CHAPTER
35

Care of the Mentally Ill in Forensic Settings

Rhonda Kay Wilson

LEARNING OBJECTIVES

After studying this chapter, you will be able to:

- Define the mentally ill forensic populations.
- Discuss the stigma of mental illness and criminality.
- Describe legal outcomes for mentally ill patients in forensic settings.
- Assess personal attitudes in caring for persons with mental illness who have committed crimes.
- Identify the nursing challenges in forensic settings.
- Discuss rehabilitation and recovery once the mentally ill person no longer needs the forensic setting.

KEY CONCEPTS

- forensic
- fairness

KEY TERMS

- court process counseling
- forensic examiner
- fitness to stand trial
- probation
- unfit to stand trial (UST)
- not guilty by reason of Insanity (NGRI)
- guilty but mentally ill (GBMI)
- conditional release

FORENSIC POPULATION

People with a mental illness are more likely to be convicted of a crime than those without a mental illness. In one study, women with at least one psychiatric admission were 3.08 to 11.27 times more likely to be convicted of a crime and men were 2.29 to 7.5 times more likely to be convicted than their non-mentally ill counterpart (Schimmels, 2005). Prisoners have three times the prevalence of mental illness than the general population (Schimmels, 2005). In a survey of 22,790 prisoners in western countries, 3.7% of men (4% of women) had a psychosis, 10% of men (12% of women) had major depressive disorder, and 65% of men (42% of women) had personality disorders. In a Chicago study, it was found that 80% of the 1,272 women in jail studied had at least one psychiatric disorder and in North Carolina, 67% of the 805 women met criteria for a psychiatric diagnosis (Schimmels, 2005).
There are different views of mental illness and criminal behavior. Some people believe that people with mental illness commit criminal acts and it is their mental illness that causes their actions. Others believe that people engage in criminal behavior who happen to be mentally ill.

**STIGMA AND CRIMINALITY**

Forensic patients suffer the combined effects of the stigma of mental illness and criminality. Although stigma is an issue for all persons with a mental illness, it is magnified for those who have committed a crime. There is often reluctance on the part of mental health professionals to treat these patients, especially if murder and childhood sexual abuse are involved. Even if the worry is unfounded, clinicians express safety concerns for themselves and other patients and may refuse to care for these patients.

Delivery of coordinated mental health care services within a humane treatment network can be interrupted by conflict between the inpatient facility and the community. When non-forensic patients receive the maximum benefit from hospitalization, they are normally discharged into the community. For stigmatized forensic patients, the community often wants a more stringent discharge threshold and unrealistically expects the hospital to guarantee compliance with community rules and structure. These conflicting views can result in patients being discharged into community settings in a poorly coordinated fashion that sets them up for failure and another trip through the system (Box 35.1).

**CRIMINAL JUDICIAL PROCESSES**

There are two sides in any arrest and conviction: one side presented by the attorney of the accused and the other by the prosecution. It is important that the accused is able to work with an attorney. A basic concept underlying the criminal judicial process is one of fairness. The individual who is charged with a crime should know the legal rules and be able to explain the events surrounding the alleged crime or be “fit to stand trial.”

Initiation of forensic psychiatric care ideally begins at the time of arrest. If the mental illness is recognized during the arrest, the forensic mental health system becomes involved prior to trial. If the mental illness is not recognized, the individual may be sentenced to prison without treatment. Once in a correctional facility, if a mental illness is diagnosed, prisoners are treated in prison or transferred to a mental hospital for treatment and then returned to prison to complete their sentences.

A forensic examiner is a key person in the legal process. The examiner is a mental health specialist, usually a psychiatrist or psychologist, who is certified as a forensic examiner and assigned by the judge to assess and testify to the patient’s competency and responsibility for the crime including the mental state at the time of an offense. This testimony is based on interviews with the offender and a review of available records. The testimony directly influences the verdicts, judgments, sentencing, and damages of the defendant. For sex offenders, the examiner assesses the likelihood of recidivism and competence to stand trial.

**Fitness to Stand Trial**

Once a mental illness is diagnosed, the person’s fitness to stand trial is determined. Fitness means that a person is able to consult with a lawyer with a reasonable degree of rational understanding of the facts of the alleged crime and of the legal proceedings as spelled out in the court case of Dusky vs. U.S. 1960 (Beran & Tommey, 1979, p. 12). In most states, when a mentally ill individual is found unfit to stand trial (UST), hospitalization in a forensic mental health facility follows. The goal of this hospitalization is to help the person become “fit” to stand trial, not to treat the mental illness. When fitness is attained, the court is notified and a hearing is held. If the court agrees that the individual is fit to stand trial, the case then goes to trial. If it is the court’s opinion that the individual is still unfit, the individual is returned to the hospital.

An individual cannot be “unfit” forever. If fitness cannot be attained within 1 year, a hearing must be held at which facts of the alleged crime are presented to a judge who rules on the case. If the charges are dismissed, the judge could order a civil commitment (see Chapter 3). If there is sufficient evidence to convict, the individual could be sent back to the hospital for further treatment to attain fitness. The maximum length of this additional treatment is based on the severity of the charge. For mentally disordered sex offenders, states usually have
special statutes for hospitalization and discharge (such as registration and community notification).

**Not Guilty by Reason of Insanity**

A possible outcome or disposition of a hearing or trial is **not guilty by reason of insanity** (NGRI). The accused is judged to not know right from wrong or to be unable to control his or her actions at the time of the crime. The rationale underlying this ruling is one of fairness. It is unfair to hold a person responsible if that individual does not know that the action is wrong or has control over his or her behavior.

After a finding of NGRI, the individual is ordered to a forensic facility for a psychiatric evaluation and the treatment recommendations are submitted to the court. Nearly all of those individuals found NGRI are also subject to involuntary commitment in a “secured” setting. Periodic reports of the individual’s progress are sent back to the court. The patient cannot leave hospital grounds without court approval and only the committing court can discharge these individuals from the hospital.

**Myths about the Insanity Plea**

There are many misconceptions about the insanity plea. One is that the insanity defense provides a loophole through which criminals can escape punishment for illegal acts. In reality, the insanity defense is extremely difficult to employ, even in the cases of severely ill individuals. As a result, despite popular belief, the insanity defense is used in less than 1% of criminal cases (see Box 35.2).

Countless newspaper articles, talk shows, and news commentaries concerning the insanity defense have bombarded the public. Some of the cases have been highly publicized. One such case was that of John Hinckley, who attempted to assassinate President Ronald Reagan in 1981 and who was found NGRI. On psychiatric examination, Hinckley was found to be living in a “fantasy world with magical and grandiose expectations of impressing and winning over” his love, actress Jodie Foster (Goldstein, 1995, p. 309). Hinckley attempted to commit a historic deed that would make him famous and unite him with the love object of his delusions. His acquittal stimulated public cries for reform of the insanity defense. Within 2½ years of John Hinckley’s acquittal, 34 states changed their insanity defense statutes to limit its use or to prevent the premature release of dangerous people.

Despite its rarity, there continues to be a variety of strongly held opinions over whether the insanity defense is a way to “beat the rap” or results in unfair, lengthy hospitalizations for those stigmatized as “bad and mad.” Many believe that hospitalizations are shorter than prison sentences. In reality, it is nearly certain that after an individual is judged NGRI, more time is spent in a mental hospital than if the person had been sentenced to a correctional facility.

**Guilty but Mentally Ill**

Different from NGRI, in which “not guilty” individuals are committed to the mental health system, **guilty but mentally ill** (GBMI) is a criminal conviction and the person is sent to the correctional system. Mental illness is considered a factor in the crime but not to the extent that the individual is incapable of knowing right from wrong or controlling their actions. The sentence for the GBMI is the same type of determinate sentence any inmate receives. Prior to release, every effort is made to ensure that patients will receive proper follow-up care in the community and close monitoring by parole staff.

Both NGRI or GBMI persons are treated for their mental disorders, but one is treated in jail and the other in a hospital. The conditions of release are different. Individuals with a GBMI are subject to the correctional system’s parole decisions, whereas an NGRI individual is discharged from the hospital through the courts upon recommendations of the forensic mental health professionals.

**Probation**

Probation is a sentence of conditional or revocable release under the supervision of a probation officer for a specified time. For the mentally ill who have committed minor offenses, probation is sometimes used instead of jail as long as care in a treatment facility can be arranged. If treatment and rehabilitation are successful, criminal charges may be dropped and a prison record avoided. Probation is also used when a criminal has served time and continued monitoring is needed once released from the correctional facility.

Probation often includes requirements such as a mental health evaluation and an order to follow through with any recommended forms of treatment. It may include restrictions on certain activities such as the use of alcohol.

**Box 35.2**

**The Case of Andrea Yates**

In March 2002, Andrea Yates, age 37, was convicted of murder for drowning her children. She was sentenced to life in prison, despite past treatment for postpartum depression and psychosis, four hospitalizations, and two suicide attempts. Andrea Yates was found guilty because in her testimony to the police she stated that she knew the criminal justice system would punish her for her actions, implying that she knew the acts were wrong in the eyes of the law. Texas law does not recognize that for someone as ill as Andrea Yates, mental illnesses can create more powerful hierarchies of right and wrong than societal law.
and other drugs, monetary fines, or mandatory community service. Successful completion of a probationary sentence for a person with a mental illness almost certainly depends on the ability and the willingness of a community mental health clinician to work cooperatively with the court and the assigned probation officer.

**Forensic Conditional Release Program**

In some states, patients who are judicially committed and found to be NGRI, incompetent to stand trial, or mentally disordered sex offenders are discharged through a forensic conditional release program. Patients whose psychiatric symptoms have been stabilized and are no longer considered a danger qualify for this program that is very similar to parole for inmates released from a correctional facility. In the forensic conditional release program, the patient is released but they must follow the conditions and criteria that are established by the program in order to maintain their discharged status. In states that do not have this program, the patient will remain an inpatient until the date expires or until the court grants them some form of conditional release. If the patient is granted a conditional release, the court will dictate the conditions of the release.

### SELF-ASSESSMENT

Self-assessment is an ongoing process in which the nurse examines personal beliefs and attitudes about patients and crimes. It is the first step toward being an effective psychiatric nurse in a forensic setting. It is essential for the nurse to be aware of personal feelings about patients’ crimes and to identify and recognize any bias toward these patients. A positive attitude toward people with mental illnesses including those who have committed a crime is basic to psychiatric nursing practice. At no time is it appropriate to convey a personal negative feeling toward the patient (Box 35-3).

If there is a negative attitude toward patients, the nurse should develop a plan to deal with the underlying feelings. In the mental health treatment environment, there are many skilled clinicians such as psychiatrists, social workers, and peers who can help the nurse talk through feelings and thoughts and assist the nurse to begin to work around or through the negativity. The nurse must want to change or explore this area in order to successfully resolve any issues he or she may have.

Some nurses have found that it is not necessary to know the details of the crime in order to work effectively with the forensic patient. The legal status and dangerousness of patients are important data, but it is not essential to know the actual crimes that patients committed.

Whereas some nurses develop biases against the patients, other nurses become too involved with patients in forensic facilities. It is essential to maintain professional boundaries and the nurse should seek assistance if he or she is unable to maintain these professional boundaries. The supervisor should be notified if the nurse finds him- or herself in a situation where professional boundaries have been broken. Together the employee and supervisor will decide the best course of action. In some cases the nurse will be relocated or change job assignments to avoid future contact with the patient; be referred to an Employee Assistance Program for counseling, or, if the breach of professionalism is too great, the employee may be encouraged to seek other employment for his or her safety and professional integrity.

### NURSING MANAGEMENT ISSUES IN FORENSIC CARE

Forensic mental health professionals who have been providing treatment of the mentally ill forensic patients have published research literature that documents evidence-based practice for forensic care. Several assessments and interventions are used predominately with forensic patients and are targeted at the specific legally relevant behaviors that are the basis for their involuntary treatment. The ultimate goals are rehabilitation and recovery.

### Assessment

The nursing assessment should be completed according to accepted standards (see Chapter 5). The development of rapport and trust are important for a successful nursing assessment. Forensic patients may be uncomfortable discussing their crime for fear of rejection by the nursing staff and treatment team. They may also be reluctant to disclose personal information if they perceive themselves to be at risk for further prosecution if information about prior criminal activity is leaked to the district attorney’s office. The nurse should reassure the patient that the focus of the assessment is mental health issues and behaviors, but not specific details of the crimes.
Risk Assessment

Risk assessment is an important determination to maintain the safety of the patient and others. Upon admission to a mental health treatment facility the staff performs a risk assessment. Patients’ current level and past history of dangerousness are reviewed and a safety plan is developed. Some state mental health facilities perform a risk assessment screening to determine placement. The patient may be sent to a maximum secure mental health treatment facility based on this risk assessment. The data obtained in the risk assessment including the patient’s known history, habits, legal status, and triggers are used to develop an individualized treatment plan.

Informed Consent

Informed consent is necessary prior to initiation of pharmacologic treatment of forensic patients. The nursing staff collaborates with the psychiatrist to educate patients about their medications and the need to take medication. The nurse also collaborates with the psychiatrist to obtain informed written or verbal consent from the patient to take medication. The informed consent is the legal responsibility of the physician, but the nurse often assists in obtaining the consent.

Forensic patients can refuse medication just as any other patient can. If patients refuse to take medication and then become a threat to themselves or others, treating psychiatrists may petition the court for enforced medication. Only after a court order is obtained is medication administered to someone who has not consented to it. If patients are not a threat to themselves or others, it is unlikely that the court will order medication administration. In these situations, the rights of the patient are respected but it is often at the expense of the patient receiving the best treatment available.

Documentation

Documentation is essential when caring for a patient with a mental illness in a forensic setting. Accurate and frequent recording of changes in mental condition, responses to treatment, and effectiveness of medication is useful information for the treatment team and the legal advocates. It is crucial that moods, behaviors, and overall mental health state are monitored and documented on a regular basis. Nursing interventions and the patient’s response to the nursing care should always be documented. In addition, medical condition and the nursing care associated with these physical problems should be recorded.

The court report is a useful communication tool for mental health clinicians to provide technical information based on clinical assessment and current research to those governing the lives of the forensic person. Ideally, the report should reflect the careful balance of the rights of the individual, mental health needs, and public safety (Box 35.4).

Specific Interventions

Court Process Counseling

An understanding of the legal proceedings is essential for any person charged with crimes. Court process counseling educates mentally ill patients about the impending legal procedures and prepares them for courtroom appearances. This intervention is used for all forensic patients—those preparing for their fitness to stand trial hearing as well as those preparing for discharge. Factual information such as roles and functions of key courtroom personnel, potential pleas that might be offered in court, and the nature of the legal process are basic to this intervention. Fitness issues are discussed as appropriate.

Patients also have an opportunity to develop skills for interacting in a courtroom through mock trials and court process games. Groups and classes are often held for patients who are unfit to stand trial. These group sessions or class sessions teach the patient about fitness issues in order for the psychiatrist, forensic examiner, and the court to find them fit. These groups and classes usually test the patient’s knowledge of the court by giving a written examination that the patient must pass prior to being found fit.

Physical Management of Aggression

Forensic patients frequently come from violent backgrounds and are normally physically aggressive. Confined to living with others who are also aggressive, these patients are easily provoked into verbal and physical aggression. Management of aggressive behavior is a priority and involves structuring the physical environment, de-escalation techniques, and pharmacological interventions.
Forensic mental health facilities focus on providing a safe and secure environment. Furniture and decorations are minimal and patient rooms are routinely inspected for any objects that can be used to cause injury to the patient or others. Patient movement and daily activities are carefully overseen and are very structured so that the staff knows the whereabouts of the patients and their activities at all times.

De-escalation techniques are commonly used in the forensic mental health setting. The primary goal of de-escalation is to resolve angry or violent conflicts in non-violent ways (see Chapter 38). Most forensic mental health facilities use a nonviolent crisis intervention model that is based on the assumption that patients should not be further provoked if they are already in a state of agitation. These patients should be given space and time to calm down. They should be addressed in a calm, reasonable, and nonthreatening tone. For staff safety, agitated patients should be de-escalated by more than one staff member. Other de-escalation techniques include distraction, active listening, and sensory modulation and integration activities (Box 35.5). At all times, the patient should be involved in the decision-making process and their wishes and preferences for de-escalation techniques should be considered and honored if possible. For example, some patients may ask to talk to someone and others may want to be left alone. As a last resort, physical holds, seclusion, or restraints to protect the patient from harming themselves or others can be applied.

Antianxiety, mood stabilizers, or antipsychotic medication can be given to assist an agitated patient in calming down. Antipsychotic medications are used for patients with psychosis and mania. The disadvantage of antipsychotic medication is the risk of side effects such as acute muscular spasms and potentially irreversible tardive dyskinesia. Antianxiety and hypnotic medications such as lorazepam (Ativan) or diphenhydramine (Benadryl) are used for as-needed management of aggressive episodes that occur despite taking antipsychotic medication as prescribed. Other medications that have been found to be helpful in managing symptoms underlying aggressive behavior are the mood stabilizers (lithium, carbamazepine, valproic acid) and beta-blockers (propranolol, metoprolol).

**Medication Compliance**

Medication administration presents unique challenges for the nursing staff. Patients frequently do not believe or trust the staff to properly treat their mental illness. When patients do not trust the staff, they often refuse to take their medication as prescribed. Nursing staff should always be vigilant and observe patients carefully to ensure that they are taking their medications and not spitting, cheeking (hiding medication in their cheeks to avoid swallowing), hiding, or throwing it away. At the same time, the nurses need to work on developing a trusting therapeutic relationship with their patients. As nurses gain the trust of the patient, the individual often agrees to try the medication.

**NURSING MANAGEMENT ISSUES IN A CORRECTIONAL SETTING**

Correctional facilities are regulated by the judicial system, not by state departments of mental health. Nursing care in these facilities is held to the same standard of care as in any setting, but the circumstances are different. For example, medications are administered through a window or opening in the bars in the cell house and are usually crushed and dissolved in water prior to giving it to the patient. Refusal of medications is not an option. If an inmate refuses medication, the authorities take the necessary steps to enforce compliance.

The nursing care in the corrections setting is conducted in a call line system. Any inmate who becomes ill or has a medical complaint notifies the guard who in turn will contact the nurse who checks the inmate and administers first aid if indicated. Following the assessment, the nurse may place the inmate on the sick call line which is either medical or psychiatric. The inmate will then be seen by the nurse or physician during office hours. If indicated, medications will be ordered. Once seen, the inmate returns back to the cell house. If physically ill, the

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**BOX 35.5**

**Sensory Modulation and Integration Activities**

**Grounding physical activities**
- Holding
- Weighted blankets
- Arm massages
- Aerobic exercise
- Sour/fireball candies

**Calming self-soothing activities**
- Hot shower/bath
- Drumming
- Decaf tea
- Rocking in a rocking chair
- Beanbag tapping
- Yoga
- Wrapping in a heavy quilt

**Comfort rooms**

The comfort room is a room that provides sanctuary from stress, and/or can be a place for persons to experience feelings within acceptable boundaries. The comfort room is set up to be physically comfortable and pleasing to the eye, including a recliner chair, walls with soft colors, murals, and colorful curtains.
patient may be admitted to the health care unit for medical treatment until the illness is resolved. If psychiatric problems persist despite medication, the patient may be transferred to a psychiatric treatment facility within the correctional system.

**PUBLIC SAFETY ON RELEASE**

The issue of public safety is often raised regarding the care and discharge of patients with psychiatric disorders. The reality is that patients with psychiatric problems are more likely victims than perpetrators of criminal activity. For patients who are admitted to treatment facilities because they have committed a crime, the development of sound conditional release programs is one approach many states use. In conditional release, patients are discharged provided they are monitored on an ongoing basis by the court. The authority to release from hospitalization or to monitor and enforce mandatory outpatient treatment varies considerably across jurisdictions. The fate of the forensic patient may lie with a legal agent (court), a clinical agent (hospital staff), or a special administrative panel (clinical review board or psychiatric security review board).

Often social and political considerations influence judges and clinicians toward conservative placement and release decisions. Judges risk adverse publicity if they release a patient who again becomes violent in the community. Clinicians, on the other hand, may be fearful of malpractice litigation for wrongful imprisonment. In reality the treatment team’s release decision is based on a variety of factors, including the patient’s potential for future violence, the current political climate, and skillfulness of the attorney who portrays the patient as having no potential for violence.

**FROM THE HOSPITAL TO THE COMMUNITY**

Providing quality services to persons with mental illness who are involved with the legal system can be a long and complicated process. There are many opportunities for an individual to “fall in the cracks” and miss receiving services that are needed to live successfully in the community. Sometimes critical services are not available and sometimes service planners, family members, and the individuals do not know how to access available services. Some mental health agencies are unwilling to serve an “ex-offender.” Patients discontinue treatment and services for a variety of reasons including medication side effects, substance abuse, long waiting lists, lack of services, and a lack of sufficient parole staff to monitor and encourage compliance.

When individuals do not receive the services they need, for whatever reason, their chances for repeat hospitalizations or legal difficulties are high.

In addition to mental health services, these patients need a wide range of other services, including medical and dental care, housing, food, and clothing. Financial and legal services along with support services such as self-help groups, and spiritual and recreational opportunities are also needed. Rehabilitation services are needed including education, training, and employment.

**SUMMARY OF KEY POINTS**

- There are special legal terms and considerations for individuals who have mental disorders and commit crimes. Those determined to be unfit to stand trial are mentally incompetent and unable to understand the proceedings against them or assist in their own defense. These patients are committed to a mental health facility for treatment until they achieve fitness. Those determined to be not guilty by reason of insanity are those who demonstrate that they had no understanding of their actions and no control over them when they committed the crime. These patients are committed to a mental health facility for treatment and then discharged after treatment.
- The patient found guilty but mentally ill applies to those who demonstrate that they knew the wrongfulness of their actions and had the ability to act otherwise. These patients enter the correctional system and receive treatment for their disorder but are returned after treatment to serve their sentences. For mentally disordered sex offenders, states usually have special statutes for hospitalization and discharge. Prisoners who develop mental illness while in prison are transferred to a mental hospital, treated, and returned to prison to complete their sentences.
- A major treatment issue in a forensic treatment facility is developing a trusting relationship and compliance with treatment.
- The role of the nurse in managing the forensic patient is to pharmacologically treat symptoms underlying aggression and at times utilize seclusion or restraints to manage physical aggression. The nurse needs to build a trusting therapeutic relationship with the patient to help the patient make informed choices about being compliant with their desired treatment plan. Another nursing intervention is to ensure that the teaching needs of the patient are met. These needs include medication education and court process education.
- Once the decision to release the forensic patient from the inpatient setting is made, often the commu-
County providers have felt reluctant to accept recipients who have been involved with the criminal justice system. They express fears about the person's level of dangerousness, protection of staff and peers, and potential liability.

The goal is to coordinate mental health services and to provide the forensic patient with a wide range of services that will help them successfully live within his or her community.

**CRITICAL THINKING CHALLENGES**

- Describe the differences between UST, NGRI, and GBMI.
- If you were mentally ill, under what circumstances do you feel a forensic patient should no longer have the right to refuse medication? Keep in mind the patient's right for informed consent.
- If you were responsible for a caseload at a community mental health center, would you be fearful of accepting a patient with a criminal background?

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**Sling Blade:** 1996. Sling Blade is a drama set in rural Arkansas starring Billy Bob Thornton who plays a man named Karl Childers who is released from a psychiatric hospital where he has lived since committing murder at age 12. He is a very simple man who thinks in concrete terms. He befriends a young boy and begins a friendship with the boys' mother. He then finally confronts the mother's abusive boyfriend. This film won many awards.

**VIEWING POINTS:** If Karl had been successfully rehabilitated, how would he have handled his rage? Would this film perpetuate the myth that people with mental illness are dangerous? Was the murder justified?

**Inside/Outside Video:** 2004. This video was developed by, and stars, consumers who have all reached recovery. The video envisions the patient on a journey to recovery and parallels. Theo's primary focus is to give the consumers hope for the future, encouraging them to take responsibility for themselves and their actions and to try to seek recovery.

**VIEWING POINTS:** This video depicts the patient with a psychiatric illness as being able to recover and needing to be involved in their care in order to get well. It shows that there is hope for patients with a mental illness and that the patients who recovered were able to obtain jobs as a consumer specialist. The qualification needed in order to apply for a consumer specialist position is that you have to have been a patient in a psychiatric treatment facility.

**REFERENCES**


