

**Forensic Mental Health Nursing**  
**Capabilities, Roles and Responsibilities**



**Forensic Mental Health Nursing**  
**Capabilities, Roles and Responsibilities**

*edited by*

**The National Forensic Nurses' Research and  
Development Group**  
**Alyson Kettles (Chair), Phil Woods and Richard Byrt**  
**on behalf of the Group**

*Chapter reviews by Mary Addo, Richard Byrt, Michael Coffey,  
Mike Doyle, Alyson Kettles and Phil Woods*



Quay Books Division, MA Healthcare Ltd, St Jude's Church, Dulwich Road,  
London SE24 0PB

British Library Cataloguing-in-Publication Data  
A catalogue record is available for this book

© MA Healthcare Limited 2008  
ISBN-10: 1-85642-362-X  
ISBN-13: 978-1-85642-362-5

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior permission from the publishers

Printed in the UK by Ashford Colour Press, Gosport, Hants

# Contents

List of contributors	vi
Preface	viii
1. Introduction	1
<i>Alyson McGregor Kettles, Phil Woods and Richard Byrt</i>	
2. The role of education	17
<i>Helen Walker</i>	
3. Nurse consultants in forensic mental health care in Scotland	27
<i>David Langton</i>	
4. Equality and diversity: Respecting the person with a learning disability	51
<i>Mary A Addo and Ian Smith</i>	
5. Power and participation in forensic services: An introduction	77
<i>Richard Byrt</i>	
6. Negative control or life saving? Perspectives on power	99
<i>Richard Byrt</i>	
7. Patient empowerment and participation: Barriers and the way forward	127
<i>Richard Byrt, Linda Hart and Linnette James-Sow</i>	
8. Role of the forensic mental health nurse in nutrition: Towards recovery	151
<i>Gillian Archibald</i>	
9. Assessment, management and treatment of sex offenders	173
<i>Paul Burbery and Mohammed Khoshdel</i>	
10. Risk assessment, measurement and management	207
<i>Phil Woods</i>	
11. Creative anger management: An overview	221
<i>Stuart Bowness, 'Algy', Richard Byrt, Romanus Ngeh, Lauren Mason and Cathy Wray</i>	
12. Creative anger management: Patients' views and experiences	237
<i>'Bede', 'Colm', 'Algy', 'Dirk', 'Ezra', 'Ferg' and Richard Byrt</i>	
13. Mental health and substance use: Problems within forensic practice	247
<i>Mick Adams and Leah Evans</i>	
14. Forensic community mental health nursing	259
<i>Michael Coffey and Richard Jones</i>	
15. Managing a forensic mental health organisation	273
<i>Gavin Garman and Fomayi Saliki</i>	
16. Mental health nursing in prison: A time for change in role	291
<i>Graham Durcan</i>	
17. Management of therapeutic boundaries	309
<i>Cindy Peternelj-Taylor and Penny Schafer</i>	
18. Conclusions: Themes, action and research for the future	333
<i>Richard Byrt, Alyson McGregor Kettles and Phil Woods</i>	
Index	347

# List of contributors

'Algy', 'Bede', 'Colm', 'Dirk', 'Ezra' and 'Ferg', among many other roles, have been service users on Cannock ward, Arnold Lodge medium secure unit, Leicester.

*Mick Adams*, RMN, BSc, CertEd(FE), is a Practitioner-Tutor at the School of Health Science, Swansea University; and a Community Mental Health Nurse, Assertive Outreach Service, Abertawe Bro Morgannwg University NHS Trust.

*Mary Addo*, PhD, MEd, MA Soc Sci, DMS, PgCertTLT, RMN, EN(G) is a Lecturer in Mental Health Nursing/Practice Education at the School of Nursing and Midwifery, Robert Gordon University and NHS Grampian (Mental Health), Aberdeen, Scotland. She teaches pre- and post-registration nursing students, and contributes to the teaching of post-graduate taught Master's degree module(s) at the Centre for Advanced Studies in Nursing, University of Aberdeen. She is involved in nursing research, has published on forensic nursing and related issues, and her interest lies in promoting positive acceptance of people with mental illness and supporting nurses in clinical practice.

*Gillian Kay Archibald*, Bsc (Hons), SRD is a senior dietitian, based at Royal Cornhill Hospital, Aberdeen, Mental Health Hospital. This includes the Blair Forensic Unit for Acute, Long-Stay and Rehabilitation services. She now specialises in the areas of acute mental illness, forensic mental illness and eating disorders after gaining experience in the specialities of diabetes, stroke care and orthopaedics. Gillian contributes to the training of dietitians, nurses and other allied health professionals visiting Royal Cornhill Hospital.

*Stuart Bowness*, BSc (Hons), RN is a senior staff nurse, Arnold Lodge medium secure unit, Leicester.

*Paul Burberry*, RMN, DipCogTh co-ordinates the Sex Offender Treatment Programme for the Adult Forensic Mental Health Services Directorate, part of Greater Manchester West NHS Foundation Trust. He is also a Cognitive Behavioural Therapist with the Directorate's Forensic Psychotherapies Department providing CBT for both inpatients and outpatients with a range of mental health concerns and personality disorders.

*Richard Byrt*, RMN, RNLD, RGN, PhD, BSc (Hons) is Lecturer-Practitioner, Nursing, at Arnold Lodge medium secure unit, Nottinghamshire Healthcare NHS Trust and the School of Nursing and Midwifery, De Montfort University, Leicester. He also has experience as a service user and carer.

*Michael Coffey* is Lecturer in Community Mental Health Nursing at Swansea University. He previously worked as a community mental health nurse in both generic and forensic mental health services. His research focuses upon aspects of community mental health nursing and particularly people's experiences of receipt of these services. He has co-edited, with Chris Chaloner, the textbook *Forensic Mental Health Nursing: Current Approaches* and, with Ben Hannigan, *The Handbook of Community Mental Health Nursing*.

*Graham Durcan*, Research and Development Manager, Criminal Justice Programme, Sainsbury Centre for Mental Health.

*Leah Evans* is Forensic Community Mental Health Nurse, Caswell Clinic, Bridgend.

*Gavin Garman*, PhD, Msc, BA (Hons), RN is Head of Forensic Nursing for the Thames Valley Forensic Mental Health Service in England. He also lectures in Forensic Psychology at Reading University, from where he obtained his PhD. He is the senior manager for over 250 nursing staff across three English counties. His interests include mindfulness and cognitive therapy, service user involvement, research and clinical governance.

*Linda Hart* is a writer, artist and campaigner. She is the author of, among other works, the MIND Book of the Year: *Phone at Nine, Just to Say You're Alive*, based on her experience as a service user.

*Linnette James-Sow*, RN, BSc(Hons) is a staff nurse working in an acute mental health setting. Linnette is also a poet and song writer during her spare time.

*Richard Jones* is Team Leader, Carmarthen and Towy Valley Crisis

Resolution and Home Treatment Team, Pembs and Derwent NHS Trust

*Alyson M. Kettles*, PhD, MSc (London), BSc (Dundee), RMN, RGN, RNT,

PGCEA (Surrey), Dip Crim, ILTM, FHEA, FRSM is Research and Development Officer (Mental Health) for NHS Grampian and is based at the Royal Cornhill Hospital in Aberdeen, Scotland. She is also Honorary Senior Lecturer for the Centre for Advanced Studies in Nursing at the University of Aberdeen where she co-ordinates and teaches on modules for the post-graduate taught Master's degrees. Her personal portfolio of research has had a forensic focus for more than the last decade, as a result of being the Link Tutor with Broadmoor Hospital while a nurse teacher at the Frances Harrison College of Nursing in Guildford and the University of Surrey. She is a well known author of mental health and forensic nursing articles and

books. Her research interests include assessment and interventions, such as risk and observation.

*Mohammed Khoshdel*, RMN, BSc, is a facilitator for the Sex Offender Treatment Programme as well as being a forensic nurse on a male acute ward. Both roles are held within the Adult Forensic Mental Health Services Directorate (the Edenfield Centre), part of Greater Manchester West Mental Health NHS Foundation Trust.

*David Langton*, BA(Hons), Dip Sy Practice, Cert Ed, RCNT, RMN, RNMH is Nurse Consultant for the Forensic Network in Scotland. Until being promoted to his current role in 2005, David had worked exclusively in High Security Hospitals having commenced work in the NHS in 1975 at Rampton Hospital, moving to the State Hospital in Scotland in 1998 as a Senior Nurse.

*Lauren Mason*, BSc (Hons), MSc is an Assistant Psychologist, Arnold Lodge medium secure unit, Leicester.

*Romanus Ngeh*, BSc (Hons), RN is a staff nurse, Arnold Lodge medium secure unit, Leicester.

*Cindy Peternelj-Taylor* RN, BScN, MSc, PhD(c) is Professor at the College of Nursing, University of Saskatchewan. Much of Cindy's career has focused on professional role development for nurses who work with vulnerable populations. In this role, she has had many opportunities to assist students and nurses with clinical and ethical concerns that emerge in practice. She is a member of the Editorial Board of the *Journal of Psychiatric and Mental Health Nursing*, and is an Associate Editor of the *Journal of Forensic Nursing*. She is currently completing a doctoral dissertation in Nursing at the University of Alberta, where she is exploring the experience of engagement of forensic clients from a nursing perspective.

*Fomayi Saliki*, MSc (Management in Health and Social Care), RMN, Dip Ed is a Forensic Community Mental Health Nurse with the Thames Valley Forensic Mental Health Service. He has worked for the service for seven years, working in both inpatient and community settings. Interests include contemporary mental health issues and diversity in patient management, engagement and quality of care.

*Penny Schafer* RN, BSN, MN, PhD(c) is currently completing a doctoral dissertation in Educational Administration at the University of Saskatchewan. The focus of her doctoral work is a postmodern discourse analysis regarding the research literature on bullying in elementary and high school students. She has a long history in forensic psychiatric and correctional nursing. Work with individuals diagnosed with personality disorders has been the focus of the majority of her career. The challenge of establishing and maintaining therapeutic relationships and facilitating psycho-educational groups are areas where Penny has developed clinical excellence.



*Ian Smith* is currently a lecturer in mental health nursing at Robert Gordon University in Aberdeen, Scotland. He worked in learning disabilities for many years prior to coming into teaching. He then taught for 16 years in this area. Ian is involved in nurse education research projects within the School of Nursing and Midwifery although most of his work is concerned with teaching. He has recently developed a distance learning module in communicating with people with learning disabilities.

*Helen Walker*, BEd, RMN, BSc, MSc (in CBT) is currently acting Senior Nurse for practice development at the State Hospital, Carstairs, Scotland. She qualified as a mental health nurse in 1991 and has experience of working in a variety of mental health settings, predominantly community, acute admissions and a high secure forensic unit. Throughout most of her career she has been actively involved in research and many posts she has held have been evenly divided between clinical and research activities.

*Phil Woods*, RMN, RPN, PhD is an Associate Professor at the College of Nursing, University of Saskatchewan. He has an extensive personal portfolio of forensic-related research. He is a well-known author of mental health and forensic nursing articles and books. His specific research interests are risk assessment and management, and violence prediction.

*Cathy Wray*, RMN, EN(M) is ward manager, Cannock ward, Arnold Lodge medium secure unit, Leicester.



# Introduction

*Alyson McGregor Kettles, Phil Woods and Richard Byrt*

This book is about issues related to the role and function of the forensic mental health nurse. We hope that you will find it enjoyable and relevant. The book originated from the determination of the National Forensic Nurses' Research and Development Group to contribute to the development of forensic and other aspects of mental health nursing. It is aimed at helping nurses to understand the changing nature and multiplicity of roles of the forensic mental health nurse, in order to enable the provision of appropriate care to patients, their carers, families and significant/relevant others, including the person harmed (the victim or survivor of an offence). It is also aimed at enabling a greater understanding to develop between professions and is designed to give examples of how professionals can work together. Much of the content of this book is relevant to forensic learning disability nursing; and to other forensic and prison mental health professionals, and to service users and organisations representing their rights and interests.

While 'forensic' can have different meanings for different people, in this book the following definition is used:

*Forensic means of the law, and is based on the Latin word 'forum', meaning 'what is out of doors'... The Ancient Romans met outside in...[forums] for public meetings, political debates and public legal hearings to try offenders... In the United Kingdom, forensic mental health nurses work with the relatively small proportion of individuals whose mental health problems are associated with offending behaviour.*

(Kettles et al, 2007:1, quoting Soanes, 2002 and citing Parker, 1985)

Forensic mental health nursing and forensic learning disability nursing are small but growing branches of nursing practice that occur in a wide range of settings, and continue to extend to other areas. The latter include hospitals and units offering low, medium and high security, 'court diversion schemes (e.g. in magistrates' [sheriff and high] courts), prisons, young offender institutions, police stations' (Kettles et al, 2007:1), community settings, and accident and

emergency units (McClelland et al, 2001; Rowe and Lopes, 2003; Wix and Humphreys, 2005). Forensic mental health nurses also work with a greater variety of professionals than, for example, nurses working in acute mental health care.

## **The forensic mental health nursing role: Then and now**

According to Kettles et al (2007:2) ‘there is an increasing need for forensic knowledge’ and understanding about the role of the forensic mental health nurse in all settings and with all groups of patients. Patients’ problems and needs, and consequently, nurses’ roles, are growing in complexity (Dale et al, 2001:19; Chaloner and Coffey, 2000; Kettles and Robinson, 2000). As has been noted in an earlier book in this series: ‘the majority of general mental health nurses work with individuals with histories of offending in (non-forensic) settings, including acute admission wards; services for children and young people and older people; therapeutic communities; and facilities for treatment and recovery, as well as individuals with problematic substance use’ (Kettles et al 2007:1, citing Kettles et al, 2002a, Woods, 2004). From this, it can be seen that the forensic mental health nursing role is not limited in relation to particular client groups or settings. Provision of safety and security for patients in high security care is no longer enough, and has not been enough for some time. In many respects, the current forensic mental health nursing role is ‘out of doors’ because it is no longer solely in the purview of high security care.

Fortunately, forensic mental health nursing has matured over the past 30 years in order to meet need and to accommodate the political, legal, social and professional necessity that has been part of development in the health services in a ‘modern’ world (Woods, 2004).

We have come a very long way from being ‘keepers’ (the forerunners of forensic mental health nurses) in Broadmoor Criminal Lunatic Asylum (Roberts, 2006) which was founded in 1863 (Kirby 2000). Until well into the 19th century, keepers, both in institutions and in the care and confinement of people in their homes, were seen as uneducated and of lowly status (Nolan, 1993), and this is reflected in some of the fiction of the time. One example is Grace Poole, the keeper caring for Mrs Rochester in *Jane Eyre*, first published in 1847 (Bronte, 1994). Neither Mrs Rochester and her mental illness nor Grace Poole, are described very sympathetically, and indeed, Grace Poole is found to have attempted murder, so she can hardly be viewed as a good early role model for forensic or other mental health nurses (Literature Organisation, 2007). Although forensic mental health nursing has travelled far since the founding of the first high security hospital, the profession faces some formidable challenges in the future.

Kirby (2000:300) states that:

*Most mental health professionals are familiar with the term 'forensic psychiatry' but they are perhaps less likely to have a clear conception of the forensic mental health nurse. Unlike many specialities, there is little understanding of what forensic nursing represents.*

This was written a few years ago, but the truth of this statement has not significantly changed. Although the profile of forensic mental health nursing has risen within forensic care, it is still, in the experience of the authors, not particularly well understood within general mental health. This is further compounded by the move towards genericism and the general taking up of such materials as the 10 Essential Shared Capabilities (10 ESCs; Sainsbury Centre, 2004). Although these initiatives are important in themselves, and intended to be of wide relevance, they make it harder for forensic mental health nurses to raise the profile of their work in the general arena. For example, there can be a general assumption that all forensic patients are the same and that they should be where they are, i.e. in secure facilities. Forensic nurses spend considerable time and effort with various groups and individuals to show that there are specific diversity issues and that offenders are individuals who require even greater understanding than those with either a single or dual diagnosis in mental health. This does fit with the 10 ESCs but it makes it seem as if the role and work of the forensic mental health nurse is the same as every other mental health nurse, when there is much more to it. Forensic mental health nurses deal with a multitude of issues, interventions, skills and capabilities that start with specifics such as the 10 ESCs but which go much further. This will be explained in more depth later in this chapter.

With the commissioning of an increased number of forensic units and an increase in the number of forensic patients receiving community care, it is likely that new roles and extensions to current roles will become the norm for forensic mental health nursing services (Coffey et al, 2007; Kettles and Hall, 2007). There are already many new roles, such as the nurse consultant and specialist forensic community mental health nurses (FCMHNs). These nurses deal with crisis situations or use particular therapies and modalities, including psychosocial interventions (PSI) and dialectical-behaviour therapy (DBT) (Coffey et al, 2007). Other forensic nurses are involved in diversion from custody (Hillis, 1999:191). 'Not only this, but substantial demands are being made on ... inpatient services by [patients with] challenging symptoms' (Kettles et al, 2007:2), which may be complicated by problematic substance use and more serious index offences (Kettles and Woodally, 2006). This means that forensic mental health nurses require a clear fundamental route into forensic care, with specialist practice courses available at postgraduate level. Currently, forensic mental health nurses can take only a very small range of courses that are specific

**Box 1.1: Components of the forensic role**

- Characteristics
- Features
- Knowledge
- Skill
- Skills
- Conceptualisation
- Competence
- Competencies
- Issues
- Definitions
- Evidence

to forensic mental health nursing, although there are other courses focused on specialist practice, such as clinical masters and doctorates (Watson and Kettles, 2007). However, there is recognition (Forensic Network, 2006) that something more substantial is required, for example, there are plans to establish a multidisciplinary forensic school in Scotland.

**Argument for a forensic mental health nursing role**

The forensic mental health nursing role has never been, and is not now, a single entity. The forensic mental health nursing role comprises many components as shown in *Box 1.1*.

Chaloner (2000:1) states that:

*The role of the forensic mental health nurse has expanded and there is a growing number and range of practice areas to which ‘forensic’ nurses make an active contribution... The expansion of the role has naturally extended the range of skills required by forensic mental health nurses and contributed to an expanding knowledge base relating to the diverse requirements of practice... The diverse range of publications generated by forensic nurses has contributed to the recognition of this ‘specialism’ and enabled a nursing ‘voice’ to be heard within the varied and complex debates relating to the treatment, care and management of mentally disordered offenders. (Box 1.1)*

Burrow’s (1993) case for forensic mental health nursing was based on the following six premises:

1. ‘The client category consists overwhelmingly of offenders with psychiatric pathology.’
2. ‘Nurses contribute towards the therapeutic targeting of any mental disorder or offending behaviour related to psychiatric morbidity.’
3. ‘These care strategies are largely incorporated within institutional

- control and custody of patients.’
4. ‘The configuration of patient pathology, criminal activity, therapeutic interventions and competencies, court/legal issues and custodial care creates the need for a formidable and accelerating knowledge base.’
  5. ‘The advocacy role is different from that in other nursing specialities, embracing both the destigmatisation and decriminalisation of the patient group.’
  6. ‘Clients’ potential for future dangerousness requires the formulation of risk assessment strategies.’

Burrow (1993:903)

However, Burrow’s six premises need to be revised to reflect current use and an updated version follows:

1. The client group consists mainly of people with a mental illness who have offended or been diverted from custody.
2. Nurses care for the client population in the various settings in which they live, and contribute to the therapeutic care and treatment of the person and his or her illness and offending behaviour.
3. The care strategies follow the patient journey through detention/secure care to community-based services, in the variety of settings in which patients can find themselves.
4. Forensic mental health nurses have specific roles which differ from other mental health nurses. These differences relate to the following areas:
  - The complexity of patients’ multiple pathologies.
  - Individuals’ criminal behaviours and recidivism in social/cultural systems.
  - Specific therapeutic/clinical competencies.
  - Specific issues related to forging therapeutic relationships/ interpersonal skills/boundary issues.
  - Avoiding negatively custodial care, but working safely in the reality of secure settings or measures to ensure safety in the community.
  - Roles related to the criminal justice system and its workings.
  - Legal issues such as the multitude of new laws, and ethics and rights-based practice.
  - Responsibility to and protection of the public.
  - Probability/risk, offence-specific assessment and care.
  - Meeting varying safety security needs applied through differing security levels.
5. Both advocacy and the delivery of culturally competent care differ from other areas of nursing, in view of the need to both de-stigmatise and de-criminalise the client group.

6. There are also specific needs to defend and maintain staff morale, as well as ensuring clinical supervision and other means to deal effectively with the emotional impact of caring for this client group.
7. The client group continues to have the potential for future dangerousness and requires staff to have coherent and consistent risk assessment, management and probability measurement.
8. Future challenges include:
  - Care that is increasingly holistic in relation to the individual's safety, and psychological, physical, interpersonal, spiritual, cultural, psychosexual, social, legal, advocacy, economic and other needs.
  - The provision of forensic services which both increasingly recognise individuals' shared humanity, and are sensitive to and meet the needs of individuals related to their diversity, including gender, age, culture, ethnicity, spirituality, varying intellectual, physical and sensory ability, sexual orientation and gender identity, in line with the Equality Act 2006 and related policy (Byrt and Hardie, 2007).
  - Provision of new services for specific groups, such as women; adolescents; and services that are gender and culturally sensitive, and which cater for specific groups of people such as survivors/victims of domestic violence; and facilities for people who are sex offenders.
  - New and/or extended roles, e.g. related to influencing relevant Government policy and 'public education and prevention' (Kettles et al, 2006:230).
  - Other challenges include the search for new knowledge and evidence through appropriate research, audit and assimilation. (Burrow, 1993; Robinson and Kettles, 1998; Kettles and Robinson, 2000; Woods et al, 2002; National Forensic Nurses' Research and Development Group, 2006, 2007)

The evidence for the forensic mental health nursing role is not of a high level, but what there is, does provide the basis for both discussion and further research. The research evidence goes back to Phillips (1983), who provided the first study which addressed some issues of the forensic nurse's role through examination of the attitudes of forensic mental health nurses. However, Phillips (1983) did not examine the role of the forensic mental health nurse per se, did address some issues of the role through examination of the attitudes of forensic mental health nurses. Other well-known studies include Niskala (1986), Kitchener and Rogers (1992), Kitchener et al (1992), Scales et al (1993) and Kettles and Robinson (1998).

Besides research evidence, conceptual evidence is also beginning to emerge, with nurses undertaking relevant concept analysis (Kettles, 2004; Kettles and Woods, 2006).



## Argument against a forensic mental health nursing role

Much of the argument against forensic mental health nursing, as a separate, specialised area of nursing, is based on Whyte's (1997, 2000) idea that forensic mental health nurses do nothing different to general mental health nurses. Whyte (1997) argued that, although nurses working in forensic areas desired to be seen as having a unique and distinctive role, their actual duties were the same as those of general mental health nurses. Interestingly, Whyte (2000: 24) shifts his position slightly in a later publication to state that:

*Rather than focusing upon the professional development of a role that, if established, is established on tenuous principles, nurses working within secure environments might be best served by 'going back to the basics of nursing work'.*

There are several problems with Whyte's (2000) premise, not least the idea that 'forensic' nursing only goes on (if it goes on at all) within high security and other secure environments.

Whyte is not the only critic of role development. Barker (2006: 387) in his editorial states that:

*Many...have reverted back to 'role analysis'; developing 'minimum data sets', which describe what nurses **do**, much as Cormack did 30 years ago, with little consideration of whether this represents what they **need to be doing**. I fear that the idea of a 'mental health' nurse makes no more sense than the idea of a 'physical health' nurse. Trapped by the history of psychiatry, mental health nurses in almost every country worldwide, continue to tinker with their inherited roles, rather than conducting a radical appraisal of their possible core function... Why not diverse groups of nurse – catering for different needs, in differing contexts – united by a single ethical imperative: to provide the conditions necessary for people to grow and develop as persons, **and to do these persons no harm**.*

In some ways, Barker is describing the way in which forensic mental health nursing is, in fact, developing. As described earlier, there are many nurses practising in different contexts who are already trying to provide the conditions necessary for people to grow and develop; and who are endeavouring to do these persons no harm, but with the added caveat that these persons do no harm to themselves or to others.

However, forensic mental health nurses certainly do have the same roles as other nurses, in terms of the provision of care and interventions through the core skill of developing appropriate nurse–patient relationships (Collins, 2000:41).

In addition, we would argue that forensic mental health nurses often apply a range of other skills applicable in other areas of mental health nursing. These include, for example, skills used in the admission and assessment of clients and patients, and in their continued treatment, rehabilitation and recovery. Skills in the administration and monitoring of psychoactive medication, and in the application of psychosocial interventions, therapeutic community principles and other specialised interventions have been demonstrated to have applicability in both forensic and other mental health services. Examples of this wide applicability across areas of mental health nursing are given, for example, in Gamble and Brennan (2006), Kettles et al (2002), and the National Forensic Nurses' Research and Development Group (2006, 2007).

## **The forensic mental health nursing role as different from other nursing roles**

Nevertheless, forensic mental health nurses work in ways that other nurses do not. For example, the most obvious differences include security levels, levels of dangerousness, types of risk assessment and management, and practice and related training and education in a variety of particular issues. The latter include security management, safety, searching, escort duty, hostage-taking and management, detention and legal issues.

However, there are also less obvious features of forensic mental health nursing that make it different. These include diagnostic or other categories of patients, including 'psychopath', 'dangerous and severe personality disorder', 'antisocial personality disorder', 'sex offender' and 'paedophile'. Forensic mental health nursing is different not only because of this diagnostic and public labelling of individuals, but also as a result of the high media profile of many of the patients, and the Government's actions in relation to offenders. This means that the staff have to deal with all the social, cultural and political consequences that ensue (Byrt, 2001; Byrt with Dooher, 2006; Kettles et al, 2006).

Additionally, the complexity issue makes forensic mental health nursing different. For example, dual diagnosis is becoming much more common in acute, community and substance misuse services. However, in forensic services, there are more usually multiple diagnoses, including combinations of two or more categories, such as mental illness, personality disorder, learning disability and substance misuse; and now the 'sociopolitical' diagnosis of dangerous and severe personality disorder can also be applied (Byrt with Dooher, 2006). It is common for triple diagnoses to be the norm, with people experiencing complex legal, psychological, social, diversity, emotional and cultural problems in their clinical presentation (Wix and Humphreys, 2005; National Forensic Nurses' Research and Development

Group, 2007). In addition, there is some evidence that forensic mental health nurses have more problems concerning patients' transference, their own counter-transference and other strong feelings than staff in other areas, and have to be constantly on their guard against this particular problem (Bowers, 2002; Mercer et al, 1999; Schafer, 2002).

The legal situation is usually complex as well, as forensic mental health nurses have to understand much more in terms of the legislation that affects each individual patient and the legal freedoms that each patient is allowed under the terms of that legislation. A few examples of the legislation that forensic mental health nurses must now be familiar with includes the following (Byrt and Hardie, 2007; Kettles et al, 2007):

- The respective Mental Health Acts applicable in their place of work, such as the Mental Health (Care and Treatment) (Scotland) Act (2003) and the Mental Health Act (2007) for England and Wales.
- The Police and Criminal Evidence Act (1984).
- The Health and Social Care Act (2001).
- Adults with Incapacity Act (2000).
- Disability Discrimination Act (2005).
- Human Rights Act (1998).
- Equality Act (2006).
- Civil Partnership Act (2004).
- Gender Recognition Act (2004).

All of the above Acts have some requirements relevant to forensic services, and which forensic mental health nurses have to know and may have to carry out in the course of their duties.

Risk assessment and management is also much more in-depth in forensic services with nurses conducting a variety of assessments, including nursing assessments and others such as the Behavioural Status Index (Reed and Woods, 2000); Health of the Nation Outcome Scales (HONOS; Wing et al, 1996) and HONOS-secure v.2 (Sugarman and Walker, 2004); the Hare's Psychopathy Checklist – Revised (PCL-R; Hare, 2003); and the HCR-20 (assessing historical, clinical and risk management issues: Webster et al, 1997) (Doyle and Coffey, 2007; Woods and Kettles, 2007).

Another of many possible considerations here, is the length of time forensic mental health nurses spend with their patients. In many instances, even with new ideas and ways of working, forensic patients are still longer term patients than many others. A person with recurring bouts of depression may be known to staff in an acute ward over a period of years as the person comes in and out of hospital, but forensic patients are often in hospital for years and face long-term input from a variety of multidisciplinary staff

when they are finally repatriated and rehabilitated to community care. The course of care is different and so the level of care is also different, with the forensic patient facing a long-term care programme approach (CPA) and risk management monitoring and intervention, for example, involving the Risk Management Authority (RMA) in Scotland. In contrast, the depressed patient may see a community nurse for a specified period of time and is more likely to attend an outpatient clinic or see the consultant psychiatrist, followed by general practitioner care in the primary care setting. Thus, the overall course of care also tends to be different because of the nature of the index offence and other identified problems (Coffey et al, 2007).

There are many reasons why forensic mental health nursing roles are different to those of other mental health nurses; and there is no need to revert back to role analysis to justify the differences, as they are quite obvious, given the patient population and the varying environments in which forensic mental health nurses find themselves.

## **Forensic mental health nurse: A developing, evolving species**

The current situation is that there are many roles and contexts in which forensic mental health nurses find themselves and this text seeks to explain, clarify and understand some of them. These are indeed evolving roles and contexts, as care and practice are constantly developing, and do not stand still for long. Where appropriate, research and future directions are discussed in each chapter.

## **Topics covered in this book**

The following is a summary of the contents of this book.

- Helen Walker deals with the educational issues in *Chapter 2*.
- David Langton, in *Chapter 3*, highlights the role of nurse consultants in forensic mental health care (in Scotland).
- In *Chapter 4*, Mary Addo and Ian Smith discuss equality and diversity in relation to respecting the person with a learning disability.
- Through *Chapter 5*, Richard Byrt introduces power and participation in forensic services.
- Richard then goes on to discuss various perspectives related to power in *Chapter 6*.
- Patient empowerment and participation: barriers and the way forward are examined by Richard Byrt, Linda Hart and Linnette James-Sow in *Chapter 7*.