . the jobs [held by street-level bureaucrats] typically could not be performed according to the highest standard of decision making in the various fields because street-level workers lacked the time, information, or other resources necessary to respond properly to the individual case. Instead, [they] manage their difficult jobs by developing routines of practice . . . [which] has important implications for the quality of treatment and services. (Lipsky, 2010, pp. xi-xii)

In effect, the forensic psychiatric street-level bureaucracy is sustained by these "routines of practice" developed by forensic psychiatric nurses—the coordination of routine checks of persons UST or NCRMD in the community, the systematic monthly urine collections, and the picture-taking rituals for law enforcement agencies. Gros (2019) considered these "routines of practice"—these methods that make the system work—as demonstrations of ways in which individuals "over-obey" political authority (p. 101). He continued as follows: "L'autorité politique ne tient que par une adhésion secrète qui fait surobéir. Si l'on ne faisait qu'obéir passivement et douloureusement aux puissants, ils n'exerceraient aucun pouvoir. C'est notre excès d'obéissance qui les fait tenir." (Political authority only holds by a secret loyalty that makes us over-obey. If one only passively and painfully obeyed the political authority, it could not wield any power. It is our excess of obedience that keeps it going.) (Gros, 2019, p. 101; my

translation). In other words, it is only through over-obeying political authority, by developing "routines of practice" for example, that street-level bureaucracies' survival is ensured. Gros (2019) proposed that one method to resist political authority is simply to *obey* the rules of institutions; not to *over-obey* them. This is what I would propose, as a course of action, for forensic psychiatric nurses who wish to transform their practice and challenge the subjugating effects of the forensic psychiatric system.

Leery of making recommendations for the practice of nurses in forensic psychiatry that would replicate a certain order of discourse, I nevertheless ask the following: What would happen to the system if nurses stopped taking pictures of patients for the purpose of aiding law enforcement agencies? What would happen if they stopped collecting urine samples for the simple purpose of determining whether or not persons UST or NCRMD consumed drugs or alcohol? What would happen if they stopped documenting clinical events highlighting the aggressiveness and rule transgressions of persons UST or NCRMD? Instead of over-obeying, what if forensic psychiatric nurses simply obeyed the rules? What would happen if they started documenting the efforts made by persons UST or NCRMD to overcome stressful events? What would happen if they informed persons UST or NCRMD about the real-life implications of disclosing information to members of the health care team, namely that it could be used as evidence to support their need for further detention and supervision? Although these practices of resistance would not change the objectifying processes inherent in the forensic psychiatric system, they might destabilize the harmonious functioning of the "forensic psychiatric network of observation and documentation" by altering the narrative about persons UST or NCRMD and forensic psychiatric nursing.

From an educational perspective, I believe that my study underscores the need to further educate nurses about the political effects and ramifications of nursing care that go beyond the nurse-patient relationship (O'Byrne, 2008) to include the way nursing care sustains hegemonic psychiatry, public safety, and neoliberal discourses. As future health care providers with ethical and deontological responsibilities, nurses and nursing students must be able to engage—and must be given opportunities to participate—in critical reflections about the effects of nursing care beyond the proximal one-on-one relationship they develop with their patients. The nursing knowledge I have produced in this doctoral project provides a matrix wherein these crucial legal and ethical reflections can originate, and partly contributes to filling the educational gap in forensic psychiatric nursing noted by Kent-Wilkinson (2011).

My study highlights the importance of teaching nurses and nursing students various specific ethical and sociopolitical bodies of knowledge relevant to the domain of forensic psychiatry (White, 1995). I decided to target two that I found particularly relevant. Although focused on forensic psychiatric nurses, these educational implications are transferable to many other domains of nursing, including public health, general psychiatry, geriatric nursing, and palliative nursing. The first ethical and sociopolitical body of knowledge with which nurses should be familiar relates to the effects of legislation on the lives and human rights of their patients, including violations of confidentiality and restrictions of freedom. In my study, such legislation was the *Criminal Code* (1985) and the Ontario *Mental Health Act* (1990). Without this sociopolitical knowledge, nurses cannot engage in critical ethical reflections about the possible harmful ramifications of their professional practices, and they may end up violating the nonmaleficence principle.

The second body of sociopolitical knowledge that I believe is imperative to teach nurses and nursing students has to do with the RB hearing procedure and the opportunities persons UST or NCRMD have to make their voices heard throughout this process. If nurses were taught about the RB hearing process and the rights of their patients in this process, my hope is that nurses would realign their conception of advocacy in forensic psychiatry. My results showed that nurses seemed to consider their advocacy role as a disciplinary tool. For them, it seemed aimed at assisting persons UST or NCRMD to progress along the graded legal steps of their disposition, rather than as a way to ensure that the health and social goals of their individual patients were met. With an understanding of the RB hearing process, nurses could advocate for the procedural rights of patients to be upheld, thereby preventing situations where persons UST or NCRMD decided not to present positions contrary to those of the hospital, out of fear that they would "rock the boat" and "upset things," as described in OB18 (see 5.2.1.2).

Conceptualizing the role of nurses in forensic psychiatry as upholding the procedural and human rights of persons UST or NCRMD is closely aligned with Timmons's (2010) finding. For Timmons, two core functions of forensic psychiatric nurses were practising with humanity, and promoting equality, diversity and human rights. Again, while my suggested educational recommendations would not inherently change the disciplinary role of nurses within the forensic psychiatric system, they might destabilize its functioning by providing space for reflection and critique, and broaden the possibilities for resistance.

Conclusion

Desiring to understand how and why the personal health information of persons UST or NCRMD was used beyond the confidential clinical setting, I set out on a doctoral research project that took me on an unexpected path. The critical ethnography I undertook revealed that the practice of nurses was vital for the efficient execution of the forensic psychiatric system's aim of maintaining public safety. Indeed, the critical discourse analysis framework I used pointed me to how the forensic psychiatric system and its culture are sustained by the work of nurses. By focusing my enquiry on how the identities of nurses and persons UST or NCRMD were reconstructed within this system, I found that forensic psychiatric nurses are involved in an intricate array of medico-legal practices that serve to reproduce the dangerousness of their patients, thus sustaining psychiatric and public safety discourses. These practices establish forensic psychiatry as the discipline with the scientific expertise to define dangerousness and to reform dangerous individuals.

My results suggest that, to ensure public safety, the forensic psychiatric system has established a plethora of rules needing to be followed by persons UST or NCRMD. It employs a vast network of observation for deviances to be identified and documented, and deploys a chain of penalties and micropenalties for purposes of reform. Although the existence of these disciplines may be founded on the premise that they mitigate factors of risk, my findings highlight that questions of morality infuse them—for example, having a clean room, waking up in the morning, and refraining from associating with certain individuals. As health care professionals working within this system, the nurses enforce the rules, identify and document moral and social deviances, and enact penalties. While these disciplinary and, arguably, punitive tasks originate from custodial requirements imposed by the RB on the forensic psychiatric hospital, they are integrated into the conceptions of what constitutes nursing care.

The provision of nursing care in forensic psychiatry is not without consequence. By providing care and documenting it within the clinical record, and by participating in various interprofessional meetings, nurses produce personal health information about persons UST or NCRMD. My findings suggest that this clinical information is subsequently cited within hospital reports as factors of risk; relied upon during RB hearing ceremonies for degradation purposes, such as demonstrating social and moral deviancy, and the need for reform; and presented in the reasons for disposition as a means of establishing dangerousness. This clinical information is further used as the justification, within reasons for disposition, for legitimizing the application of disciplinary measures such as prolonged surveillance and detention. Information produced by nurses about persons UST or NCRMD constitute morality-infused factors of risk, which reconstruct—day after day, week after week, and year after year—their dangerous identities. Indeed, the forensic psychiatric system seems sustained by a conceptual overlap between notions of risk, dangerousness, and immorality. Far from being constrained by the custodial forensic psychiatric system, nursing care is an integral part of a disciplinary machine that constantly keeps persons UST or NCRMD under the supervisory gaze of the RB.

Such a conception of nursing care clearly engenders significant ontological and ethical reflections. From an ontological perspective, it makes one question the notion of "persons" in forensic psychiatric settings. Much like nurses working in the domain of public health, the ultimate benefactor of the care dispensed by forensic psychiatric nurses on persons UST or NCRMD is the general public. Through their practices of care, they assist the forensic psychiatric system in protecting the population against dangerous persons. By participating in the enactment of the "geographical progress," for instance, nurses ensure that persons UST or NCRMD gradually reintegrate into the community in a way that upholds the sociomoral values

of that community, including safety, productivity, and autonomy, and reconstructs their identities in line with these values.

From an ethical perspective, my results question the possibility of confidentiality in forensic psychiatry. It is widely known that clinical records may be subpoenaed and be used as evidence during public legal proceedings. In forensic psychiatry, the personal health information of persons UST or NCRMD is used, on an annual basis, as evidence during public RB hearings through the hospital's reports. Considering the real-life implications such disclosures may have on the lives of persons UST or NCRMD, in terms of their degradation, supervision, detention, and reform, it is worth questioning the purpose for which certain pieces of information are inscribed by nurses within the clinical record.

It is also worth questioning the way that this personal health information is used during public RB hearings and within public reasons for disposition. The extent to which persons UST or NCRMD are aware (or not) that behaviours they exhibited and words they said were going to be used as evidence against them during RB hearings should also be investigated. As professionals bound by an ethical code of conduct rooted in principles of nonmaleficence, nurses working in forensic psychiatric settings have a deontological duty to reflect on these questions, since the care they provide has implications beyond the one-on-one encounter they have with their patients. Notwithstanding the fact that my research was conducted in a forensic psychiatric setting, such a reflection should be undertaken by nurses in all care settings, and especially in those which may be conceived as Goffmanesque total institutions—long-term care homes, prisons, group homes, and shelters, among many others.

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Appendices

Appendix A: Initial Email to Ontario Review Board

FW: ORB Hearing Dates/Times

Tan, Manuel (MOHLTC)
Tue 5/28/2019 10:23 AM
To:

2 attachments (35 KB)
Aug. 6 - 9 Hearing Schedule.pdf; June 25th Hearing Schedule.pdf;

Good morning,

Currently the Board has hearings on June 25th and the week of Aug. 6th. Attached are copies of the hearing schedule for your convenience.

Please advise which hearing/s you wish to observe and I will notify the panel of your attendance.

Manny Tan
Deputy Registrar
Ontario Review Board
Tel: (416) 314-0153
Fax: (416) 327-8867

NOTE: This message and any attachments are intended only for the use of the individual(s) or organization(s) to whom or to which it is addressed and may contain privileged information and should not be read by, disclosed to or delivered to any other individual or organization. If you have received this communication in error or you are not the intended recipient(s), please notify us immediately by e-mail to orb@ontario.ca. Any dissemination, distribution, copying or disclosure of this communication in any form whatsoever is strictly prohibited; you must delete permanently the original message and all copies of the original message from your E-mail/Internet Client/Server Software/computer systems; and destroy all hard copies that may exist. Thank you in advance for your cooperation.

On Thu, May 2, 2019 at 12:53 PM Jean-Laurent Domingue < > wrote:

> Good day,
>
> My name is Jean-Laurent Domingue. I am a PhD candidate at the University of Ottawa, School of Nursing. Part of my doctoral research project involves the observation of public annual ORB hearings at the
>
> Can you send me the dates and times for the annual ORB hearings being held in for the months of June, July, August and September?
>
> All the best,
>
> Jean-Laurent Domingue, RN, MScN, PhD (C)

Appendix B: Institutional Research Ethics Board Letter of Approval

RESEARCH ETHICS BOARD LETTER OF APPROVAL

Date: 10 July 2019

Investigator Name: Mr. Jean-Laurent Domingue

Protocol ID Number: 2019014

Study Title: *Exploring the Production of "Dangerous Persons" in Forensic Psychiatry: A Critical Ethnography of the Ontario Review Board (ORB)*

Submission Type: Initial Application

Review Type: ☒ Full Board Review ☐ Delegated Review

Date of Approval: 10 July 2019

Approval Expiry Date: 10 July 2020

Dear Mr. Domingue,

Thank you for submitting the above noted protocol to the lesearch Ethics Board for review. The study identified above has been reviewed by the REB and is approved. Approval expires on the expiration date noted above.

The following documents are approved:

Document Name/Title	Document Version Date
Protocol, v. 2	July 5, 2019
Interview Guide, v.1	May 29, 2019
Recruitment Material – Email Script, v. 1	May 29, 2019
Informed Consent Form (English), v. 1	May 29, 2019
Informed Consent Form (French), v.1	May 29, 2019

No changes to, or deviations from the approved documents should be initiated prior to submitting an appropriate amendment and obtaining written approval from the Research Ethics Board, except when necessary to eliminate immediate hazard(s) to study participants.

An Annual Progress Report must be submitted a minimum of 30 days prior to the date of study expiration if the study will continue beyond the expiration date.

If the study is completed by the expiry date noted above, a Study Closure/Termination report must be submitted to the REB.

Sincerely,

Acting Vice-Chair, Research Ethics Board

You must retain a copy of this letter for your study file

Appendix C: University of Ottawa Research Ethics Board Letter of Approval

31/07/2019

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Lettre d'approbation administrative | Letter of administrative approval

Numéro de dossier / Ethics File Number	H-07-19-4797
Titre du projet / Project Title	Exploring the Production of "Dangerous Persons" in Forensic Psychiatry: A Critical Ethnography of the Ontario Review Board (ORB)
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
CÉR primaire / Primary REB	
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	31/07/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	10/07/2020

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Jean-Laurent DOMINGUE	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Jean-Daniel JACOB	École des sciences infirmières / School of Nursing	Superviseur / Supervisor
Amélie PERRON	École des sciences infirmières / School of Nursing	Co-superviseur / Co-supervisor

Conditions spéciales ou commentaires / Special conditions or comments:

REB Protocol ID Number: 2019014

Appendix D: Follow-up Emails to the Ontario Review Board

Re: FW: ORB Hearing Dates/Times

Jean-Laurent Domingue
Fri 9/20/2019 11:21 AM
To: Tan, Manuel (MOHLTC)

Hi Manny,

As promised, I am informing you that I will be attending the ORB hearings at the on Sept 27 and Oct 7, 8 and (maybe) 9.

Would you happen to have the schedules for these hearings and for the hearings in November?

Thanks,
Jean-Laurent Domingue, RN, MScN, PhD (C)
École des sciences infirmières / School of Nursing
Faculté des sciences de la santé / Faculty of Health Sciences
Université d'Ottawa / University of Ottawa
451, chemin Smyth Road
Ottawa, Ontario K1H 8M5
Bureau 1480B / Office 1480B

On Fri, Jul 12, 2019 at 9:27 AM Jean-Laurent Domingue < wrote:

> Hi Manny,
>
> Following up to an e-mail send July 2nd.
>
> I attended the hearings on June 25. Thank you for our communications.
>
> Can you send me any schedules for July hearings (if there are any) and for August hearings (if there has been any changes from the schedule you sent me (Aug 6th to 9th) at the
>
> Also, do you have a provisional hearing schedule for September
>
> Thank you very much,
> Jean-Laurent Domingue

Appendix E: Observation Guide

Guide Type	Observation Categories	Specific Areas of Interest
" Approach Guide"	Location within the broader environment	▪ Name of the hospital. ▪ Portrayed nature of the institution (hospital, mental health centre, forensic psychiatry wing). ▪ General location of the hospital. Any historical significance to this location. ▪ Location of the RB hearing within the hospital. ▪ Access the RB hearing (badge entrance, security, locked doors).
	Physical characteristics	▪ Objects in the room (chairs, tables, TVs). ▪ Atmosphere of the room (colors of walls, furniture, lighting). ▪ Disposition of the room (location of door(s), tables, "panic buttons," intercoms). ▪ Physical location of board members. ▪ Physical location of the person NCRMD or UST. ▪ Physical location of the Crown & defence counsel.
	Rules & procedures	▪ General flow of the hearing (pre-hearing, during the hearing & post hearing). ▪ Speaking order. ▪ Formal/informal leaders.
	Actors & their roles	▪ Actors present at the board hearing and their capacity (lawyer, psychiatrist, psychologist). ▪ Perceived gender and ethnicity of the different actors (members of the board, Crown and defence counsel, representative of the hospital, person NCRMD or UST, spectators). ▪ General appearance of the actors (age, clothes). ▪ Presence/Absence of other health care providers than the psychiatrist and their roles during the hearing. ▪ Mention of the (alleged) victim and context.
" Systematic Guide"	Sketch	▪ Include drawing of physical characteristics and actor location.
	Content of interactions	▪ Content and distribution of interactions (space & time). ▪ Dominant discourses. ▪ Type of language used based on the actors involved in the interaction (jargon, infantilizing) ▪ Reference to other supporting documents or social practices.
	Dynamics of interactions	▪ Type of questions asked, actor to whom they are asked and perceived reason for which they are asked. ▪ Attitudes of actors. ▪ Nonverbal and para-verbal interactions. ▪ Side interactions (conversations, stare, eye contact) and context of these interactions. ▪ Reactions of actors during the hearing.

*Adapted from the observation guide characteristics defined by Martineau (2005) supplemented by information from literature review and theoretical influences.

Appendix F: Interview Guide

The interview location will be determined by the participant. The interview will take less than one hour. The interview will be recorded with the consent of the participant. Six main open-ended questions will guide the course of the interview. The intent of these questions is to understand the day-to-day work of the nurse in relation to the RB hearing ritual.

Demographic Questions—for sampling purposes only

1. What gender identity do you most closely identify to?
2. Do you identify as a visible minority and/or a member of an equity-seeking group?

Interview Questions

1. Can you walk me through your day if you are looking after a person NCRMD or UST who has a yearly RB hearing that day?
2. What work goes into preparing for an annual ORB hearing?
3. How do you see your work (e.g., nursing documentation) being used in yearly ORB hearings?
4. How is the disposition used in your setting?
5. How is the reasons for disposition used in your setting?
6. How do you consolidate your professional responsibility at providing (health) care with the hospital's responsibility at maintaining the safety of the public?

Follow-up areas of enquiry

Care

- Nursing interaction with persons NCRMD or UST pre/post RB hearing.
- Evidence submitted to the RB (nursing documentation/nursing practice).
- Nursing perspective in care translated to the RB hearing.
- Conflicting care perspectives at the RB hearing.

Custody

- Internal use of the RB documents (disposition, reasons for disposition).
- Supervisory requirements (urine drug screens, living arrangement, no contact orders).
- Disposition breaches (nursing involvement).

Rituals and artifacts

- Pre/Post RB team meetings.
- Changes in dispositions (Detention to Conditional / Conditional to Absolute / Conditional to Detention).
- Use of reasons for disposition.
- Breaches in disposition.
- Portrayal of the person NCRMD or UST at the RB hearing.

Appendix G: Recruitment Email

Email subject line: Recruiting nurses for a research project on ORB hearings

Good day,

I am a registered nurse and a PhD candidate currently recruiting nurses for my doctoral research project.

I am looking for nurses who have worked in forensic psychiatry and who have assisted to at least one ORB annual hearing.

The title of my study is: Exploring the Production of "Dangerous Persons" in Forensic Psychiatry: A Critical Ethnography of the Ontario Review Board (ORB)

The purpose of the study is two-fold. On one hand, by taking a close look at the ORB annual hearings, I will explore how the ORB hearings come to define the "dangerousness" of persons not criminally responsible on account of mental disorder (NCRMD) or unfit to stand trial (UST). On the other hand, I will explore the contribution of forensic psychiatric nurses to this process. By doing so, I hope to problematize fundamental questions relating to forensic psychiatric nurses' dual, sometimes contradicting, ethical responsibilities of beneficence (for society) and nonmaleficence (for the person NCRMD or UST).

If you decide to participate, **your participation** will consist of one meeting lasting 60 minutes. You will choose the location (e.g., private room at the BMHC, room at the University of Ottawa) and the time of the meeting that is most convenient to you. During this meeting, I will ask open questions about your work as nurse in forensic psychiatry and about how it is enmeshed with the procedures inherent in the ORB annual hearings. The interview will be audio recorded unless you are opposed to it, in which case I will take notes to document your answers. The audio recording, its transcription (or notes) and the analysis will be given an alphanumerical code (i.e., 1N) and will not include any information enabling for your identity or your workplace to be known.

If participating in this study is something that interests you or if you would like to obtain more information, please feel free to contact me by email or by phone.

I've attached the consent form to this email (English and French copies)—it contains more information about the study. Feel free to take the time you need and ask me any questions pertaining to it.

Thank you,
Jean-Laurent Domingue, RN, BScN, MScN, PhD(C)

Appendix H: Consent Forms

English Consent Form

Researcher: Jean-Laurent Domingue, RN, BScN, MScN, PhD (C)
School of Nursing
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Co-supervisor: Amélie Perron, RN, PhD
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Title of the study: Exploring the Production of "Dangerous Persons" in Forensic Psychiatry: A Critical Ethnography of the Ontario Review Board (ORB)

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Jean-Laurent Domingue, doctoral candidate, with the support of his co-supervisors Drs. Amélie Perron and Jean-Daniel Jacob.

Purpose of the Study: The purpose of the study is two-fold. On one hand, by taking a close look at the discourses shared during ORB annual hearings, the researcher will explore the effects of ORB hearings on the construction of identities for persons not criminally responsible on account of mental disorder (NCRMD) or unfit to stand trial (UST). On the other hand, the researcher will explore the contribution of forensic psychiatric nurses to this identity construction process. By doing so, the researcher will be able to problematize fundamental questions relating to forensic psychiatric nurses' dual, sometimes contradicting, ethical responsibilities of beneficence (for society) and nonmaleficence (for the person NCRMD or UST).

Participation: My participation will consist of one meeting with the researcher lasting 60 minutes. I will choose the location (e.g., private room at the [anonymized], room at the University of Ottawa) and time of the meeting. During this meeting, the researcher will ask open questions about my work as a nurse in forensic psychiatry and about how my work is enmeshed with the ritualistic procedures inherent in the ORB annual hearings. The interview will be audio recorded unless I am opposed to it, in which case the researcher will take notes to document my answers. The audio recording, its transcription (or notes) and the analysis will be given an alphanumerical code (i.e., 1N) and will not include any information enabling for my identity or my workplace to be known. To participate in this research project, I need to have worked in forensic psychiatry and have assisted to at least one ORB annual hearing.

Risks: My participation in this study may entail that I share information about my professional practice as a nurse in forensic psychiatry which may cause feelings of emotional and psychological discomfort. Under no circumstance will I be required to answer questions that have the potential to cause such feelings. If I feel anxiety, apprehension, or elevated levels of stress, I will be redirected to my employee assistance program (EAP) and/or emergency services (as appropriate) to receive support. The data retrieved from the interview will not be used to appraise my performance. The purpose of the research is to explore nursing practices, not to evaluate them.

Benefits: I will not directly benefit from participating in this research project, nor will I receive compensation for my participation. However, by participating in this study, I will contribute to knowledge development in nursing and, more specifically, in forensic psychiatric nursing. I will be part of project that seeks to explore how, by holding annual hearings, the ORB assisted by health care providers (including nurses), construct identities for persons NCRMD or UST.

Confidentiality: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the information I will provide during the interview will only be used for the purposes of this research project. My name will not be associated with any analysis or results. Rather, I will be assigned an alphanumerical code.

Anonymity will be protected in the following manner. The researcher will use a fictitious name when using segments of my interview to support his results in scientific publications and in professional and educational presentations. In addition, the name of the institution where I work or the city in which it is located will not be mentioned in any resulting publications or presentations. I understand that limits to anonymity include the risk of being seen with the researcher by a colleague, especially if I choose a public location to conduct the interview.

Conservation of data: All the raw data pertaining to the interviews (audio recordings and transcriptions or notes) and associated consent forms will be securely kept in a locked location within the offices of the researcher's co-supervisors at the University of Ottawa for a period of five years, after which they will be destroyed. Access to the data will be limited to the researcher and to his co-supervisors.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences or having to justify my choice. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Jean-Laurent Domingue of the School of Nursing, Faculty of Health Sciences, University of Ottawa, whose research is under the supervision of Dr. Jean-Daniel Jacob and the co-supervision of Drs. Amélie Perron.

I agree to have my interview audio recorded: □ **Yes** □ **No**
I agree to be directly quoted for purposes of publications or education sessions: □ **Yes** □ **No**

I do not give up any of my legal rights by signing this consent form.

If I have any questions about the study, I may contact the researcher or his co-supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the Clinical Research Support Manager at [anonymized]
Tel.: [anonymized]

Email: [anonymized]

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: Date:

Researcher's signature: Date:

French Consent Form

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Titre de l'étude: Explorer la production de 'personnes dangereuses' en psychiatrie légale : Une ethnographie critique de la Commission ontarienne d'examen (COE).

Invitation à participer: Je suis invité(e) à participer à l'étude mentionnée ci-haut conduite par Jean-Laurent Domingue, candidat au doctorat, avec le support de ses co-directeurs, la Dre. Amélie Perron et le Dr. Jean-Daniel Jacob.

But de l'étude: Le but de l'étude est double. D'une part, en étudiant les discours inhérents aux audiences annuelles de la COE, le chercheur va explorer les effets des audiences de la COE sur la construction identitaire des personnes non criminellement responsable pour cause de troubles mentaux (NCRTM) ou inaptes à subir leur procès (ISP). D'autre part, le chercheur va explorer la contribution des infirmières travaillant en psychiatrie légale à ce processus de construction identitaire. En ce faisant, le chercheur sera en mesure de problématiser des questions fondamentales liées aux doubles responsabilités éthiques de bienfaisance (pour la société) et de nonmalfaisance (pour la personne NCRTM ou ISP) qu'on les infirmières travaillant en psychiatrie légale.

Participation: Ma participation consistera d'une rencontre de 60 minutes avec le chercheur. Je vais choisir l'emplacement (p.ex. local privé au [anonyme], local à l'Université d'Ottawa) et l'heure de cette rencontre. Pendant cette rencontre, le chercheur me posera des questions ouvertes au sujet de mon travail comme infirmier(ière) en psychiatrie légale et la façon avec laquelle mon travail est entrelacé avec les procédures inhérentes aux audiences annuelles de la COE. L'entrevue sera enregistrée (audio) à moins que je m'y oppose. Dans ce cas, le chercheur prendra des notes pendant l'entrevue. Un code alphanumérique (p.ex. 1N) sera donné à l'enregistrement audio, sa transcription (ou les notes) et à son analyze, et ne contiendra pas d'information pouvant divulguer mon identité ou mon lieu de travail. Pour participer à cette étude, je dois avoir travaillé en psychiatrie légale et avoir assisté à au moins une audience annuelle de la COE.

Risques: Ma participation dans cette étude pourrait me pousser à partager des informations au sujet de ma pratique professionnelle en tant qu'infirmier(ière) en psychiatrie légale pouvant me causer des sentiments d'inconfort émotionnel et psychologique. Sous aucune circonstance devrais-je répondre aux questions ayant le potentiel de provoquer de telles réactions. Si je ressens de l'anxiété, de l'appréhension ou des niveaux de stress élevés, je serai redirigé(e) à mon Programme d'aide aux employés (PAE) et/ou aux services d'urgence pour recevoir l'aide nécessaire. Les données recueillies pendant l'entrevue ne seront pas utilisées pour évaluer ma performance. Le but de l'étude est d'explorer les pratiques infirmières, pas de les évaluer.

Bénéfices: Je ne tirerai aucun bénéfice direct de cette étude et je ne recevrai aucune compensation pour ma participation. Par contre, en participant à cette étude, je contribuerai au développement des connaissances en sciences infirmières et, plus particulièrement, aux soins infirmiers en psychiatrie légale. Je ferai partie d'un projet ayant pour but d'explorer comment, en tenant des audiences annuelles, la COE avec l'aide des professionnels de la santé (incluant les infirmières) construit des identités pour les personnes NCRTM ou ISP.

Confidentialité: Le chercheur m'a rassuré que l'information que je partagerai demeura strictement confidentielle. Je comprends que l'information partagée pendant l'entrevue sera seulement utilisée pour mener à terme ce projet de recherche. Mon nom ne sera pas associé aux analyses ou aux résultats. Au contraire, un code alphanumérique me sera assigné.

L'anonymat sera protégé de la façon suivante. Le chercheur utilisera un nom fictif quand il utilisera des segments de mon entrevue pour justifier ses résultats au sein de publications scientifiques ou lors de présentations professionnelles ou éducatives. De plus, le nom de l'institution où je travaille ou la ville dans laquelle elle se retrouve ne sera pas mentionnée dans ces publications ou présentations. Je comprends qu'il y a des limites à l'anonymat dans le mesure où un collègue pourrait m'apercevoir avec le chercheur, spécialement si je choisis un lieu public pour la rencontre.

Conservation des données: Les données brutes tirées des entrevues (enregistrements audio, transcriptions ou notes) et les formulaires de consentement seront conservés dans un endroit verrouillés à l'intérieur du bureau d'un des co-directeurs à l'Université d'Ottawa, pendant cinq ans, après quoi le tout sera détruit. L'accès aux données sera limité au chercheur et à ses co-directeurs.

Participation volontaire: Je n'ai aucune obligation de participer à l'étude. Si je choisis de participer, je peux me retirer de l'étude à n'importe quel moment et/ou refuser de répondre à n'importe quelle question sans subir de conséquences ou d'avoir à justifier mon choix. Si je me retire de l'étude, toutes les données recueillies jusqu'au moment de mon retrait seront détruites.

Acceptation: Je, _____, consens à participer à l'étude décrite ci-haut conduite par Jean-Laurent Domingue de l'École des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa, dont l'étude est sous la supervision du Dr. Jean-Daniel Jacob et la co-supervision de la Dre. Amélie Perron.

Je consens à avoir mon entrevue enregistrée (audio): □ **Oui** □ **Non**

Je consens à ce que mes propos soient cités intégralement au sein de publications et de sessions éducatives: □ **Oui** □ **Non**

Si j’ai des questions au sujet de l’étude, je peux communiquer avec le chercheur ou ses co-directeurs.
En signant ce formulaire de consentement je n’abandonne aucun de mes droits légaux.

Si j’ai des questions au sujet de la conduite éthique de cette étude, je peux communiquer avec le responsable au soutient de recherche clinique, [anonyme]

Tel.: [anonyme]
Email: [anonyme]

Il y a deux copies du formulaire de consentement. Je peux en conserver une.

Signature du (de la) participant(e): Date:

Signature du chercheur: Date: