A Thorn in the Flesh? Forensic Inpatients in General Psychiatry

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PURPOSE: To illuminate whether and how taking care of forensic inpatients is experienced as a burden among staff and managers in general psychiatry.

DESIGN AND METHODS: Qualitative analytical strategies based on interviews and questionnaires.

FINDINGS: The interplay between physical environment, bottlenecks, poor information exchange, lack of knowledge and competences, complex psychopathology, and a vague and therefore uncomfortable task of nursing leads to a focus on criminal offenses rather than mental disorders and an increased risk of brutalization and stigmatization in nursing practices. Members of staff identify the care of mentally disordered offenders in general psychiatric units as either “a parking space” or a very difficult or frightening course, where staff members tend to behave like pleasers in order to avoid risks of conflict or physical violence. Either way, it seems hard to provide sufficient mental health care.

PRACTICE IMPLICATIONS: Nationwide training and teaching as well as knowledge exchange between specialized forensic psychiatry and general psychiatry are recommended. Further exploration is needed on patient perspectives and on avenues to increase efficiency and decrease bottlenecks throughout the clinical pathways. Furthermore, we need additional knowledge of the impact on general patient populations’ resources for treatment and their safety.

Care for mentally disordered offenders is organized and run in a number of different ways throughout Europe due to modifications in legislation, philosophy of law, traditions, and division of labor. Furthermore, there also seem to be remarkable differences in incidence and prevalence of sentences to treatment as a result of legislation and judicial practice. Even within Scandinavian countries, which due to the Nordic welfare model usually are comparable in a number of ways, the practices, number of sentences, length of stay, and division between specialized forensic units, general psychiatric units, or prisons providing mental health care vary a lot and are not easily compared.

In the following, we outline the Danish model of general psychiatry taking care of the majority of mentally ill offenders along with a growing tendency toward increased specialization. Further comparison and research will prove whether our identification of a number of challenges when taking care of forensic inpatients in general psychiatric settings is recognized by managers and staff working in similar contexts.

The Danish Penal Code, section 68, includes a number of different measures, from placement in mental hospital to purely outpatient treatment. Mentally ill offenders sentenced to treatment or placement according to the Danish Penal Code are cared for within the mental health system in either specialized forensic units or in general psychiatry. The overall aim of the sentences is to prevent (similar) future crime.

Sentences are based on forensic psychiatric assessments. According to the Danish Penal Code, section 16, persons who at the time of the criminal act were irresponsible due to psychosis or similar conditions are not punishable, but will most inevitably be sentenced to psychiatric treatment. Furthermore, according to section 69, mentally deviant but not psychotic offenders can be sentenced to treatment or placement instead of prison, if regarded more expedient, in order to prevent reoffending.

During the past 20 years, the number of mentally ill offenders in Denmark has increased dramatically from 964 in 1990 to 2,638 in 2010 (Danske Regioner, 2011; Kramp &
It is estimated that the number of individuals sentenced to placement or treatment has now reached between 3,000 and 4,000 patients (Danske Regioner, 2011; Deloitte, 2012; Justitsministeriet, 2014). The annual number of new sentences has been between 600 and 750 over the past 5 years (Justitsministeriet, 2008, 2010, 2011, 2012; Justitsministeriet, 2014).

Simultaneously with the steep increase in psychiatric sentences, the number of psychiatric hospital beds has been reduced. In the late 1970s before establishing community care, there were about 12,000 beds. Today, the total number of beds is approximately 2,760 (Statens Serum Institut, 2014). During the last 10 years, there has been a 40% increase in the overall number of patients treated in general mental health services. The majority of these are patients diagnosed with nonpsychotic mental disorders. However, this development has led to a growing pressure on the actual number of psychiatric beds. All in all, forensic patients represent only 4% of all psychiatric patients treated in mental health services, but they take up disproportionally more resources and attention. This is primarily due to longer inpatient stays, but also a growing use of outpatient services (Madsen, Hvenegaard, & Fredslund, 2011). Furthermore, mentally ill offenders are heavily stigmatized in the press as well as in public debate (Jacobsen, Martin, Andersen, Christensen, & Bengtsson, 2010; Vendsborg, Blinkenberg, Kistrup, Lindhardt, & Nordenstof, 2011).

Concurrently with the reduced number of beds in general psychiatry there has been a nationwide increase in the number of beds dedicated to forensic patients: In all five regions, specialized forensic units have been established as well as a number of specialized forensic assertive community treatment teams. The number of forensic psychiatric beds has increased to about 330 (Danske Regioner, 2011). Historically, the majority of patients sentenced to placement or treatment have been treated in general mental health care. A minor group of severely psychotic as well as extremely dangerous patients is to be placed in the maximum secured hospital “Sikringen,” which is the only one of its kind in Denmark and holds 30 beds. Although the specialized forensic units and their specialized beds are part of the public mental health system, there has been a tendency over the last decades toward an increased specialization and a growing division of labor, where specialized forensic psychiatry takes care of the most complex patients in terms of psychopathology and dangerousness, and general psychiatry takes care of the rest.

Hence, the majority of mentally ill offenders are still cared for in general psychiatry. Although there are regional differences, a recent mapping has estimated that approximately 60% of the forensic patients are treated in general psychiatry (Danske Regioner, 2011).

The vast majority of forensic patients are treated as outpatients and approximately 20% as inpatients. However, this figure is dynamic, and most long-term treatment sentences consist of interplay between hospitalization, readmissions, as well as periods of outpatient care. A sentence to treatment usually starts with admission, shifting to outpatient care when compliance is established and readmission when conditions are changing (i.e., substance abuse, medication nonadherence, or increased risk of recidivism to criminality [Sundhedsstyrelsen, 2010]). The mental health system is obliged to receive patients admitted due to treatment sentence and to support the aim of preventing new criminal acts.

This minor part of the forensic patient population occasionally in need of admission, however, attracts a lot of attention. The forensic patients treated in general psychiatry have been characterized as “a cuckoo in the nest,” indicating that forensic patients take up beds and push out other patients because of their court-ordered sentences (Danske Regioner, 2010). In other words, forensic patients in general psychiatry are seen to block beds that it is felt should be used for patients with acute and disturbed presentations. The remarkable increase in sentences to placement or treatment undoubtedly contributes to putting pressure on a reduced number of psychiatric beds. However, informal discussions with staff in general psychiatric units indicate that this is not only a matter of capacity: Nursing and treating forensic patients in general psychiatry are also described as “a burden,” “a difficult task,” and “a thorn in the flesh.”

Sentences to treatment involve a complex contribution of psychopharmacological treatment as well as psychiatric nursing, social support, and ADL (activities of daily living) training in order to prevent reoffending. The overall doctrine is that there is no specific forensic treatment, and that mentally ill offenders are to receive standard albeit individualized psychiatric treatment, with special attention to often multiple problems present among forensic patients, including the obligation to prevent new crime (Kramp, 2009). The content of psychiatric nursing is a large extent seems to depend on which theoretical frame is chosen, for instance, a psychodynamically inspired milieu-therapeutic approach or cognitive behavioral therapy (Buus, 2009; Kragerup & Sletterød, 2011). A recent study on psychiatric nursing found that knowledge of the content of psychiatric nursing practices and interactions between forensic inpatients and staff is sparse (Gildberg, 2012). Therefore, it is highly relevant to take a closer look at the field in which the majority of forensic inpatients are treated. To our knowledge, no prior studies have examined nursing practices in caring for mentally ill offenders in general psychiatric locked units in a Danish context.

**Purpose**

The goal of the study was to illuminate whether and how providing nursing care of forensic patients in general psychiatry
is perceived as difficult or problematic, in what ways, and why this is experienced as a burden among staff and managers.

**Design and Methods**

The study was based on a qualitative analytical design including:

- Semistructured focus group interviews with staff (nurses, social and health assistants, and psychiatric nurse aides)
- Individual interviews with nursing heads of units
- Questionnaires to heads of care and development as well as to nursing heads of units

Central research questions were:

- What challenges do nursing staff in general psychiatric units experience in their professional work and interaction with forensic inpatients?
- What practices toward preventing new crime, reducing substance abuse, and supporting recovery and rehabilitation are used in relation with forensic inpatients?

The study was performed as a small-scale study within the Capital Region of Denmark. Three individual interviews with nursing heads of units as well as three focus group interviews, with a total number of 14 members of staff, were carried out in three of the eight mental health centers providing general (adult) psychiatric care. Questionnaires were distributed to a total number of 20 managers (either heads of care and development or nursing heads of units). We received 14 answers from seven centers. Due to remarkable differences in catchment areas within the Capital Region, we tried to secure geographical and sociodemographic variation when deciding in which centers to perform interviews. Furthermore, we excluded mental health centers where members of the research group were, or had been, employed.

The first interview with a nursing head of unit was performed as a pilot interview, and subsequently we decided to include it in the data collection. It was also our intention to pilot a focus group interview, but it proved very difficult to gather members of staff owing to workload and security measures.

All interviews were recorded, transcribed verbatim, and analyzed using content and textual analysis focusing on identifying themes and patterns. The main focus in the study has been on nursing staff’s day-to-day interaction with patients, and on their practices and experiences.

Findings in interviews have been compared to findings from questionnaires, and differences and similarities were identified. Interviews with nursing heads of unit as well as questionnaires answered by managers also provided us with useful knowledge on the structural frameworks of the units. This knowledge on the context contributed to a deeper understanding of the nursing practices taking place within this framework. Themes were discussed and further elaborated in our interdisciplinary research group, and then data were looked at and analyzed again until we had identified and agreed on a number of main themes.

In vivo quotations are marked with quotation marks and are used to ensure that concepts and expressions stay as close as possible to the informants’ own words. Some of these quotations may seem punitive and disparaging. However, phrases such as “good old schizophrenics” or “criminals” are carefully chosen, evaluated, and rendered in our analyses to underline what seems to be the case, that members of staff use such expressions without thinking of themselves as thereby contributing to and being part of stigmatizing and stereotyping processes.

**Findings**

The study has revealed five main themes where caring for forensic inpatients in general psychiatry is perceived as difficult.

**The Task of the Unit and Its Physical Environment**

The units in the study are closed general psychiatric units. Their main task is to provide care for acutely ill, often psychotic, or severely self-harming patients, including compulsory admissions according to the Danish Mental Health Act. According to staff, these patients are generally admitted for shorter periods of time and are often transferred to further outpatient care as soon as their condition is stabilized. On top of this task, the units are also obliged to receive a large variety of mentally ill offenders with multiple measures: some being sentenced to long-term placement or treatment, some being readmitted for shorter periods of time, and others still being in custody while undergoing forensic psychiatric assessment and awaiting police investigation, trial, and sentence.

As a consequence, staff must be capable of caring for short-term as well as long-term admissions within the same unit. Whereas the tasks related to the short-term admissions seem relatively clear—that is, consisting of assessments, traumatology, or taking care of the acutely agitated psychotic patient—the task of longer term caring ideally requires more attention to rehabilitation, social functioning, as well as preventing loss of functions. However, the physical environment in these units appears to be an obstacle for taking care of the long-term admitted forensic patients in a number of ways. Firstly, the possibilities of exercising ADL or offering activities such as physical exercise, cooking, or teaching are very limited. Secondly, the outdoor environment appears to be inappropriate because it is not sufficiently secured, so the risk of escape or receiving drugs is high. Thirdly, the physical settings also make it difficult for staff to secure the regulations required for patients in
custody. Managers confirm that the number of activities offered is rather limited, and that the physical environment is not suitable to meet the needs of patients in custody if not allowed to communicate with the outside world.

While prisoners are entitled to fresh air during the day, forensic patients in closed units cannot legally claim daily access to outdoor environments. The main concern among staff, however, is that it appears difficult to maintain the level of functioning among some of the forensic patients. “We have so little to offer these patients,” as one member of staff puts it. As a consequence, staff members characterize the forensic clinical pathway in general psychiatric units as a “parking space” or “storage.”

It is for each mental health center to decide how to allocate the forensic patients referred for inpatient care and whether to group them in a single general psychiatric unit or to distribute them into several units within the center. Managers were asked about advantages and disadvantages related to the way their mental health center had decided to place mentally ill offenders. The variety of answers again underlines the complexity of this field. When the decision was to gather mentally ill offenders in a specialized unit within general psychiatry, the argument is that it improves the skills and knowledge among staff on how to deal with this patient population. Furthermore, it is argued that this arrangement protects the general psychiatric population and reduces fear and anxiety among them. If the decision was to spread forensic patients across several units within a mental health center, the argument is, as one manager frankly puts it, “to share the burden,” or make sure that all units are experienced in taking care of mentally ill offenders. The caseload of mentally disordered offenders apparently differs a lot: Some centers receive a relatively large number whereas others have very few. The most common way of organizing the care seems to be to disperse the patients and thereby diluting the impact on the general psychiatric care.

Bottlenecks and Information Exchange

Another reason why caring for forensic patients appears difficult and onerous is related to poor cooperation between sectors and systems, unsystematic exchange of information, or bottlenecks. According to staff, they spend a lot of time on telephone calls, searching for information or asking for papers to be submitted in order to clarify the specific court-ordered circumstances or other relevant information about the patient. Staff experience long periods of waiting for court orders to be signed, agreements being made with responsible consultants in community care, as well as extraordinarily long waiting times for cases to go to court. According to staff, patients in custody often seem to wait several months or even longer for their trial without obvious needs of inpatient care, meanwhile “taking up beds.” This could indicate that non-forensic patients according to staff were more entitled to or more in need of a bed in the unit. The managers are concerned that mentally ill offenders take up beds and cannot be discharged due to their court-ordered sentences. As a consequence, general psychiatric patients are moved or discharged before their psychiatric condition has improved adequately.

There appear to be a number of congestions within the mental healthcare sector as well as in the cooperation with external partners such as police, courts, probation services, social residences, or social services in general. This is the cause of great frustration among managers as well as staff members and leaves them with the feeling of wasting time and energy when relevant information is not shared in systematic ways. This poor exchange of information appears between judicial, social, and mental healthcare systems, but certainly also within the mental health sector itself.

Lack of Knowledge

Closely related to the problem of poor information exchange is lack of knowledge and competences on forensic psychiatric measures. Members of staff feel they lack knowledge in a number of areas, but first and foremost knowledge of the different psychiatric measures to either placement or treatment. Unclear expressions such as “I don’t know the legislation” or “I don’t know about the meaning and content of the specialized measures” were articulated among members of staff who specifically asked for courses on judicial and forensic psychiatric measures.

There are several types of treatment sentences, from permanent inpatient placement to solely outpatient treatment, which entail a number of different regulations. This brings about considerable variety in clinical pathways: A forensic patient sentenced to placement is subject to years of hospital stay, whereas others sentenced to psychiatric treatment face shorter readmissions due to medication nonadherence, substance abuse, or relapse into criminality. Another group among forensic patients are those hospitalized or in custody while a forensic psychiatric assessment is being made. This variety definitely poses a challenge for the staff as it requires a high level of knowledge of laws and regulations. The variety of measures imply that the staff members in a general psychiatric unit need to be capable of dealing with patients transferred directly from prisons, patients with new (or altered) sentences, as well as patients in need of short-term readmission. In other words, staff members have to manage a hodgepodge of regulations and problems and establish a constant overview of which patients are embodied by which legislation. However, as one member of the staff indicates, the number of different sentences to treatment and placement and their various regulations seem to be more problematic than (the number of) forensic patients themselves.
Dual Diagnosis and Psychopathology

Comorbidity and complex psychopathology may be another explanation as to why the task of handling forensic patients appears to be difficult. Staff describe some of the forensic patients as problematic and difficult because of intensive substance abuse or because they are “strong patients” manipulating and exploiting other patients. Substance abuse appears as a main obstacle, and staff members express despair and resignation toward keeping substances out of the units. According to staff, they try to confront patients with the risks related to substance abuse, but with no systematically implemented dual diagnosis assessment and treatment it appears to be a never-ending job. The problem of substance abuse in general psychiatry is extensive not only among forensic patients. A recent mapping has indicated that at least 50% of the inpatient population suffers from comorbidity of substance abuse and mental disorder. The number might be even higher among the mentally ill offenders. There is a huge lack of knowledge in this area, but the general impression is that substance abuse has increased rapidly over the past 20–30 years, that drugs are easily brought into closed units and cause numerous problems, especially the risk of conflicts, exploitation, and aggressive behavior among patients (Danske Regioner, 2011; Jacobsen & Schepelern, 2011). Furthermore, handling deviant and antisocial behavior requires remarkable energy and causes anxiety and uncertainty among staff because these patients are hard to correct and difficult to handle: “[Y]ou feel under the surface that they are threatening and very well aware what they do and don’t want.” Other members of staff explicitly accentuate that they feel insecure and behave like pleasers in order to avoid outbursts of anger or violence. Managers seem very much aware of the risk of anxiety among staff, but also point toward the risk of anxiety and insecurity among non-forensic patients within the unit.

The general impression is that staff members experience lack of relevant competences in order to deal with antisocial behavior (Danske Regioner, 2011). This underlines what is also described in the literature that dealing with personality disorders and psychotic disorders within the same unit is an extremely difficult task because this requires quite different approaches (Wobbe, 2007).

The nursing heads of unit interviewed were asked to reflect on the results from a recent study showing that patients in general psychiatry experience stigma and a hierarchy of mental disorders or feel patronized by mental health staff, especially if suffering from schizophrenia or personality disorders (Jacobsen et al., 2010). On the one hand, these characteristics are familiar to the nursing heads of unit, but at the same time they maintain that this may be happening elsewhere but not in their unit. They all point toward their task as managers to address fear and anxiety among staff when receiving patients with a record of serious offenses or a history of violence.

What Is the Task?

At least two different narratives are at stake in the ways in which staff talk about and characterize the forensic patient population. On the one hand, the group of mentally ill offenders is perceived as demanding and troublesome, as strong patients with complex or deviant social behavior causing increased problems with substance abuse, and risk of threats or violence against staff or other inpatients. On the other hand, staff members describe the forensic patients as medically well treated and often appearing without obvious psychotic symptoms, sometimes “quiet,” “manageable,” and “easy to get along with.” Perhaps even so quiet and easy that they tend to be forgotten in a hectic day shift, where the contact person needs to focus on the recent compulsory admitted psychotic patient “climbing the walls,” as one member of staff puts it. Furthermore, staff members underline the wide opportunities for establishing sustainable therapeutic alliances due to the often long-term admissions. The narrative of the complex patient population contributing to increased risk of violence, aggressive or antisocial behavior, absconding, drug dealing, or even weapons brought into the units is also present among managers.

The paradox between these representations of well-treated, compliant, and manageable patients versus tremendously difficult, manipulating, or demanding patients underlines what has been argued elsewhere, namely that there is no such entity as the forensic patient (Turner & Saltner, 2008). What is reflected in these opposite narratives about the forensic patients is the great variety within the forensic patient population. The hodgepodge of very complex clinical pathways, psychopathology, deviant social behavior, dual diagnosis, criminal offenses, and sentences to either custody, treatment, or placement, however, seems to obscure what is actually the task of the nursing staff. Especially when talking about the compliant not openly psychotic forensic patient, it appears difficult for the staff to actually identify the task of nursing. Staff members simply find it hard to see what nursing and treatment strategies would be relevant, apart from “the patient taking his medication.” Staff also emphasize that the main issue related to the group of “well-treated” patients is “not their disease but their criminal behavior.” When asked about which specific crime preventive strategies are used in the unit, it seems hard for the staff to identify, and crime prevention does not occur as part of the nursing strategy. As one member of staff puts it: “We do not have anything care-related to offer them now that they are medically well-treated.” When asked about how they work with rehabilitation, one member of staff frankly answers: “[A]ctually we don’t.” A few of the units are supported by dedicated forensic rehabilitation
teams, but whether or not there is access to this kind of support, the task of rehabilitation tends to be seen as someone else’s job. Bearing in mind that our general knowledge about the content of psychiatric nursing practices is limited (Gildberg, 2012), and that the field seems to be marked by a significant freedom of methodology, it is not surprising that staff find it difficult to identify elements of crime prevention in their clinical practice. As a consequence, the task of caring for forensic patients if not in acute stages appears unclear. Furthermore, an unclear task combined with lack of knowledge as well as anxiety related to antisocial behavior and histories of criminality also makes it an uncomfortable task.

However, as described above, to some extent members of staff point out what could have been done or offered in terms of training, exercising, or teaching in order to improve, maintain, or prevent reductions in level of functioning if the structural framework, physical environment, and architecture of the unit were different and adequate.

**Discussion**

Our study has focused on the experience and perceptions of nursing staff. As a consequence, we have paid special interest to the ways in which the patient population is described and characterized. Some of these narratives and their possible implications will be discussed in this following section.

According to a number of staff members, forensic patients previously treated in general psychiatry tended to be “good old schizophrenics” or “proper mentally ill” all of a sudden going insane, throwing plates or furniture out of the window, or setting things on fire. Nowadays, however, they have typically committed more serious crimes and appear more dangerous, less orthodox, and more difficult to deal with. As indicated in a recent mapping, staff members in specialized forensic psychiatry tend to face a growing complexity among their patients (Jacobsen & Schepelern, 2011). It may very well be the case that the patient population has changed, and this also affects patients distributed to general psychiatry although, according to visitation criteria, only less complex forensic patients should be referred to general psychiatry. Knowledge on the growing patient population and its possible transformations is very sparse for the time being, but the point is that staff in general psychiatry experience a change. Taking a closer look at this narrative therefore might provide us with a deeper understanding of how staff members perceive their task and practices.

The experience of changes in the behavior of the patient population might also have intensified the focus on criminal acts. When preparing questions for the interview, we decided not to ask explicitly about levels of anxiety among the staff because we did not want to impose the idea and perception of dangerous criminal forensic patients. However, stereotypical pictures of “criminals” and “dangerous criminals” appeared during our interviews. Members of staff, for instance, described their interactions with patients focusing on the criminal acts prior to hospitalization or sentence, and they also addressed the risk that knowledge and details about criminal acts might affect their nursing practices, especially in cases of serious violent offenses. Dealing with knowledge about offenses seems to be a hard balancing act; a certain level of knowledge is relevant in order to perform violence risk assessment and maintain a secure environment. Knowledge about index criminality is also very much needed in order to prevent similar future crime. At the same time, a professional distance supported by supervision and reflection is needed in order to avoid a judgmental approach. The overall impression from the interviews is that awareness and knowledge of offenses were not systematically used in order to establish violence risk assessments or develop nursing plans. Rather, the focus tended to be on criminal behavior as immanent, and as a feature far more conspicuous than the mental disorder that led to the sentence or hospitalization. As a consequence, criminal acts and criminal behavior are a major cause of anxiety among staff. This focus on the criminal acts and dangerousness may overshadow the fact that the forensic patient first and foremost is a patient in a hospital, in need of psychiatric care and treatment. It may also overshadow that the majority of patients are admitted due to a court-ordered sentence based on a psychiatric evaluation. Staff as well as managers complained about forensic patients “taking up beds.” Although the “cuckoo” metaphor, as introduced in public debate by the interest organization Danish Regions in 2010, is not used explicitly among staff and managers, the idea seems present. When the forensic patients are described as “criminals,” “medically well-treated,” and not openly psychotic but with a deviant social behavior and/or a personality disorder, they appear as a category that is rather different from “the proper” and “seriously mentally ill” non-forensic patients. This easily leads to a distinction between deserving and undeserving or worthy/unworthy patients, where persons with severe mental illness in psychotic stages seem more obviously entitled to care than complicated, not openly psychotic offenders on long-term admissions. Such linguistic distinctions combined with lack of knowledge, poor information exchange, complex psychopathology, dual diagnosis, as well as the experience of a poorly demarcated or uncomfortable task of nursing and controlling may contribute to brutalization and stigmatization in the care and treatment of mentally ill offenders. However, these distinctions and narratives coexist with the narrative of the manageable and well-adapted mentally ill offenders who fit in quietly in a hectic unit. They may not be at risk of brutalization, but when staff characterize the clinical pathways of these patients as a long-term parking space, it seems relevant to ask if they are actually sufficiently cared for. Either way,
these narratives frame the complexity and variety of a growing patient population of mentally ill offenders.

Limitations

The study has shed light on the unique and individual experience among a limited number of staff and managers within the Capital Region of Denmark. However, it is important to bear in mind that informants included in our study share solid experience due to the fact that the Capital Region is taking care of approximately one third of the total number of mentally ill offenders in a Danish context.

Members of staff to take part in the focus group interviews were, for practical reasons, picked by the nursing heads of unit in consideration of security matters and whether they could safely leave the unit for one and a half hours. Although we asked for dispersal regarding educational level and working experience, relying on the manager to invite staff for interviews certainly increases risk of bias. This study has underlined that research taking place this close to clinical practice must constantly adjust according to the daily staff members, numbers of acute cases, and security levels within each unit.

Implications for Nursing Practices

Caring for mentally ill offenders is a complex and demanding task requiring specific knowledge and competences as well as a broad interdisciplinary approach and communication. In a Danish national context, systematic training and educational activities are provided to nursing staff working in specialized forensic units, while this is not the case for staff in general psychiatry. Our findings indicate that this is also very much needed in general psychiatry. Members of staff demand specific teaching in legal matters concerning the different sentences to custody, treatment and placement, and their implications, as well as dual diagnosis treatment and knowledge on nursing practices toward patients suffering from severe personality disorders.

Furthermore, our study has illustrated the need to elucidate the double task of treating/caring and control/prevention. This may clarify the task of caring for mentally ill offenders and that this not only involves sufficient medical treatment but also a wide concept of psychiatric care focusing on rehabilitation and prevention of future offenses. Improvement of information exchange is also very much needed between sectors as well as within the mental health sector: For instance, knowledge of visitation criteria may also facilitate a deeper understanding of which patient groups the staff in general psychiatric facilities are supposed to provide care for, and why.

This improvement of information exchange could benefit from implementation of a number of tools such as:

- Individual list of specific regulations for patients in custody placed in the relevant patient’s file as well as on the whiteboard in the staff room
- A simple template in each patient file providing contact details for the psychiatrist responsible for the treatment, contact persons in social psychiatry/residential institutions, Prison and Probation Services, as well as information about the specific sentence to treatment and which regulations to bear in mind
- Systematic clinical supervision implemented in each unit on a regular basis
- Knowledge exchange on rehabilitation, case management, and integration models in order to improve coherent clinical pathways
- Knowledge exchange between specialized forensic units and general psychiatric units taking care of mentally ill offenders, especially addressing risk of brutalization among staff, when taking care of patients suffering from severe personality disorders or how to maintain a nonjudgmental approach
- Knowledge exchange on implementation of violence risk assessment tools

Furthermore, our study underlines the need for additional future studies on patient perspectives, on avenues to increase efficiency and decrease bottlenecks throughout the clinical pathways, as well as knowledge of the impact on general patient populations’ resources for treatment and their safety.

Further research within similar contexts with division of labor between general psychiatry and specialized forensic psychiatry will hopefully show whether our identifications of challenges when caring for mentally disordered offenders in general psychiatric settings are recognized elsewhere. We also expect our study and findings to be succeeded by further international discussion on the need for increased specialization or subspecialization, more dedicated beds, or development of specialized forensic nursing.

References


