Case Report

Implementation of the Mental Health Nurse Practitioner Role in Forensic Settings: A Case Report

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ABSTRACT

This is a case report about the implementation of the mental health nurse practitioner role in forensic psychiatric settings. We will present its implementation and issues encountered during this process, such as a lack of understanding of the role in staff teams, scope of practice limitations, tension stemming from the conflict between treatment and punishment approaches, and the risk of medicalization of nursing. This case report, based on the authors' experiences, represents an early contribution to research on advanced nursing practice in forensic psychiatry, an area that has yet to receive much attention in the literature.

KEY WORDS:

Advanced practice; forensic psychiatric nursing; nurse practitioners; role implementation

In 2017, the Canadian province of Québec introduced the title of "mental health nurse practitioner (MHNP)," a new specialty in advanced nursing practice (Ordre des Infirmières et Infirmiers du Québec, 2019). Two years later, in 2019, the first students to be educated in this specialty completed the program. As in other countries, including the United States, Australia, and Great Britain, this is an emerging specialty. In addition, in 2019, a forensic psychiatric institution in Québec added the role of MHNP to its roster of services. The integration of this role in forensic psychiatry has received little attention from researchers. Indeed, on the basis of the literature reviewed, no study has examined the implementation of the MHNP role in forensic settings.

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The purpose of this article is to present the implementation of the MHNP role in a specialized environment and to identify the recommendations and challenges encountered. First, we will summarize the literature on: (a) forensic psychiatric nursing; and (b) the general role of the MHNP. Next, we will present a case report on the integration of the nurse practitioner role in a Canadian forensic psychiatric institution. Last, we will discuss actions to ensure a successful integration of this advanced practice role in forensic settings.

Literature Review

Forensic Psychiatric Nursing Role

Forensic psychiatric nursing is a specialty situated at the intersection of the health and judicial systems (Holmes, Perron, Jacob, Paradis-Gagné, & Gratton, 2018; Kent-Wilkinson, 2010; Koskinen, Likitalo, Aho, Vuorio, & Meretoja, 2014). This nursing practice is carried out in secure environments that pose significant clinical and ethical issues (Holmes, 2005; Peternelj-Taylor, 1999) such as balancing protection of the public with individual rights, ensuring care while considering security needs (Jacob, 2014), and autonomy versus paternalism (Peternelj-Taylor, 1999). Mason, Lovell, and Coyle (2008) described the social control mandate required of nurses working in these settings as:

> Security versus therapy. This is possibly the central dilemma for nurses working within secure

> psychiatric settings. [.. .] The dilemma is felt in the tension between, on one hand, attempting to provide a therapeutic service, and, on the other hand, operationalizing the security procedures. (p. 120)

Forensic psychiatric nurses collaborate with a variety of health and justice practitioners (Holmes et al., 2018; Mason, Lovell et al., 2008). They provide care to potentially violent patients with severe mental disorders; most of whom have committed crimes for which they have been prosecuted. They represent a captive and vulnerable population (Holmes, 2005) with very complex health and social problems (Newman, Patterson, Eason, & Short, 2016), and they present significant clinical challenges for nurses (Koskinen et al., 2014). Forensic psychiatric patients exhibit a high prevalence of substance abuse, are frequently diagnosed with personality disorders, present with extensive trauma histories, and engage in suicidal behavior and self-injury (Bowen & Mason, 2012; Martin et al., 2013).

According to Mason, Lovell et al. (2008) and Mason, Coyle, and Lovell (2008), forensic mental health nursing is viewed as a specialty composed of several specific competencies. Nurses in this field must have advanced knowledge of psychopathology and psychopharmacology (Bowen & Mason, 2012; Koskinen et al., 2014; Newman et al., 2016). In addition, they must be able to carry out risk assessment and risk management (Bowen & Mason, 2012), be knowledgeable about the judicial system and criminology (Martin et al., 2013; Mason, Coyle et al., 2008), possess advanced interpersonal and communication skills (Koskinen et al., 2014), and have extensive clinical experience (Mason, Lovell et al., 2008). Forensic psychiatric nurses must also be able to respond to the complex needs of the clients they serve while promoting a holistic, client-centered approach (Koskinen et al., 2014; Martin et al., 2013).

MHNP Role

On the basis of their advanced academic education and training, MHNPs assess, diagnose, treat, and manage various mental health issues. According to Jones (2018), MHNPs can be significant actors in the care and treatment of vulnerable populations. They can serve populations who are not sufficiently reached by the health system (Wand & White, 2015), including persons involved in the criminal justice system and those who are homeless (Baker, Travers, Buschman, & Merrill, 2018; Jones, 2018). In the province of Québec, MHNPs can perform certain advanced practice activities that are regulated under the Nurses Act (2019) such as prescribing examinations and treatment and using diagnostic measures. Although they can practice independently, they must first establish a partnership with a physician (Regulation Respecting Specialized Nurse Practitioners, 2019). We have seen, however, that MHNPs' autonomy varies considerably from one province or country to the next (Fisher, 2005). In some U.S. states, for instance, they can independently admit and discharge patients (Baker, 2010). In the state of New Hampshire, MHNPs can testify in court proceedings and submit a report to the court to obtain an order for involuntary commitment to a hospital (de Nesnera & Allen, 2016). This is not the case in the province of Québec, where MHNPs' autonomy is more restricted.

In general, patients are highly satisfied with the services they receive from nurse practitioners (Horrocks, Anderson, & Salisbury, 2002). Wortans, Happell, and Johnstone (2006) inform us that patients appreciate MHNPs because they spend more time on consultations, education, and health promotion. These authors also mention the open, welcoming, and nonthreatening therapeutic relationship that exists between patients and MHNPs.

Description of the Case

We will now consider the recent implementation of the MHNP role in a forensic psychiatric facility in Eastern Canada, based on the experience of the second author (V. G.), a recent graduate of the MHNP program. The MHNP role is being integrated in three different environments: (a) an admission–readmission unit of a forensic psychiatric hospital (psychiatric evaluation, consultation, and short-term treatment); (b) the municipal court (assessment of the accused's fitness to stand trial); and, primarily, (c) provincial detention centers. In these different settings, the MHNP works with psychiatrists and interdisciplinary teams made up of various health and justice practitioners (e.g., nurses, criminologists, social workers, specialized educators, and correctional officers).

The integration of the new role into these forensic settings can be complex, and to date, various obstacles have been encountered. First, medical staffing in the different units of the forensic psychiatric hospital is quite substantial, compared with that of the detention facilities. Further efforts are thus required to show the added value of MHNPs to the medical profession and promote its integration. Second, patients hospitalized in a subspecialized hospital setting appear to have very complex health issues. However, the general training offered to MHNPs is not oriented to the care of patients presenting such a high degree of complexity. MHNPs must therefore be capable of adapting to work with these patients. Third, professional practice guidelines (legislation and regulatory standards) can impede implementation of the MHNP role. For example, in a forensic psychiatric hospital setting, MNHPs' autonomy is limited by their inability to perform forensic activities (e.g., psychiatric examination to place a person under confinement and assessment of fitness to appear at trial) and to admit and discharge patients.

Faced with these barriers to the implementation of the MHNP role, clinicians, doctors, and managers collaborated

to ascertain the priority needs that an MHNP could meet. Most of the care needs appeared to be situated in the detention centers connected with the forensic psychiatric hospital. The MHNP therefore mainly works in these centers.

Although a significant proportion of incarcerated individuals have mental health problems, it appears that screening, follow-up, and treatment of these problems are deficient in detention centers. This is mainly because of a lack of clinical staff, lack of training for nurses and correctional staff, and a prison culture that focuses more on coercion than care. In this context, the gradual integration of MHNPs is a good solution for filling the gaps in mental health services.

MHNP's Daily Role

When the MHNP (the second author) is scheduled to work in a detention center, she begins her shift by talking to the nurse assigned to the psychiatric medical clinic and deciding which patients will be seen during the day. The MHNP assesses the patients' mental health problems after conferring with the general practitioner who made the consultation request. The incarcerated person's sector and patient safety rating (i.e., high, medium, or low security) must be considered to determine whether he or she can move freely or needs to be accompanied to the health unit.

MHNP consultations are requested mainly for the purpose of prescribing or adjusting medication for different problems (e.g., attention-deficit disorder with or without hyperactivity, anxiety disorders, psychotic disorders, bipolar disorder, substance use disorders, and personality disorders). However, mechanisms for the care and follow-up of patients still need to be improved, including working with the nurses on-site in the various detention centers where the MHNP is present.

When patients desire clinical follow-up after their stay in detention, the MHNP collaborates with various professionals to ensure management and continuity of care upon their release to the community. Whenever possible, external psychiatric services are contacted (e.g., assertive community treatment teams), departure prescriptions are filled, medication is given to the person, and referrals are made to various services available in the community.

MHNPs who work in a detention center clinic typically meet with 12–15 patients a day. The current caseload is roughly 50 patients. The caseload is somewhat small at the moment, considering the high rate of mental health problems among individuals in detention. In the months since the MHNP role was implemented, however, the caseload has steadily increased.

Challenges and Opportunities

Integrating MHNPs in detention settings is a promising solution to ensure adapted mental health services. Several projects to facilitate their contribution are currently under development. In addition to increasing patient screening and treatment services, MHNPs provide education and training to clinical and prison staff. These training sessions will raise staff awareness of the mental health issues affecting incarcerated clients (e.g., retraumatization and stigma). They can also teach mental health intervention strategies. Plans for MHNPs to implement psychoeducational follow-up inspired by psychotherapy approaches as well as emotion and stress management groups are underway.

To ensure continuity of care after release from detention, various improvements remain to be made. Currently under discussion, for instance, is a project to set up a specialized team to provide accommodation and psychiatric follow-up for people who have been detained and are homeless. As suggested by Baker et al. (2018), the MHNP role is most appropriate for this clientele, who are typically poorly served by existing services.

Discussion

Several challenges were encountered in the implementation of this new role in forensic settings. First, we noted the need to further promote the MHNP role, which is not yet well understood by teams, physicians, and managers in clinical settings. A similar finding was reported by Baker (2010), who noted: "The role of the MHNP needs to be promoted and education provided to not only medical and allied health colleagues, but also nursing staff, in particular clinical staff" (p. 219).

We have seen that various obstacles can complicate the implementation of the MHNP role in a clinical setting, such as lack of managerial support, medical dominance, and scope of practice limitations (Hampel, Procter, & Deuter, 2010). In addition, Wand and White (2015) concluded that adequate support is required to implement the MHNP role.

This initial experience has also shown the importance of maintaining the specificity of the MHNPs' nursing role. Despite the fact that MHNPs work closely with psychiatrists and are authorized to perform a range of medical activities (e.g., prescription of tests and medication, assessment of mental disorders), their practice must remain rooted in nursing science. The risk of MHNPs' practice being medicalized is raised by Wortans et al. (2006) and Wand and White (2015). Another important challenge in detention settings is the conflicting approaches of care and punishment for individuals with severe mental health disorders and disruptive behaviors. MHNPs must be able to integrate into teams with potentially divergent views on the care of persons who have committed crimes. They must be conscious of the tensions between the principles of care and control/custody. In this respect, they will have to learn to work in interdisciplinary teams with various health and justice professionals (Baker, 2010; Holmes et al., 2018; Martin et al., 2013), while playing the role of patient advocate.

Ultimately, we believe that the integration of MHNPs into detention and forensic institutions will improve access

to quality care and psychiatric treatment. Implementation of this role will provide correctional officers with more training on mental health issues and the appropriate interventions. Such clinical improvements will, in our opinion, reduce the risk of aggression both among incarcerated persons and toward staff. Prevention of disruptive behavior and reduction of recidivism could also be improved, as well as prevention of suicidal risk.

Conclusion

As with any organizational change, the arrival of a new advanced practice professional role can raise several issues. The experience of implementing the MHNP role in forensic settings has shown us the importance of having a medium- and long-term vision for this new practice. It is also necessary to properly assess the priority health needs of the clientele and communicate the role to teams before implementation.

In conclusion, MHNPs can help improve the health conditions of patients who are struggling with mental health issues (Creamer & Austin, 2017). This advanced practice role provides access to specialized, safe, and efficient care (Wand & White, 2015). In addition, the integration of this specialty promotes access to pharmacological treatment, which can prevent relapses and hospitalizations (Fisher, 2005; Wortans et al., 2006). This practice also reduces waiting times for access to consultation and necessary treatment (Baker, 2010; Kaye et al., 2009), especially for an underserved population. Additional research is needed to better define the MHNP's role in forensic settings and to assess the benefits and challenges of integrating this new role in such settings.

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