Standards of Practice for Forensic Mental Health Nurses—Identifying Contemporary Practice

Trish Martin, RN, DN\textsuperscript{1,2}, Tessa Maguire, RN, Grad Dip FBS\textsuperscript{1,2}, Chris Quinn, RN, Grad Dip (MHN)\textsuperscript{1,3}, Jo Ryan, RN, BEd\textsuperscript{1}, Louise Bawden, RN, BAppSci \textsuperscript{1}, and Monica Summers, RN, Grad Dip (AdvClinNsing)\textsuperscript{1}

ABSTRACT
Forensic mental health nursing is a recognized field of nursing in most countries. Despite a growing body of literature describing aspects of practice, no publication has been found that captures the core knowledge, skills, and attitudes of forensic mental health nurses. One group of nurses in Australia have pooled their knowledge of relevant literature and their own clinical experience and have written standards of practice for forensic mental health nursing. This paper identifies the need for standards, provides a summary of the standards of practice for forensic mental health nurses, and concludes with how these standards can be used and can articulate to others the desired and achievable level of performance in the specialty area.

KEY WORDS:
Forensic mental health nursing; forensic psychiatric nursing; knowledge; role; skills; standards

Forensic mental health nursing practice can be defined as undertaking an assessment, developing a formulation, planning, implementing, and evaluating nursing care and treatment, within a therapeutic alliance, with people experiencing mental illness and who have a history of criminal offending or who present a serious risk of such behavior. Across many international jurisdictions, this definition will broadly capture what it is that forensic mental health nurses (FMHNs) do and who their patients are. Common sites where these nurses practice are law courts, police custody centers, prisons, secure hospitals, and community services.

However, not all FMHNs work with criminal offenders and could, for example, be undertaking a mental health assessment and providing nursing treatment and care to victims of trauma or providing mental health assessment and advice (American Nurses Association & International Association of Forensic Nurses [IAFN], 2009). Lyons (2009) made a distinction between the roles of forensic psychiatric nurses and correctional psychiatric nurses in the United States. Forensic psychiatric nurses assess victims and perpetrators and provide expert evidence and make recommendations for treatment. Correctional psychiatric nursing appears to be concerned with providing that treatment. The role of FMHNs may be more aligned to that of correctional nurses, although it should be noted that Kent-Wilkinson (2011) does not make this distinction and merges the roles.

Despite attempts in the literature to describe this emerging area of nursing, no recent publication has captured the potential scope of practice of FMHNs. Charged with the responsibility for the scope of practice and professional development of nurses at one Australian forensic mental health service, a group of senior nurses decided to develop standards that would describe and guide the practice of FMHNs with adult forensic service patients (FSPs). These standards are grounded in the experience of these senior nurses and the relevant literature.
Mental health nursing is a specialty of nursing, and the authors of the standards subscribe to recognized acceptance of FMHN as a subspecialty of mental health nursing. Therefore, these FMHN standards must be considered as building on nursing standards that are common to all nurses (e.g., the National Competency Standards for the Registered Nurse authored by the Australian Nursing and Midwifery Council, 2003) and further as building on mental health nursing standards (in Australia, e.g., the Standards of Practice for Australian Mental Health Nurses authored by the Australian College of Mental Health Nurses, 2011). Replication of standards was inevitable as nurses in forensic settings are delivering core mental health nursing care, albeit in a modified, extended, or adapted manner, to meet the needs of the patients and the context. Meeting the standards of nursing and mental health nursing is therefore a necessary requirement before meeting these FMHN standards. In addition to being a subspecialty of mental health nursing, FMHN is also a subspecialty of forensic nursing (Kent-Wilkinson, 2011), and the Forensic Nursing: Scope and Standards of Practice (American Nurses Association & IAFN, 2009) provide another set of practice standards for FMHNs to consider.

The development, use, and monitoring of professional standards assist services toward the assurance of quality care (Neville, Hangan, Eley, Quinn, & Weir, 2008; O’Brien, Bobby, Hardy, & O’Brien, 2004) by ensuring that health professionals are accountable for the provision of safe, competent, and ethical care (Peternelj-Taylor & Bode, 2010). This paper describes the rationale and the process of developing standards for FMHNs. The individual standards will be identified and explained, and lastly, the implications for FMHN practice will be given.

The Knowledge, Skills, and Attitudes of FMHNs

The FMHN practices at the interface of justice and mental health where the patient population does not fit neatly in either department. It is a complex field for nurses whose undergraduate training does not address offending issues or prepare them to care for patients who can “evoke feelings of disgust, repulsion and fear” (Jacob, Gagnon, & Holmes, 2009, p. 153).

The competencies of FMHNs were first reported by Niskala (1986) in Canada. Of the 13 general areas of competency, the two that appeared to be directly specific to FMHN were maintaining security and instructing offenders. In England, Benson (1992) surveyed clinical nurse specialists in forensic mental health to identify the elements of skill and knowledge most relevant to their practice. Assessment and management of dangerous behaviors, criminology, law and professional accountability, therapeutic use of security, social policy, and ethics were identified, but the nurses had received little appropriate education and did not believe themselves to be competent in all areas.

Dhondea (1995) in Australia also attempted to make sense of what nurses do in a forensic mental health setting, and like Niskala (1986), the findings were limited to only two of the six recommendations being directly relevant to forensic mental health: maintaining security and understanding legal processes affecting patients. Burnard and Morrison (1995) found that nurses in forensic contexts had difficulty in articulating exactly what it is that they did that might be therapeutic. This resulted in Peternelj-Taylor (2008) still asking “What knowledge and skills are required to provide competent and ethical nursing care in restrictive correctional environments?” (p. 186). The question can be broadened to include all forensic contexts.

Exploration of the role of the FMHN has continued with some attempts to identify the required knowledge and skills. Bowring-Lossock (2006) claimed that there were benefits to clarifying the role of FMHNs and through a literature review identified task-orientated competence and desirable personal qualities. These included safety and security, risk assessment and management, management of violence, providing therapy, knowledge of offending and legislation and ethics, report writing, understanding the criminal justice system and “jail craft,” understanding public attitudes, having an appreciation of control and the secure environment, and the nurse–patient relationship.

One research project (Mason, Coyle, & Lovell, 2008; Mason, Lovell, & Coyle, 2008) investigated the skills of FMHNs. The top 10 special nursing skills were identified by surveyed FMHNs as skills for nursing personality disorders, listening skills, confidence, clinical knowledge, communication skills, nonjudgmental attitude, empathy, patience, knowledge of offending behavior, and multidisciplinary working (Mason, Lovell, et al., 2008). Personal qualities were reported more often than nursing skills. The FMHNs then identified the top 10 aspects of nursing care to be developed as personality disorders/psychopathic disorders, nursing team working, offense-related work, research skills, multidisciplinary team working, communication skills, psychosocial interventions, nursing diagnoses, addictions, and consistency among staff (Mason, Coyle, et al., 2008). Mason, Coyle, et al. described this list as a “disparate farrago of areas and interventions” (p. 137) and concluded that there is still some distance to go before the skills and competencies of FMHN are clearly delineated.

Timmons (2010) drew on the framework of an earlier study (United Kingdom Central Council, 1999) to survey mental health nurses in a high security setting in Ireland. Some highlighted findings include the therapeutic alliance
being a vehicle to keep patients safe and manage their needs and risks, and a reduced confidence to undertake specialist assessments and address offending behavior. Twenty per cent of survey respondents did not consider risk assessment to be very important, and very few nurses worked directly with families. Finally, supporting recovery and human rights although important was challenged by the need for security and risk management. Much of the role was focused on mainstream mental health nursing practice, and the specialist forensic practice was reported as being deficient. These findings support those of Martin and Street (2003) where examination of nursing case file entries in a forensic unit failed to confirm the nurses’ contention that their practice was comprehensive and therapeutic. The patient’s offense and other forensic-related needs received little mention.

This brief review that sought to identify the knowledge and skills of FMHNs can conclude that more attention is required to clearly articulate the specialist role of FMHN. This paper reports on the work of one group that have attempted to capture the core knowledge and skills in the form of standards of practice.

The Function of Standards

Standards of practice are authoritative statements that reflect current knowledge and understanding along with the values and priorities for a profession (Beal et al., 2007; Canadian Federation of Mental Health Nurses, 2006; Peternelj-Taylor & Bode, 2010). Standards provide stated expectations of accepted performance by “incorporating vital information and new trends in the field, and linking these with expected outcomes” (Beal et al., 2007, p. 14). They also define the scope of practice for individual nurses (O’Brien et al., 2004), and guide the practice of nurses across a range of clinical environments and include professional knowledge, skills, and attitudes (Australian College of Mental Health Nurses, 2011). Through standards, nurses articulate to others the scope of practice and are held accountable for safe, competent, ethical, and legally defensible nursing care.

Standards for FMHNs

Standards of practice for FMHN should be linked directly to professional accountability, be representative of the specialist nature of this role, and reflect the growing body of knowledge of FMHN (Peternelj-Taylor & Bode, 2010). The Forensic Nursing: Scope and Standards of Practice (American Nurses Association & IAFN, 2009) is useful in providing guidance but is more oriented toward the forensic nurse role where evidence collection and the care of victims of crime are the focus.

The Royal College of Nursing (RCN, 1997) in the United Kingdom identified the core competencies and advanced nursing practices for mental health nurses working with FSPs. The core competencies were generic mental health nursing competencies; however, the advanced nursing practices included risk assessment and management, assessment and management of dangerousness, cognitive therapies, behavioral therapies, and social skills training (RCN, 1997). In 2009, the RCN (2009) released a guide for nurses working in the criminal justice system, and although the guide discusses the health and social needs of offenders, no guidance is given for FMHNs. Work undertaken in Scotland to identify core competencies for nurses in forensic mental health settings (National Board for Nursing, Midwifery and Health Visiting for Scotland, 2000) identified three competencies: risk assessment; professional, legal, and ethical aspects of care; and interpersonal.

Although these standards have been useful guides to practice, they have not provided the specific direction that is needed to identify the scope of practice and the practice challenges of FMHN.

Process of Writing the Forensic Mental Health Nursing Standards of Practice 2012

In the absence of standards and charged with the responsibility for the management and professional development of nurses at one Australian forensic mental health service, a group of senior nurses decided to write standards to guide mental health nurses in forensic and correctional settings, or when caring for a patient with a forensic history. A prolonged process of reviewing the literature, examining local practice against ideal practice, discussion, debate, and compromise resulted in the current 16 standards. The main areas of difficulty were deciding what areas of practice justified a standard and what areas were to be woven through all standards, and deciding what content was unnecessary because it was adequately covered in core nursing and mental health nursing standards. When the standards were considered to be complete, 36 nurses from across Australia and overseas, known to the authors through their publications or demonstrated leadership in FMHN, were invited to comment on the standards. Twelve nurses, from nine countries (England, United States, Canada, New Zealand, Ireland, Wales, Sweden, Norway, and Australia) generously provided feedback and recommendations and confirmed that the standards captured the core FMHN knowledge, skills, and attitudes. The Consumer Consultant and the Family and Carer Advocate who worked with the authors provided additional feedback that strengthened the standards by adding emphasis
to patient-centered care and family/carer-sensitive practice. The standards presented in this paper are the result of this work.

The Forensic Mental Health Nursing Standards of Practice

For each of the 16 standards, there is a rationale and descriptive statements that describe the knowledge, skills, and attitudes that are required to meet the standard. For the purpose of this paper, we have provided a brief rationale and references for further reading for each standard. The insufficiency of contemporary nursing references is an indication of the early development and evidence base of this field of nursing (see Table 1).

### Standard 1: Security

In secure settings, the FMHN maintains an attitude of vigilance and adheres to the security policies and procedures that are in place to prevent FSPs escaping from the facility or absconding from approved leave. Effective rehabilitation requires that FSPs are given opportunities to practice skills and test their progress in real-life situations consistent with security requirements. Security procedures can be exceedingly invasive; however, it is the carrying out of the procedures that can have the greatest impact on patients and the ongoing relationship with patients. Insensitivity can potentially damage the results of effective interpersonal work. Integrating therapeutic goals with security requirements needs constant appraisal of organizational processes and nurse–patient relationships to ensure that opportunities for therapeutic practice are maximized (Collins, 2000; Collins & Davies, 2005; Dale & Gardner, 2001; Davison, 2004).

### Standard 2: Legal Framework

The FMHN requires knowledge of legislation and the criminal justice system processes to provide nursing assessment and treatment that is congruent with the FSP's legal status and treatment (Bowring-Lossock, 2006; Humphreys, Oppong-Gyapong, & Mason, 2001; Kent-Wilkinson, 2009).

### Standard 3: Ethical Practice

Practicing in justice settings where the values and policies potentially conflict with the principles of mental health nursing practice and caring for FSPs in all settings can result in FMHNS experiencing ethical dilemmas and problems. The FMHN must also manage personal moral judgments that conflict with professional nursing obligations to provide treatment and care to FSPs (Austin, 2001; Fisher, 1995; Kettles, Coffey, & Byrt, 2010).

### Standard 4: Interdisciplinary Teamwork

The FMHN practices as a member of an interdisciplinary team at the interface of the criminal justice system and mental health system, and in justice settings, the interdisciplinary team can include custodial officers, community corrections officers, police officers, security officers, and court staff. Although an interdisciplinary approach allows for a broad theoretical base that draws on the knowledge and skills of each discipline to enhance treatment and care, the FMHN acknowledges the potential for enculturation to criminal justice values (Holmes, Perron, & Michaud, 2007; Turnbull & Beese, 2000; Weiskopf, 2005).

### Standard 5: Therapeutic Relationship

Inherent tensions in the therapeutic relationship with FSPs prevail, including: the security requirements of custodial

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**TABLE 1. Forensic Mental Health Nursing Standards**

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<th>The forensic mental health nurse will:</th>
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<tr>
<td>1. Structure the treatment environment to integrate security with therapeutic goals.</td>
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<td>2. Apply knowledge of the legal framework to service delivery and individual care.</td>
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<td>3. Conduct forensic mental health nursing practice ethically.</td>
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<td>4. Practice within an interdisciplinary team that may include criminal justice staff.</td>
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<td>5. Establish, maintain, and terminate therapeutic relationships with forensic service patients using the nursing process.</td>
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<td>6. Integrate assessment and management of offense issues into nursing care processes.</td>
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<td>7. Assess for the impact of trauma and engage in strategies to minimise the effects of trauma.</td>
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<td>8. Assess and manage risk potential of forensic service patients.</td>
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<td>9. Manage the containment and transition process of forensic service patients.</td>
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<td>10. Promote optimal physical health of forensic service patients.</td>
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<td>11. Minimize potential harm from substance use by forensic service patients.</td>
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<td>12. Practice respectfully with families/carers of forensic service patients.</td>
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<td>13. Advocate for the mental health needs of forensic service patients in a prison or police custodial setting.</td>
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<td>14. Support and encourage optimal functioning of forensic service patients in long-term care.</td>
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<td>15. Demonstrate professional integrity in response to challenging behaviors.</td>
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<td>16. Engage in strategies that minimize the experience of stigma and discrimination for forensic service patients.</td>
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environments are grounded in distrust rather than trust; the legal status of FSPs challenges notions of voluntary treatment; and the experience of FSPs can result in attitudes of suspicion, hostility, and subversion to treatment goals. The FMHN recognizes these tensions and makes prudent use of self and interpersonal therapeutic skills (Encinares, McMaster, & McNamee, 2005; Martin, 2001; Peternelj-Taylor, 1998, 2001; Rask & Aberg, 2002).

**Standard 6: Offense Issues**

It is the alleged/offending behavior that differentiates the patients of the FMHN. Knowledge of the criminogenic needs of the FSP and the circumstances, nature, and consequences of the patient’s offending is integrated within the comprehensive nursing process, which promotes personal recovery and reduces recidivism. The FMHN works in partnership with FSPs and their families/carers/significant supports to facilitate an understanding of offending behavior and mental illness (Burrow, 1993; Martin, 2001, 2010; Rask & Levander, 2001).

**Standard 7: Trauma**

Exposure to trauma is a common experience for FSPs and includes exposure to traumatic experiences (such as being a victim of or witness to abuse or neglect), trauma related to committing the index offense, trauma related to detention (including isolation from supports, community role loss), trauma related to experiencing coercion in secure settings), and trauma related to the impact of the secure environment (such as locked doors and loss of privacy). The FMHN must assess for the impact of trauma, implement appropriate treatment, and avoid inadvertently retraumatizing FSPs (Aiyegbusi, 2002; Aiyegbusi & Tuck, 2008).

**Standard 8: Risk**

The FSP may be at risk to self or others based on a number of static and dynamic risk and protective factors. The FMHN engages with mental health and criminal justice processes to manage risk at individual, interpersonal, organizational, and community levels (Doyle, 2000; Encinares et al., 2005; Kettles, 2004; Lyons, 2009).

**Standard 9: Transition**

Transition between environments such as between higher and lower security environments or returning to the community are potentially stressful events for the FSP. This stress can result in decompensation of mental state, which may lead to behaviors such as deliberate self-harm, harm to others, or absconding, which can compromise the transition. Care and treatment planning for FSPs incorporates judgment about risks, protective factors, available resources, and therapeutic objectives (Coffey, 2011, 2012; Skelly, 2001).

**Standard 10: Physical Health**

The lifestyle of many FSPs renders them vulnerable to poor physical health. Incarceration imposes potential threats to physical health. These threats include mental state disturbance, substance use, unsafe sexual behavior, victimization, and interpersonal violence. The FMHN must consider environmental risks and individual needs when planning any interventions promoting the health of the FSP (Prebble et al., 2011; Toman, 1999).

**Standard 11: Substance Use**

There is an association between substance use and offending behavior, especially violence, for people with mental illness. The FMHN needs to address substance use by FSPs to reduce risk to health and minimize reoffending (Dale, 2001; Price & Wibberley, 2012).

**Standard 12: Families/Carers**

Mental illness and the nature of the offense and its consequences have an impact on family members/carers and their relationships with the FSP. The FMHN needs to demonstrate skill and sensitivity in working with the family/carers around these significant issues (Gasson, 2001; James, Martin, & Vine, 1997; MacInnes, 2000).

**Standard 13: Advocacy**

Detention can impact on the FSP’s mental health and access to treatment. Provision of health care is not the primary focus in a prison or police custodial setting, and FMHNs are uniquely positioned to advocate for the mental health needs of FSPs and negotiate for appropriate and timely healthcare (Doyle, 1999; Kitchiner, 1999; Weiskopf, 2005).

**Standard 14: Long-term Care**

Legal status and enduring mental illness can result in long-term care of FSPs in secure settings and the community. Special needs of FSPs in long-term care arise from a range of factors including loss of hope and institutionalization. The FMHN maintains therapeutic optimism and promotes “a life worth living” using an open, flexible, and transparent approach (Haines, 2000; Kitchiner, 1999).

**Standard 15: Challenging Behaviors**

The FMHN will encounter adverse incidents, some extreme in their consequences, including deliberate self-harm, violence, and other offending behavior. Theoretical understanding of causative factors, empathic and flexible limit setting, consistent care and treatment planning, and monitoring of emotional responses to FSPs with challenging
behaviors are necessary to maintain therapeutic effectiveness (Chandley, 2002; Mason, 2000; Schafer, 2002).

**Standard 16: Stigma and Discrimination**
Attitudes toward mental illness and offending behavior are influenced by misinformation, ignorance, fear, and sensationalist representation in the media, and FSPs are disadvantaged through the negative appraisal by others and by internalized impacts on identity, self-concept, and personal recovery related to forensic status and mental illness. The FMHN is aware and demonstrates that understanding, support, education, and advocacy are necessary to combat stigma and discrimination (Martin, 2001; Martin & Ryan, 2011).

**Conclusion and Implications for Forensic Mental Health Nursing Practice**
The standards presented in this paper represent only the core knowledge, skills, and attitudes of FMHNs, and further development of these standards is needed to address advanced practice. The nursing contribution to the interdisciplinary assessment, formulation, treatment, and evaluation of care given to FSPs is clearly identified in the standards. These standards can be used to guide practice, develop educational programs, and plan research in forensic mental health nursing. The standards have not been evaluated, and their usefulness to the field will be evident by their application by individual nurses or services and through citation (e.g., Nizette, McAllister, & Marks, 2012).

Employers of nurses can refer to the standards to establish nursing profiles, to develop position descriptions that articulate expectations of nurses, and to guide performance appraisals. At the inpatient forensic service where the authors are employed, the standards have been used as a framework to develop an orientation program for nurses who are new to forensic mental health. This program was suggested by the Scottish “New to Forensic” introductory educational program (Walker, Langton, & Thomson, 2011).

The brief review of the literature in this paper illustrates that nurses are beginning to come to terms with the need to adapt traditional mental health nursing when working with people experiencing mental disorder and who have a history of criminal offending or who present a serious risk of such behavior. Forensic mental health nursing has been mired in a problematic discourse that positions the forensic context and antisocial behaviors of the patient as impediments to good practice, rather than acknowledging that a hybrid practice needs to develop that satisfies professional nursing requirements, forensic/justice/correctional service demands, community expectations, and especially FSPs’ needs. These standards can assist nurses to recognize what it is about forensic mental health nursing that is “more” than simply practicing mental health nursing in a forensic context.

**References**


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**Erratum: Advocating for Pregnant Women in Prison: The Role of the Correctional Nurse**

The last sentence of the abstract for the above article, should read:

*Given the national emphasis on gender responsive treatment in prisons and jails, a window of opportunity exists to be a voice for these women and make significant changes in health care for this largely underserved population.*

**Reference:**