

## Forensic Psychiatry.ca

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### **Risk & Risk Management in Forensic Psychiatric/Mental Health Nursing: A Brief Annotated Bibliography** ©Avery Gudgeon, 2004

Forensic psychiatric nurses work with offenders who have been deemed mentally disordered and thus have no place in the judicial/ penitentiary system. Within secure psychiatric settings, they must provide care for and maintain custody of these patients, a paradoxical role that makes this type of nursing unique. Although coinciding with psychiatry, psychology and clinical criminology in some respects, this nursing discipline is nonetheless distinct. In the literature, there exists a debate over the true status of forensic psychiatric nursing as a specialty: some declare it a distinct role with unique requirements and responsibilities, while others believe that the profession needs to further define its nurse-patient relationship and develop more standardized formal training.

Risk assessment and management have become increasingly important in forensic psychiatric nursing, as nurses work with patients who have a high probability of displaying violent behaviour. However, as an emerging practice, no standardized universal training or instruments exist, and there has been much recent research into the development of risk assessment and management models.

Although not exhaustive, this annotated bibliography is a collection of recent literature regarding forensic psychiatric nursing and aims to highlight the particulars of this practice. It is divided into three sections: role/ education, interventions/ therapy, and risk assessment and management, with a particular focus on the nursing perspective. It was compiled by a third year student enrolled in the Bachelor of Health Sciences program at McMaster University in Hamilton, Ontario. My research began as an interest project and has continued as an independent study required by the course, Health Sciences 3H03: Inquiry Project. The project was completed under the direction of Dr. Chris Webster, Senior Research Consultant, Forensic Services, St. Joseph's Healthcare, Hamilton.

The literature search was conducted between Spring 2003 and Spring 2004, using Ovid Medline and combinations of search words such as: 'forensic nursing,' 'forensic psychiatry,' 'forensic psychiatric nursing,' 'job description,' 'nurse's role,' 'psychiatric nursing,' and 'risk assessment.' A variety of nursing and mental health journals were accessed electronically or through McMaster University libraries, most frequently: the Journal of Psychiatric and Mental Health Nursing, the Journal of Psychosocial Nursing and Mental Health Services, Nursing Times, and the Journal of Psychosocial Nursing. Papers were included on the basis of apparent pertinence to the topic and currency. Within my research, I found that the same points were often made by different authors, but no effort was made to determine primacy as all information was simply summarized and categorized by content.

#### **Role and Education of Forensic Psychiatric/Mental Health Nursing In the Literature (General)**

As an emerging specialty, the role of the forensic psychiatric nurse is not yet universal, and the term "forensic" has expanded to include nurses working with both victims and perpetrators in a variety of settings. The articles

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in this section discuss the emerging role of the forensic psychiatric nurse, the debate over the existence of a specialty, role tensions, and training issues.

### ***Role – forensic nursing – with perpetrators***

Barton, S. (1995). Investigating forensic nursing. *Kansas Nurse*, 70(6): 3-4

- Kansas: Focuses on forensic nurses who care for victims of crime
- Nurses also use their therapeutic abilities to work with the perpetrators of criminal acts. In correctional facilities, forensic psychiatric nurses assess, evaluate, and use therapeutic interventions while working with criminal defendants. Other practitioners working in private offices manage therapeutic regimens with either victims or offenders

### ***Education/ training – burnout***

Ewers, P., Bradshaw, T., McGovern, J. M., & Ewers, B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of Advanced Nursing*, 37(5): 470-6

- UK: Mental health nurses working in secure environments with patients suffering from serious mental illness have been shown to be at risk of clinical burnout syndrome
- Clinical burnout has been described as a syndrome occurring in staff working in the care professions which results in emotional exhaustion, depersonalization and reduced personal accomplishment
- Clinical burnout has been shown to have a negative effect on the well-being of staff, the quality of interactions between staff and clients, and undesirable consequences for the organizations in which staff work
- Psychosocial Intervention Training (PSI) is a relatively new innovation that helps clinicians to conceptualize their patients' problems within a more empathetic framework and trains them in the skills to intervene effectively
- Study: aimed to evaluate the effect of PSI on the knowledge, attitudes and levels of clinical burnout in a group of forensic mental health nurse
- Found that staff in the experimental group showed significant improvements in their knowledge and attitudes about serious mental illness and a significant decrease in burnout rates

### ***Role – forensic community nurse – developing***

Friel, C., & Chaloner, C. (1996). The developing role of the forensic community nurse. *Nursing Times*, 92(29): 33-5

- UK: Generic mental health teams face anxieties and pressures in caring for/ managing difficult/ dangerous patients, which is reflected in the number of requests for forensic specialist opinion
- The Care Program Approach (CPA) has raised standards of aftercare and increased the accountability of key community mental health personnel
- Evolving role of the forensic community mental health nurse (FCMHN): being asked to offer independent advice and recommendations re: care/ management of forensic psychiatric patients – these recommendations may form the basis of the clinical team's plan for treatment and management in the community
- Need for education/ preparation of nurses as they are increasingly required to conduct formal assessments and produce comprehensive/ influential clinical/ managerial reports

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- Emphasis placed upon examining the patient's history of, and potential for, offending
- There are few, if any, definitive assessment instruments available specifically for nurses
- Chiswick (1995): 5 useful indicators are: index of behaviour or event and antecedents, use of alcohol and other substances, psychosexual behaviour and interests, mental state examination, and attitude to treatment received

### ***Role – forensic nursing – caring***

Hammer, R. (2000). Caring in forensic nursing: Expanding the holistic model. *Journal of Psychosocial Nursing & Mental Health Services*, 38(11): 18-24

- United States: Forensic nursing brings together the disciplines of nursing, forensic science, medical science, sociology, and psychology with law enforcement and the criminal justice system
- Until the IAFN recently designated forensic nursing as a unique specialty, nurses had practiced forensic nursing for many years without formal recognition of the domain as a sub-discipline for specialized study
- Such recognition requires that the specialty define and explicate its major conceptual base – must remember that caring remains the hallmark of professional nursing practice
- Complex role in providing caring encounters for victims of violence as well as the perpetrators of criminal acts – some difficulty may arise because of the dichotomy of roles that presents itself in many forensic situations and the need to avoid conclusions of innocence or guilt; further, the nurse's need to protect and preserve human dignity may seem to be in conflict with the objectives of the other members of the forensic team
- Article provides recurring themes in the definition of caring as well as an instrument developed to measure caring

### ***Role – forensic nursing – debate***

Maeve, M. K., & Vaughn, M. S. (2001). Nursing with prisoners: The practice of caring, forensic nursing or penal harm nursing? *Advances in Nursing Science*, 24(2): 47-64

- United States: This article critically analyzes three philosophic stands toward nursing care with prisoners and suggests their philosophic commensurability within traditional nursing practice
- The idea of providing decent, sound health care for prisoners is not always popular
- It is widely reported/ accepted that incarcerated men and women have increased rates of serious and chronic physical and mental illnesses (diabetes, hypertension, depression)
- If one accepts the idea that criminal behaviour is unhealthy behaviour, the potential scope of health care needs becomes exponentially greater
- Nurses may be licensed practical nurses (LPNs) with about one year of vocational training or registered nurses (RNs) with varying levels of education/ preparation
- The pool of available nurses and physicians for prison settings is somewhat limited due to the nature of the job, the pay, and the setting/ location ? there is a professional stigma associated with working in correctional health care
- Ethical problems: maintaining confidentiality, using chemical restraint for security rather than medical purposes, working with under-qualified personnel providing care outside their scope of practice, caring for addicted prisoners, caring for the mentally ill, caring for incarcerated mothers and their newborns, managing for

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the visitation rights of children whose parents are incarcerated, dealing with violence, coping with prolonged isolation/ segregation of inmates, and providing appropriate planning for released prisoners

### *From a caring perspective:*

- Caring associated as the fundamental core of nursing, and caring always involves relationship (even with an offender)
- When feelings of natural caring are distorted, nurses must find a way to respond to and overcome obstacles through ethical caring

### *From a forensics perspective:*

- In 1995, the American Nurses Association officially recognized forensic nursing as a specialty
- The International Association of Forensic Nurses (IAFN) recognizes varying roles: nurse coroner, nurse investigator, forensic psychiatric nurse, legal nurse consultant, and the forensic correctional/ institutional nurse
- Inconsistencies of definitions lead to role ambiguity
- Adding the term 'forensic' assured a formalized interface with the criminal justice system = new set of expectations for the outcomes of psychiatric nurses' evaluations and treatment interventions
- Forensic psychiatric nurses are increasing their involvement in the transition between institutionalization and community living; they can affect patients' re-institutionalization so as to maintain safety in the community

### *From a penal harm perspective:*

- In general, penal harm medicine and nursing exist when any health care provider supports and enforces penal harm through nursing and/ or medical actions
- During orientation processes at jails and prisons, nurses are substantively ordered not to care – this type of occupational socialization is intended to protect nurses but some may 'forget' their healing/ caring role

### ***Role – forensic psychiatric nursing – developing***

Mahony, C. (1997). Managing the risk. *Nursing Times*, 93(18): 73-6

- Wales: Spectrum of care for forensic psychiatric nursing encompasses special hospitals, medium- and low-security hospitals, and community nursing
- In 1996, the Special Hospitals Service Authority was abolished and replaced with the High Security Psychiatric Services Commissioning Board – prisons, police stations, probation teams, secure units and mainstream mental health services will all come under the Board's scrutiny
- Nurse Ray Rowden, appointed first director of the board, wants "to see people writing more about their work, a vibrant research programme in forensic mental health nursing, and nurses acting as consultants and trainers to colleagues in mainstream mental health services" (p. 75)
- Ged McCann, county development officer for mentally disordered offenders in North Yorkshire, predicts that the future will see more forensic psychiatric nurses working in a range of community settings. McCann says: "The biggest training challenge is that health-service staff haven't a clue how criminal justice works and vice versa. There is a big role for forensic CPNs in educating other professionals" (p. 76)

### ***Role – forensic psychiatric nursing – debatable specialty***

Martin, T. (2001). Something special: forensic psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, 8: 25-32

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- Australia: This paper refutes the claims that forensic psychiatric nursing has achieved the status of a specialist area of nursing
- There is a lack of consensus regarding the stage of development of forensic psychiatric nursing as a specialist area. Lynch (1996); Peternelj-Taylor & Johnson (1995); Burnard (1992); and Burrow (1993) concur with the view that it is a specialist area, while Mason & Mercer (1999); Whyte (2000); and Doyle (1998) disagree
- Author suggests that the claim of working in a specialized area of nursing practice is not supported in the literature or by evidence of specialist practice. Forensic psychiatric nursing will remain a subspecialty of psychiatric nursing until what is distinct and therapeutic about the practice is made clear
- Three requirements are necessary if forensic psychiatric nurses wish to achieve specialty status. First, forensic nurses have to consolidate their role in the containment and care of patients. Second, they have to return to the nurse-patient relationship as the foundation of psychiatric nursing practice. Third, within that relationship, nurses must expand their practice to include dealing with offence issues
- At present, discussion of the offence is often avoided due to a lack of education or because of their attitude to the offending behaviour. Exploring the offending and risk behaviours allows nurses to contribute to the decisions that will determine ongoing detainment, leaves or discharge. Expansion of their role would require education in criminology, substance use, grief issues and counseling skills

### ***Role – tensions – literature review***

Mason, T. (2002). Forensic psychiatric nursing: a literature review and thematic analysis of role tensions. *Journal of Psychiatric and Mental Health Nursing*, 9: 511-520

- UK: The aims of this literature review were to analyze the existing literature on forensic psychiatric nursing, to undertake a thematic analysis for emerging themes, and to construct a theoretical framework for further research
- In the UK, there exist four main areas of concern regarding secure psychiatric provision: 1. Treatment efficacy of secure psychiatric settings, 2. Tension created through the political move towards community care provision, 3. The complexity surrounding personality disorder, 4. The 'prisonization' of the secure psychiatric wards
- The results of this literature review were the identification of a series of major issues, which were broadly categorized as negative and positive views, security vs. therapy, management of violence, therapeutic efficacy, training, and cultural formation.
- Negative views have been located within socialized values of distaste for particular types of offences and these values may lead to the contamination of professional practice. Negative views are also noted in nurses' commentary regarding the effectiveness of their skills to treat mentally disordered offenders
- Positive views are often expressed in relation to the extent to which forensic psychiatric nurses feel that they are in control of particular situations, and when they feel that their efforts are appreciated
- Security versus therapy is the central dilemma for forensic psychiatric nurses. In the UK the role of security falls to nursing staff, while in the USA and Canada most units have security personnel to undertake those tasks (Day 1983)
- Management of violence is necessary as the potential for violence among an offender population with mental disorder is ever present
- Therapeutic efficacy is of central importance in the delivery of care;

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however, the formation of a therapeutic relationship in secure psychiatric settings is difficult, as the patient views the nurse as being part of the 'system' of detention

- Training to undertake forensic nursing in secure psychiatric services has become a growing concern internationally. Byrt (1990) found that nurses required training in nurse-patient relationship, listening skills, personal qualities and self-awareness
- Culture has an impact on the delivery of care; the ward culture can be negative or positive as a result of the difficulty of establishing the fine balance between security and therapy
- From here, domains of practice emerged as a framework for further research: medical vs. lay knowledge, transference vs. counter-transference, win vs. lose, success vs. failure, use vs. abuse, and confidence vs. fear

### ***Role – community psychiatric nursing***

Parish, C. (2002). Carers in court. *Nursing Standard* (Harrow-on-the-Hill), 16(41):12

- UK: Court diversion schemes designed to intercept people with mental health problems staffed by community psychiatric nurses whose job it is to ensure that people are properly assessed and diverted to appropriate services
- The criminal justice mental health liaison service at the Mersey Care NHS Trust in Liverpool provides a 'safety net' at each stage of the criminal justice system – intervene to get more appropriate sentencing
- Nurses use knowledge/ expertise to perform risk assessment and decide what the patient needs – hospitalization, medication, etc.

### ***Role – forensic psychiatric nursing***

Peternelj-Taylor, C. (1999). Forensic psychiatric nursing: The paradox of custody and caring. *Journal of Psychosocial Nursing and Mental Health Services*, 37(9): 9-11

- Features the contributions of forensic psychiatric nursing experts from Canada, the United States, and the United Kingdom
- Forensic psychiatric nursing bridges gap between the mental health care system and the criminal justice system; it is defined as the integration of mental health nursing philosophy and practice within a sociocultural context that includes the criminal justice system to provide comprehensive care to individual clients, their families, and their communities
- These nurses face a dual obligation of custody (legal system; community) and caring (health system; individual) ? this paradox is the single factor that most differentiates forensic psychiatric nursing from forensic nursing in general
- The protection of society is seen as a direct consequence of the processes of control and custody
- The health consequences of violence are of concern to both the health care system and the criminal justice system and require a coordinated multidisciplinary approach
- Forensic nursing described as a contemporary area of nursing practice that is still in its development stage

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### ***Role/ Education – improving care/ training needs***

Rask, M., & Aberg, J. (2002) Swedish forensic nursing care: nurses' professional contributions and educational needs. *Journal of Psychiatric and Mental Health Nursing*, 9: 531-539

- Sweden: Utilizing content analysis, this report analyzes data regarding how nursing care could contribute to improved care and the organizational changes needed, as well as what knowledge the nurses need to meet future demands

#### *Niskala (1986):*

- There are several roles/ skills that forensic psychiatric nurses must be knowledgeable about to be able to meet the needs of the patients in their care

- The types of competence rated most important by nurses: effective communication, the maintenance of security, the performance of the nursing process, and the maintenance of a professional role

- The skills nurses stated they needed most often include: to initiate relationships, to listen effectively, to document in a clear and concise manner, to maintain confidentiality, and to cope with institutional and environmental stressors

- Nurses reported a need for more training on 66 of the 162 skills/ competencies items Study:

- Nurses working in five Swedish forensic psychiatric units filled in a questionnaire designed for general psychiatric nursing, but modified for forensic use

- How nursing care could contribute to improved care and the organizational changes needed:

- Analysis of issues resulted in four different categories: humanistic basis in nursing care, organization of care, nurses' need of knowledge, and essence in the nurses' work

#### *Findings:*

- An interpersonal nurse-patient relationship based on trust, empathy, respect and responsibility for the patients' personal resources and knowledge is the essence of nursing care and a way to improve care

- The organization needs to be more influenced by/ based on nursing care where clinical supervision and the patient's social networks have more distinguished roles Knowledge the nurses need:

- Analysis developed 10 categories with specific content: Nursing care, Developing relationships, Humanistic and basic human values, Theoretical models and treatment techniques, Psychopathology and medication, Basic and further training, In-service training adapted to the ward-specific problems, Documentation and evaluation, Clinical supervision, and Knowledge about other caring professions

#### *Findings:*

- The nurses' educational needs emanate from different treatment modalities, how to perform different treatments, how to establish developing relationships, and in-service training adapted to the ward-specific problems

### ***Role – forensic psychiatric nursing – developing***

Sekula, K., Holmes, D., Zoucha, R., Desantis, J., & Olshansky, E. (2001). Forensic psychiatric nursing: Discursive practices and the emergence of a specialty. *Journal of Psychosocial Nursing & Mental Health Services*, 39(9): 51-57

- North America: Describes the concept of forensic nursing and questions its existence as a specialty. Much debate and controversy has accompanied the development of specialty practices in nursing. Traditionally,

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nurses have been trained as generalists and nurses with extensive clinical experience in a particular area of practice are considered specialists – by this definition, no formal education beyond the entry level is required to call oneself a specialist

- The International Council of Nurses (ICN) defined specialization in nursing as a level of knowledge and skill beyond basic nursing education; in 1992, the National Council of State Boards of Nursing further defined the requirements by stipulating that in addition to basic nursing education, advanced practice nursing requires a graduate degree in nursing with a concentration in the identified area of practice
- Two models for specialization in nursing are used in practice: the first is the collaborative model (similar to the medical model in that it views patients within disease categories); the second is the clinical nurse specialist model (based on nursing models of practice which views patients within nursing theories of care)
- While Whyte (1997) argues that forensic nursing is not a legitimate specialty within nursing, Lynch (1993, 1995) and Burrow (1993), among others, believe that forensic nursing is a specialty of its own with unique responsibilities created by the intersection of the mentally ill person as both the patient and the criminal
- The development of forensic nursing has been attributed to the increased rate of incarceration and the failure of deinstitutionalization
- However, inconsistent definition of role makes it more difficult to identify forensic nursing as a specialty, as well as to provide education and set standards. The acceptance of this specialty could facilitate further development of a knowledge base, accelerate the development of assessment and intervention skills, encourage research in the area, and promote a sense of identity for nurses working in this marginalized domain of practice

### ***Role – multidisciplinary team-work – ethical references***

Mason, T., Williams, R., & Vivian-Byrne, S. (2002). Multi-disciplinary working in a forensic mental health setting: ethical codes of reference. *Journal of Psychiatric and Mental Health Nursing*, 9: 563-572

- UK: Reports on a research project on multidisciplinary team-working within a medium secure forensic unit
- In healthcare settings, teams will comprise individuals from differing professional groups whose roles within the team also differ; each must have some understanding of other members' roles to maximize the functioning of the overall team. Team-working is central to effective healthcare delivery
- The focus of forensic mental healthcare is the delivery of service through a systemic structure incorporating mental health and criminal justice issues. Individuals involved in these multidisciplinary clinical teams come from professions such as psychiatry, clinical psychology, social work, nursing, occupational therapy, and probation. Each professional group brings their own profession's value system, normative practices, ideological framework, and code of conduct
- A review of the literature reveals definitional difficulties and different proposed typological frameworks applied to multidisciplinary team-working
- Brooker & Whyte (2000): aimed to assess the extent to which professions working in forensic settings were clear about their role in teams, and agreed about the core skills needed by all team members. Referring to overall identification, 55% of subjects identified with both their profession and the team – indicates that these two areas of identification are interacting with each other, although multidisciplinary tensions were also noted across professional groups

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- Robinson & Kettles (1998): forensic nurses feel they provide a link between disciplines in a pivotal role central to communication; however, some have difficulties contributing to the team and feel they have low status within it

### *Study:*

- Two questionnaires were developed, one delivered to groups/ teams and one to individuals, with the aim of obtaining feedback from a wide range of workers regarding the systems, processes, and structures in place to support their practice
- The results highlight a three-level ethical code referencing system employed by both groups and individuals: (a) a reference system within their own ideological framework; (b) a reference to the local unit's/ Trust's ethical codes; and (c) each profession's general code of conduct
- When these codes of reference differ, tension is created in deciding which to follow
- Further, within this referencing system exists three polarized continua labeled: (a) individual versus group accountability; (b) local versus national policies; and (c) informal versus formal reference points – multidisciplinary decision-making must be made within this complex structure

### ***Education/ training – leadership***

Pullen, M. L. (2003). Developing clinical leadership skills in student nurses. *Nurse Education Today*, 23: 34-9

- UK: Need for strong leadership within the NHS: The NHS Plan (2000) states that nurses need to take a lead role in the running of local health services
- The literature identifies a number of skills deemed to be essential for clinical leadership – four skills discussed in the article are self-knowledge, communication skills, risk taking, and keeping informed
- Self-knowledge: it is important that a leader develops an awareness of the messages that their own body conveys to others; also must know own strengths and weaknesses so as to help the team achieve desired goals
- Communication skills: these are encouraged throughout pre-registration nurse education; communication is a two-way process and students are taught active listening skills
- Risk taking: risk taking is one of the defining characteristics of leadership, however the culture of the NHS is one of risk aversion
- Keeping informed: the need to know what is happening both locally and globally, in order to ensure that actions taken are synchronized with other events
- This paper analyzes the ways these skills are currently developed in one University's pre-registration nursing curriculum and concludes that although many opportunities are available to develop these skills in the classroom environment, there are many pressures that prevent use of these skills in a practice environment

### ***Therapeutic tool/ nursing skill – leadership – education/ training***

Scheick, D. M. (2002). Mastering Group Leadership: An Active Learning Experience. *Journal of Psychosocial Nursing*, 40(9): 30-9

- United States: Leading therapeutic groups is an underused by viable treatment role for nurses in all specialty areas – it is a skill that can increase nurses' repertoire of therapeutic responses

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- Learning results from both passive reception and active processing of information
- Active learning encompasses a range of teaching-learning strategies emphasizing students' involvement, investment, and responsibility to learn
- Learning how to lead a group begins by being in a group; each year nursing students are given more of a leadership role accompanied by journal writing to internally process and self-evaluate – students self-teach and expand the therapeutic repertoire of responses
- Recognition that the skills required to produce good group work are different than those required to produce good individual work
- Psychoeducational group model is used in clinical setting
- Structured exercises are used to help facilitate group progress and to help determine the level of self-exploration or intensity

### ***Role/ Education – training issues in forensic practice – multidisciplinary***

Mason, T., & Gerry, C. (2002). Towards a 'forensic lens' model of multidisciplinary training. *Journal of Psychiatric and Mental Health Nursing*, 9: 541-551

- UK: Paper reports on research undertaken to identify if common areas of multidisciplinary training in forensic mental health practice exist in the literature; review of literature and curriculum documents
- Multidisciplinary working is central to forensic practice
- Professional training has taken a diffused approach – each profession has formulated areas of study for appropriate 'forensic' expertise, usually involving basic training pertaining to the profession followed by postgraduate studies
- This method of training is unclear and may not be appropriate, so it is necessary to identify what the required skills are to care for/ manage this patient population, as well as establishing whether they are evidence-based and to what extent they can be measured
- Debate, particularly in forensic nursing, is centred on two points: first, whether generalist principles of professional working practices are merely being applied to a specific patient population; second, whether there is a unique body of knowledge known as 'forensic'.

### **Forensic Psychiatric Nursing**

- The term 'forensic' nursing was generally accepted in the literature in the mid-1980s to denote those who work with mentally disordered offenders in secure psychiatric services
- Difficult to define, but the disparate nature of the inchoate profession is highlighted – the contrasting aims of caring and custody
- Dale et al (1995): failure to address the inadequacies of syllabi to skill a nursing workforce to manage and treat mentally disordered offenders is a major concern
- Brooker & Whyte (2000): report aimed at multidisciplinary team-working in secure psychiatric settings; argued that inter-professional training should take place at the clinical interface, and that it should focus on client-centred, problem-based learning exercises that allow for reflexive learning
- An important finding of this review is that process is just as important as content in the care/ management of mentally disordered offenders. The process is assisted by a knowledge base that is related to forensic practice

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and constructed from 13 broad multidisciplinary training areas: legal, assessment, treatment, evaluative, research, management, multidisciplinary, service development, risk, forensic, other, security, and ethical issues

- Forensic practice is at an early stage of development, and the process requires facilitation in order for a specific knowledge to emerge. This process involves developmental work in the 13 areas and specific training is required for staff to take action in these areas. This modeling provides evidence to support common areas of multidisciplinary forensic training

## ***Role – forensic nursing – definition***

Whyte, L. (1997). Forensic nursing: a review of concepts and definitions. *Nursing Standard*, 11(23): 46-7

- UK: Considers the evidence for the existence of forensic nursing as a sub-specialty in mental health care; the author argues that forensic nursing as a distinctive branch of nursing does not exist

Lynch 1993, 1995:

- forensic nursing is the application of forensic science to nursing

- differentiated between 4 areas of forensic nursing:

- 1. clinical forensic nursing: application of clinical and scientific knowledge to questions of law and criminal/civil investigation of survivors of traumatic injury and for patient treatment involving court-related issues

- 2. Sexual assault nurse examiner: clinical examination of victims and therapeutic interventions

- 3. forensic psychiatric nurse: involved in the assessment of, and interventions with, criminal defendants before court hearings

- 4. forensic correctional/ institutional nurse: specializes in the care, treatment, and rehabilitation of individuals who have violated criminal law and have been committed for therapy to hospitals

- In the US and Canada, the term forensic psychiatric nurse can be used in the same sense as forensic correctional/ institutional nurse

- The emphasis of Lynch's work in the US is much more upon the issues surrounding the victim, compared with the UK emphasis which is predominately perpetrator centred – author believes there is a clear distinction between the roles/ responsibilities of forensic nurses in relation to the victims and perpetrators (care versus control)

- Author believes that a nurse must contribute to assessment in the justice process to be called 'forensic'

- also states that the work of all mental health nurses is being influenced increasingly by the forensic aspect of mental health care; mental health nursing is simply evolving as mental health and justice systems come into contact more frequently to become more forensic in nature

## **Risk Assessment and Risk Management**

Risk assessment and management are important in both secure psychiatric settings and outpatient services, in which patients are reintegrated into the community. The papers in this section discuss the theory behind risk assessment and management, some approaches to their implementation, and their central importance in forensic psychiatric nursing. More specifically, instruments that have been developed for use in practice are described and evaluated for their predictive ability.

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### ***Assessment – research – developing tools***

Belfrage, H., & Fransson, G. (2000). Swedish Forensic Psychiatry: A field in Transition. *International Journal of Law and Psychiatry*, 23(5-6): 509-514

- Sweden: New legislation of 1992 required risk assessments in forensic psychiatric examinations; although the body of knowledge in this field was poor, at present (2000) there is no area in the field of forensic psychiatry or the correctional system that is subject to more research projects than risk assessment and risk management
- Sweden has been influenced by international researchers, mainly from Canada, in the area of risk assessment. There is a trend in favour of structured risk assessments, and Canadian instruments like the HCR-20 Violence Risk Assessment Scheme (Webster, Douglas, Eaves, & Hart, 1997), the Spousal Assault Risk Assessment Guide (Kropp, Hart, Webster, & Eaves, 1995), the Sexual Violence Risk-20 (Boer, Hart, Kropp, & Webster, 1999), and the Psychopathy Checklist-Revised (PCL-R)/ PCL-Screening Version (PCL:SV) (Hare 1991; Hart, Cox, & Hare, 1995), are implemented into clinical practice
- The Swedish National Board on Forensic Medicine is responsible for the forensic psychiatric assessments, which take place during a trial, before a sentence is given. A team consisting of a psychiatrist, a psychologist, and a social worker work together to complete the assessment within four weeks, and although it is up to the court to make the final decision, the team's suggestions are usually followed
- Risk management procedures (within Sweden's civil psychiatric and special forensic psychiatric hospitals) are introduced at the beginning of the treatment, focusing on the individual's risk factors and on the establishment of risk management models to minimize them. Swedish law requires that patients participate in planning for all forms of compulsory treatment
- To meet the requirements for final discharge, the court must decide that there is no longer a risk for relapse into serious criminality as a function of the mental disturbance and that there is no need for the patient to be held at a psychiatric hospital - these requirements are rarely fulfilled

### ***Assessment and management – risk escalators***

Heyman, B., Buswell Griffiths, C., & Taylor, J. (2002). Health risk escalators and the rehabilitation of offenders with learning disabilities. *Social Science & Medicine*, 54: 1429-1440

- UK: This paper presents a study of risk management in a hospital within the UK National Health Service (NHS) which attempts to rehabilitate offenders with learning disabilities. Analysis is based on the metaphor of a 'risk escalator' with a focus on emergent properties of a downward risk escalator
- The concept of a risk escalator provides a way of understanding how the dilemma of balancing patient safety against autonomy is dealt with by hospital staff
- Health and social care systems can be characterized as risk escalators if they possess three attributes: first, risk managers (health professionals) should agree upon the ordering of the severity of a set of related risks; second, a range of responses should exist that can be calibrated against risk severity and which provide different balances between autonomy and safety; third, it should be possible for individuals to be propelled up or down a risk escalator by positive or negative feedback
- Positive and negative risk feedback can occur because risk identification changes behaviour and/ or because the emotional impact of a risk assessment itself affects risk indicators

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- In rehabilitation systems, risk escalators may bring patients downward towards greater autonomy if justified by negative feedback, but this trajectory may be blocked or reversed; ideally, behavioural management and therapeutic systems work together to facilitate movement down the risk escalator

### *Study:*

- Designed to illuminate patient and staff experiences of the rehabilitation of offenders within a mental health care system. The research focuses primarily on patient experiences and the obtained data relates more to the behavioural management system than to biennial progress reviews or psychotherapy
- Decisions to move a patient depend on communication between different groups of health professionals – interviews highlighted the gap in risk assessment which could open up between front-line staff who shared their lives with patients and more distant senior colleagues empowered to decide their progress
- *Four major issues were identified in the present study:*
  - 1. The smooth running of the downward risk escalator was compromised by organizational complexities; further, patients did not necessarily seek to move down the risk escalator
  - 2. The slow-moving downward risk escalator towards rehabilitation was counter-balanced by a rapid transit up escalator which swiftly moved those judged unable to manage a given degree of autonomy into a more controlled environment. This privileged safety over rehabilitation and created a tendency towards under-achievement
  - 3. Travelers may actively manage their journeys on risk escalators; some patients and staff identified inherent tensions between behavioural compliance and therapeutic openness, and the ability to act in an expected manner in order to gain autonomy
  - 4. Riskiness may, like other nebulous attributes, be seen as a general trait of individuals, indexed by any domain

### ***Risk assessment/ management – community release***

Kelly, T., Simmons, W., & Gregory, E. (2002). Risk assessment and management: A community forensic mental health practice model. *International Journal of Mental Health Nursing*, 11: 206-213

- Australia: Risk assessment and management are central to mental health practice; professionals must consider the probability that their patient will act in a destructive manner and intervene to prevent such behaviour (Mullen 2001)
- In Victoria, the Crimes (Mental Impairment and Unfitness to be Tried) Act (1997) reformed the detention, management and release of persons found by a court to be not guilty on the grounds of insanity by providing a legal structure for such forensic patients to move from secure inpatient facilities into the wider community
- Under the Crimes Act 1997, the court can impose a range of orders including custodial and non-custodial supervision orders as well as unconditional release
- This new legislation has created challenges for all stakeholders by significantly changing the lifestyle and life opportunities of this client group and their carers (Martin et al. 2001)
- Responsibility regarding outcomes may extend from the forensic patient, carers, courts, and wider community. Although ultimately a Supreme Court decision to release forensic patients, it is clinicians who manage the risk on a daily basis

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### ***Forensic Risk Management Model***

- The challenges have necessitated development of the Forensic risk assessment and management practice model, with the objective to provide a framework that optimizes community safety while acknowledging the rights of the individual
- Mental health nurses developed the model to work with mentally ill offenders who have committed homicide in the past and are now living in the community. It is based on the practical experience of mental health care practitioners, risk assessment research, and literature
- The model is a three-pronged approach to risk assessment and management:

#### ***1. Risk Profile***

- Serves as a tool to collate information pertaining to the offence and to the patient's total experience, and to provide a historical overview of the illness-related factors, contextual circumstances, and dispositional factors that have been associated with past violence

#### ***2. Risk Assessment***

- Process of assessing the individual patient against his or her specific risk factors as well as against other known general risk factors, such as substance abuse (Mullen 2001)
- The function is to determine whether the clinician needs to take action for the protection of the patient or community by activating the risk management plan
- Risk is a dynamic factor, and assessment is more accurate at predicting violence in the short term (Tardiff 1989); frequent risk assessment is therefore essential

#### ***3. Risk Management Plans***

- A collaborative and proactive exercise developed by the clinician in consultation with the patient, their carers, and other relevant agencies
- The plan documents strategic directions for immediate response in patient management in times of increased risk, and serves as a communication tool
- Distinguishes between two levels of response – after identification of increased risk and assessment, it may be decided that the patient can remain in the community with additional support, or that the patient must be recalled to hospital

#### ***Management – intervention – issue of restriction***

Kozub, M. L., & Skidmore, R. (2001). Least to most restrictive intervention: A continuum for mental health care facilities. *Journal of Psychosocial Nursing & Mental Health Services*, 39(3): 32-38

- United States: The article reviews current research/ literature to formulate a usable continuum of interventions in response to violent/ aggressive client behaviour AND hopes to help hospital staff meet requirements of standards
- Responses must be proactive, effective in meeting patient needs at the time, satisfy ethical/ regulatory requirements

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- Public interest in the use of seclusion/ restraint has led to the revision of regulatory standards such that seclusion/ restraint only to be used as a last resort; the Health Care Financing Administration (HCFA) and the Joint Commission on Accreditation of HealthCare Organizations (JCAHO) each have released a set of revised standards to guide health care organizations in the acceptable use of these interventions
- Two main levels of response to escalating patient behaviour exist: 1. least restrictive interventions; 2. seclusion/ restraint. The less restrictive end of the continuum provide a greater number of options for interventions, and include verbal techniques, time out, medications, and therapeutic holding for children. Interaction and redirection is a method of resolution at earliest intervention level in which early detection of the escalating situation is key. The patient is provided with consequences of escalation vs. de-escalation: self-control and choice decreases as emotional response escalates. Seclusion/ restraint used together is the most restrictive intervention in the continuum. Patients who need to be controlled at this level have been determined to be unsafe in all of the less restrictive levels of intervention, and they must be constantly monitored.
- Two constants of intervention are “processing out” and medication. Processing out, or debriefing, is important at all levels. The second constant involves patients’ ability to request medications and staff’s responsibility to offer them at any point in the intervention process
- Strategies for implementation of less restrictive interventions include education (prevention and management of disruptive behaviour, least restrictive interventions, and assessment), training in the proper/ safe use of seclusion/ restraint, and support/ leadership from management

### ***Assessment – risk factors – rehabilitation***

Lindqvist, P., & Skipworth, J. (2000). Evidence-based rehabilitation in forensic psychiatry. *British Journal of Psychiatry*, 176: 320-323

- Britain: This paper discusses some essential features of a forensic psychiatric rehabilitation system to create a conceptual framework for research and practice
- The assessment of the probability of mentally disordered offenders committing violent and criminal acts continues to be subject to extensive research
- Research must be grounded in clinically-based studies linking risk assessment to management if it is to be applicable; studies should be both qualitative and quantitative, with a focus on the questions of whether or not, to what extent and when forensic psychiatric rehabilitation alters the individual’s level of risk
- Actuarial risk assessment tools, developed to further define which groups of people with mental illness show/ have an increased risk of violent behaviour, are largely based on static and historical factors that cannot hope to be targeted or changed by rehabilitation; this may lead to inaccurate evaluations
- Risk assessment can be linked to at least four dynamic features of the individual patient and their treatment setting: the disorder itself, family problems and poor sociocultural circumstances, substance misuse, and anti-therapeutic system dynamics
- There has been insufficient analysis of external factors and their influence on prognosis; it is essential to focus therapeutic rehabilitative efforts on factors both within the patient and their rehabilitative environment. Such external factors include: shared values and goals, staff continuity, timing of the initiation of the rehabilitation process, family relationships, social networking/ peers, process insight, and future plans
- Research aimed at analyzing the effects of forensic psychiatric rehabilitation is fraught with difficulty, whether quantitative or qualitative, and will be hampered by such problems as: the complexity of forensic treatment

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systems, the problems of constructing randomized-controlled studies (RCTs) with patients in treatment systems, and the inability of current risk assessment tools to assist reliably in rehabilitation

- To conduct a natural experiment, it is suggested that a number of separate forensic psychiatry services be organized into a joint collaboration; this would preserve a true clinical rehabilitative environment and allow for comparative research

### ***Risk Management – forensic psychiatric nursing – workplace violence***

Morrison, E., Morman, G., Bonner, G., Taylor, C., Abraham, I., & Lathan, L. (2002). Reducing staff injuries and violence in a forensic psychiatric setting. *Archives of Psychiatric Nursing*, 16(3): 108-117

- USA: Little progress has been made towards improving understanding of violence by the mentally ill, and programs aimed at the prevention of such violence are rare

- This report describes the administrative and clinical efforts of the staff in a maximum security psychiatric facility when addressing an alarming increase in violence and serious staff injuries

- At the study hospital, the administrative team developed a plan examining strategies for supporting/ protecting staff during violent crises – strategies included a more lenient definition of ‘emergency’ for the use of seclusion/ restraint, new restraint products, the implementation of a Security Management Team (SMT), and Aggression Management Plans (AMP) on selected high risk patients. A nurse consultant with knowledge in violence was also hired to work with the staff in forensic psychiatry – short-term goal was to be an advocate for staff and to decrease violence, and long-term goal was the education of staff related to violence

- AMP: developed and implemented for managing the nine identified high-risk patients. They provided for a means of early physical intervention, which included seclusion and restraint (under a more targeted definition of emergency) for the safety of staff. The AMP identified the appropriate clinical interventions for three stages of escalation

- Data suggests that the units in the study hospital successfully reduced staff injuries as well as the overall amount of aggression and violence; use of seclusion/ restraint also decreased overall

- Several implications can be drawn for nurses: first, organizational issues affecting quality of care in forensic psychiatric settings should be addressed such as mandatory overtime, staff injuries, and violence. Second, staff injuries and violence are not necessary in forensic psychiatric settings; violence can be reduced. Third, staff morale is an issue that also must be addressed because of its relationship with the quality of care

### ***Risk assessment – tools – VRAG & HCR-20***

Tengstrom, A. (2001). Long-term predictive validity of historical factors in two risk assessment instruments in a group of violent offenders with schizophrenia. *Nordic Journal of Psychiatry*, 55(4): 243-249

- Sweden: Studies have shown that individuals with a major mental disorder (MMD) have an increased risk of committing a violent crime. As most individuals with MMD do not commit crimes, the crucial question is which mentally disordered individuals have a higher risk of committing or recidivating in violent crimes

- The literature points to historical variables as the best predictors of future violence among all offenders, regardless of mental health status: previous criminality, start of criminality at an early age, and childhood conduct problems

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- Several risk assessment guides/ checklists have been developed during recent years (Borum 1996) – two of the best-known are the HCR-20, Assessing Risk for Violence (Webster et al. 1997), and the Violence Risk Appraisal Guide (VRAG) (Harris et al. 1993; Webster et al. 1994)
- The HCR-20 is a 20-item checklist for prediction of future violence among personality-disordered or mentally disordered violent offenders. H refers to historical, of which there are 10 items. C refers to clinical, and R to risk; each comprises 5 items. No specific weighting procedure was adopted; all items are rated from 0 to 2, 0 indicating absence and 2 indicating definite presence of an item
- The VRAG is a 12-item actuarial risk assessment guide for prediction of violent recidivism among violent offenders. To optimize prediction, this tool utilizes a weighting procedure in which the items most strongly related to recidivism are given a wider range of scores and more degrees of freedom

### *Study:*

- Investigation of the long-term predictive validity of the VRAG and the historical part (H-10) of the HCR-20 in predicting violent recidivism in a sample of violent offenders with schizophrenia
- Results indicated that both H-10 and VRAG had a moderate ability to predict violent recidivism and that H-10 had a slightly better accuracy – most of the items in H-10 but only half of those in VRAG correlated significantly with violent recidivism
- It is concluded that historical factors seem to play an important role for the long-term prediction of future violence among a group of severely mentally ill individuals

### ***Management – intervention – attitudes re: restriction***

Terpstra, T. L., Terpstra, T. L., Pettee, E. J., & Hunter, M. (2001). Nursing staff's attitudes toward seclusions & restraint. *Journal of Psychosocial Nursing & Mental Health Services*, 39(5): 20-28

- United States: Although there is a large body of literature on the use of seclusion and restraint, only a few studies have focused on the attitudes of staff toward their use. The perceptions and attitudes of nursing staff will influence not only their interactions with patients but also their choice of interventions when responding to an identified need or problem
- Seclusion and restraint use has received increased attention in recent years; society has demanded that people with mental illness be treated with the least restrictive methods possible. Guidelines issued by different nursing and mental health associations suggest that seclusion and restraint be considered emergency interventions aimed at protecting patients in danger of harming themselves or others, and that they should be used as infrequently as possible
- Nurses are often on the front line, interacting with patients who may be violent or who display disruptive behaviours and choosing to use these as interventions
- Among physicians and therapists, attitudes have polarized over time
- Objections to seclusion and restraint use have been based on ethical grounds, with the use of these interventions being viewed as punitive and as a violation of patients' basic rights of freedom and dignity. Some also believe these interventions are counter-therapeutic and induce dependency on staff
- Steele (1993) surveyed 28 employees in four inpatient psychiatric facilities regarding attitudes: found that although 60% saw the use of restraint or seclusion as therapeutic, many also expressed concerns about potential abuse of rights, loss of dignity, and control over persons who are at a power disadvantage
- Study examined attitudes of 65 neuropsychiatric hospital staff members in the Midwestern United States

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- Pro-restraint: decreased physical injury, greater control over violent behaviour, physical reassuring contact by staff, immediate feedback
- Pro-seclusion: more freedom of movement, decreased external stimuli, patient has greater control
- Pro-medication: less restrictive, calming effect, greater control
- Staff must be educated about the therapeutic value of seclusion and restraint as well as alternatives. Kozub and Skidmore (2001) discussed a variety of least restrictive approaches which include interaction and redirection, setting limits, using time outs, and safe physical escort techniques

### ***Risk assessment – institutional violence – dynamic factors***

Wang, E.W., & Diamond, P.M. (1999). Empirically Identifying Factors Related to Violence Risk in Corrections. *Behavioral Sciences and the Law*, 17: 377-389

- United States: Correctional violence is a large problem in modern America. Because of problems associated with predictions involving human judgment, formal (actuarial, mechanical, algorithmic) have been proposed as alternatives to informal (clinical) prediction models for all domains, including violence (Grove & Meehl, 1996; Monahan & Steadman, 1994; Quinsey et al., 1998)
- Actuarial violence prediction literature has focused almost exclusively on community violence, typically of individuals (offenders or psychiatric patients) following institutionalization, as opposed to institutional violence.
- Risk factors are different for community and institutional violence
- Institutional research may have some advantages over community research: first, short-term may be more accurate than long-term predictions; second, violent behaviour can be more accurately assessed because it is more likely to be detected; third, environmental variability is constrained in institutions
- Methodological problems have plagued community research: criterion variables have been weak and predictor variables have been narrow and not linked to theory, and are usually static as opposed to dynamic (which can be targeted for clinical intervention)
- Structural modeling was used to predict institutional aggression among male mentally ill offenders using the predictors of anger, antisocial personality style, current violent offense, ethnicity, and impulsivity. Measures included the Barratt Impulsiveness Scale, the Buss-Perry Aggression Questionnaire, the Personality Assessment Inventory, age, ethnicity, current violent offense, victim injury from current offense, and institutional incidents of physical and verbal aggression
- Results indicated anger, antisocial personality style, and impulsivity are stronger predictors of institutional aggression than are ethnicity and current violent offense, with anger being the best predictor
- Results suggest dynamic variables (such as anger) can be targeted for clinical intervention to reduce institutional violence; the contribution of dynamic indicators to the prediction model offers the possibility of linking prediction and management models of risk assessment, intervening to manage the risk, and assessing the relative risk of an individual at different points in time

### ***Risk assessment – corrections-based psychiatric hospital - PAI***

Wang, E.W., Rogers, R., Giles, C.L., Diamond, P.M., Herrington-Wang, L.E., & Taylor, E.R. (1997). A Pilot Study of the Personality Assessment Inventory (PAI) in Corrections: Assessment of Malingering, Suicide Risk, and Aggression in Male Inmates. *Behavioral Sciences and the Law*, 15: 469-482

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- United States: Provision of mental health services to correctional populations demands that clinical staff efficiently and effectively screen patients for severe mental disorders and other conditions that require immediate intervention

- Screening instruments used in corrections should: be short, easy to read, assess response sets and response styles, assess severe Axis I disorders, assess problematic Axis II disorders, and assess violence potential

- An important consideration in assessing the treatment needs of mentally disordered offenders is the selection of versatile clinical measures that address a broad range of psychopathy and problematic behaviours

### *Study:*

- An archival study

- Examined the usefulness of the Personality Assessment Inventory (PAI) in assessing problematic behaviours in a corrections-based psychiatric hospital. The problematic behaviours studied/ assessed were forms of acting out (suicide and aggression towards others) and response style (motivations to malingering)

- As evidence of criterion validity, selected PAI scales were compared to evidence of malingering on the Structured Interview of Reported Symptoms (SIRS), suicidal threats and gestures, and ratings of aggression on the Overt Aggression Scale (OAS)

- Results supported the continued examination of the PAI in assessment of malingering, suicide risk, and aggression in male inmates receiving or requesting psychiatric treatment

### ***Risk assessment – instruments – HCR-20***

#### Uncorrected Proof

Watt, A., Topping-Morris, B., Rogers, P., Doyle, M., & Mason, T. (2003). Pre-admission nursing assessment in a Welsh Medium Secure Unit (1991-2000): Part 2 – comparison of traditional nursing assessment with the HCR-20 risk assessment tool. *International Journal of Nursing Studies*

- Wales: This study assessed the quality of nursing risk assessments through comparison with the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997)

- The need for nurses to account for their actions and decision-making has increased with the movement towards evidence-based practice. Developed in 1991, pre-admission forensic nursing assessment is a tradition that has no research evidence base, little documentary support and is an expensive drain on nursing resources from clinical environments

- Evaluation is possible through comparison of the information obtained in pre-admission nursing assessments with a well-established and validated risk-assessment tool: HCR-20

- The HCR-20 was developed as a broad-band violence risk assessment tool and identifies markers for previous, current, and future risk. Evidence suggests that the HCR-20 demonstrates good predictive validity and it is recommended for use as a professional guideline to structure clinical assessments. One historical item of the instrument (psychopathy) was omitted because it required administration of the Psychopathy Checklist Revised (Hare, 1991a, b)

- The information traditionally collected by forensic nurses to aid risk assessment at the Caswell Clinic was found to be sufficient to rate over 80% (n=16) of the 19 rateable items of the HCR-20

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- Although the issue of evidence-based practice is important to nurses, not every aspect of clinical practice has an evidence base. In such cases, some traditional practices (nursing attempts to validate experiential and intuitive practice) may have greater use

## ***Risk assessment and management***

Woods, P. (2001). Incidents: reporting and management. In: Dale, C., Thompson, T., & Woods, P. (Eds.), *Forensic Mental Health: Issues in Practice*. London: Bailliere Tindal in association with the Royal College of Nursing, pp. 99-107

- UK: Violence in the workplace is a real problem, particularly in forensic mental health settings. Although research has been undertaken in relation to all aspects of violent incidents, it is difficult to generalize from the literature as differing definitions and measurements of violence are used

- It is important that incident monitoring is maintained on a regular basis. Health service guidelines indicate that reporting systems should: be simple to use, be based on a standard definition of incidents, allow for the timely collection of data and investigation, and be able to record detailed/ complete information regarding the incident (NHSE 1997)

### *Incidents:*

- Definitions range from the vague to the more complete; a suitable definition may be: 'any behaviour which could be physically or psychologically damaging to the individual, another individual or property' (p. 100)

- There is agreement within the literature that high priority should be given to a number of factors which are related to violence: factors predisposing to violence, environmental factors, and the nature of the incident

#### *1. Factors predisposing to violence:*

- Generally, these factors form the actuarial base of any risk assessment and management strategy. Individual characteristics of age; gender; ethnicity; length of stay; and previous history of violence are important. For instance, it is reported in the literature that younger patients tend to be involved in more violent incidents

#### *2. Environmental factors:*

- The importance of environmental factors such as type of ward, location of incident, patient density, time of day, day of the week and seasonal variation often overlooked. These factors can assist in monitoring the occurrence of violent incidents

#### *3. Nature of the incident:*

- It is important to record the nature of the incident, such as the victim and the severity of incident. Nursing staff appear to take the brunt of most violent incidents, although they are involved in direct patient care and are more likely to be available for attack.

### *Reporting:*

- A few authors have published incident-reporting systems which have been empirically examined in order to determine their usefulness

- The best known of these is the Staff Observation Aggression Scale, SOAS (Palmstierna & Wistedt 1987), with a recently revised version, SOAS-R (Nijman et al 1999). The main variables measured when aggressive

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behaviour occurs are: provocation; means used by the patient; target of aggression; consequence(s) for the victim(s); and measure(s) to stop aggression

- The SOAS can be used in conjunction with the Broset Violence Checklist (Almvik & Woods 1998, 1999) to measure violence in the first three days following admission by assessing confusing, irritability, boisterousness, verbal threats, physical threats and attacks on objects

### *Management:*

- It is necessary for information to be reported or collated in order for an incident-reporting system to feed into the management of incidents from the organizational perspective  
- Collection of information allows analysis of the incidents which occur

### ***Risk assessment and management***

Woods, P. (2001). Risk assessment and management. In: Dale, C., Thompson, T., & Woods, P. (Eds.), *Forensic Mental Health: Issues in Practice*. London: Bailliere Tindal in association with the Royal College of Nursing, pp. 85-97

- UK: This chapter explores key issues of risk assessment and management within forensic mental health care from both the individual patient and organizational perspectives, with an emphasis on clinical context

## **Risk Assessment**

- Risk can be defined as the probability of a bad consequence or as the likelihood that a particular adverse event will recur (Prins 1996); within forensic mental health care, risk assessment is concerned with three interrelated components: the risk posed in the past, now, and in the future

- Assessments need to be systematic and based on the population undergoing assessment (Pollock & Webster, 1990; Monahan & Steadman, 1994). Literature points to three foci for the future of risk assessment research: first, there should be an actuarial focus; second, there are situational variables; third, attention should be on varied populations upon which predictions are made (Monahan 1984)

- The Royal College of Nursing (1998) suggest that the aims of risk assessment are to: identify the hazards, identify who is at risk, evaluate the risks, make a record of the findings, and review and revise the assessment

### ***Approaches to risk assessment:***

- There are two main approaches: actuarial or statistical, and clinical

- The actuarial approach is based on the assumption that an individual coming from a population within which a certain type of behaviour is common is more likely to display this form of behaviour (Pollock & Webster, 1990)

- The clinical approach is based upon professional opinion; it looks for explanation of specific violent behaviour and is concerned with how individuals behave. Some researchers are opposed to this approach because it may be contaminated by assessor bias

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### ***Good practice in risk assessment:***

- Little effort has been made to develop frameworks for clinical usage in making risk assessments (Borum 1996); however, factors can be identified that predispose an individual to behave dangerously (McClelland 1995) and that may serve as indicators for good practice in risk assessment
- Commonly recognized, although static, actuarial variables are: previous history of violence, age under 30, male gender, concurrent drug/ alcohol abuse, and active psychotic symptoms. An important point to emphasize is that these actuarial risk markers only provide a guide for risk management planning and any assessment must be individualized to the particular person through inclusion of individual risk factors

### ***Assessment - prediction of recidivism - variables***

Bonta, J., Hanson, K., & Law, M. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123(2): 123-142

- Ontario: Results of the study showed that the major predictors of recidivism were the same for mentally disordered offenders as for nondisordered offenders; criminal history variables were the best predictors, and clinical variables showed the smallest effect sizes
- The findings suggest that the risk assessment of mentally disordered offenders can be enhanced with more attention to the social psychological criminological literature and less reliance on models of psychopathology
- Psychopathological theories focus on psychological dysfunction, biological dysfunction, or both as the basis for criminal behaviour; in contrast, the theories of rational offenders have viewed criminal behaviour as a predictable consequence of learning histories, values, and social structures
- 2 general camps within theory of rational offenders: sociological criminology and social psychology
- Meta-analysis examined 4 domains of predictors: personal demographics, criminal history, deviant lifestyle-history, and clinical
- In general, the predictors of recidivism among mentally disordered offenders were almost identical to the predictors found among nondisordered offenders – for both general and violent forms of recidivism
- Most of the clinical variables were either unrelated or inversely related to recidivism
- In studies that compared the recidivism of mentally disordered offenders with nondisordered offenders, the mentally disordered offenders were less likely to recidivate
- Assessments of dangerousness by clinical staff have not been very accurate; in contrast, objective, empirically derived risk assessment measures proved to be the best predictors of recidivism

### ***Risk assessment and management – mental health nursing***

Crowe, M., & Carlyle, D. (2003). Issues and innovations in nursing practice: Deconstructing risk assessment and management in mental health nursing. *Journal of Advanced Nursing*, 43(1): 19-27

- New Zealand: Paper aims to critically examine the concept of risk in mental health nursing practice through the historical, clinical, cultural, political and economic structures that underline contemporary understandings of risk and its management
- Assessment and management of risk are necessary in mental health nursing; they protect the welfare of consumers of mental health services and the community, and also play a role in protecting nurses against

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potential litigation. Despite its emphasis in clinical practice, there exists very little mental health nursing literature providing a critical analysis of the topic

- *Historical*: There is a long historical association of risk and mental disorder. Responsibility of those classified as mentally disordered shifted between legal, medical and administrative practitioners until the mid-19th century, when psychiatrists took control. This process of medicalization, the application of scientific principles to the mind and its mental health, has introduced psychiatric diagnosis and the concept of risk inherent in prognosis
- *Clinical*: Clinical risk assessment and management occurs in the context of broader risk management – organizational, financial, political, legal (Mental Health Commission, 1998)
- While an actuarial process is an integral part of the assessment process, reliance upon statistical generalizations is not recommended. There is no fixed or essential risk that reveals itself through observation, but rather meaning is attributed to some characteristics and not others through a process of aggregation. Individuals are thus evaluated based on their likeness or difference from aggregated norms and this evaluation determines the amount of surveillance and discipline required
- *Cultural*: Risk is defined in a way that reflects the values of dominant culture, and what is attributed to normality. According to Beck (1999), risk is always culturally constituted and as such is always imbued with culturally determined values

### ***Risk assessment – mental health patients***

Doyle, M. (1998). Clinical risk assessment for mental health nurses. *Nursing Times*, 94(17): 47-9

- UK: successive governments since the 1950s have continued the policy of providing care for people with mental health problems in the community – results in a heightened public anxiety about the risks associated with people with mental illness
- Recurring themes in tragedies involving mental health patients: failure of clinicians to obtain sufficient knowledge about a service user's history, poor communication between disciplines, lack of collaboration between agencies, lack of resources and failure adequately to assess and manage risk
- The care program approach (CPA) was introduced in 1991 to provide a framework for the care of mentally ill people outside hospital
- Supervised discharge legislature came into effect April 1, 1996 under section 117 of the Mental Health Act 1983 – ensures that a service user who has been detained in hospital for treatment receives aftercare services
- Need for connection between available literature/ research and practical frameworks for risk assessment and management
- Risk management cycle of 6 stages to reflect the dynamic characteristics of risk assessment and management: 1. Identify the potential for harm, 2. Risk assessment, 3. Rate risk, 4. Implement risk management measures, 5. Monitoring of risk management measures, 6. Review
- Methods of risk assessment may include: record review, interview, observation, rating scales or psychometric tests, and physical investigations – then risk can be rated

### ***Assessment – impulsivity***

Fish, K. (2002). Assessment of impulsivity among psychiatric inpatients. *Journal of Psychosocial Nursing & Mental Health Services*, 40(6): 30-35

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- United States: Impulsivity can be defined in many ways; the general consensus is that the term is usually reserved for maladaptive behaviour, which typically results in undesirable consequences
- Important to nurses due to their close contact with patients and their responsibility for modifying and managing behaviour
- Webster and Jackson (1997): impulsive individuals can be well described by five categories: interpersonal dysfunction, lack of plans, distorted self-esteem, rage/ anger/ hostility, and irresponsibility
- Impulsivity is one of the defining characteristics of many adult psychiatric disorders and is also a key component in the clinical risk assessment of anger and aggression
- Understanding the effect of impulsivity on personality, behaviour, and coping abilities is essential for assessment and care/ management of impulsive patients
- By assessing impulsivity, it may be possible to identify those patients at high risk for suicide, self-destructive acts, violence, or other unpredictable behaviours
- Assess impulsivity to be able to see strengths/ weaknesses, coping skills, and to provide support and design interventions for particular patients

### ***Risk assessment – general nursing***

Harrison, A. (2003). A guide to risk assessment. Nursing Times, 99(9): 44

- UK: Risk assessment is linked to risk management, whereby a mutually agreed plan, aimed at reducing identified risks, is negotiated with the individual concerned
- Although risk assessment is a core nursing skill, it needs to occur within the multi-professional context and involves other relevant disciplines
- Risk assessment provides useful information when devising care plans
- Key principles:
  - The nursing goal is the minimization of risk and the prevention of harm or further harm
  - Risk management plans must be constantly evaluated and amended as risk is a dynamic process
  - ‘Risk factors’ are based on population studies and do not necessarily allow practitioners to identify risks in a particular individual
  - Research suggests engagement and psychological support are key nursing strategies for reducing risk – empathy, active listening and involvement in care planning can reduce self-harming behaviour
  - Training, continuing education and clinical supervision increase the effectiveness of clinical work and risk assessment practice

### ***Risk management – intervention – detention and nurses’ rights***

Houlihan, G. D. (2000). The nurses’ power to detain informal psychiatric patients: a review of the statutory and common law provisions in England and Wales. Journal of Advanced Nursing, 32(4): 864-870

- UK: Mental Health Act (1983) developed to improve the rights of patients, especially with respect to consent to treatment and the care of mentally disordered offenders

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- Patients who are admitted informally to psychiatric hospitals are not subject to the statutory restrictions; they have two basic rights under common law: may leave hospital whenever they like and may refuse to accept any form of treatment which they do not want
- Concern regarding rights of informal patients – some believe the rights may not exist in reality for certain patients
- Section 5(4) of the MHA (1983) introduced statutory powers for nurses of the ‘prescribed class’ to detain, for up to 6 hours, a patient who is receiving treatment for mental disorder as a hospital in-patient ? attempt to clarify the legal position of nurses when dealing with a psychiatric emergency
- Under 5(4), the nurse may use the minimum force necessary to prevent the patient from leaving – minimum medical or physical intervention
- Important: effective risk assessment of the patient by the nurse before invoking 5(4) at the time of emergency – adequate training vital
- Criminal Law Act (1967) – under section 3(1) a person may use such force as is reasonable in the circumstances in the prevention of crime, or in affecting or assisting the lawful arrest of offenders or suspected offenders or persons unlawfully at large
- This may include physical restraint or seclusion, and the power does not apply when the patient is insane and by definition not capable of committing a crime
- The Police and Criminal Evidence Act (1984) – under section 24(4) a person has the power to arrest without warrant anyone who is in the act of committing an arrestable offence or anyone who has reasonable grounds for suspecting someone to be committing such an offence

### ***Management/ intervention – psychiatric patients – entitled***

- Kerr, N. (2002). Clinical Management of “Entitled” Clients. *Journal of Psychosocial Nursing*, 40(12): 40-5
- United States: Entitled clients harbour excessive and unrealistic expectations about what the world owes them – a mismatch exists between what they desire, need, and expect from others (expectations), and what is feasible given the prevailing circumstances (reality)
  - Internal and external factors will influence this process of misguided entitlement, which can be situational or characterological
  - Traits common to entitled psychiatric patients: aggression, sociopathy, and paranoia, although narcissism and depression have also been pointed to
  - Once aroused (after goal attainment fails due to mismatch), they tend to discharge their emotions through action – will avoid reflection, realization of feelings and imperfection, dependency on others
  - The use of empathetic mirroring is necessary to establish rapport by making clients feel understood, and to prevent aggressive outbursts by decreasing their frustration level
  - Confrontation can be a useful therapeutic tool by drawing a patient’s attention to the negative consequence of his or her dysfunctional behaviour, but often occurs out of exasperation
  - After rapport established, the goal is to identify entitled thought patterns/ behaviours and to explore the irrational nature of the underlying assumptions – interventions aimed at uncovering the irrational beliefs and at strengthening ego functions

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### ***Risk assessment – instruments – various forensic professionals***

McGregor Kettles, A., Robinson, D., & Moody, E. (2001). A review of clinical risk and related assessments in forensic psychiatric units. *Journal of Psychiatric and Mental Health Nursing*, 8: 281-283

- UK: Providing care for mentally disordered offenders presents clinicians with difficult decisions regarding risk, and there is a need for evidence-based methods of risk assessment; the aim of this study was to identify the nature and extent of clinical risk assessments (CRA) in use in forensic settings
- The term CRA refers to the concept of risk assessment, while Risk Assessment Instrument (RAI) refers to tools and instruments used for risk assessment purposes
- A questionnaire developed by the authors was distributed to a sample of qualified forensic professionals (forensic consultant psychiatrists, forensic psychologists, social workers and nurses)
- Responses highlight the diversity of instruments in use; although every forensic secure unit is attempting to use some form of CRA and to structure their individual assessments, there is little coordination or uniformity. Respondents identified a total of 124 tools currently in use: 67 locally-developed RAIs and 57 individually named RAIs, such as the HCR-20
- There is a need for communication between professionals about the types of risk and related assessment they are using and about the use of appropriate instruments in the assessment of people moving between units; co-ordination is needed as currently there exists much overlap and inconsistency

### ***Risk assessment and management - editorial***

Mullen, P.E. (2000). Forensic mental health. *British Journal of Psychiatry*, 176: 307-311

- Britain: Editorial
- Forensic psychiatrists within the court process must maintain the dignity of a medical expert against pressures (institutional and fiscal) of manipulation by lawyers
- Forensic mental health involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led, or could lead, to offending
- Risk assessment and risk management have emerged as central elements in all of mental health practice, but particularly in forensic practice; this emergence has coincided with an expansion of the role of the forensic psychiatrist
- Mental health services have a responsibility to provide care and support to those mentally disordered people with an increased probability of acting violently. Although highly problematic, the aim is to identify in advance and manage such risks before they manifest in violence. The challenge for forensic mental health professionals is to move from risk assessment to the therapeutics of risk management.

### ***Risk assessment – mental health patients***

Noak, J., & House, M. (1997). Assessment of the risks posed by people with mental illness. *Nursing Times*, 93(1): 34-36

- UK: Judgments about the dangers people pose to themselves or others are commonplace in psychiatric practice
- Move to community care and open wards has meant unavoidable risks for people with mental health problems

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- The common factors associated with violence and dangerousness appear to be past history of violence, past history of crime, alcohol misuse and dependence disorder, being male, young age and economic status
- Individuals have different definitions of dangerousness; there is the need for a systematic, objective approach to assessing dangerousness
- MacArthur Risk Assessment Study: four main categories upon which to base risk predictions are dispositional/individual, historical, contextual, and clinical
- Many variables are involved in a comprehensive assessment of risk; however, there are no direct indicators and each may become more important when other factors are present or may be neutralized by them
- Risk assessments should take place regularly because individuals' circumstances change
- Inter-agency collaboration plays an important part in assessment – need for communication between agencies and individuals
- Monahan and Steadman (1994) make recommendations: risk must be treated as a probability estimate that changes with time according to context; managing risk as well as assessing it must be a goal

### ***Risk – violence against psychiatric nurses***

Quintal, S. A. (2002). Violence against psychiatric nurses: An untreated epidemic? *Journal of Psychosocial Nursing & Mental Health Services*, 40(1): 46-55

- United States: This article explores possible precipitants and risks associated with episodes of violence
- Health care workers, especially psychiatric nurses, continue to be victims of assaultive behaviour from their clients. However, the importance of this assaultive behaviour has been minimized by clients, hospital staff management, and society
- The ways clients cope with personal crisis depends on the resources available and can be positive or negative; part of negative crisis resolution includes violence against others
- The standard definition of employee injury used in reporting to the Occupational Safety and Health Administration (OSHA) includes injuries resulting in lost work days, loss of consciousness, restriction of work or motion, termination of employment, transfer to another job, or medical treatment – excludes the assaults suffered by nursing staff
- An interaction of individual, socio-psychological, interpersonal, situational, and sociocultural factors led to increased rates of workplace assaults by clients
- Individual characteristics that were found to be correlated highly with violent behaviour include the client's diagnosis, history of violent behaviour, young age, neurobiology, and genetic predisposition. A previous diagnosis of psychosis, substance abuse, organic brain disorders, dementia, mental retardation, or personality disorder were correlated highly with assault.
- Interpersonal, situational, and environmental factors include the communication between nursing staff and clients. Factors that may have an influence on communication include nursing staff attitudes, educational and experience levels of staff, and limit setting and communication styles of nursing staff. Socio-cultural factors include the desensitization to violence by hospital management, the legal system, the public, and especially client assaulters. This has led society to assume that people with mental illness are not accountable for their actions.
- There are actions that can be taken by nursing staff to address this growing concern, including: performing complete assessments on every client on admission to inpatient psychiatric units; educating health care workers

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(non-violent self defense and communication) and clients (coping skills); advocating for legislation to protect health care workers; introducing the Occupational Safety & Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (1998); providing emotional support to health care workers who have been assaulted

### **Current assessment instruments available**

- HCR-20 (Webster et al 1997):
- Consists of a mixture of static historical variables and dynamic clinical and risk management variables; each of the 20 items is measured on a three-point scale, with a lower score indicating less risk
- Extensive research has focused on the instrument's predictive ability, which looks promising
- Violence Prediction Scheme (Webster et al 1994):
- Combines both an actuarial and a clinical component. The actuarial component is the Violence Risk Appraisal Guide, VRAG (Rice & Harris 1995); research indicates promising predictive validity. The clinical component is a mnemonic, the ASSESS-list
- Behavioural Status Index (Robinson et al 1996, Woods et al 1999):
- Developed to assist in the clinical assessment of social risk and in construction of meaningful and measurable intervention strategies
- Consists of three related subscales: behaviours which are associated with risk in a forensic context; the degree of insight into causality and current status shown by an individual; and assessment of current communication and social skills. Each item is measured on a five-point ordinal scale

### ***Risk Management:***

- A risk management plan focuses on the likelihood of the probability or outcome occurring; it is the link between risk assessment information and the known or potential interventions
- The plan should state the nature or level of the anticipated risk and how it can be avoided, and must be continuously reviewed if it is to be effectively evaluated – 'dynamic risk assessment'
- The individual must be informed of the risk(s) which have been identified, what will happen if they occur and why; this may involve the individual being given the opportunity to select from a range of alternative management strategies

### ***An organizational risk management strategy:***

- This strategy aims to create a more coordinated, systematic and focused approach to the management of risks. It embraces organizational, cultural, clinical, employee, environmental, and incident reporting issues, all of which are developed around a risk management policy statement
- From the wider forensic service perspective, the fundamental underpinning issues to any risk management strategy must be a coherent and manageable communication and evaluative process, that encompasses all relevant legislation

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### **Intervention and Therapy**

The articles in this section describe the interventions used in therapy and in building effective nurse-patient relationships, both in secure psychiatric settings and outpatient services. The importance of clinical supervision is also discussed.

#### ***Intervention/ therapeutic tool – making connections***

Austin, W. (2001). Relational ethics in forensic psychiatric settings. *Journal of Psychosocial Nursing & Mental Health Services*, 39(9): 12-17

- Canada: Although intended to be places of healing, forensic settings are places defined by the requirement to confine psychiatric patients who are also offenders. In these settings, nursing care is situated within a responsibility to protect society, so that forensic nurses must provide not only care for patients but custody of them. This dual role creates a tension distinct to this specialty area

- As making connections with patients is the necessary work of nursing, forensic nurses must do so even with patients who evoke strong, negative emotions: those who have committed morally reprehensible acts, or those who are threatening or dangerous, or who regard the nurse suspiciously as an enforcer of their confinement or as a punisher. (Patients may view some psychiatric nursing interventions as punishment, such as the use of privilege systems, medications, and restraint and seclusion)

- This is recognized as an ethical concern

- The Relational Ethics Project (University of Alberta) explores the ethical commitments required by everyday health care situations. Relational ethics is based on the assumption that ethical practice is located in relationship. A relational ethic approach demands a daily commitment to the people in one's care and shapes the way one relates to them. The core elements of relational ethic are mutual respect, engagement, and attention to the environment. An ethics framework that requires the consideration of multiple perspectives, opening of conversational discussions, and attention to context can be a potential tool for nurses coping with the tension between custody and caring

#### ***Intervention/ therapy – outpatient services – CPL patients***

Epstein, H. J. (1993). Providing outpatient services to criminal procedure law patients: the clinician's perspective. *Psychiatric Quarterly*, 64(3): 295-302

- New York, USA: This article identifies a number of the elements involved in implementing an effective program for the care and treatment of the Conditionally Released Criminal Procedure Law (CPL) Patient

- Different communities have different thresholds for violence and nonconformity as well as different expectations for care and treatment – results in differences among the social/ political realities of the local community and local social/ legal service systems

- Although the Conditionally Released CPL patient population is not homogeneous, there are a number of shared factors: the majority of the CPL patients have a diagnosis of a major mental illness and a history of prior psychiatric hospitalization, as well as an history of criminal behaviour

- Despite the difficult nature of their illnesses and conditions, the author believes that therapeutic gains can be achieved if these patients are provided with comprehensive treatment

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- It is the personality disorder (traits) that appears to present the most difficult challenges to clinicians – due to the fact that medication is not invariably effective and their maladaptive behaviour is more disturbing to others than it appears to be to the patient
- Must recognize that the very behaviours identified as pathology (threats, intimidations, lying, manipulation, etc.) are simultaneously the patients' best, learned behaviours designed to help them cope and adapt. Before these behaviours are challenged, the patient must develop alternatives.
- Under the law, patients are committed for care and treatment - staff who work with this population must be able to be empathetic and supportive, while also using authority and limit setting comfortably
- An effective clinician will integrate a variety of roles: therapist, educator, advocate, case-manager/ networker, and 'parole' officer
- Must recognize that these patients are truly involuntary and absence of motivation is a given. For treatment to be successful, the client's desire to participate in and benefit from it must be increased by identifying and appealing to the individual's particular needs and his or her pleasure associated with gains in personal control and overcoming challenges

### ***Intervention/ therapy – outpatient services***

Lorbergs, K. A. (2001). Framing nursing practice within a forensic outpatient service. *Journal of Psychosocial Nursing & Mental Health Services*, 39(9): 35-41

- Ontario: The trend of deinstitutionalization (towards community-based psychiatric rehabilitation) began in the 1950s and continues today
- In Ontario, resources have been reallocated from the inpatient to the outpatient sector to provide additional support to those with mental illness moving into the community
- This article describes care within the context of the Forensic Outpatient Service, which was opened in 1999 to foster community reintegration of forensic patients through intensive clinical and case management
- The service helps mentally disordered offenders living in the community under the jurisdiction of the Ontario Review Board (ORB) until they receive an absolute discharge or are released from the ORB
- The forensic outpatient team consists of three RNs, two social workers, two caseworkers, an occupational therapist, and five part-time psychiatrists who work together to help patients maintain mental stability, reintegrate into the community, manage their risks, and improve their quality of life
- The team must become familiar with patients' mental health and criminal histories in order to monitor and manage behaviour
- The forensic outpatient nurse assumes responsibility for the assessment, planning, implementation, and evaluation of the case management plan to best meet the needs of the patients; the role also includes ensuring continuity of good quality care and linking patients who are given an absolute discharge to other rehabilitation programs. Further, he or she must have broad knowledge/ understanding of the legal system.
- The nurse works with the patient to draft the terms of supervision in the form of a contract; the patient is aware of the consequences of violating the contract, which include implementation of the risk management plan, outlining care/ management, formulated by the nurse
- This means the nurse must have expertise in assessing early signs and symptoms of deterioration in mental status – criminogenic factors (lifestyle factors that lead to criminal behaviour) can be determined through such

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instruments as The Violence Appraisal Guide (VRAG) (Quinsey, Harris, Rice, & Cormier, 1998) and the HCR-20 Assessing Risk for Violence

- The nurse is faced with the responsibility of balancing patients' rights to treatment in the least restrictive and least intrusive environment while minimizing public risk. Community acceptance of the patient is difficult to achieve at times, but is possible through education and demonstration of successful rehabilitation

### ***Therapeutic tool – humour***

Minden, P. (2002). Humor as the focal point of treatment for forensic psychiatric patients. *Holistic Nursing Practice*, 16(4): 75-86

- United States: 'The Humor Group' based on preposition that humour can catalyze therapeutic change and that a sense of humour is an innate human potential

- Humour as laughter has been shown to: mitigate pain, enhance immunological function, facilitate physical health, strengthen mental functioning, attenuate stress, and improve social health

- 'The Humor Group' was led by the researcher and 64 nursing students in a 16-week clinical rotation and involved 129 male forensic psychiatric patients

- Intent of 'the Humor Group:' to give students practice leading a group and using humor therapeutically; to provide patients with a mirthful place of respite; to help individuals from disparate socio-cultural backgrounds transcend mutual stereotypes by sharing laughter

- Research question: what difference did 'the Humor Group' make in the health of its patient participants?

- Interviewees noted benefits in the physical (46%), mental (100%), social (77%), and spiritual (46%) dimensions of their health

### ***Clinical Supervision***

Rogers, P., & Topping-Morris, B. (1997). Clinical Supervision. *Nursing Management*, 4(5): 13-15

- UK: Overview of the development of clinical supervision for forensic mental health nurses working in a medium secure unit

- Clinical supervision for nurses has become an integral aspect of health care delivery, as an increasing number of key documents are demanding that nursing services incorporate clinical supervision into practice development

- The balance in providing a therapeutic environment and maintaining security can be difficult to achieve and often present the nurse with stressful dilemmas. Clinical supervision should aim to assist the nurse in objective decision-making at all times

- The Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (RCP 1996) concluded that services need to facilitate continued professional development for all staff and recommends that services address the scope/ quality of direct staff-patient contact. This recommendation represents a need for clinical supervision to focus on patient outcome as well as staff outcome. To date, much has been written about the professional benefits resulting from clinical supervision (NHSME 1993)

- Developmental and managerial approaches to clinical supervision are focused on relationship issues alone, or service issues. A problem-oriented approach to supervision was developed to ensure both a pragmatic and flexible means of working

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- This model is based upon a collaborative process of the supervisee and the supervisor addressing clinical issues where the supervisee is having problems. The supervisor encourages/ supports the supervisee in developing solutions to identified problems within a framework of evidence-based practice. This allows for audit and outcome measurement
- Practical application of the problem-oriented supervision model involves adequate training in problem-solving and of nurses as clinical supervisors, as well as a clinical supervisor register, support group, and consultant
- Recording and monitoring systems, such as guidelines for contract, have been introduced to improve conformity
- Standards and audit exist to ensure high quality of clinical supervision in terms of clinical effectiveness, supervisee satisfaction, and cost effectiveness
- Clinical supervision is a costly, time consuming and essential service requirement; however, it lacks any real evidence to suggest it improves clinical effectiveness. The authors are looking to evaluate their problem-oriented approach and admit further research is necessary

### ***Intervention/ therapy – difficulty with mentally disordered offenders***

Ryan, L. (1997). Integrated Support: A Case Approach to the Management of Impulsive People. In: C.D. Webster & M.A. Jackson (Eds.), *Impulsivity*. New York: Guilford, pp. 424-433

- Canada: Those who simultaneously pose disciplinary and psychological problems fall between the cracks of the criminal justice and the mental health system – there is no single place where they belong
- The formulation of the “mentally disordered offender” has blurred the once clearly separate concepts of patient and offender, treatment and punishment, assessment and judgment
- The institutional conditions and professional attitudes that influence the treatment of disturbed and disruptive individuals are complex and have as much to do with the political climate as with the theoretical orientation of a particular clinician
- The standard response of the criminal justice system or the mental health system is geared toward the “mad” or the “bad” component in an individual – the combination of disturbed and disruptive behaviour is most often interpreted separately (and incorrectly)
- Treatment programs in prisons are scarce; on the other hand, psychiatric hospitals are reluctant to admit patients with a history of criminal behaviour or violence due to safety issues – each system does not want or cannot adequately serve these individuals
- Primary goal of programs dealing with mentally disordered offenders should be the provision of the skills necessary to cope in the community

### ***Therapeutic tool – recovery***

Lunt, A. (2002). A theory of recovery. *Journal of Psychosocial Nursing*, 40(12): 32-9

- United States: Psychiatry remains dominated by the medical model, which treats complex human behaviour, specifically behaviour that can be classified as dysfunctional or symptomatic, as a disease
- Research continues to support professionals’ beliefs in the efficacy of psychiatric medications and may overestimate the power of such psychotropic medications

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- However, recovery involves far more than bringing symptoms under control; many with mental illness believe that the biochemical solution alone will only propel them partially down the road because it does not offer what is sought in recovery: a dream, a goal, a journey, a direction, an inspiration, a faith or a hope
  - This article aims to move the concept of recovery beyond a model or a set of principles to a theory of recovery
  - The recovery process is a time to redefine the self and a time of active change and questioning regarding how people see themselves; empowerment is the process by which others help them in that redefinition and action
  - Need for a positive recovery process (vs. simple medical model) because negative behaviours must be replaced with positive actions to prevent leaving a void in clients' lives
  - Patients must move from posing regretful questions of "why," which imply explanatory cause, to purposeful questions of "how," which imply action
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