Psychiatric and Mental Health Nursing third edition continues to deliver students and lecturers an authoritative and accessible approach to mental health nursing. The combined efforts of a highly-respected and experienced editorial team and the expertise of the contributors have resulted in a valuable and influential text, with a strong focus on evidence-based practice and recent research.

This new edition places an important emphasis on recovery and strengths across all chapters dealing with mental health nursing practice, providing students with the confidence to engage a recovery-oriented, empathic and holistic approach to psychiatric and mental health nursing. This edition also includes a new chapter on forensic mental health nursing and addresses the integration of mental health care into primary health care. An increased focus on preventative mental health strategies and current and emerging interventions will help students to develop the knowledge, skills and attitudes necessary to interact effectively with clients and their families.

FEATURES
- A new chapter on Forensic Mental Health Nursing
- A strong recovery focus throughout
- An increased focus on preventative mental health strategies and current and emerging interventions
- Case studies, critical thinking challenges and nurses’ stories provide contextual reinforcement for students
- An evidence-based framework and up-to-date research integrated throughout
- Client-focused with a clear, holistic approach
- Free online Evolve resources available

RUTH ELDER RN, BA(Hons), PhD
Ruth formerly taught and coordinated subjects and courses in mental health nursing for both undergraduate and postgraduate students at Queensland University of Technology. Her nursing practice has predominantly been in community mental health and community health, where she worked both as a mental health nurse and as a community liaison nurse.

KATIE EVANS RN, BA, MLit, PhD
Katie has researched and taught at the University of Queensland, Queensland University of Technology, Griffith University, Central Queensland University and Queensland Health. She currently designs and delivers education programs across nursing, mental health and forensic mental health on a freelance basis and is working with the Viet Nam Nursing Project at Queensland University of Technology, teaching, writing and directing the distance learning program.

DEBRA NIZETTE RN, Credentialed MHN, Dip Appl(Nursing EdI), BAppSc(Nursing), MNurStudies, FRNIA, FACMHN
Mental health nursing requires specialist skills and knowledge, and self-awareness, which Debra believes are informed by and developed through nurses’ work with consumers and carers. Debra’s current role as a mental health nursing advisor enables her to support and promote practice embedded in holism and humanism that is consumer led and recovery oriented. The mental health nurses and colleagues Debra works with are passionate about education, practice and role development and leadership. Collectively they generate resources for students and nurses to achieve mental health literacy or progress to specialisation, and support strategies to enhance the therapeutic potential of mental health nurses currently in practice.

Ruth Elder
Katie Evans
Debra Nizette

3rd edition
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The knowledge and expertise of the mental health/psychiatric nurse are no less challenging today than they were in the day of Hildegard Peplau, the ‘mother of psychiatric nursing’. No longer is our area of expertise and specialisation granted the protection of separate registration across Australia and New Zealand. It is our own self-regulation through standards outlined by Australian and New Zealand mental health nursing colleges and our postgraduate specialist programs that are defining our parameters of practice.

The existence of a text for Australian and New Zealand nursing students and as a relevance point for mental health/psychiatric nurses is not only significant but also vital. The need for nurses to undertake both undergraduate and postgraduate mental health/psychiatric nursing programs to become mental health/psychiatric nurses will ensure that our services and consumers have the benefit of contemporary evidenced-based practitioners.

This text demonstrates active adult learning principles in its style of engagement with its readers. As a basis for undergraduate education it provides the cornerstones and fundamentals of our practice. From this grounding students are better prepared for the postgraduate arena of study, which then frames them with the tools for and recognition as a mental health/psychiatric nurse.

The uniqueness of this text is in its solid location of our two countries. The Indigenous, ethical, social and political contexts will assist students to understand our professional knowledge and consumer care/support in the constructs of our wider society, thus acknowledging the wider factors that are socio determinants of mental health and mental illness.

The challenge that this text creates is twofold. First, ensuring that students are supported by lecturers/tutors who themselves have the appropriate mental health/psychiatric nursing specialist skills to be role models for learning; and second, ensuring that our health/hospital care settings provide environments conducive to this learning with our consumers.

I hope you enjoy this text and thank the contributors for their time in its development.

Dr Frances Hughes
Chief Nursing and Midwifery Officer
Queensland Health
Preface

Psychiatric and Mental Health Nursing was first conceived in response to the clear need to provide Australian and New Zealand nurses with an accessible text designed to actively engage undergraduate nursing students with the relevant contexts in which they were learning and working. It was also essential to provide understanding of the unique legislative, policy and cultural contexts of psychiatric and mental health nursing work in Australia and New Zealand. As the text has evolved over the past 10 years, these initial goals have remained at the forefront of our writing, and this third edition continues to provide a valuable and influential text that is grounded in the realities of these contexts.

The third edition emphasises the need to adhere to the principles of evidence-based practice and to use the most recent research from primary sources. As an acknowledgement of the sustained growth of the consumer movement, we have incorporated a strong recovery and strengths focus across all chapters dealing with mental health nursing practice and its specialties. We promote consumer and student-centred approaches, and focus closely on providing students with examples and guidance about helpful and transformative communication. Wherever possible, specific suggestions about what the practitioner can do and say during interactions with clients have been provided. This hands-on approach is designed to actively engage undergraduate nursing students in developing the knowledge, skills and attitudes necessary to interact effectively with clients and their families.

All contributors to the text have been selected for their acknowledged expertise in the field of mental health. Chapters written by nurses working in clinical and management contexts, as well as nurse academics, communicate approaches employed by skilled nurses to counselling, assessment, interviewing, history taking and a range of interventions. Nurses’ stories and case studies drawn from the experiences of practising psychiatric mental health nurses are included to assist students in developing insights about the realities of mental health nursing.

The text is divided into four parts:
• **Part 1** explores broad areas such as the history of mental illness and mental healthcare, the nurse, contexts of practice and politico-legal implications embedded in practice.
• **Part 2** aims to contextualise practice, examining theories about mental health and wellness across the lifespan and within societies and cultures, as well as exploring crisis, loss and assessment issues.
• **Part 3** develops a better understanding of the major mental illnesses; examines DSM-IV-TR diagnoses, interventions and effective treatments; and incorporates the client’s experience of mental illness. A new chapter on forensic mental health nursing has been included to explain the work of mental health nurses who assist people with mental disorders who have become involved with the criminal justice system.
• **Part 4** focuses on psychopharmacology and therapeutic skill development for practice, and applies skills to clinical situations.

This edition continues to acknowledge the importance of a client-focused approach and supports a holistic philosophy of practice with a strengthened focus on recovery. This assists the beginning practitioner to understand that mental wellness is a concept that balances mental disorder, and that mental disorder is caused by a complex web of circumstances. A healthy society requires that mental health needs are acknowledged and services developed to enhance the existing protective factors in our communities.

We hope that the third edition of this text continues to have wide appeal and that its practical approach provides the relevant support to students and teachers, as well as practitioners in any setting who work with people who have a mental health problem. In an environment where technological, professional and health service evolution is continuous and inevitable, we continue to stress the importance of a personal, empathic and holistic approach to psychiatric mental health nursing practice.

*Ruth Elder  
Katie Evans  
Debra Nizette  
June 2012*
About the editors

**Ruth Elder**  
RN, BA(Hons), PhD
Ruth taught and coordinated subjects and courses in mental health nursing for both undergraduate and postgraduate students at Queensland University of Technology. Her primary interest was in the care and rehabilitation of people with chronic mental disorders. Ruth’s own nursing practice was predominately in community mental health and community health, where she worked as both a mental health nurse and a community liaison nurse.

**Katie Evans**  
RN, BA, MLitSt, PhD
Since training as a psychiatric nurse in Sydney, Katie has researched and taught at the University of Queensland, Queensland University of Technology, Griffith University, Central Queensland University and Queensland Health. At present she designs and delivers education programs on a freelance basis in a range of domestic and overseas contexts for nursing, mental health and forensic mental health students. Katie also works with the Viet Nam Nursing Project at Queensland University of Technology: teaching, writing and directing the distance learning program. Her research includes a master’s degree tracing the social evolution of women from Homer to Euripides, and a PhD investigating mental illness in the ancient Graeco-Roman literature.

**Debra Nizette**  
RN, Credentialled Mental Health Nurse, Endorsed Midwife, DipAppSc(Nursing Ed), BAppSc(Nursing), MNurStudies, FRCNA, FACMHN
Debra is interested in the interpersonal nature of nursing (mental health nursing in particular) and believes that students who develop self-awareness and understanding of others are able to recognise their therapeutic potential. Debra’s aim is to support learning to assist students to achieve this potential through her role in the nursing program at the Australian Catholic University in the areas of mental health nursing, psychosocial and professional aspects of health and nursing care and therapeutic communication.
Contributors

Gail Anderson
RN, RM, MN, Adolescent Mental Health Cert, MACN
Clinical Nurse Consultant, Adolescent Health,
Westmead Hospital, NSW

Peter Athanasos
RGN, RPN, BA, BSc(Hons)
Discipline of Psychiatry, Flinders University

Murray Bardwell
RN, Credentialled Mental Nurse, DipAppSc, BN, MNSt (Flinders)
Mental Health Clinician (Peri Natal),
St John of God Hospital, Ballarat, Vic

Patricia Barkway
RN, CMHN, BA, MSc(PhC), FACMHN
Senior Lecturer, Mental Health Nursing, School of Nursing and Midwifery, Flinders University, Adelaide, SA

Jan Barling
RN, MN, DipAppSc, BA, MRCNA, FACMHN
Lecturer, Health and Human Sciences,
Southern Cross University, NSW

Pat Bradley
FACMHN, CMHN, MMHN, Grad Dip Health Ed, RPN, RGN
Adjunct Professional Associate, School of Health, HDR
Student, Research Centre for Health and Wellbeing,
Charles Darwin University, NT

Michelle Cleary
RN, PhD
Associate Professor, Alice Lee Centre for Nursing Studies, Yong Loo Lin School of Medicine,
National University of Singapore, Singapore

Janette Curtis
RN, BA, PhD, DipPubHlth, FRCNA, MACMHN
Senior Fellow, University of Wollongong, NSW

Ruth De Souza
Dip Nurs, GradDip Adv Nursing Practice, MA, PhD
Senior Lecturer, School of Health Care Practice,
AUT University, Auckland, New Zealand

Ruth Elder
RN, BA(Hons), PhD

Katie Evans
RN (Psychiatric Nurse), BA, MLitSt, PhD
Director of Distance Studies, Viet Nam Nursing Project,
Queensland University of Technology, Brisbane, Qld

Kim Foster
RN, BN, DipAppSc, MA, PhD, MRCNA, FACMHN
Associate Professor Mental Health Nursing,
Sydney Nursing School, The University of Sydney, NSW

Michael Groome
(Ex MHN) BA, MSc, PhD, MAPsS
Former Lecturer, School of Nursing, Australian Catholic University (Ret.); Clinical Psychologist

Hineroa Hakiaha – Ngati Awa, Ngai Tuhoe, Ngati Maniapoto
RN, BN, PGDipN (MH), MN (Applied)
Service Manager – Mental Health & AoD
Te Rūnanga o Kirikiriroa Trust Inc

Charles Harmon
RN, DipTeach(Nursing), BHS(Nursing), MN, PhD, FACMHN
Lecturer, School of Nursing & Midwifery,
Faculty of Health, University of Newcastle, NSW

Deanne Hellsten
BNursSc, MMentalHlthNurs, Masters of Health (Research)
Program Manager / Nursing Director Rehabilitation Institute of Mental Health, Alcohol, Tobacco Other Drugs Services, Townsville Health Service District, Qld

Kristin Henderson
RN, RM, RPN, Member ACMHN, DipAppSc(Nursing Ed), BNursing, GradDip Sciences Communication, Master Health Science (Deakin)
Team Leader Inpatient & Consultation-Liaison, Child & Youth Mental Health, Royal Children’s Hospital,
Children’s Health Services, Qld
Jan Horsfall
PhD

Debra Jackson
RN, PhD
Professor of Nursing, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney, NSW

Trish Martin
RPN, DN
Director of Nursing Research, Victorian Institute of Forensic Mental Health/Adjunct Associate Professor, Monash University, Vic

Phillip Maude
RN, PhD, MN(Res), BHSci, DipMHN, Cert Addictions, FACMHN
Associate Professor, Coordinator, Graduate Diploma in Mental Health Nursing, School of Health Sciences (Nursing and Midwifery), RMIT University, Vic

Brian McKenna
RN, PhD
Associate Professor, Director, Centre for Mental Health Research, School of Nursing, the University of Auckland; Nurse Consultant, Auckland Regional Forensic Psychiatry Services, Waitemata District Health Board, New Zealand

Paul Morrison
RN, RMN, PhD, BA, PGCE, Grad Dip Counselling, AFBPsS, CPsychol MAPS
Professor of Nursing and Health Studies, Murdoch University, WA

Wendy Moyle
RN, BN, MHSc, PhD
Professor of Nursing & Director, Research Centre for Clinical and Community Practice Innovation, Griffith Health Institute, Griffith University, Brisbane, Qld

Eimear Muir-Cochrane
RN, Credentialled Mental Health Nurse, BSc (Hons), Grad Dip Adult Ed, MNS, PhD, Chair of Nursing (Mental Health), School of Nursing and Midwifery, Flinders University, SA

Debra Nizette
RN, Credentialled MHN, Endorsed Midwife, DipAppSc(Nursing Ed), BAppSc(Nursing), MNursStudies, FRCNA, FACMHN
Mental Health Nursing Advisor, Queensland Health, Qld

Louise O’Brien
RN, BA, PhD
Professor of Nursing (Mental Health), University of Newcastle, NSW, and Western NSW Local Health District

Anthony O’Brien
RN, BA, MPhil (Hons), FNZCMHN
Senior Lecturer, School of Nursing, Faculty of Medical and Health Sciences, University of Auckland, New Zealand

Michael Olasoji
RN, RPN, BNurs(Hons), PGDipMHN, PhD Candidate (RMIT), MACMHN
Clinical Nurse Educator, Alfred Health, Vic

Christine Palmer
RN, CrMHN, DipAppSc(Nursing Ed), BAppSc(Nursing), MNurs, FACMHN
Mental Health Nurse in private practice

Philip Petrie
RN, BN, MEdStud
Executive Director, Allevia, Bankstown, NSW

Julie Sharrock
RN, Credentialled MHN, General Nurs Cert, Crit Care Cert, Psych Nurs Cert, BEd, MHSc (Psych Nurs), AdvDip Gestalt Therapy, MRCPNA, FACMHN, MISPAN
Mental Health Nurse, Coordinator Consultation-Liaison Psychiatry, St Vincent’s Hospital, NSW

Vicki Stanton
RN, RMRN, Credentialled MHN, BA(SocWel), MA(SocSc), Grad Dip Public Health, Grad Cert Mgmt, FACMHN
Clinical Coordinator, Aboriginal Mental Health, South Eastern Sydney Local Health District, NSW

Chris Tawa
RN, DipN, BN, PGCertHS(MH), Cert Ad Tch, MN(Dist), FNZCMHN
Principal Lecturer, School of Nursing & Human Services, Faculty of Health, Humanities & Science, Christchurch Polytechnic Institute of Technology, New Zealand

Richard Taylor
RN, RPN, BEd
Senior Lecturer/Assistant Head of School, School of Nursing, Midwifery and Paramedicine, Australian Catholic University, Melbourne

Barbara Tooth
BA(Hons), PhD (Clinical Psychology)

Kim Usher
RN, DipNTeach, DipHSc, BA, MNSt, PhD, FRCNA, FACMHN,
Professor of Nursing and Associate Dean for Research Studies, James Cook University, Cairns, Qld

Timothy Wand
MHN, RN, NP, DAS(Nurs) Grad Dip MHN, MN(Hons), PhD
Nurse Practitioner, Mental Health Liaison, Royal Prince Alfred Hospital, NSW
Reviewers

Maureen Barnes  
PhD, DipClinPsych, MAPS  
Senior Clinical Psychologist, High Secure Inpatient Service, The Park Centre for Mental Health, QLD

Janette Curtis  
RN, PhD, DipPubHlth, BA, FRCNA, MACMHN  
Senior Fellow, University of Wollongong, NSW

Elizabeth Emmanuel  
BN, MN, MHN, Midwife, PhD  
Senior Lecturer, School of Nursing, Midwifery & Nutrition, James Cook University, Qld

Gihane Endrawes  
BN, PhD, MHSc (Edu), Grad C (Research), CMH, CHP, MANZCMHN, MANTS  
Lecturer, University of Western Sydney, NSW

Susan Gallagher  
RN, BEd Nursing, MA(Ed), MCMHN, MRCN  
Senior Lecturer, School of Nursing, Midwifery and Paramedicine, Australian Catholic University, NSW

Linda Goddard  
RPN, RNMH, BHSc (Nsg), MEd, PhD  
Senior Lecturer, School of Nursing, Midwifery & Indigenous Health, Charles Sturt University, NSW

Val Goodwin  
RN, BN(Hons), PhD (Melb), MACMHN  
Senior Lecturer, School of Nursing, Midwifery and Paramedicine, Australian Catholic University, Ballarat, Vic

Julie Harris  
RN, DipAppSc (Nursing), BNurs, MEd (T&D), MRCNA  
Lecturer, Department of Nursing and Midwifery, University of Southern Queensland, Qld

Catherine Hungerford  
BA, BHlthSc, BCounsStudies, GradDipEd, MLitt, MN (MH NursPract), PhD  
Assistant Professor, University of Canberra, ACT

Janet Kerswell Unnasch  
RN, GradDipMH, Cert IV TAA  
Mental Health Nursing Consultant and Lecturer

Robert Laing  
RN, BA(Hons)Psych, MCur, MACMHN  
Casual Lecturer, School of Nursing and Midwifery, Murdoch University, WA; Casual Lecturer, School of Nursing and Midwifery, University of Tasmania, Tas

Sue Liersch  
RN, MN, Credentialled Mental Health Nurse, BN(Hons), PhD Candidate, Churchill Fellow  
Lecturer, University of Wollongong, NSW

Andrea McCloughen  
BN, MN (Mental Health), PhD, MRCNA, FACMHN, MSTTI  
Senior Lecturer, Mental Health Nursing, Sydney Nursing School, The University of Sydney, NSW

Nani McCluskey  
RPN, PG Cert Mental Health, MA (Applied) Nursing  
Māori Mental Health Professional, Community Mental Health, Wairarapa, New Zealand

Tom Meehan  
RN, MPH, MSocSc, PhD  
Associate Professor, University of Queensland & The Park, Centre for Mental Health, Qld

Paul Morrison  
RMN, RN, PhD, BA, PGCE, GradDip Counselling, AFBPsS, CPsychol, MAPS  
Professor of Nursing and Health Studies, Murdoch University, WA

Daniel Nicholls  
RN, BA(Hons), PhD  
Clinical Chair in Mental Health Nursing, ACT Government Health Directorate & University of Canberra, ACT

Alan Robins  
RPN, MHN, BA, GradDipPubPol, MEd(Prel), MSW (Hum Serv M’ment), MACMHN, Accred Role Trainer, MANZPA, MIAGP

Rachel Rossiter  
RN, DHSc, MN(NP), MCouns, BCouns, BHlthSc  
Senior Lecturer, Program Convenor, M Mental Health Nursing (NP), School of Nursing and Midwifery, University of Newcastle, NSW
Mental health nurses have begun to identify the knowledge, skills and attitudes that are required to work with forensic clients.

There is an overrepresentation of people experiencing mental illness in criminal justice processes.

Forensic clients are heterogeneous groups of people whose offending behaviour may or may not be related to their experiences of mental illness, or the mental illness may be a result of the offending behaviour.

The role of forensic mental health services has progressed from mainly providing containment to providing treatment for forensic clients.

Risk assessment, treatment and management processes continue to develop and to be used by nurses to meet the needs of clients and to ensure safety for the community.

The role of mental health nurses in forensic and justice settings is exciting but also fraught with ethical dilemmas.

civil commitment
court liaison nurse
criminalisation of the mentally ill
criminal justice system
deinstitutionalisation
diversion
fitness to plead
forensic mental health nurse
not guilty on the grounds of mental illness
recidivism
risk assessment and management
risk factors
security
special circumstances courts
structured clinical judgement

The material in this chapter will assist you to:

demonstrate awareness of the needs and experiences of forensic clients
identify specific nursing interventions for forensic clients
describe the components of forensic mental health services
explain common links between mental illness and offending behaviour
discuss the skills, knowledge and attitudes that are central to forensic mental health nursing
utilise the structured clinical judgement approach to risk assessment, treatment and management
develop an understanding of nursing in criminal justice and forensic mental health settings.
Introduction

The context of mental healthcare is constantly changing and the proactive response of mental health nurses to such changes is reflected in the evolution of our profession. This chapter focuses on the needs and wellbeing of people experiencing acute or chronic mental illness who have been charged with a criminal offence or are suspected of committing a criminal offence (Bradley 2009). The chapter provides a description of forensic clients and overviews what is known about the relationship between mental illness and offending behaviour. For many reasons, people experiencing mental illness are overrepresented in the criminal justice system. Forensic mental health services have developed in New Zealand and Australia to provide containment, assessment, treatment and management of forensic clients. These services have grown from the recognition that neither the criminal justice system nor the mental health system can adequately provide services for forensics client and that the two systems must work in partnership to meet the needs of clients, and at times the need for community safety.

The criminal justice system includes the police who arrest people alleged to have committed a crime and the courts responsible for making determinations of guilt or innocence and for imposing penalties if the person is found guilty. Imprisonment and community-based orders are possible penalties. When the person is thought to be experiencing mental illness, there are options for diversion from police custody, court or prison to mental health services for assessment and treatment. However, most mainstream mental health services do not have the structural security or available treatment options to contain, assess, treat and manage certain forensic clients and so forensic mental health services have been developed.

Forensic mental health services are generally independent of the criminal justice system and are managed within the health sector. Components of forensic mental health services include services within police custody centres, prisons and courts. Secure hospitals and community services are also essential components.

Australia and New Zealand do not particularly recognise specialties of nursing but the term ‘forensic mental health nurse’ is used in this chapter to identify mental health nurses who practise in criminal justice or forensic settings. Similar to other health fields, there are more nurses than other specialists and nurses possess the knowledge, skills and attitudes that are required to provide comprehensive care for complex forensic clients. Although this chapter focuses on nursing in criminal justice and forensic settings, there is no doubt that nurses in mainstream services will, at some time, work in partnership with clients to address forensic mental health needs.

Forensic mental health nurses in Australia and New Zealand primarily focus on forensic clients—the perpetrators or alleged perpetrators of crime. This role should not be confused with the title ‘forensic nurse’, which is prominent in countries such as the USA. Forensic nursing practice is more (but not exclusively) focused on the needs of victims of crime or those bringing an issue to court (including roles such as sexual assault nurse examiners). These roles are less advanced in Australia and New Zealand (Lawson 2008).

The development of forensic mental health services

Since the 1950s, mental health services have undergone major restructuring internationally in response to deinstitutionalisation. This process involved large psychiatric hospitals being closed down in favour of a network of mental health inpatient wards attached to general hospitals and community mental health centres to meet the needs of mental health clients. Deinstitutionalisation in New Zealand commenced in the 1960s and gained momentum in the 1970s and 1980s, with bed numbers decreasing from 350 per 100,000 population in 1970 to less than 50 per 100,000 by the year 2000 (Simpson et al 2003). Deinstitutionalisation in Australia has followed a similar path over the same period: the number of public and private psychiatric hospital beds has fallen from 30,000 in the early 1960s to 8000 in 2006, while the general population in Australia has doubled (White & Whiteford 2006).

Deinstitutionalisation is one factor that has led to the development of forensic mental health services. Prior to deinstitutionalisation, people experiencing mental illness were often admitted early in the development of their symptoms and were commonly detained for long periods of time. Being contained within the asylum may have meant that residents were protected from the consequences of many of the factors that predispose them to, or increase their risk of, offending. Such factors include lack of insight, poor understanding of early warning signs of relapse of mental illness, pro-criminal or pro-violence thinking, substance use, poor stress tolerance, lack of impulse control, poor problem solving and lack of social skills. Nurses in the asylum provided care, support and risk management that ameliorated the impact of these factors and also reduced exposure to circumstances that can lead to offending behaviour (such as poverty, social disadvantage and victimisation). Furthermore, offences might not have been reported by staff because a considerable level of disturbed and deviant behaviours were tolerated in the asylums and treated as clinical problems rather than criminal offences. When the asylums closed, increasing numbers of people experiencing mental illness who committed offences made contact with the criminal justice system. It is this social process that is referred to as ‘the criminalisation of the mentally ill’ (Hiday 2003).
Tragic events have also precipitated this change. In New Zealand in the 1980s, the deaths of people in asylums, suicides in prisons and homicides in the community perpetrated by mental health clients precipitated the transformation of services. The Mason Report (Mason et al. 1988) placed the responsibility for the management of forensic clients with the health sector and recommended that services should occur wherever this population presented, within a regionalised landscape of forensic mental health services. The impetus for change was similar in Australia (Mullen et al. 2000). The difficulty of treating forensic clients in prison and the decreasing ability to securely contain them in mainstream services for extended periods have also contributed to the need for forensic mental health services. Forensic clients require specialised services that address both their mental health needs and offence-related behaviour.

Identifying forensic clients

Forensic clients have complex needs that forensic mental health nurses must thoroughly assess in order to provide holistic care in partnership with the clients and their carers. Apart from the clinical need for treatment, many clients have rehabilitative needs related to social, cultural and adaptive malfunctioning and patterns of offending that can present as a risk to themselves or others.

The legal status of forensic clients

Forensic clients are subject to criminal justice legislation and policies that vary greatly between Australian states and territories and between countries, but the groups of forensic clients described below (Australian Health Ministers’ Advisory Council 2002) can generally be found in most places. Local legislation and policies will determine where the client is placed following arrest, sentencing and release, and will identify the conditions, the duration of treatment and the rights of the client. In Australia, a National Statement of Principles for Forensic Mental Health was drawn up by the Forensic Expert Reference Group of the National Mental Health Working Group of the Australian Health Ministers’ Advisory Council and endorsed by the Senate Select Committee on Mental Health. In this statement, the groups of forensic clients are identified as:

- offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- prisoners with mental illness requiring secure inpatient hospital treatment
- selected high-risk offenders with a mental illness referred by releasing authorities
- prisoners with mental illness requiring specialist mental health assessment and/or treatment in prison
- people with mental illness in mainstream mental health services who are a significant danger to their carers or the community and who require the involvement of a specialist forensic mental health service (Australian Health Ministers’ Advisory Council 2002, pp 3–4).

Defendants appearing in court must be fit to plead. If mental illness prevents a person from meeting certain criteria (including having an understanding of the nature of the charge and the trial, being able to enter a plea and being able to give instructions to the legal practitioner), then that person is likely to be ordered by the court to receive treatment until the person is fit to return to court. A small number of clients are never fit and other processes are put in place to ensure their treatment and supervision.

Clients are found not guilty by reason of mental impairment by the court when it has been proved that the person was so unwell at the time of the offence that they did not understand the nature and quality of the act (the offence) or did not know that the act was wrong. Clients who are found not guilty due to mental impairment are required to undertake treatment; the duration and location of the treatment will depend on the severity of the offence and the risk status of the client.

A prisoner experiencing mental illness will require a transfer to a secure hospital for treatment if an adequate level of treatment and care cannot be provided at the prison or if the prisoner is unwilling to accept treatment. The policy in New Zealand and Australia is that prisoners cannot be treated involuntarily in prison, as the potential for abuse of psychiatric treatment is ever-present in prisons. Some offenders in prison who are experiencing mental illness can adhere to treatment and need an equivalent level of treatment and care that is available in the community, such as outpatient appointments with a nurse. This service may be provided by prison mental health in-reach teams. Some prisons have mental health units for the short-term assessment and treatment of prisoners. Some high-risk prisoners will be referred to either a forensic hospital or a community team for assessment and treatment following release from prison.

Wherever forensic mental health nurses practice, it is their responsibility to understand the legislation that affects their clients. Forensic clients and their carers can be confused by the legal processes and requirements. The nurse's knowledge of the law needs to be used proactively to assist forensic clients and their carers to understand the function and impact of criminal justice legislation and policies and to optimise care in the context of integrating security, safety and therapeutic intent. The nurse is also
required to provide information to clients and carers to ensure that they are aware of their rights.

Websites that may assist you to gain some understanding of legislation related to forensic mental health are listed in Box 22.1.

**Demographic characteristics**

Research examining forensic clients generally describes a similar population in terms of demographic characteristics: young, male, never married, low socioeconomic status, unemployed, poor educational achievement and itinerant living situations prior to conviction (Ogloff et al 2004; Silver & Teasedale 2004). However, the number of imprisoned women and female forensic clients is growing in both Australia and New Zealand (Office of the Auditor-General 2008; Australian Bureau of Statistics 2010).

There is an overrepresentation of Indigenous peoples and post-colonisation immigrant populations in forensic mental health services. Colonisation usurped the self-determination of Indigenous peoples and similarly immigrant populations are required to adapt to the social reality of the dominant culture. Such social adjustments place considerable pressure on disadvantaged groups. These pressures are reflected in a number of adverse social indicators such as poor educational achievement, high unemployment rates, high crime rates and poor health statistics. In New Zealand, Māori and Pacific Islander ethnicities are overrepresented in New Zealand prisons. Although Māori comprise 16% of the general population and Pacific Islanders 6% (Statistics New Zealand 2007), they make up 50% and 12% of the prison population, respectively (Office of the Auditor-General 2008). The situation is similar in Australia. The imprisonment rate for Aboriginal and Torres Strait Islanders (1892 per 100,000 adult population) at June 2010 was 14 times higher than the rate for the non-Indigenous population (Australian Bureau of Statistics 2010).

**Cognitive and social skills**

When a person’s ability to think clearly and relate constructively to others is compromised by mental illness, the likelihood of antisocial behaviour including violence and offending is enhanced (Welsh & Ogloff 2003; Woods et al 2004). However, the reasons for compromised cognitive and social ability are complex and may not relate directly to mental illness. These reasons may relate to diminished learning opportunities in the context of the family, environment and culture; harsh or inconsistent parenting; delinquent peer associations; and acquired brain injury. A significant proportion of forensic clients have a history of traumatic childhood experiences (Schofield et al 2006) and acquired brain injury. Therefore, the development of cognitive and social skills is a rehabilitative requirement of forensic mental health services (Ch 25 describes social skills training in more detail). Limitations in cognitive and social skills can mitigate against a socially positive response to life’s challenges (Bennett et al 2005).

**Social disadvantage**

When assessing the needs of forensic clients, forensic mental health nurses must also consider the client’s sociocultural context. The influences of membership of minority disadvantaged groups and low socioeconomic status are especially important (Blumenthal 2000).

Forensic clients are more at risk of victimisation compared to the general population (Wolff & Shi 2009). Victimisation includes being subjected to violence, intimidation, sexual exploitation and financial exploitation. These needs require integrated health, justice and social care agency responses, in order for this population to attain acceptable levels of social functioning and quality of life (either in prison or in the community) and to avoid re-offending (Harty et al 2009).

Violence may be the reality of high-crime neighbourhoods where people experiencing mental illness live (Monahan 2002). There is an indication that people experiencing mental illness move into, or fail to rise out of, low socioeconomic localities because of the impact of the social stigma attached to the illness (Sadock & Sadock 2003). The stigma, symptoms and course of the illness may prevent people from acquiring vocational qualifications and securing stable employment. Surviving on benefits can result in them living in lower socioeconomic areas, where local community norms may be more supportive of offending and there is the possibility of increased contact with others who are offenders (Hiday 2003).
Forensic mental health nurses need to work with those forensic clients with identified sociocultural needs to help them to develop or restore protective social alliances with their family and community. Supporting social care goals and strengthening cultural identity can prevent further offending and assist with the client’s recovery.

**Mental illness and risk to others**

The relationship between mental illness and criminal behaviour is complex and varies between individuals. Nurses need to identify the unique relationship for each client so that they can ascertain the risk and protective factors that need to be addressed in treatment and risk management strategies. Most offenders who progress from assessment to remain on the caseload of forensic mental health nurses have experience of serious mental illness (a psychotic illness or major depression).

The 20-year study undertaken by Wallace, Mullen and Burgess (2004) found that the overall frequency of violent offences was significantly higher among people experiencing schizophrenia than among the comparison community subjects (8.2% versus 1.8%). The rate of violent offending among people experiencing schizophrenia gradually increased over the years of the study but there was no difference in the rate of increase when compared to the comparison subjects over the same period. Most people experiencing schizophrenia are not violent and do not commit criminal offences, but rates of violence and offending are higher than for comparison community subjects.

The offences committed by clients experiencing schizophrenia reflect a range of factors that are present before, during and after periods of acute illness (Hodgins 2002; Wallace et al 2004). These factors are presented in the section on risk assessment later in the chapter. Taylor (2004) has attributed more serious violence to delusions leaving people fearful and frightened by those around them and with a decreased ability to control personal responses to these perceived threats. Monahan (2002) stated that if a person with a psychotic disorder experiences voices that command violent acts, this increases the likelihood of violence. A study by Swanson et al (2006) found that positive symptoms of schizophrenia (such as hallucinations, delusions and disorganised thinking) increase the risk of serious violence, while negative symptoms (such as loss of energy, loss of the experience of pleasure and loss of drive) lower this risk. These international studies have found modest increases in criminal and violent behaviour with serious mental illness, but also note that there is no evidence that mental illness causes criminal behaviour; rather, several factors mediate mental illness and offending. These factors include antisocial tendencies or peers, and alcohol or drug abuse (Fazel & Danesh 2002).

**Substance use**

Substance abuse is common in psychiatric populations, offender populations and the community generally (Mullen et al 2000). (See Ch 20 for more information about substance use and abuse, and their association with coexisting mental disorders.) Forensic clients have high rates of substance abuse and these coexisting conditions have a link to offending and risk of violence (Hodgins 2002; Ogloff et al 2004). Although the majority of people experiencing schizophrenia are not violent, they are four to five times more likely to be violent when substance abuse is implicated. (See Box 22.2 for the relationships...
between schizophrenia, substance use and offending.) It is not clear whether the relationship is immediate or mediated, or there may be some common cause (Taylor 2004). However, the links between coexisting disorders, a complex array of other risk factors and the potential for violence remains poorly understood (Hodgins 2002; Taylor 2004).

Forensic clients are a heterogeneous population, presenting with multiple, complex biopsychosocial needs. Many move between the criminal justice sector and the mental health sector as the two systems compete to shift difficult individuals (Skipworth et al 2010). The task of contemporary forensic mental health services lies in smoothing the tensions of this interface and providing specialist assessment and treatment for the benefit of clients. The voices of forensic clients’ experiences of personal tragedy, engagement with services and the road to recovery are rare in the international literature; Chisholm (2008) provides one such a narrative.

**Forensic mental health services**

**Police custody centres**

The process of entering the criminal justice system commences at the point of arrest. In New Zealand police attend to more than 9250 mental health call-outs per year (New Zealand Police 2008). Most of these offences are misdemeanours and typically involve public nuisance behaviours such as urinating in a public place and survival crimes such as shoplifting or leaving a restaurant without paying (Hiday 2003). Management of this behaviour requires arrangements between mental health services and the police, so that forensic clients can be diverted from the criminal justice system to inpatient or community mental health services (Bradley 2009).

Decisions on diversion require consideration of public safety, the safety of the offender and the seriousness of the charge, and they can occur at any stage of the criminal justice process. For example, if a person experiencing a psychotic mental illness is arrested for shoplifting food in order to eat, diversion to general mental health services may be possible. However, if the charge is aggravated assault, then criminal justice processes would proceed and the person’s mental health needs would be managed within the criminal justice system. In this case, the person might be remanded to prison while the court process proceeds and their mental health needs would be addressed within the prison.

In the absence of initial mental health service involvement, and in cases of alleged serious offending such as violent offences, people experiencing a mental health emergency may be transported to police holding cells. The person’s impaired mental health state may come to the attention of police officers, who can initiate a mental health response. This often involves contact with a mental health crisis nurse, who undertakes an assessment and makes recommendations to the officers. In both Australia and New Zealand some police services employ nurses to work in police custody centres to assist with mental health, physical health and addiction needs (Paulin & Carswell 2010; Witham 2000). The main mental health role of these nurses is to screen for and identify mental illness and substance abuse, as soon as possible. Following assessment, nursing interventions typically focus on managing substance intoxication, withdrawal and overdose; acute symptoms of mental illness; and self-harm and suicidal behaviour.

Nurses in custody centres are also involved in training police on how to identify mental illness, undertake a risk assessment and relate to people experiencing mental illness. Such education can provide police with greater understanding and an increasing ability to recognise mental health problems, identify options for ensuring the safe containment of people experiencing mental illness and refer them to appropriate services for assistance.

**The courts**

The courts are another potential point of diversion from the criminal justice system to mental health and addiction services. In the USA and Canada, this has led to the development of ‘special circumstances courts’ such as mental health courts, and drug and alcohol courts. The aim of such courts is to interrupt the cycle of offending by facilitating access to treatment for those people with mental health and addiction problems (Wiener et al 2010). The delivery of services and treatment progress are monitored through court review by the judge.

Such innovations are also taking place in Australia and New Zealand (Richardson & McSherry 2010), although the models vary. For example, while some courts have established specialist mental health sitting, others employ court liaison nurses to advise judges, lawyers and the police on issues regarding the mental health, addiction status and needs of people presenting to court (Turnbull & Beese 2000). Court liaison nurses accept referrals from the police, from lawyers who have concerns about the defendant, from the judge who might stand down proceedings for referral purposes and from a variety of other sources including the probation service, mental health services, families and self-referrals. Referrals usually arise from concerns about behaviour suspected of being related to mental illness, intellectual disability, communication difficulties or alcohol and drug problems.

A police summary of facts can often be made available to the nurse before the person is interviewed and assessed. The assessment involves a mental state examination (MSE) and risk assessment. In the MSE, close attention is paid to behaviour, thoughts, feelings and ways of relating that might be indicative of the presence of mental illness. In the risk assessment, close attention...
is paid to the extent to which the presence of symptoms of mental illness, substance use, personality disorder and the person’s social circumstances might impact on the level of risk that the person poses to themselves or other people. The level of risk will influence the judge’s decision about where the person is to be placed and whether treatment is identified as a condition.

If the charges are minor, such as those cases involving public nuisance, the court liaison nurse may be required, at the request of the court, to facilitate the person’s engagement with general or forensic mental health services, in either an inpatient or a community setting. The objective is to secure mental health service placement without the impediment of court processes and associated incarceration (Hartford et al 2004).

If the charges are serious, such as violent offending or sex offending, the judge may request a forensic psychiatric or psychological assessment. These reports generally provide comment on issues of fitness to plead and whether the person was mentally impaired at the time of the offence. The report may also make suggestions about treatment options for the person.

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NURSE’S STORY: KEVIN SEATON, COURT LIAISON NURSE

I have been employed in the court liaison service for 11 years. Before becoming a court liaison nurse, I had never entered a court and had no dealings with the criminal justice system. On my first day on the job, I helped assess a young man who had been arrested after an unprovoked attack on his neighbours with a knife. He believed they were aliens who had implanted a computer chip in his brain. We had to transfer this man to a secure forensic mental health unit for further assessment and treatment.

I thought to myself, what have I let myself into? I knew nothing about the court process, court protocol, how to address a judge or, more importantly, how to translate an MSE into a letter to the court that the judge would understand. As a court liaison nurse I found myself caught between the police who want to convict, the defence lawyers who want the charges withdrawn and the judge who wants advice on the mental health and risk status of the defendant and guidance as to where they should be placed. I really struggled trying to make sense of the court process, the criminal legislation and trying to do the ‘right’ thing for the client/defendant.

I was only two weeks into the role when I found myself in court supporting a mentally ill defendant. The aim, supported by the lawyers and the judge, was to seek bail to the local general mental health facility under mental health legislation. Unfortunately, there were no beds in the region. When this was explained to the judge with the suggestion of the alternative of a further remand in prison for two days to allow a bed to be secured, the judge’s retort was vehement: ‘Don’t expect me to look after your mental cases in prison. You find a bed.’ I was so embarrassed being spoken to like that in a full courtroom. But I also felt that I should have somehow been able to ‘find the bed’ this person needed, and by not doing so I had failed to provide care for this person.

These are the sorts of challenges you are presented with when working in the courts. Although initially they made me uncomfortable, the challenges quickly helped me to understand the different agendas in the court context, through which the court liaison nurse is required to stay impartial. The skill is to provide clinical information that is accurate, with a clear rationale as to why certain recommendations are made. Possible responses from the judge need to be anticipated with alternative suggestions being pre-planned. Sound knowledge of legislation and criminal justice processes is imperative.

Court liaison nurses need to be competent and confident not only in their MSE abilities, but also in the recommendations that arise from these assessments. The MSE must also be accompanied by a thorough assessment of risk to self and others.

Court liaison nurses are independent autonomous practitioners, often working in relative professional isolation outside the usual comfort zone of a hospital setting. The court setting is alien territory, working alongside non-health professionals who have a unique professional language and etiquette, which the nurse has to learn to become effective. No senior medical staff are readily on hand for advice and assistance. Peer clinical supervision is imperative. We see and hear horrific details of offending, so support and guidance from colleagues who understand the role and its demands are critical for both competent clinical practice and our own wellbeing.

The work is both challenging and rewarding. Over the years I have had to hone my clinical skills to enable me to practise at a level of autonomous practice I would not have thought possible 11 years ago. I have had to learn to speak and write in a ‘legalistic’ language rather than just ‘nurse clinical speak’. I get to wear nice professional clothes (no jeans and sandals in court) and work and talk with professionals outside the mental health setting. Judges acknowledge me and listen to and respect my opinion. The stress is high, the hours of work long, but I would work nowhere else.

Court liaison roles have some unique challenges for nurses. A qualitative study of the role in the UK found that nurses experience tensions in functioning within a ‘ritual bound environment complicated by competing professions and protocol’ (Turnbull & Bee 2000, p 290). Mental health nurses are trained to function in mental health services where a relatively structured environment provides a frame of reference to guide their practice. In contrast, the court is not a clinical environment but is the domain of court officials, the police, defence parties, prosecution parties and probation services. Each has its own language and philosophical approach that may hamper attempts to focus on mental health. Nurses working in the courts (or any part of the criminal justice system) must recognise the potential for enculturation to criminal justice values. They need to work to maintain professional resilience by engaging in a range of professional and organisational strategies including reflection, professional development and clinical supervision. The nurse’s story on Kevin Seaton describes the ways in which court liaison nurses need to negotiate both the legal and mental health systems, and make sense of their competing demands, in order to achieve the best outcomes for their clients.

Prison

There are some forensic clients for whom diversion from court is untenable due to the serious nature of their offending or other risk factors, or for whom sentencing to prison is required. Epidemiological studies of prison populations internationally have indicated that there is a two- to fourfold increase in the prevalence rates of those experiencing psychotic illness and major depression in prison compared to the general community (Fazel & Danesh 2002). This means that between 10% and 15% of offenders in many prisons have a serious mental illness. Furthermore, anxiety disorders, alcohol abuse, substance abuse and personality disorders all feature in this population, either as discrete diagnoses or as coexisting conditions (Brinded 2000). A recent report written in Australia (Ogloff et al 2006) identifies that screening and assessment for mental illness in justice agencies across Australia is inconsistent and that rates of major mental illnesses (such as schizophrenia and depression) are between three and five times higher in prison populations than those expected in the general community.

The reasons for the high prevalence rates of mental illness in prisons are complex and hotly debated. The overrepresentation of forensic clients may reflect that some offending is truly higher among some forensic clients; or that their offending is more easily detected; or that they are less able to defend themselves during court proceedings. It is also the case that when some people are imprisoned their psychological wellbeing is adversely affected by life in prison. Regardless of the reason, prisons have assumed the roles of acute mental health units and detoxification units by default.

Within the prison context, there are also high rates of offenders experiencing mild to moderate mental illnesses (such as anxiety and lower grade depression), alcohol abuse, drug abuse and problem gambling. A number of prisoners will experience anxiety and depression as a result of imprisonment. These mental health needs are primarily addressed by general practitioners and nurses employed by the prison, often supplemented by specialist alcohol and drug and gambling services (Dowell et al 2009).

The number of offenders with mental health problems in prison is also increasing due to a corresponding increase in the overall prison population. This is an international phenomenon. The international mean imprisonment rate for 218 countries has been calculated at 145 per 100,000 population. Australia’s rate is just below the mean at 129 per 100,000 and New Zealand’s rate is above it at 185 per 100,000 (Walmsley 2009, p 6).

In prison, offenders with mental health problems have the right to access mental health and addiction services equivalent to those accessible by the general population (Welsh & Ogloff 2003). The care and treatment of those experiencing serious mental illness (psychotic illness and major depression) may be delivered by external forensic or mainstream mental health services (in-reach services), forensic mental health services contracted to be on site, or correctional health services (part of the prison service). Regardless of the model, multidisciplinary mental health teams provide assessment and voluntary treatment for prisoners in New Zealand and Australia.

Prison mental health nurses case-manage offenders, addressing therapeutic needs within an environment designed for custodial purposes. This results in unique challenges. Nurses frequently face access constraints as space and privacy are limited; officers may be too busy to escort a client to an interview with the nurse; the prison may be in ‘lock down’ with no entry allowed into the prison and no movement allowed within the prison because of security threats; or perhaps the client has been transferred to another location. Within the prison environment, there are often difficulties in meeting the expressed needs of offenders with mental health problems for meaningful daytime activities, psychological interventions, medication education and multidisciplinary team expertise (Durcan 2008).

Prisons are designed to be places of punishment, retribution and deterrence and nurses working in prisons require a conscious commitment to maintain professional standards and ethical practice. The work of mental health nurses in prisons is generally not governed by mental health legislation. Small teams of nurses and sole practitioners can experience detachment from professional values and nurses need to recognise the potential for enculturation to criminal justice.
values. Prison regulations are at odds with what nurses can take for granted. For example, nurses are civilians in a prison and can make recommendations but not decisions for prisoner management; nurses have limited access to prisoners out of hours when prisoners are generally locked in their cells; and giving something seemingly innocuous to a prisoner can be considered as a contraband infringement. Nurses can maintain their professional resilience and therapeutic optimism by engaging in a range of professional and organisational strategies including reflection, professional development and clinical supervision, and by ensuring that they take opportunities to meet with mental health nursing colleagues.

Although nurses face challenges when working in prisons, they also experience many opportunities to practise in innovative, independent and expert ways. Nurses have key roles in many of the processes that are required for effective mental health service delivery in prisons, including:

- systematic mental health screening for mental illness at the time of reception
- ongoing mental health assessment and active treatment through a form of outpatient services

NURSE’S STORY: KATHERINE DUFFY, CLINICAL NURSE THERAPIST IN A PRISON MENTAL HEALTH TEAM

My role as a clinical nurse therapist was developed following recognition of the need for specialist psychological interventions for offenders with mental health problems. The remit I was given, as the first clinician to take this role, was to develop and implement group and individual interventions for clients on the case load. The team covers four separate prison sites including maximum security, remand and a women’s facility, and as such the people in these environments have quite diverse issues and circumstances, making the role a challenging and complex one.

It became clear that one of the areas of greatest need was the special needs unit of one of the prisons. This tends to be the area where individuals with severe and chronic mental health issues are housed and often they are unable to attend the programs that they need to meet the requirements of the parole board. This is a consequence of being unable to mix with mainstream prisoners due to their vulnerability. The requirements of the parole board often include education on mental health issues, education about the impact of drugs and alcohol on mental health and offending behaviour, and anger management. If prisoners are unable to attend these programs, they are unable to achieve parole.

It also became clear that there are a group of prisoners with complex mental health needs who are often transferred between prison and forensic mental health inpatient units. While these individuals are inpatients, they are able to attend therapeutic programs, which they often find extremely beneficial. Unfortunately, on their return to prison, they are unable to continue to work on issues that they have begun to address and the initial progress made by this hard work is lost.

It was decided that the first program to be run would be a ‘recovery’ program. This would address the issue of offenders in the special needs unit being unable to attend psycho-education groups; it would also provide some continuity of care between the prison and the inpatient units.

Building on this concept of continuity of care between prison and hospital, a group was devised by the occupational therapist and me on the acute admissions unit. This was a cognitive behavioural therapy (CBT) based group to look at new ways of managing stress. The idea was that we would co-facilitate the program in each environment, providing not only common understanding of concepts and language but also some continuity in terms of staff working with offenders. The group was a great success and we had unanimous positive feedback from participants, prison staff and the parole board. Not only are these groups now being run on a regular basis on the acute admissions unit and the special needs unit, but they have also been adapted for use at the women’s prison.

In addition to the development and implementation of group programs, there have also been a huge number of referrals for individual CBT. The variety of different issues that people can present with was a little overwhelming initially. The clients have often had very difficult histories with multiple traumas throughout their lives; they also often have coexisting major mental illness and personality disorders. Many of the referrals have been for people experiencing posttraumatic stress disorder related symptoms, depression, anxiety, obsessive compulsive disorder, hearing voices and self-injury behaviours.

I have been in this role for two years and no two days of that time have ever been the same. One thing that continues to surprise me is the motivation of the offenders that we work with. They attend weekly, having completed tasks that were set for them, and they actively engage in group activities. In fact, they are probably the most motivated group of service users I have ever worked with. Feedback such as ‘if you don’t learn this stuff then your mind is like an untrained monkey in the tree of life’ and ‘I have learned that my mental illness is like a motorcycle and drugs are the fuel that make it go’, make the hard work of planning and facilitating these groups worth every minute!
• administration of psychiatric medications in safe amounts
• a range of options in which treatment can take place—acute assessment or high-dependency needs units and rehabilitation units within correction centres
• referral processes that are required to facilitate access to psychiatric treatment outside of a prison when necessary
• systematic identification, treatment and supervision of prisoners with suicidal tendencies
• crisis intervention services
• assisting with the transition of, planning for and treatment of prisoners being transferred to other prisons or released. Post-release community transition can include making referrals for accommodation, employment, substance-use programs and other necessary supports (Ogloff 2002; Weiskopf 2005).

The nurse’s story by Katherine Duffy on p 413 demonstrates how nurses can contribute to the mental health of prisoners, despite the challenges of the location.

**Forensic mental health hospitals**

Forensic mental health hospitals (and units) take a range of forms that are influenced by local legislation, policies and other services that are available. Some forensic hospitals are stand-alone facilities, some are co-located with prisons and others are set within larger mental health services. These hospitals are able to provide specialist assessment and treatment in conditions of safety and security.

The clients who are generally found in the forensic setting are those who are:
• found unfit to plead
• found not guilty due to mental impairment at the time of the offence
• referred from courts for assessment and treatment
• prisoners who require involuntary treatment under mental health legislation
• referred from general mental health services who are too high a risk to be managed in a less secure environment

Forensic hospitals are able to provide acute care, rehabilitation, continuing care and pre-discharge planning to enable the safe and successful return of clients to the referring agency or placement in the community. Primarily the hospitals aim to assess and treat the forensic client’s mental illness, as well as to treat and manage, when present, substance use and personality disorder. There is also a need for risk assessment, treatment and management of factors related to offending behaviour. Work in the hospitals also supports the personal recovery of forensic clients, ameliorates the factors that decrease clients’ quality of life and facilitates successful re-integration into the community. Ultimately, forensic hospitals are charged with the responsibility of ensuring public safety through the safe containment of clients but more importantly through returning rehabilitated clients to the community. This challenge is reflected in the nurse’s story by Tony Berry opposite.

Forensic mental health hospitals are complex settings where the role of integrating therapy, recovery, safety and security is not well understood by justice agencies, mainstream mental health services or the community generally. Security refers to all the processes that ensure clients do not escape from the hospital or abscond from approved leave (Tilt 2000). The failure to maintain security may have implications for public safety should the offender abscond or be absent without approval. There are repercussions for the offender who escapes or absconds. They may lose leave privileges, be transferred to a more secure setting, or experience delayed discharge or release. Integrating therapeutic goals with security requirements is a challenge and the mental health nurse needs to creatively maximise therapeutic endeavour within the constraints imposed by security requirements. This emphasis on safety and security has physical, procedural and relational dimensions (Davison 2004).

**Physical security**

Forensic hospitals use a variety of technologies and structural elements to assist in the maintenance of physical security. These include:
• locked doors
• high walls and fences
• surveillance cameras
• locking systems
• alarms
• scanning devices such as metal detectors.

**Procedural security**

Procedural security refers to the policies and procedures that outline the requirements to maintain security and safety. These include:
• counting clients to detect escape
• counting and safe storage of equipment, tools and implements

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**CRITICAL THINKING CHALLENGE 22.1**

• What might be your response if you were assigned the care of someone who had killed another person and was found not guilty due to mental impairment (related to the client’s experience of mental illness)?
• How could your response influence your care for this person?
• What measures could you put in place to protect the therapeutic relationship if you were experiencing negative feelings towards this person?
For example, when searching a forensic client’s bedroom the nurse would be observing for frayed carpet, pieces of glass or other self-harm items, too many electrical items and cords—these observations are all concerned with safety. The cleanliness of the contents of the room, what clothing and personal items the client has, what hobbies and personal interests are evident could relate to therapeutic goals and provide information about the client’s mental and social state. The presence of maps, large sums of money and personal identification could identify security concerns. Anything identified by the nurse can be used as an opportunity for discussion with the client.

Nurses working within these facilities undertake assessment, assist with treatment and rehabilitation and facilitate recovery. Effective treatment and rehabilitation require that forensic clients are given opportunities to practise and test their progress in real-life situations. Leave is therefore an important component of hospital treatment, but approval of leave is dependent on factors such as legal status, risk assessment and the perceived contribution of leave to facilitate rehabilitation goals. Leave from the hospital remains a vulnerable area for forensic mental health services, because political and media reactions to escapes or absconding are generally extreme. The impact on nurses is great as they are often the escorts for clients, but the greatest impact is on the client: not only is the absconding client affected by having their level of security reviewed, but all clients can be affected when all leaves stop or when stricter conditions of leaves are applied to all clients. Nurses carry a great responsibility to sometimes protect forensic clients from their own actions.

**NURSE’S STORY: TONY BERRY, INPATIENT FORENSIC MENTAL HEALTH NURSE**

A pool hall may seem an odd place for a forensic mental health nurse to be found during work hours, but not if you’re Tony Berry and the people you are supporting are practising drug-refusal techniques.

“We go into pool halls and bars to practise drug-refusal skills in the real world, so service users experience the sensory effects of these environments. By ordering their own non-alcoholic drinks at the bar, the people we are supporting have to talk to bar staff and cope with this new experience of not drinking’, explains Tony.

‘Before the community outing, we do a motivational interviewing group program (You Call the Shots) and theory sessions that focus on goal setting, assertiveness training, drug-refusal skills and relapse prevention. These programs focus on the skills and strengths of people, their communication with others, and what they need to do to cope with cravings and offers of alcohol and drugs in the community. It is a progressive thing. Once we know they have grasped the theory, we choose people who are ready for the community part. The people we are supporting are referred through the multidisciplinary team reviews’.

Tony runs the program in his role as a forensic mental health nurse on a secure 20-bed mental inpatient rehabilitation unit. The alcohol and drug program was developed with the realisation that more than 90% of service users in the inpatient area had been heavily involved in alcohol and drugs in the weeks leading up to their index offence. It is part of the overall wellness and recovery programs at the facility.

Source: Adapted from Te Pou 2010 Fostering change: Tony Berry, forensic psychiatric nurse. Handover Winter 5–6.

**CRITICAL THINKING CHALLENGE 22.2**

Identify how nurses can integrate therapeutic, safety and security goals when undertaking the following procedures:

- searching a bedroom
- counting cutlery
- supervising a person
- screening communication.

For example, when searching a forensic client’s bedroom the nurse would be observing for frayed carpet, pieces of glass or other self-harm items, too many electrical items and cords—these observations are all concerned with safety. The cleanliness of the contents of the room, what clothing and personal items the client has, what hobbies and personal interests are evident could relate to therapeutic goals and provide information about the client’s mental and social state. The presence of maps, large sums of money and personal identification could identify security concerns. Anything identified by the nurse can be used as an opportunity for discussion with the client.

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ETHICAL DILEMMA

A client’s presentation, ability to meet rehabilitation goals and risk assessment indicate that he is ready for escorted leave in the community. However, you are aware that his violent offence has attracted substantial interest from the media, including the publication of his photo. How could you balance the client’s rights for rehabilitation in the community with the rights of the general public to feel safe?

Security procedures can be invasive and some are exceedingly invasive. However, it is the way the procedures are carried out that can have the greatest impact on clients and on nurses’ ongoing relationship with patients. Insensitivity can potentially damage the results of effective interpersonal work (Collins 2000).

The community

The correct treatment, support and level of supervision are essential to assist forensic clients to maximise their success in transition from prison or a forensic mental health hospital to the community. Crucial supports include early, meaningful engagement with mental health services and substance-use agencies. Justice agencies may also be involved if the client is on bail or parole or another order requiring ongoing justice involvement. Assistance to address social care needs is crucial and includes the need for housing, food, financial assistance, employment and social supports (Freudenberg et al 2005).

The planning to establish this support should commence a number of months before a person is released from custody. Those agencies who will work with the client after they leave custody should start building a relationship with them by visiting them while they are still in prison or hospital. This pre-release planning and relationship-building bring together a variety of possible supports in partnership with the client. Through this process it is more likely that all involved will clearly understand each other’s roles and be able to demonstrate a clear commitment to the client following release. In addition, this ensures time for trust to be established, which makes engagement more likely once the client is in the community.

Imprisoned offenders constitute a small proportion of the sentenced population, with the criminal justice system favouring community sentencing options (Elias 2009). Little is known about the rates of mental illness in this population, although literature from the UK indicates that approximately 30% of the probation caseload have had formal contact with mental health services (Brooker et al 2008). Clients who offend and have been placed on community-based orders are usually linked to general mental health services. Furthermore, general mental health services engage with clients with complex needs who may have a forensic history or patterns of behaviour indicative of potential criminal involvement. Specialist community forensic liaison roles involving mental health nurses and psychiatrists have been piloted to assist mainstream mental health services to manage this group of clients.

Specialist community forensic mental health teams have also been established to assist forensic clients transitioning to the community from forensic hospitals and prisons. The model of care of these teams often involves intensive case management with the goal of eventual transfer to general mental health services. Forensic mental health community services provide assessment, consultation and ongoing treatment or shared care with general mental health services.

In Australia there are numerous sources of referral to community forensic mental health services, including forensic mental health hospitals, justice agencies (courts, prisons, community corrections or the parole boards) and legal aid centres. Forensic clients are not always well accepted by mainstream community mental health services and tend to be referred to community forensic mental health services if they have a past history of violence and other offending; high levels of anger, suspicion or hostility; poor response or non-adherence to treatment and service engagement; or substance misuse (Gilmour & Edment 2001).

As case managers in community forensic mental health teams, nurses coordinate necessary services including health, legal, social, vocational, financial and accommodation services. They assist to manage mental illness, substance abuse, offending and other specific concerns, in order to facilitate clinical recovery and support personal recovery. The community care of forensic clients also requires working with families and carers. Collaboration is often required for joint management with other agencies to comprehensively address complex needs and avoid duplication in services (Edment 2002).

The knowledge, skills and attitudes required of the forensic mental health nurse

In Australia and New Zealand, the term ‘forensic mental health nurse’ is applied to a nurse working in forensic mental health or criminal justice settings, rather than being a professionally recognised classification. Most mental health nurses, at some time, will provide care and treatment for clients with an offending history or at risk of offending. When a client has committed an offence and is experiencing mental illness, the nurse is expected to apply the core knowledge, skills and attitudes of nursing generally, mental health nursing...
specifically and the additional or enhanced skills that are required to work effectively with forensic clients. The following section considers some of the knowledge, skills and attitudes that are needed by mental health nurses providing care and treatment to forensic clients in police custody centres, prisons, forensic mental health hospitals and the community.

Assessment and management of risk

In forensic mental health nursing, the nurse undertakes rigorous risk assessment processes with forensic clients to identify the factors that indicate risk to self or others and the protective factors that mitigate such risk. Forensic mental health risk assessment has developed considerably since Monahan (1983) argued that psychiatrists and psychologists appeared to be wrong at least twice as often as they were right in their unstructured clinical predictions of violence. We have since moved from a second generation of actuarial prediction to a third generation of structured professional judgement. The third generation of violence risk assessment has moved beyond the prediction of an adverse event to the identification of the risk factors that contribute to the likelihood of an adverse event, a focus on dynamic factors that are open to clinical modification to reduce such risk, and an emphasis on protective factors that if enhanced also diminish the potential for adverse events (Mullen 2000). Prevention and management of offending, especially violence, have become the focus of contemporary risk assessment in forensic mental health.

Following assessment, the nurse implements evidence-based interventions to manage risk and assists forensic clients to self-manage their risk behaviours. This dynamic process requires ongoing risk assessment and adaptation of interventions according to the client’s changing risk status. All of these processes are therapeutic tasks that should occur within the context of the therapeutic relationship (Mullen 2000). Risk assessment and management involve a structured professional judgement based on a three-phase sequential process. This process encompasses gathering accurate information, understanding the person’s pathway to violence and developing a pathway to safety (Evans et al 2006).

Gathering accurate information

The first phase of structured professional judgement in risk assessment involves an understanding of the client’s historical involvement in risk behaviour through gathering accurate information about past incidents. For each event, a description must be gathered of what actually transpired. For example, in cases of violence the following factors could be identified:

- hazard identification (which event will occur?)
- imminence (how soon?)
- hazard accounting (how frequently? how serious?)
- scenarios of exposure (in what context?)
- risk characterisation (what conditions are present?)
- nature of violence (instrumental or reactive?)
- targets/victims
- weapon use (what type? how lethal?) (Woods 2001)

This form of assessment enables an understanding of the event but it is also necessary to comprehensively assess the range of factors that have been found to be correlated to the risk being assessed. A number of forensic risk assessment tools have been developed through extensive research and validation studies to assist in the process of structured professional judgement. These tools are formally administered but can also be used as aide’s memoir to assist in covering the range of risk factors that need to be considered in gathering information and pattern recognition. They also enable clarification of those risk factors that are static (cannot be changed) and dynamic (can be changed through risk management).

The three most-used forensic risk assessment tools are as follows:

- The HCR-20 (Historical, Clinical and Risk 20; Webster et al 1997). This 20-item risk assessment tool assists in articulating risk to others through historical involvement in violence and the presence of the mental health-related and situational risk factors.
- The START (Short-Term Assessment of Risk and Treatability; Webster et al 2009). The START is an adaptation of the HCR-20 that considers more general risks beyond risk to others. It also assists in the identification and assessment of protective risk factors, which, if present, could prevent or reduce the likelihood of an adverse event.
- The Level of Service/Case Management Inventory (Andrews et al 2008). This assessment tool identifies and measures the risk factors of offenders. The tool also assists in the identification of strategies for treatment planning and management of offenders in justice and forensic mental health settings to reduce recidivism.

Risk factors considered in these tools include the items shown in Box 22.3.

Comprehensive information needs to be collected in a systematic manner. Some of the sources that help to contribute to the collection of comprehensive information about the client are: interviews with the forensic client, their family/carers and any person with relevant information to contribute to the process; a review of the clinical files and other documentation (e.g. legal reports, incident reports); and the use of relevant risk assessment tools.

Risk assessment requires input from the multidisciplinary team. Other health professionals contribute expertise in specific areas, and criminal justice staff should also be consulted as they often have information about the client that augments the assessment.
Understanding the pathway to violence

A detailed understanding of individual events, supported by a structured risk assessment and clinical judgement, enables the second phase of structured professional judgement, which is the determination of the client’s pathway to violence. The factors that have been identified in the assessment are pulled together in a risk statement that allows for specific treatment and management strategies to be identified. For example: ‘This person is at risk of (specific risk behaviours) when they are experiencing (specific internal factors) in the following circumstances (specific situational aspects that support the behaviour)’ (Evans et al 2006).

Developing a pathway to safety

Historical factors provide good information about a client’s offending, but the risk factors and attributes of the offender are usually dynamic in nature and can be altered through active treatment and management. Identification of these risk factors and attributes automatically highlights what can be done in order for a risk to be averted. Therefore, management of these factors constitutes the third phase of structured professional judgement, which is developing a pathway to safety for the individual.

The offending risk assessment is a transparent and accountable process that aims to improve the consistency of decisions that inform treatment and risk management to prevent offending. The process is useful to determine the appropriate setting for the forensic client, to identify those forensic clients requiring intensive interventions and to inform leave and discharge decisions. The risk assessment facilitates effective communication between the people and agencies involved with the client and forms the basis for advice or reports for ongoing treatment and management.

BOX 22.3
RISK FACTORS CONSIDERED IN THE THREE MOST-USED FORENSIC RISK ASSESSMENT TOOLS

- Adherence with medication
- Antisocial attitudes
- Antisocial patterns of behaviour
- Barriers to release
- Case-specific factors
- Companions/peers
- Coping skills
- Criminal history
- Early maladjustment
- Education
- Emotional state
- Exposure to destabilisers
- External triggers
- Family/marital
- Impulsivity
- Insight
- Leisure/recreation
- Material resources
- Medication adherence
- Mental state
- Occupation
- Personal support
- Personality disorder
- Plans
- Previous violence
- Prior supervision failure
- Prison experience—institutional factors
- Psychopathy
- Recreation
- Relationships
- Responsiveness to treatment
- Rule adherence
- Self-care
- Social skills
- Social support
- Stress
- Substance use
- Young age at first violent incident

CRITICAL THINKING CHALLENGE 22.3
Consider the risk assessment factors that are included in the commonly used forensic mental health risk assessment tools (see Box 22.3). Select a few factors and identify what mental health nursing strategies could be used to treat and/or manage these factors.

Use of coercion

Given the emphasis in forensic mental health nursing on risk assessment, risk management, security and safety, the ability to implement these processes with therapeutic intent suggests a challenge. The tension is amplified by the use of legal mechanisms that support all of these processes. It is preferable that mental health clients enter into treatment voluntarily; however, some forensic clients may not be competent or willing to enter into such arrangements.

The therapeutic goal of legal sanctions to enforce treatment is that of beneficial outcomes for the person suffering from mental illness. Yet the paradox is that it may result in the recipient experiencing limited choice, limited autonomous decision making or limits to their ability to act on their own volition (coercion). This may in turn be detrimental to the therapeutic intent, create mistrust of those trying to help and lead to long-term difficulties of engagement with those services intended to assist. Significant coercion is experienced by forensic clients admitted to forensic hospitals under mental health legislation (McKenna et al 2003).

Therefore, it is important that nurses understand how coercion is perceived by clients and implement strategies to reduce clients’ perceptions of coercion in attempting to achieve the goal of beneficial therapeutic outcomes. The best strategies are grounded in the therapeutic relationship, which is the cornerstone of mental health nursing practice. Irrespective of their placement in a forensic service, clients should be exposed to processes that are fair and free from the value biases and vested interests of decision makers (including nurses), and that include mechanisms for correcting bad decisions. Clients should be able to express their views

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and have these views considered seriously by clinicians. This open and honest dialogue should leave clients feeling that they have been treated with dignity, respect, politeness and concern. Forensic clients also require accurate and relevant information about the procedures they are involved in (McKenna et al 2006).

As soon as the door is locked or constraints are placed on a forensic client’s freedom, a power dynamic is created between the nurse and that person. This power dynamic is further enhanced by the rules through which the cohesiveness of the ward community is maintained. It is inevitable that the nurse, as the main enforcer of these rules, is perceived to hold power over the forensic client. This is often a source of conflict, as forensic clients often struggle with rules, authority and impulsivity related to antisocial beliefs and values. Within the custodial environment of a forensic hospital there is limited flexibility. It is important that what little flexibility exists is framed to allow the optimal degree of choice and autonomy for clients.

Nurses can reduce client frustration by providing explanations as to why certain rules apply and giving clients the opportunity to discuss their concerns about security requirements, rules and limits that have been imposed. Such empathic, open, honest discussions can help alleviate client concerns. For example, a client may request time alone at a time when staff numbers and other ward concerns make the supervision required difficult. Rather than flatly refusing this request, the nurse can express a spirit of compromise by creatively exploring other options, such as delaying the time alone to another time of the day when ward priorities are less pressing. Situations like this can escalate into conflict, or they can be treated as therapeutic opportunities to assist clients to problem solve, delay gratification and show understanding of the needs of others.

Safety
The need for safety in the forensic mental health hospital is crucial. Forensic clients generally have a mental illness, a history of offending, and personality attributes and ways of acting and reacting that heighten their potential for risk of harm to self and others. Nurses working in forensic hospitals are likely to be caring for clients who consistently present with seriously challenging behaviours, including aggression and violence (Mason 2002; Murphy & McVey 2003). Aggression may be an inevitable outcome of providing treatment to involuntary forensic clients, some of whom will have limited skills to manage anger that is provoked by the ongoing demands, expectations and conflict of inpatient treatment (Daffern 2007). While mental illness may influence a client’s aggression, other behavioural and cognitive processes (recent history of substance abuse, entrenched negative attitudes, antisocial behaviour) play a significant role in increasing the potential for aggressive behaviour (Daffern et al 2007a). The most common offence committed by forensic clients is violence (Braham et al 2008). Forensic hospital nurses are faced with managing behaviours that are not always related to clients’ mental states, and the consequences available for such actions may be insignificant for clients who have been exposed to punitive conditions during incarceration and may have experienced mistreatment during their life (Daffern et al 2007a).

Although there are barriers that work against nurses in forensic hospitals being able to safely manage forensic clients, there are also opportunities, such as the benefits of longer admissions, resulting in reduced access to illicit substances and increased access to treatment (Daffern et al 2007b; Mullen 2006); a higher staff–patient ratio (Kennedy 2002), providing the opportunity for nurses to work with clients to undertake assessment, treatment and other environmental interventions; and access to best-practice risk assessment and management tools. Martin and Daffern (2006), in their study of clinicians at one forensic hospital, found that clinicians reported confidence in their ability to manage aggression in an environment where aggression is frequent. Certain organisational factors that are generally more developed in forensic hospitals (such as training, competent colleagues, a physical environment that is designed to prevent and manage aggression, policies and procedures) can support a perception of safety, which may then contribute to confidence in effectively managing aggression.

Promote optimal physical health
Forensic clients are at a high risk of developing metabolic syndrome and associated physical illnesses such as diabetes, cardiovascular disease and respiratory problems (Gray 2002). Although a key contributing factor is the use of antipsychotic medications (Graham et al 2008), restrictions on activities and lifestyle choices in custodial environments contribute to physical health deficits. Forensic mental health nurses must contribute to an environment that promotes a healthy lifestyle...
through health education and health-enhancing activities. A comprehensive nursing health assessment must include physical health and the nurse must work with the client, their family and the multidisciplinary team to develop, implement and evaluate treatment plans that promote and enhance optimal physical health. In the literature there are examples of mental health nurses initiating healthy living programs targeted to address physical healthcare concerns with forensic clients (Prebble et al 2011).

The ethical dimension in forensic mental healthcare

For some nurses, the ability to provide care can be potentially compromised by the complex presentation of some forensic clients. Antisocial personality attributes that are not pleasant to relate to may present as a contributing factor that clouds the forensic mental health nurse’s ability to place moral judgement to one side—for example, when the nurse becomes the target of hostile, manipulative or threatening behaviour, or when the client splits staff into those liked and disliked and attempts to play staff off against each other. Forensic mental health nursing research has articulated the difficulties that nurses face in confronting moral judgements concerning offending behaviour. Poor judgements regarding this behaviour compromise the delivery of nursing care. For instance, framing a client as primarily ‘bad’ can result in a total absence of planned care in the form of care plans for this client (Mason et al 2002).

It is essential that forensic mental health nurses recognise and manage their personal feelings and values related to the offences committed by forensic clients. Nurses who focus on the offences and allow their feelings and values to dominate their clinical perspective of service users will be ineffective in providing care. Often, professional dissonance is experienced. Equally inappropriate is the belief that the offending behaviour is not a concern of the nurse. In such cases nurses may choose to ignore offending behaviour because they find the personal and moral effects distressing. But by ignoring the offending behaviour, a significant forensic client need is not addressed. It is offending and other antisocial behaviours that distinguish clients within the forensic mental health setting. The professional response is to view offending behaviour as another need to be addressed during therapeutic engagement with the forensic client. Clients need to understand the factors associated with their offending behaviour in order to increase their personal choice and responsibility.

Nurses are involved in both individual and group processes aimed at addressing offending behaviour. However, the specific complexities of offenders, coupled with the very nature of the custodial environment, create a tension in the caring role (Austin et al 2006). Failure to resolve this tension can lead to the adverse development of ‘cultures of toughness’ (whereby intimidation and force are used to manage clinical settings), boundary violations (whereby professional relationships revert to personal, even intimate, relationships), counter-transference difficulties (whereby nurses allow personal issues to cloud the therapeutic relationship), cynicism regarding the value of the therapeutic relationship and avoidance in addressing the needs of forensic clients.

Strategies to manage this tension include professional supervision, exposure to new ideas through staff development initiatives and the development of a culture of critique, which continuously scrutinises clinical decision making, practice and communication with forensic clients. Mental health nurses can turn to professional codes of conduct and ethics to assist in solving ethical dilemmas. (See Chs 1, 5 and 24 for more information about clinical supervision, professional relationships, counter-transference and other professional and ethical practice issues.)

Multidisciplinary team involvement

Multidisciplinary team input at all levels of service delivery is an accepted practice in mental health care. The multiple disciplinary perspectives, knowledge and skills enhance assessment and treatment of clients. The mental health nurse works as a member of a multidisciplinary team at the interface of the criminal justice and mental health systems and is likely to be working in teams that include criminal justice staff. These staff can include prison officers, community corrections officers, police officers, security staff, court staff, solicitors and lawyers. Other external agency staff may also join teams to support clients’ mental health, social care and recovery needs, including alcohol and drug providers and staff from the non-governmental sector such as supportive accommodation providers and disability employment agencies.

Mental health nurses need to understand the Australian and/or New Zealand politico-legal context (see Ch 4) in which they are working. They also need to develop ways of working collaboratively and without compromising professional nursing standards with justice colleagues whose focus may not be primarily on healthcare. Nurses based in prisons and police custody centres work in settings that are not health-oriented and where the culture is custodial. Working effectively with the range of justice staff is best achieved when the interface between the disciplines is flexible and versatile and there is understanding of complementary interests and skills (Woods et al 2000). The nurse’s stories of Kevin Seaton and Katherine Duffy demonstrate that forensic
mental health nurses can and do integrate nursing skills effectively within the framework of the criminal justice system.

While effective communication can improve assessment and treatment, provide support and reduce risk, nurses must be aware of issues of confidentiality related to healthcare and adhere to policies and legislation regarding verbal and written communication with justice colleagues. They must also be aware of the potential for enculturation to criminal justice values. Evidence of this may be reflected in the adoption of language used by custodial officers and an unhelpful attitude to offenders in the nurse’s care. This can be exacerbated by isolation from the broader context of healthcare if nurses are primarily working in one place, such as a prison. Nurses can work to maintain professional resilience by engaging in professional processes such as education and clinical supervision and maintaining links to mental health nurses who are external to the custodial setting.

**Culture and family**

Chapter 7 in this book describes Indigenous mental health. There is a strong need for cultural competency and cultural safety in forensic mental health nursing. This is a critical component of care in forensic mental health given the overrepresentation of Indigenous and migrant cultures in forensic mental health services. There is a strong awareness in forensic mental health services of the cultural needs of the communities served and the necessity for an appropriate response to these needs. This has led to innovation in service responses, including Indigenous courts and the development of secure rehabilitation services combining Indigenous and other professional approaches to recovery. Forensic mental health nurses must pay attention to cultural needs throughout the therapeutic process. Additional cultural expertise may be needed to assist this; for example, the inclusion of local Indigenous elders in forensic mental health consultation processes, community outreach and rehabilitation plans.

Central to any culture is the family. Family members have the potential to provide a vital link to the community for the client and to promote the client’s wellbeing through supportive relationships. However, mental illness, and the nature of the offence and its consequences, may compromise this potential. For example, family members are more likely to be victims when perpetrators of serious violence have a mental illness (Simpson et al 2003). Furthermore, containment of the client can have an impact on family function (emotional, financial or social). The nurse must be part of the multidisciplinary team endeavouring to assist in healing family relationships and maximising the potential of the family to be partners in addressing the needs of forensic clients.

**Minimising stigma and discrimination for forensic clients**

The possible outcome of clients’ engagement with forensic mental health services is double stigma: criminality and mental illness. Community attitudes towards both are misinformed, ignorant and fearful. The media, through which the public becomes ‘informed’, tends to present offenders with mental health problems in a manner that potentially feeds into this stigma (McKenna et al 2007). This stigma in turn impacts on identity, self-concept and self-esteem. Understanding, support, education and advocacy are necessary to combat stigma and discrimination. It is crucial that forensic mental health nurses work in partnership with forensic clients in this regard.

**Conclusion**

We hope this chapter has assisted you to explore the practice reality of forensic mental health nursing. We especially hope that it assists the learning of undergraduate nursing students, upon whom future innovations in such services will depend. If we could sum up the challenges of forensic mental health in one word, it would be ‘complexity’. This complexity relates to the needs of forensic clients, the configurations of services to meet these needs and the law that dictates service provision. All of these present as challenges to forensic mental health nursing practice. However, the satisfaction with nursing in this area is a direct corollary of this complexity. It has instilled in us a passion for working with offenders with mental health problems. If it is a career pathway that you also intend to embrace, we look forward to what you have to offer this crucial task of serving some of the most vulnerable people in our society. The relationships we establish with forensic clients are pivotal to what we do, although there is recognition that forensic clients often come to the relationship with a history of trauma, distrust and cynicism. Breaking through such barriers is possible when you maintain therapeutic optimism and an ethical approach to care. Enjoy the work!
MAIN CASE STUDY: REDEMPTION VERSUS STIGMA

In 2007, a part-time employee at a zoo was sacked when the media revealed to his employer that he was a service user at the local forensic mental health service. Six years earlier the man had tragically killed his mother when he was psychotically ill. The courts found him not guilty for reasons of insanity and since then he had engaged well with services addressing mental health and offending related needs. The employment was part of a rehabilitation pathway towards successful integration into the community (Rudman 2007). In response to this event a fellow service user wrote the following letter to the editor, which exemplifies the stigma offenders with mental health problems experience.

Dear Editor,

One of my mother’s catchphrases was ‘make yourself useful’. I think every human needs to feel that they have something, however small, to contribute, to someone or to society. Even though we are all here [in a forensic mental health service] because we have violated human laws in some way, we feel this need too. Perhaps especially much because we have all done wrong: we need to make up for our bad deeds, to try to balance the scale somehow. In a recent newspaper article about prisons, the author stated that the main desire of the prison population is to be able to make up for the harm they have done to family and society. Apart from the odd psychopath, I guess most of us are not so evil that we can live easily with the harm we have done.

In this sense, being incarcerated without anything constructive to do is truly the worst punishment. There is no way to balance the scale, no way to contribute in the smallest way, no hope even of looking after ourselves, as everything is done for us, provided for us. All that are left are very long days of reliving again and again the past. This is justice I suppose, and when I was a normal person I would not have cared for the emotional suffering of prisoners as long as they were away from ‘good’ people. Now, I am obsessed with the idea of redemption—I suppose it is hard to contemplate being consigned to the scrapheap for the rest of my natural life, just though this may be.

Watching Oprah today, she said what many others have expressed also, that you cannot fill your life with things, even with ambitions or achievements. The only way you can fill yourself with life is to give yourself away.

Making yourself useful, seeking redemption, giving yourself away—three ways to see the business of living. Easily done perhaps when we are well and free, and something that most people do as naturally as breathing; giving time, effort and care to family, friends, neighbours, work, and leisure interests. But when you have gone off the tracks, or have to struggle with mental illness, when you cannot work, when family and friends do not call any more, when your freedom has been taken away, how can you give? Yet that is the only thing to live for, and when you are sure you have no way left to give, then that must also be the end of living.

So how can we incorporate usefulness, giving and redemption into this environment? There are so many limitations, society needs to be kept ‘safe’ from us, and many of us have problems that separate us from ‘normal’ people. But we may still have potential to contribute, the will to work. I have met people here who are talented in art, music, writing, sport; whose talents are wasted in the aimlessness of daily life here. Although the staff do their best to facilitate outings and activities, the structure of the system and the limits of their time make this an uphill battle. I am told that this used to be a working farm, with inmates providing all the labour, producing and cooking their own food and doing all chores for themselves. This must have been so much healthier an environment, apart from saving the taxpayer a lot of money. Perhaps there is not the space for this now, but the small efforts at enterprise that are provided now are much appreciated by those that have the chance to participate—surely this approach could be expanded so that we are all gainfully occupied each day?

The other thought that occurs is that voluntary work could be encouraged. Many inmates are not considered a threat to others and do not need supervision—could they not try to redeem themselves and make use of any potential they have by giving of themselves in any of the hundreds of volunteer organisations that exist in the community? There are groups to suit any inclination: working with animals, youth, local or regional conservation, helping new migrants, teaching English, coaching sports, helping the infirm, disabled or dying, constructing housing for disadvantaged families—the list could go on forever.

I understand that we have to earn the right to be trusted again with any degree of liberty. But for those that are judged not to be a risk to society, who are trusted to go to the shops unescorted, there should be more opportunity to do something with that liberty, to contribute. I believe we all want to live again, to be useful, to give. Source: Rudman B 2007 Zoo’s sacking of Burton less than a fair go. New Zealand Herald, 28 March.
EXERCISES FOR CLASS ENGAGEMENT

Discuss the following questions with your group.

• Explore your own responses to caring for forensic clients whom the general public might consider to be ‘bad’ and ‘mad’. Brainstorm what sort of challenges these clients might present for nursing care.

• What factors could influence the therapeutic relationship when the client is also an offender?

• The court liaison nurse or prison nurse needs to work closely with justice colleagues whose focus is not primarily on healthcare. Discuss some of the challenges you might encounter in working collaboratively with justice colleagues.

• Brainstorm the different skills, knowledge and attributes you believe are required of the forensic mental health nurse when working in a prison, court or forensic mental health hospital setting.

• Wherever forensic mental health nurses are working, it is their responsibility to understand the legislation that impacts on their practice. Locate from websites in your state or country the criminal justice legislation regarding ‘unfit to plead’ and ‘not guilty by reason of mental illness’ (or its equivalent). What are the implications of these laws for clients (i.e. where people are sent, for how long and how clients can have their legal status changed)?

• The mental health nurse must always be thoughtful about engaging the service user’s family, carers or significant others in their treatment. When a client is also an offender, what do you think might be the needs and concerns of the family/carers/significant others? What can mental health nurses do in their work with them?

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