Research Involvement and Engagement

COMMENT Open Access

Building capacity in patient-oriented research: reflections on cultivating relationships within a high-secure forensic mental health hospital

Sevil Deljavan[1], Kayla Zimmermann[2], Amber Scott[2], Kristy Allen[1], Ryan Neil[3], Cara Evans[1], Elnaz Moghimi[1,4], Colleen Dell[5], Linzi Williamson[6] and Christopher Canning[1,7*]

Abstract

Building trusting relationships is critical to the success of patient-oriented research. However, in high-secure forensic mental health settings, distrust, discrimination, and restrictive practices pose unique barriers to building relationships. This commentary explores the challenges, strategies, and lessons learned in fostering meaningful connections with forensic patients at a high-secure hospital. Initially focused on assessing readiness to conduct patient-oriented research, the team pivoted to relationship building, guided by the mentorship of peer researchers and patient advocates. Navigating institutional complexities, the team adopted a patient-centered approach informed by the principles of respect and human connection. Key strategies included shadowing experienced patient advocates embedded within the hospital, attending patient community meetings, and engaging in informal interactions with patients. These efforts enabled the team to move from observing interactions to engaging in patients' daily lives through shared experiences. A major milestone was the successful planning and execution of a knowledge sharing event that brought together patients, staff, researchers, and external stakeholders to explore how to put patient-oriented research approaches into practice. Despite the progress, the team faced many challenges, including skepticism from staff and patients, and disruptions inherent to a high-secure environment. The commentary discusses critical lessons for overcoming these challenges, including the importance of patience, adaptability, and respecting boundaries. It emphasizes the intrinsic value of building relationships beyond research outcomes and advocates for incorporating diverse team expertise to foster trust and authentic connections. The commentary also highlights the perspectives of a current forensic patient and co-author, who shares how the team's efforts made him feel valued as a person. His reflections add to the narrative by highlighting the impact of respectful interactions on relationships. By sharing these insights, this commentary aims to inspire other research teams to prioritize relationship building as a foundational step toward meaningful participatory research in forensic mental health care.

Plain English summary

Building trust is important for patient-oriented research, but it can be especially hard in high-secure forensic mental health hospitals. Distrust, discrimination, and strict rules make it hard to form connections. This article explores the

*Correspondence:
Christopher Canning
ccanning@waypointcentre.ca

Full list of author information is available at the end of the article

challenges and strategies of a research team in building relationships with patients in a high-secure hospital. The team started by looking at whether hospital staff and patients were ready for patient-oriented research but quickly realized that building relationships should be a first step. They worked with peer researchers, patient advocates, and mentors to focus on respect and human connection. They learned from patient advocates, attended patient meetings, and talked informally with patients. Over time, they became more involved in patients' daily lives. One important moment was an event where patients, staff, and researchers gathered to discuss how patient-oriented research can be done at the hospital. The team still faced challenges, like distrust from staff and patients, as well as disruptions in the hospital. They learned to be patient, flexible, and to respect boundaries. Building trust and real connections helped them go beyond just research goals. A patient who helped write this article shared how the team made him feel valued as a person, not just a patient. By sharing these experiences, the article hopes to encourage other researchers to focus on building relationships in forensic patient-oriented research.

Keywords Forensic mental health, High-secure settings, Participatory research, Patient-oriented research, Trust building, Patient engagement, Inclusive research, Human-to-human connection

Background

Participatory research approaches in mental health have the potential to enhance the relevance and impact of research [1] by ensuring that studies address what matters most to patients, ultimately leading to improvements in health services, systems, and patient outcomes [2]. Patient-oriented research (POR) is one such approach that strives to engage patients as equal partners throughout the research process, from setting priorities to conducting research and translating findings into practice and policy [3–6]. POR shares many similarities with other participatory research approaches, such as participatory action research [7], community-based research [8], and participatory practice research [9], but is distinct in its specific focus on improving health and healthcare systems [3]. Participatory research approaches differ from traditional research, where patients have a more passive role—either as subjects in clinical research [10] or as respondents providing input to answer research questions [11]. The success of POR fundamentally depends on establishing strong, trusting relationships between researchers and patients [12], guided by the principles of inclusiveness, mutual respect, co-creation, relationality, and power-sharing [3]. While participatory research approaches are increasingly embedded in mental health research, their application in forensic mental health remains rare [13].

Forensic mental health care

Forensic mental health care provides treatment and rehabilitation for individuals with serious mental illness who have come into contact with the criminal justice system, often because they have been found Not Criminally Responsible (NCR) or unfit to stand trial [14]. Forensic care varies worldwide [15], but in well-resourced systems, multidisciplinary teams—including psychiatrists, psychologists, nurses, social workers, and occupational therapists—work together to address patients' physical and mental health needs [16]. Care is provided within a spectrum of security levels, with high-secure settings characterized by strict safety measures such as secure perimeters, locked units, surveillance systems, and closely supervised movement [17, 18].

A central challenge of forensic mental health care is balancing its dual mandate: promoting recovery and reintegration while ensuring the safety of patients, staff, and the public. Because patient stays are determined by ongoing risk and mental health assessments rather than fixed time periods, individuals may experience long and indeterminate hospitalizations. While forensic mental health care is intended to be recovery-oriented, some studies report that patients experience these environments as restrictive and coercive [14, 19–22]. These conditions can create significant barriers to recovery and reintegration, contribute to poor patient outcomes, and perpetuate the marginalization of forensic patients [23, 24]. However, efforts to enhance patient autonomy, engagement in treatment, and access to rehabilitative opportunities continue to evolve and reflect the ongoing tension between security needs and therapeutic goals in forensic mental health care.

Participatory research in forensic mental health settings

Despite its alignment with strengths-based, recovery-oriented care, participatory research in forensic mental health settings remains scarce [18]. Several structural and cultural barriers may contribute to this. Power dynamics pose a major challenge [25], as principles integral to meaningful patient engagement—such as collaboration and power-sharing—are difficult to uphold when patients are involuntarily detained or receiving court-mandated treatment [25–27]. Informed consent presents additional complexities, requiring researchers to ensure that participation is voluntary and that consent processes accommodate patients' cognitive and literacy needs [25, 28–30]. Additionally, long-term stays can foster passivity among patients, reducing opportunities for empowerment or collaboration [26]. Confidentiality concerns may also

discourage patient involvement in research conducted within the institution in which they are receiving forensic care [25]. Nonetheless, forensic practices have increasingly shifted toward more patient-centered models of care over the past decade, creating opportunities for participatory research and POR.

Addressing the gap

Some participatory research literature highlights the need for mutual respect and trusting relationships between researchers and forensic patients [31]. However, there remains a notable gap in practical guidance on how to develop and maintain these relationships to achieve successful research partnerships. This proved challenging for our forensic POR (fPOR) team working in a high-secure hospital. Without clear guidance, we faced uncertainty in fostering trust and collaboration while laying the foundation for POR in this setting.

The existing literature on building relationships and trust in forensic mental health settings focuses primarily on clinical care, including therapeutic relationships between patients and clinicians [32–34] and self-disclosure as a therapeutic technique [35]. These relationships are intended to support patient recovery [36], and key qualities such as transparency, honesty, empathy, respect, and consistency are fundamental [32]. This gap presents an opportunity to examine our team's approach to building trust between researchers and forensic patients, offering insights that may inform future participatory approaches in forensic mental health settings.

In this commentary, we share our fPOR team's experiences in building relationships with patients in a high-secure forensic hospital. One of the co-authors, RN, is a current forensic patient and provides his perspective on the team's approach. Grounded in ethical principles—including justice, respect for persons, and concern for welfare—our team recognizes the importance of centering these values when involving patients (or vulnerable persons) in research and as research partners. Our goal is to offer practical insights and reflections we wish had been available to us at the outset of our POR project. By discussing the challenges, successes, and lessons unique to our context, we hope to encourage other research teams in similar settings to prioritize relationship-building as a foundational step toward meaningful research partnerships with patients.

Our research team

Our fPOR team is based at an academic and teaching mental health hospital in Ontario, Canada. The team is made up of the following members: (1) a Principal Investigator (CC) who leads and directs all project activities; (2) a postdoctoral fellow (CE) who contributes advanced research expertise; (3) an ethnographer (EM) who explores the team's relational and power dynamics; (4) a knowledge translation and implementation coordinator (KA) who focuses on knowledge mobilization and patient engagement; and (5) a research analyst (SD) who manages project activities and contributes to patient engagement efforts. Two patient advocates and peer researchers (AS and KZ) from the Patient/Client and Family Council (PCFC) are also part of the research team. PCFC plays a key role in the hospital in peer support and patient advocacy, which is elaborated upon further below. With KZ and AS's established relationships with patients, they play a key role in ensuring all project activities remain patient-centred.

The team also benefits from ongoing mentorship from POR experts at the University of Saskatchewan, who have established long-term patient partnerships through a therapy dog program. Their approach highlights that trust building can go beyond human interactions, incorporating animal-assisted services as a key element of POR in forensic settings. Regular meetings together provide continuous support, helping us refine our strategies and ensure alignment with POR principles and best practices.

Our shift to prioritizing relationships

In the initial phase of our implementation project, our team planned to assess the hospital's readiness for fPOR by conducting interviews with both staff and patients [18]. However, during a pivotal team meeting, our mentors raised concerns about conducting patient interviews at this early stage, primarily due to the absence of established relationships between the research team and patients. Recognizing the significance of these concerns, we decided to set aside our initial research agenda and shifted the focus toward building genuine connections with patients on the high-secure forensic units. Recognizing that many team members were navigating uncharted territory, we fully committed to this effort, guided by and collaborating closely with AS and KZ from PCFC.

The patient/client and family council approach

PCFC is a non-profit organization that started in the mid-1990s as a consumer/survivor initiative with the primary goal of ensuring people living with mental illness and addictions experience the highest quality of life in both hospital settings and the community. Since its founding, PCFC has been instrumental in mental health advocacy and system improvement at local, regional, and provincial levels. As a peer-led organization, all PCFC members have personal experience with the mental health or addictions systems (though not necessarily the forensic system), either directly or through supporting a friend or family member.

At the hospital, PCFC members are easily identifiable by their green badges, which symbolize their role as patient advocates and visually distinguish them from staff. They are paid employees of PCFC, an independent non-profit, not the hospital. Central to PCFC's efforts is the Peer Support Program, where peer workers regularly visit the forensic units and provide patients with a reliable and safe space to express their feelings and concerns. Their influence extends beyond these interactions; they also participate in hospital events involving patients' friends and families, becoming integral members of the forensic inpatient community. Additionally, PCFC members include Experience and Engagement Representatives who actively champion the patient voice and advocate for systemic changes through their involvement in community and governmental organizations.

PCFC staff ground their approach in the principles of consistency, confidentiality, and respect—key elements in establishing and maintaining trust with patients. By actively listening and working alongside patients, PCFC not only empathizes with their challenges but also empowers them to engage in addressing these challenges and advocating for improvements. Their commitment to confidentiality reinforces their role as trusted allies. Unlike hospital staff, PCFC does not document interactions with patients, allowing for open, honest communication without fear of repercussions, solidifying the trust patients place in them.

PCFC's established relationships with patients and the principles underlying their approach provide important insights into trust building in forensic settings. Understanding their role is important, as their expertise in patient engagement informed our own strategies for developing meaningful relationships with patients. Guided by their insights, the following section shares our journey as a novice POR team in a forensic setting working towards building connections with patients in this unique and highly challenging environment.

Our efforts as a novice POR team in forensics

Our approach to building relationships with patients developed naturally, grounded in our commitment to honesty, respect, and human connection. Before we began our visits to the units, we engaged in discussions within our team about how best to present ourselves and our intentions. We were aware of the potential impact our presence could have, and we were determined to approach this environment with the utmost care, ensuring that our actions would not inadvertently cause harm or distress to patients.

From the first day we stepped onto the units, we made it a priority to introduce ourselves by name. We understood that a simple, sincere introduction could be the first step in laying a foundation of trust. When patients—understandably curious about our presence—inquired about our roles, we responded with full transparency. We explained that we are not clinical staff or decision-makers in their care but a research team looking to learn how to work together. We were clear that our primary focus was on building relationships, but we also conveyed why these connections were vital to us as researchers, emphasizing that trusting relationships were foundational to our work as POR researchers.

In those early months, we assumed a largely passive role, closely shadowing AS and KZ as they interacted with patients. These observations provided lessons on communication, active listening, and the subtleties of trust-building in a high-secure environment. AS and KZ modelled how to navigate conversations with sensitivity, balance professionalism with authenticity, and recognize when to step back or engage. Through these observations, we learned that in this setting, intentional interactions are essential, and even the smallest actions (and inactions) could greatly influence the quality of relationships being formed.

Initially, our visits were brief—often one or two hours at a time, once every few weeks—accompanied by AS or KZ. Over the course of a few months, as we grew more familiar with the environment and patients became more comfortable with us, we gradually began to establish our presence on the units. We understood the importance of honouring patients' space and boundaries, so we introduced ourselves in subtle and approachable ways. One of our first steps was to attend monthly community meetings, where patients and staff would gather to discuss concerns and share updates. These meetings allowed us to listen, learn, and slowly become a part of the community.

Our regular visits to Vocational Services—a program offering meaningful work within the hospital—became another key strategy. These visits provided opportunities to engage with patients in a familiar and comfortable setting, where conversations could flow naturally, and connections could grow stronger through the patients showcasing their work and the pride they took in it. Each interaction felt like a step closer to bridging the gap between the patients and us.

As we became more familiar with the environment, our role naturally evolved from quiet observers to active participants. We sought out opportunities to immerse ourselves in patients' daily lives, understanding that authentic connection comes from shared experiences. We began visiting patients more regularly, on an almost weekly basis. By working closely with Recreational Services, we began participating in everyday activities—joining patients for courtyard gatherings, engaging in informal coffee chats, building puzzles, and enjoying games like cards, ping-pong, and pool. These moments,

though seemingly ordinary, held meaningful opportunities to break down barriers and build trust in a way that felt natural and unforced. We also made an effort to participate in cultural and holiday events like the annual family picnic and holiday bash, where the atmosphere is filled with a sense of community and belonging. These gatherings were more than just events; they were opportunities to laugh, share stories, and connect on a human level.

As our relationships strengthened—following nearly a year of trust building through interactions unrelated to research—we gradually began incorporating research discussions into some of our casual visits. Deciding when to introduce these conversations was guided by patient comfort levels, which varied across individuals and sometimes fluctuated for the same patient across time. Signs that patients were open to discussing research included when they began expressing curiosity about our work, asking about research activities, or showing interest in getting involved. We remained attentive to these cues and allowed patients to set the pace of these discussions. Importantly, we made sure to clarify with them that no consent was required, as these conversations were meant to increase familiarity with research rather than to collect data or initiate a study. Conversations allowed us to explore patients' understanding of the research process, their experiences with past research, identify gaps in their knowledge, and begin addressing these gaps. To support this, we adopted an integrated knowledge translation (IKT) approach, which is central to participatory research approaches like POR. IKT emphasizes partnerships between researchers and knowledge users—those intended to benefit from the research—throughout the research process to enhance both its impact and relevance [37].

The challenges we've encountered

Building trusting relationships within the high-secure units has been a challenging process, and our journey has been anything but linear. One of the most pressing challenges we faced early on was the skepticism from staff. When we first began making visits to the units, it was clear that our presence was met with caution. Many staff members were unfamiliar with us, questioned our intentions, or remained distant. This created a sense of underlying tension as we worked to find our place in an environment that was not quite ready to welcome us. This challenge was further compounded by the reactions of some patients, especially those who were new to the unit or experiencing acute symptoms. Many appeared hesitant to engage with us, making it clear that trust would take time to build. More broadly, this highlights how distrust permeates forensic settings [18]. Patients and staff may distrust one another, and even among staff, frontline workers can be wary of those who are not directly exposed to their daily realities on the units [18]. Skepticism runs in all directions, making relationship building an ongoing challenge.

The inherent demands of the high-secure setting create ongoing challenges that test our ability to build and maintain relationships. Our visits are often interrupted by sudden and unpredictable events. Lockdowns can occur with little warning, temporarily restricting movement within the hospital. Incidents involving restraint or seclusion can arise just as suddenly, with the atmosphere shifting in an instant from calm to tense. These moments serve as reminders of the environment we are working within—where physical safety and security can override other priorities.

Patient turnover remains a persistent challenge. Patients with whom we had formed strong connections occasionally transition to lower-secure programs or facilities. While these transitions reflect progress in their recovery, they also result in the loss of relationships with potential for further engagement. This continual shift in the patient population necessitates repeated introductions, clarification of our roles, rebuilding of relationships from the ground up, and gauging interest among new patients. However, it has also created opportunities to refine and adapt our approach based on experience and feedback.

The COVID-19 pandemic introduced additional challenges. Outbreaks on the units led to temporary closures, disrupting our efforts and preventing regular engagement. Each interruption set us back slightly, forcing us to regain momentum upon our return.

Despite the challenges, we reached a point a year into the project where we could begin planning a knowledge sharing event that would bring together a diverse group of knowledge users, including hospital leaders, frontline staff, researchers, external stakeholders, and three patients who expressed interest in attending. The goal of the event was to discuss what might be needed to create a roadmap toward fPOR. Planning this event presented its own set of unique challenges, especially because the collaborative dialogue—where current forensic patients and hospital staff would gather and share perspectives about how to conduct participatory research—was something that had not been attempted before at the hospital. The novelty of the event meant there was no established guidance or precedent to follow. Ensuring the event could be held both safely and meaningfully for patients and other attendees required careful coordination. We had to navigate logistical hurdles, such as securing appropriate spaces, managing security protocols, and aligning the event's goals with the hospital's strict safety standards. Additionally, we had to be mindful of the needs of

patients, ensuring the event would be safe, accessible and engaging without overwhelming them.

Our successes

The progress we have made in building relationships with many patients on the high-secure forensic units is clear. Nearly a year into our dedicated efforts, we have witnessed a shift in how some patients perceive us. One particularly moving example is a patient who creates a beautiful origami piece for us during each visit, offering a small, friendly gesture. Many patients greet us by name and some even anticipate our visits. In a few cases, patients have even approached us to discuss how they can get involved in research—conversations initiated entirely by them.

Another success has been our ability to conduct in-depth interviews with patients about their perceptions of the barriers and facilitators to POR in forensic settings. What makes this achievement particularly noteworthy is the fact that these participants have freely and excitedly consented to share candid accounts of their views on POR—a level of openness that would have been more challenging just a year ago.

A milestone in our IKT approach has been the knowledge sharing event hosted by our research team (see Appendix A for the event agenda). As we planned the event, we worked collaboratively to ensure that the patient experience was considered at every stage of the planning process. To help prepare patients to participate in the event, we slowly introduced basic concepts of research and POR, both in conversation and through preparing patient-friendly materials (see Appendix B). We then started to invite patients who showed an interest in research to participate in the event, tailoring our other event materials to be patient-friendly as well (see Appendix C).

Our colleagues in other areas of the hospital, including security staff and clinical managers, were supportive of patient participation in the event and worked closely with our team to ensure that patients could actively engage in discussions about POR in a way that valued their contributions and respected their needs and perspectives. This required time to build trust and entailed creating a shared vision of what patient involvement would look like in practice. This collaboration highlights the strong relationships we have developed not only with patients, but also with some hospital staff, and their growing interest and trust in our work.

With the goal of creating a meaningful experience for patients, we considered which aspects of the event would be most engaging for them. As a result, we presented our research to the broader group during the morning session and invited patients to join us for lunch, therapy dog visits, and group discussions in the afternoon. Patients sat with familiar members of the research team and had the opportunity to spend time with the therapy dogs. In the afternoon, participants chose which topics to discuss, with the research team acting as facilitators at each table to ensure patients always had a familiar face nearby. As facilitators, it was remarkable to witness patients and other participants—including senior leadership staff—engaging in conversations over lunch and during discussions, fostering shared understanding and common ground.

The success of the knowledge-sharing event was evident in the feedback we received from participating patients, who expressed that they enjoyed the experience and are eager to continue working with us. Since the event, we have observed ripple effects throughout the hospital, as patients' experiences and needs that were voiced during the event have been shared by senior leadership in meetings.

We are seeing a growing interest in research among patients, with more of them expressing curiosity about how they can become involved. This shift is particularly meaningful, as it reflects the progress we have made in building relationships where patients are becoming more engaged and empowered to contribute. Our efforts to include them in discussions, listen to their insights, and provide clear information about research have helped to demystify the process.

Ultimately, by building on the strong relationships we have established with patients, we aim to transition from relationship building to maintaining these connections while conducting POR projects. As a potential first study, we hope to explore how the principles of POR can align with and enhance relational security practices in forensic settings. This research will investigate how forensic hospitals can balance risk management with therapeutic care in ways that promote both staff and patient wellbeing.

While these early successes are encouraging, we recognize that creating an environment supportive of forensic POR requires ongoing work with people and systems beyond our research team. This is the next step in our fPOR roadmap. As well, sustaining this type of work requires long-term financial and institutional support. Forensic hospitals can amplify patient voices by embedding lived experience researchers within the broader system. This approach has the potential to improve the impact of research and facilitate the uptake of research findings [38]. Doing so will require institutional support and a commitment from granting agencies to provide ongoing funding for projects that naturally take more time.

We also acknowledge that these successes represent the perspectives of researchers. It is critical to include the perspectives of patients as well, whose voices are often silenced or go unheard. To understand the impact of our

efforts, I (RN) would like to provide a few thoughts as a current patient about how the research team's relationship-building efforts have been received.

> *In my view, working and communicating with the fPOR team has been a really different experience for me compared to what I'm used to with research. They feel positive, genuine, and very authentic. They are not just here to ask questions or get information from me; they actually care and show interest in my day and in what I have to say. With other research teams, it has felt cold, disconnected, and distant. I feel like I am answering questions in a rigid, military way. I don't even remember those researchers' names because there was no personal connection. But working side-by-side with this team, I feel comfortable, like I have nothing to hide, and I can just be myself, and that's important.*
>
> *It is not only about what someone says, but also about how they say it. The fPOR team is clearly knowledgeable in this area. With them, I don't feel judged for my past—they treat me like a human being, with respect, not just a patient or someone with a bad past. That makes all the difference, especially in a place like this where we already face so much judgement from others, and so many people and the public believe we should be in prison, not a mental health hospital. Being here, though, feels like a real second chance, at least for me.*
>
> *When it comes to staff on the units, one thing that always stands out to me is a particular staff member I really appreciate. Most of the time, when I share my concerns with staff, they say, "just talk to your doctor," or brush it off as if they don't care, but not everyone is like that. This one staff member takes the time to come right into my room, sit down, and have a real conversation with me. He doesn't keep his distance like the rules say or act like I'm a dangerous villain. Instead, we just talk about regular everyday things—our interests, what is going on in our lives. It is things like this and being around the fPOR team that remind me that I am deserving of respect and understanding despite my involvement in the forensic mental health system.*
>
> *My reflections highlight the importance of creating safe and inclusive environments where patients feel respected and valued as individuals. I hope these thoughts challenge us to continue improving our practices and ensure that connections between patients and researchers remain meaningful and collaborative.*

Lessons learned thus far

Based on our research team's journey, we have identified several key elements critical in building relationships with patients within high-secure forensic settings.

1. Diverse research teams: The value of having a diverse team for relationship building cannot be overstated. Team science, for example, is a collaborative approach to research that emphasizes how combining interdisciplinary expertise can foster research innovation [39]. Each team member brings unique expertise—whether in community engagement, research methods, or mental health advocacy, among others. Utilizing these skills has proven essential to advancing our relationship building efforts. As well, having peer researchers on the team, who focus on ensuring patient wellbeing and bring nuanced understandings of patients' experiences, helps us to approach relationship building with sensitivity and care.
2. Relationships with staff: Building strong connections with hospital staff is crucial for facilitating meaningful relationships with patients. Security personnel, frontline staff, and clinical leaders often serve as gatekeepers to patient access and are involved in patients' daily routines. Gaining their trust and buy-in is essential for effective engagement. While relying on professional gatekeepers may present challenges, it can also be beneficial to engage with someone who can provide support from within the hospital [29].
3. Informal, human-to-human interactions: Regular, informal interactions are vital in establishing trust and fostering lasting relationships. Moving beyond formal roles and the conventional patient-researcher relationship to build connections rooted in mutual respect, trust, and authenticity allows for relationships that are more meaningful. When researchers step outside of their professional role, it creates space for patients to step outside of their patient role, enabling both to connect on a human level. Sharing personal details—such as hobbies, favorite music, or stories about pets—helps break down barriers and fosters connections. Unlike in clinical care, where self-disclosure is used by clinicians to support a patient's recovery [40], self-disclosure by researchers functions more like workplace interactions among colleagues—social and informal, but still within professional boundaries.
4. Patience: Building relationships in high-secure forensic environments requires significant time and patience. Trust and respect cannot be rushed and are built over time [31]. They must be nurtured through consistent, authentic interactions over an extended

period. Attempting to accelerate the process can be counterproductive, potentially reinforcing feelings of distrust and powerlessness. Funding bodies rarely account for this reality. Supporting POR in forensic settings requires flexibility in research timelines and funding structures to ensure the relational groundwork can be put in place.

5. Adaptability: Each patient in a high-secure forensic setting is unique, and a one-size-fits-all approach to relationship building is ineffective. Some patients connect through humor, others through shared activities, and still others through intellectual or philosophical discussions. Being flexible and responsive to these individual differences allows us to tailor our interactions in ways that resonate with each patient, fostering mutual regard [41] and authentic connections.
6. Respecting boundaries: It is essential to acknowledge that building relationships with every patient may not be possible or welcomed. Some patients may not have the communication skills to engage with researchers, and researchers may not have the skills to fully interpret their needs [18]. Additionally, some patients may remain less responsive to our efforts. In these settings, being trauma-informed is crucial; we must respect that some patients may never feel comfortable talking to researchers, and it is important to honour those boundaries. Recognizing and accepting this reality is a vital part of conducting ethical and compassionate research in such environments.
7. The value of strong relationships in IKT: Integrating knowledge into practice relies on patient partnerships [26]. Strong relationships significantly enhance the effectiveness of IKT practices, which are central to POR and other participatory research approaches. The time and effort invested in IKT have proven to be worthwhile, not only in improving the quality of our work but in also strengthening the quality of our relationships with patients. Strong relationships have also helped us gain broader organizational support and buy-in, as stakeholders are beginning to recognize the value of patient engagement and the tangible benefits it brings. Ultimately, the foundation of trust and collaboration we've built has made IKT practices more impactful and has ensured that our work is truly patient-centered and embraced by the wider community.

Conclusion

The experiences and insights shared in this commentary are intended to initiate a broader conversation on relationship building in high-secure forensic mental health care settings. Building relationships with patients in these environments is a highly delicate and complex process. While we do not claim to have all the answers, our research team has made significant strides in cultivating these connections.

Much of the commentary reflects the perspectives of researchers and peer researchers, but the forensic patient perspective is equally, if not more, important. It offers invaluable insights into the nuances of building relationships in high-secure settings and highlights aspects of trust and collaboration that we may not fully grasp. Including more patient perspectives can enhance our understanding of what it means to engage in participatory research within forensic environments, and we are eager to build our capacity to do so in the future.

At the same time, we must have a clear understanding of fPOR's challenges and ethical considerations. Given that many patients have described feeling genuinely respected in these interactions, the sudden disruption of relationships—whether due to unexpected patient transfers or the conclusion of a project—can be a source of unintended harm. Researchers also bear the emotional and ethical weight of these disruptions. These realities underscore the need for researchers to be transparent about limitations, manage expectations, and assess the sustainability of engagement beyond the duration of a funded project.

Despite these ongoing considerations, our fPOR team's ultimate goal is to leverage the relationships we have established to form meaningful patient partnerships in research. However, we also recognize the intrinsic value of these relationships beyond research. They are not merely a means to an end but are vital in their own right. We are committed to maintaining and nurturing these connections as an integral part of our work.

Abbreviations

POR	Patient–oriented research
fPOR	Forensic patient–oriented research
NCR	Not criminally responsible
IKT	Integrated knowledge translation
PCFC	Patient/Client and Family Council
REB	Research Ethics Board

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s40900-025-00691-6.

Supplementary Material 1

Acknowledgements

Not applicable.

Author contributions

SD: conceptualization, patient engagement, writing - original draft. KZ: mentorship, patient engagement, writing - original draft. AS: mentorship, patient engagement, writing - original draft. KA: conceptualization, patient engagement, writing - original draft. RN: patient perspective, writing - original draft. CE: writing - review & editing. EM: writing - review & editing. CD:

mentorship, writing - review & editing. LW: mentorship, writing - review & editing. CC: funding acquisition, conceptualization, supervision and guidance, writing - review & editing. All authors read and approved the final manuscript.

Funding
The authors declare financial support was received for the authorship and publication of this article. It is funded by a CIHR Training Grant: Patient-Oriented Research Training Grant (185625) to Dr. Canning.

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Waypoint Research Institute, Waypoint Centre for Mental Health Care, Penetanguishene, ON, Canada
[2]Patient/Client and Family Council, Midland, ON, Canada
[3]Current patient at Waypoint Centre for Mental Health Care, Penetanguishene, ON, Canada
[4]Department of Psychiatry, Faculty of Health Sciences, Queen's University, Kingston, ON, Canada
[5]Department of Sociology & School of Public Health, University of Saskatchewan, Saskatoon, SK, Canada
[6]Department of Psychology & Health Studies, University of Saskatchewan, Saskatoon, SK, Canada
[7]Department of Psychiatry, Temerty Faculty of Medicine, University of Toronto, Toronto, ON, Canada

Received: 9 December 2024 / Accepted: 15 February 2025
Published online: 06 March 2025

References

1. Vaughn LM, Jacquez F. Participatory research methods: choice points in the research process. J Particip Res Methods. 2020. https://doi.org/10.35844/001c.13244.
2. Wayne K, MacNeill L, Luke A, Anthonisen G, McGavin C, Wilhelm L, et al. Enhancing patient-oriented research training: participant perceptions of an online course. Res Involv Engagem. 2024. https://doi.org/10.1186/s40900-024-00629-4.
3. Canadian Institutes & of Health Research. Strategy for patient-oriented research - patient engagement framework. CIHR. 2019. https://cihr-irsc.gc.ca/e/documents/spor_framework-en.pdf. Accessed 15 May 2024.
4. Mallidou AA, Frisch N, Doyle-Waters MM, MacLeod MLP, Ward J, Atherton P. Patient-oriented research competencies in health (PORCH) for patients, healthcare providers, decision-makers and researchers: protocol of a scoping review. Syst Rev. 2018. https://doi.org/10.1186/s40900-020-0180-0.
5. Allen ML, Salsberg J, Knot M, LeMaster JW, Felzien M, Westfall JM, et al. Engaging with communities, engaging with patients: amendment to the NAPCRG 1998 policy statement on responsible research with communities. Fam Pract. 2017;34:313–21.
6. Tarpey M, Bite S. Public involvement in research applications to the National research ethics service: comparative analysis of 2010 and 2012 data. Eastleigh: INVOLVE; 2014.
7. Wharewera-Mika J, Cooper E, Wiki N, Prentice K, Field T, Cavney J, et al. The appropriateness of DUNDRUM-3 and DUNDRUM-4 for Māori in forensic mental health services in new Zealand: participatory action research. BMC Psychiatry. 2020. https://doi.org/10.1186/s12888-020-2468-x.
8. Perez LM, Treadwell HM. Determining what we stand for will guide what we do: community priorities, ethical research paradigms, and research with vulnerable populations. Am J Public Health. 2009. https://doi.org/10.2105/AJPH.2007.125617.
9. Uggerhøj L, Andersen ML. In between participatory practice research and practitioner research—concepts in transition. Br J Soc Work. 2024. https://doi.org/10.1093/bjsw/bcae099.
10. McCarron TL, Clement F, Rasiah J, Moran C, Moffat K, Gonzalez A, et al. Patients as partners in health research: a scoping review. Health Expect. 2021. https://doi.org/10.1111/hex.13272.
11. Bird M, Ouellette C, Whitmore C, Li L, Nair K, McGillion MH, et al. Preparing for patient partnership: a scoping review of patient partner engagement and evaluation in research. Health Expect. 2020. https://doi.org/10.1111/hex.13040.
12. Zibrowski E, Carr T, McDonald S, Thiessen H, Van Dusen R, Goodridge D, et al. A rapid realist review of patient engagement in patient-oriented research and health care system impacts: part one. Res Involv Engagem. 2021. https://doi.org/10.1186/s40900-021-00299-6.
13. Rutherford R, Bowes N, Cornwell R, Heggs D, Pashley S. A systematic scoping review exploring how people with lived experience have been involved in prison and forensic mental health research. Crim Behav Ment Health. 2024. https://doi.org/10.1002/cbm.2324.
14. Markham S. The totalising nature of secure and forensic mental health services in England and Wales. Front Psychiatry. 2021. https://doi.org/10.3389/fpsyt.2021.789089.
15. Crocker AG, Livingston JD, Leclair MC. Forensic mental health systems internationally. In: Roesch R, Cook AN, editors. Handbook of forensic mental health services. New York: Routledge; 2017. pp. 3–76.
16. Haines A, Perkins E, Evans EA, McCabe R. Multidisciplinary team functioning and decision making within forensic mental health. Ment Health Rev J. 2018. https://doi.org/10.1108/MHRJ-01-2018-0001.
17. Davison S. Specialist forensic mental health services. Crim Behav Ment Health. 2004. https://doi.org/10.1002/cbm.604.
18. Evans C, Deljavan S, Zimmermann K, Allen K, Moghimi E, Canning C. Determinants of readiness to implement forensic patient-oriented research: a study of barriers and facilitators in a high-secure hospital. Front Psychiatry. 2025. https://doi.org/10.3389/fpsyt.2024.1509946.
19. Tomlin J, Egan V, Bartlett P, Völlm B. What do patients find restrictive about forensic mental health services? A qualitative study. Int J Forensic Ment Health. 2020. https://doi.org/10.1080/14999013.2019.1623955.
20. Tomlin J, Bartlett P, Völlm B. Experiences of restrictiveness in forensic psychiatric care: systematic review and concept analysis. Int J Law Psychiatry. 2018. https://doi.org/10.1016/j.ijlp.2017.12.006.
21. Markham S. Diagnosis and treatment of ASD in women in secure and forensic hospitals. Adv Autism. 2018. https://doi.org/10.1108/AIA-09-2018-0027.
22. Hörberg U. The Art of Understanding in forensic psychiatric care'– from a caring science perspective based on a lifeworld approach. Issues Ment Health Nurs. 2018. https://doi.org/10.1080/01612840.2018.1496499.
23. Tomlin J, Völlm B. Diversity and marginalisation in forensic mental health care. New York: Routledge; 2022.
24. Mezey G, Youngman H, Kretzschmar I, White S. Stigma and discrimination in mentally disordered offender patients– a comparison with a non-forensic population. J Forensic Psychiatry Psychol. 2016. https://doi.org/10.1080/14789949.2016.1172658.
25. Völlm B, Foster S, Bates P, Huband N. How best to engage users of forensic services in research: literature review and recommendations. Int J Forensic Ment Health. 2017. https://doi.org/10.1080/14999013.2016.1255282.
26. Dell CA, Williamson L, McKenzie H, Mela M, Akca D, Cruz M, et al. Conducting patient oriented research (POR) in a forensic psychiatric facility: a case study of patient involvement. Int J Forensic Ment Health. 2023. https://doi.org/10.1080/14999013.2022.2080305.
27. Livingston JD, Nijdam-Jones A, Brink J. A Tale of two cultures: examining patient-centered care in a forensic mental health hospital. J Forensic Psychiatry Psychol. 2012. https://doi.org/10.1080/14789949.2012.668214.
28. Livingston JD, Nijdam-Jones A, Lapsley S, Calderwood C, Brink J. Supporting recovery by improving patient engagement in a forensic mental health hospital: results from a demonstration project. J Am Psychiatr Nurses Assoc. 2013. https://doi.org/10.1177/1078390313489730.
29. Faulkner A. The ethics of survivor research: guidelines for the ethical conduct of research carried out by mental health service users and survivors. 2004. https://www.cerrisweb.com/wp-content/uploads/Faulkner-recherche-participative.pdf. Accessed 1 May 2024.
30. Davidson KM, Espie CJ, Lammie C. Conducting randomised controlled trials: finding better ways to explain research to people with anti-social personality

disorder who have low literacy levels. Crim Behav Ment Health. 2011. https://doi.org/10.1002/cbm.811.
31. Faulkner A, Morris B. Expert paper: user involvement in forensic mental health research and development. 2003. https://regroup-production.s3.amazonaws.com/documents/ReviewReference/821608051/Faulkner_Morris%20%282003%29%20Expert%20Paper%20-%20User%20involvement%20in%20forensic%20mental%20health%20research%20and%20development.pdf?response-content-type=application%2Fpdf%26X-Amz-Algorithm=AWS4-HMAC-SHA256%26X-Amz-Credential=AKIAYSFKCAWYQ4D5IUHG%2F20250212%2Fus-east-1%2Fs3%2Faws4_request%26X-Amz-Date=20250212T225728Z%26X-Amz-Expires=604800%26X-Amz-SignedHeaders=host%26X-Amz-Signature=e8f00b3f7a5ce8a6f37326566b53867cdbd933c1561764811ba333acdef870c2. Accessed 10 Feb 2025.
32. Marshall LA, Adams EA. Building from the ground up: exploring forensic mental health staff's relationships with patients. J Forensic Psychiatry Psychol. 2018;29:744–61.
33. Askola R, Nikkonen M, Putkonen H, Kylmä J, Louheranta O. The therapeutic approach to a patient's criminal offense in a forensic mental health nurse-patient relationship - the nurses' perspectives: the therapeutic approach to a patient's criminal offense. Perspect Psychiatr Care. 2017. https://doi.org/10.1111/ppc.12148.
34. Rose DN, Peter E, Gallop R, Angus JE, Liaschenko J. Respect in forensic psychiatric nurse-patient relationships: a practical compromise. J Forensic Nurs. 2011. https://doi.org/10.1111/j.1939-3938.2010.01090.x.
35. Rachwal F, Gredecki N. A phenomenological investigation into the use of therapist self-disclosure in compassion-focused therapy with forensic clients. Int J Offender Ther Comp Criminol. 2024. https://doi.org/10.1177/0306624X241227409.
36. Moyles J, Hunter A, Grealish A. Forensic mental health nurses' experiences of rebuilding the therapeutic relationship after an episode of physical restraint in forensic services in Ireland: a qualitative study. Int J Ment Health Nurs. 2023. https://doi.org/10.1111/inm.13176.
37. Boland L, Kothari A, McCutcheon C, Graham ID. Building an integrated knowledge translation (IKT) evidence base: colloquium proceedings and research direction. Health res policy syst. 2020; https://doi.org/10.1186/s12961-019-0521-3
38. Kilbourne AM, Evans E, Atkins D. Learning health systems: driving real-world impact in mental health and substance use disorder research. FASEB BioAdvances. 2021. https://doi.org/10.1096/fba.2020-00124.
39. Tebes JK, Thai ND, Salas E, Kazak AE, Mcdaniel SH. Interdisciplinary team science and the public: steps toward a participatory team science. Am Psychol. 2018. https://doi.org/10.1037/amp0000281.
40. Pinto-Coelho KG, Hill CE, Kearney MS, Sarno EL, Sauber ES, Baker SM, et al. When in doubt, sit quietly: a qualitative investigation of experienced therapists' perceptions of self-disclosure. J Couns Psychol. 2018. https://doi.org/10.1037/cou0000288.
41. Cook T, Inglis P. Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability - final Report. 2008. https://regroup-production.s3.amazonaws.com/documents/ReviewReference/731351503/NHS_understanding_research_consent_and_ethics_a_participatory_research_methodology_in_a_medium_secure_unit.pdf?response-content-type=application%2Fpdf%26X-Amz-Algorithm=AWS4-HMAC-SHA256%26X-Amz-Credential=AKIAYSFKCAWYQ4D5IUHG%2F20250212%2Fus-east-1%2Fs3%2Faws4_request%26X-Amz-Date=20250212T230727Z%26X-Amz-Expires=604800%26X-Amz-SignedHeaders=host%26X-Amz-Signature=bca77a5cf15169d7ac9edd96ab1718dad75b6ade9047f743ddc5b1ebf155d201. Accessed 10 Feb 2025.

Publisher's note