THE DEVELOPING ROLE OF THE PSYCHIATRIC NURSE PRACTITIONER IN CORRECTIONS

By

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INTRODUCTION

State and federal prisons have undergone dramatic transformations. Studies indicate that the rate of seriously mentally ill among the criminal justice system appear to be disproportionately represented (Abramsky & Fellner, 2003). According to Abramsky and Fellner in *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, between 200,000-300,000 men and women in US prisons suffer from a serious mental illness such as schizophrenia, bipolar disorder or major depression. In 1999, the Bureau of Justice Statistics reported 16% of state prison inmates had a self reported mental illness or had been hospitalized overnight in a mental hospital (Ditton, 1999). Other studies indicate the prevalence of Americans with serious mental illness in prison is three to four times higher than in the general population (Council of State Governments, n.d; National Commission on Correctional Health Care [NCCHC], 2002; Veysey & Bichler-Robertson, 2002). In addition to a psychiatric diagnosis, 13% of the mentally ill incarcerated have a co-occurring substance abuse disorder and among those diagnosed with schizophrenia, major affective disorder, or antisocial personality disorder, the prevalence rate is 90% (Ditton; National Institute of Corrections, 1996). In the 1990’s, more mentally ill persons were in U.S. jails and prisons than in public psychiatric hospitals (Ditton). Those in need are turned away from services because resources are limited within the communities (Aufderheide & Brown, 2005). The police are becoming the first responders’, the jails the crisis centers, and prisons’ the mental health hospitals of our nation.

Our nation far exceeds the incarceration rates of other countries (Bonzcar, 2003). Many experts agree that the criminal justice system has become the treatment facilitator for an increasing number of seriously mentally ill (Abramsky & Feline, 2003; National
Alliance for the Mentally Ill [NAMI], 2001). Correctional administrators due to constitutional requirements have a legal duty and responsibility to provide adequate mental health care and are unable to shift responsibility to the community. Correctional administrators are faced with tight budgets and asked to fulfill an enormous unfunded mandate (White & Gillespie, 2005).

The report of the President’s New Freedom Commission on Mental Health (2003) recognized a need to address the mental health issues in the criminal justice system by encouraging the development of diversion programs, adoption of established guidelines in correctional health care, and the expansion of re-entry programs. In November 2005 Congress appropriated $5 million dollars toward the Mentally Ill Offender Treatment and Crime Reduction Act. The U.S. Department of Justice has approved funding for grants to establish mental health courts, expand prisoners’ access to mental health treatment while incarcerated and upon re-entry into the community, provide resources for pre-trial diversion programs, and support cross training for law enforcement officials and mental health personnel dealing with adult and juvenile offenders with mental illness (Council of State Governments, n.d.).

At midyear 2005 the nation’s prisons and jails held 2,186,230 inmates behind bars, a 3.5% annual average of people incarcerated from 1995 to 2005 (Harrison & Beck, 2006). As the incarceration rates increased, proportionately so did the number of incarcerated mentally ill. The need for mental health services within the criminal justice system is seen by the outgrowth of the volume of those being incarcerated (Fagan & Ax, 2003). Mentally ill offenders offer many challenges as they enter the criminal justice system with high rates of homelessness, unemployment, alcohol and drug use, physical
and sexual abuse and chronic health problems (Ditton, 1999). Beyond intrinsic offender needs, social changes over the past several decades expanded opportunities for mental health professionals to offer services within correctional facilities (Fagan & Ax).

This paper will explore the role development of the Psychiatric Mental Health Nurse Practitioner (PMHNP) in the field of corrections. The PMHNP is an advanced nurse practitioner with prescriptive authority in every state with the exception of Georgia, who delivers cost effective primary mental health services as a valuable member of the mental health partnership. For optimal utilization of role development Brown’s Framework (Brown, 1998) for Advanced Practice Nursing will be implemented to understand the comprehensive practices of the PMHNP in the field of corrections. The PMHNP is new to the field of corrections and competencies and aspects of the role development will be discussed, as well as issues that are specific to working in the field of corrections. Outcome criteria and recommendations for further research to evaluate future recommendations for studying the impact of the PMHNP in corrections will be examined.
SCOPE OF PROBLEM

Between 1974 and 2001 a 3.8 million increase of incarceration rates had impacted all aspects of the criminal justice system (Bonczar, 2003). The rising number of mentally ill inmates within the criminal justice system can be attributed to social and political factors affecting the treatment of the mentally ill. Some of these factors include:

- Deinstitutionalization – Deinstitutionalization began in the 1960s as advocates envisaged the mentally ill living more independently within the community with the development of psychotropic medications and supportive community resources. Insufficient funding was provided for community programs and fragmentation in treatment services such as mental health, substance abuse, general medical care, homelessness, and transportation created disparities within the system. Concomitantly states reduced their budgets for mental hospitals, leaving the mentally ill without resources (Aufderheide & Brown, 2005; Hills, Siegfried, & Ickowitz, 2004; The Sentencing Project, 2002).

- Public Attitude - Although Americans are re-thinking their position on mandatory minimums (Peter D. Hart Research Associates, 2002) prior to 2000 a more punitive response to public attitude was adopted toward those who committed street crimes. Mandatory-minimum sentencing and three-strike laws, increasing length of sentences, reducing availability of parole and probation, and cracking down on parole violations were enforced (Aufderheide & Brown).

- Criminalization of the Mentally Ill – Poverty and transient lifestyles of many people with serious mental illness brings them into contact with law
enforcement. Acutely psychotic persons with restricted access to community services through “Mercy Arrests” leads to easier access into treatment in the criminal justice system than in the community (Aufderheide & Brown; Hills et al.).

- **Barriers to Commitment** – Changes in the mental health laws made involuntary commitment more difficult as most states require psychiatric hospitals to show clear and convincing evidence individuals being committed involuntarily are either dangerous to themselves, others, or gravely disabled. Laws regarding both involuntary treatment and involuntary commitment are controversial and advocacy groups and service providers are deeply divided (Aufderheide & Brown; The Sentencing Project).

- **Lack of Pre-Release Planning and Systems Integration** – A lack of coordination between the criminal justice system and community services fragments mental health care for low income or indigent individuals with disabling mental illness who rely on federal entitlements for income support, medications, and mental health care (The Sentencing Project).

Historically correctional facilities are not structured to provide mental health care, but those who have committed crimes and incarcerated does not diminish their need for services (White & Gillespie, 2005), nor their constitutional rights (Estelle v. Gamble 1976). For the past 50 years prison reform has been based on humanitarian efforts and individual rights, but a third vision of reform is self motivated from public health effects and harm to communities. Chronic medical and mental illness comprises severe strain to communities, flowing from the inability of sick inmates to reintegrate into society, and
the costs of recidivism when failure to reintegrate contributes to inmates’ return to crime (Jacobi, 2005). Ten million adults are booked into local jails each year, 700,000 have active symptoms of serious mental illness, with most likely a co-occurring substance abuse disorder (The Sentencing Project, 2002) and two million offenders will be released into the Nation’s communities (Jacobi). According to the National Institute of Justice, 82% of probation and parole agency directors indicated the success of treatment for the mentally ill offender indicates a need to access qualified mental health professionals (The Sentencing Project).

The Correctional Mental Health Care Standards & Guidelines for Delivering Services (NCCHC, 2003) recognizes the PMHNP as a qualified provider within correctional health care. Guided by the American Nurses Association’s (ANA) draft document, Corrections Nursing: Scope & Standards of Practice (2004) the PMHNP supports the mission of the reentry movement (Jacobi, 2005) to reduce recidivism. The PMHNP provides cost effective prevention, screening and treatment, collects accurate data for improvement of correctional mental health care, overcomes barriers for improvement to effective prevention, screening and treatment control, and provides discharge planning according to the NCCHC (2002) to improve the likelihood of successful reentry into the community.
BROWN’S FRAMEWORK

Brown’s 1998 Framework for Advanced Practice Nursing is a broad comprehensive conceptual model that represents an integrative synthesis of literature on advanced nursing practice. Although the central competency of advanced practice nursing is considered to be direct clinical care, the advanced practice nurse has specialized skills beyond their direct care functions such as administration, research, education, and community health that is portrayed within Brown’s overarching framework along with environments that surround and impact advanced nursing practice (Spross & Lawson, 2005). Brown’s model was developed in 1998 and this paper will reflect updated literature represented in the original framework. Core concepts of the framework are conceptual frameworks within themselves (Brown, 1998) and nursing as an evolving profession, through research and practice has refined some of the concepts or formulated others into documents by professional organizations.

The purpose for utilizing Brown’s framework is to guide the reader systematically through the conceptual frames that identify the role and function of the PMHNP in the correctional mental health care field. The four main concepts of the framework and 17 more specific concepts underlying the main components of the original framework are outlined below with a description of what advanced practice nurses encounter within their profession. Further clarification of the role of the PMHNP in the correctional mental health care field will follow after reviewing a generalized description of advanced practice nursing.

Role Legitimacy

- Graduate Education
• Certification

• Licensure

The advanced practice nurse provides services based on the needs of the specialty population and the organizational framework in which his or her role is performed. Criteria for advanced practice nursing includes a graduate degree with concentration within a nursing category, professional certification of practice within a specialty area, and that all advance practice nurses carry current licensure as registered nurses (Hamric, 2005). Advanced nursing practice licensure is regulated by the state board of nursing in most states or joint authority with the board of medicine.

Environment

• Society

• Health Care Economy

• Local Health Care Conditions

• Professional Nursing

• Advanced Practice Community

Environmental conditions have created opportunities for advanced practice nurses within the health care system. Brown (2005) recognized five conditions that support the field of advanced practice nursing. They are as follows:

1. Advance practice nurses respect societal values, attend to the health care needs of the population, and follow the ethical conduct of their profession.

2. Economic forces within the health care delivery system have opened up opportunities for advanced practice nurses in relation to managed care and cost containment practices.
3. Local health care conditions are understandings, agreements and arrangements (i.e., types of patients, job descriptions or contracts) that employ advanced practice nurses. Local health care conditions involve networking, collaboration, consultation, referral and supportive professional relationships.

4. Involvement within the discipline of nursing and synergistic efforts of researchers, theorists, and clinicians to formulate knowledge, education, practice, and political action structures supports the credibility and viability of advanced practice nursing.

5. Advanced practice community involvement with educational institutions, specialty organizations and informal contracts between advanced practice nurses determines the utility, configuration, and evolution of advanced practice nursing.

**Advanced Practice Nursing**

- Scope
- Focus
- Orientation
- Domains
- Competencies

The central concept is advanced practice nursing. Brown’s definition of advanced practice nursing is “professional health care activities that (1) focus on clinical services rendered at the nurse-client interface, (2) use a nursing orientation, (3) have a defined but dynamic and evolving scope, and (4) are based on competencies that are acquired through graduate nursing education” (Brown, 1998, p.161). Essential to the nursing profession is the ability to describe advanced practice nurses’ direct care practice to the public and
policy makers (Brown, 1998). To articulate the standards of the profession, inform society about the parameters of practice, and guide the states in the rules and regulations determining practice, the scopes of practice were developed to define specialization for advance practice nurses in different roles (ANA, 2000). The focus of advanced practice nursing is direct clinical care. Direct clinical care describes the activities and functions performed with clients to assist with their health, illness, and wellness concerns, goals, and problems (Brown, 1998). The direct clinical care competency has five characteristics and is referred to as orientation in Brown's framework. These characteristics are embedded in the traditional values of nursing and are as follows:

1. Holistic framework
2. Formation of partnership with patients
3. Expert clinical reasoning and skillful performance
4. Use of research evidence
5. Diverse approaches to health and illness management.

Advance practice nurses are committed to these values and enact them in their daily interactions with patients along with the strategies that succeed each of them (Brown, 2005).

Advance practice nursing involves nursing knowledge and skills and is not a medical practice, although advance practice nurses may perform medical therapeutics (Hamric, 2005). Domains and competencies refer to the defined knowledge, skilled performance and discretionary judgment of the nursing profession and core requirements for entry level advanced practice nurses. The domains and competencies are outlined in the 2002 National Organization of Nurse Practitioner Faculties (NONPF) document, The
Domains and Core Competencies of Nurse Practitioner Practice. The domains for direct clinical practice are listed below:

1. Management of Patient Health/Illness Status
2. The Nurse Practitioner-Patient Relationship
3. The Teaching-Coaching Function
4. Professional Role
5. Managing and Negotiating Health Care Deliver Systems, and
6. Monitoring and Ensuring the Quality of Health Care Practice

Additional competencies that further define the role of the advanced practice nurse are:

1. Expert Guidance and Coach
2. Consultation
3. Research Skills
4. Clinical and Professional Leadership
5. Collaboration and
6. Ethical Decision-making

Knowledge, skilled performance and discretionary judgment of the domains and competencies provided by the advanced practice nurse are necessary for the promotion of optimal mental health, prevention and treatment of psychiatric disorders and health maintenance and essential to successful practice (Hamric, 2005; NONPF, 2003).

Outcomes

- Patient
- Health Care
- Nursing
• Individual

There is an increased demand for accountability within the health care system to evaluate the outcomes of advanced practice nursing. The evidence concerning advance practice nursing impact on individual, organizational and community outcomes has been documented as comparable or superior to that of other core providers (Ingersoll & Mahn-DiNicola, 2005). Advanced practice nursing impact occurs at the patient, health care, nursing, and individual level.

1. Patient outcomes assessments identify behavior, functional status, disease control, and satisfaction with care.

2. Health care outcome assessments identify improved accessibility to care, availability of diverse health care services, and lower cost in delivery of care.

3. Professional nursing outcomes assessments identify role designs, career advancement, leadership, and cooperative agreements.


Interest in these outcomes is driven by individual, local and national reimbursement and accreditation expectations (Ingersoll & Mahn-DiNicola, 2005). Outcome assessments validate advanced practice nursing to policy makers, who have the power to sanction advanced nursing practice through legislation, regulations, and funding (Brown, 1998). Employers, consumers, insurers, and competing providers are requesting advanced practice nursing justify their contributions (Ingersoll & Mahn-DiNicola).

Brown’s Framework provides an organized, coherent, and consolidated description of advanced practice nursing. It is an internally consistent, externally 
congruent framework that integrates concepts and provides structure for past and future work related to advance practice nursing. Relationships among the concepts create general explanatory power for the framework (Brown, 1998) and will guide the process of understanding the phenomena so that holistic and comprehensive care is provided (Spross & Lawson, 2005).
ROLE LEGITIMACY

Role development involves developing the expertise of the professional group to offer a broader or expert service to patients from within the body of knowledge that defines the professional group and specialty (Evans & Wells, 2001). A characteristic of advanced practice nursing is a recognition that health care of the individual takes place in complex environments that must be developed and nurtured if care is to be patient centered and effective (Brown, 1998). Correctional nurses are sometimes referred to as forensic nurses, who deliver care to inmate populations and do so in a caring relationship that facilitates the health promotion of incarcerated patients (Pertemelj-Taylor, 2005; Weiskopf, 2005). Correctional health services are provided within juvenile detention centers, community corrections, jails, lock ups, and both juvenile and adult correctional institutions (ANA, 2004; Scott & Gerbasi, 2005).

Practicing nursing in corrections is like stepping through the looking glass, everything is the same, yet different (Smith, 2005). Although the clinical aspects are the same, confinement and security is the primary mission, and yet it does not exclude the PMHNP from making a valuable contribution to the prevention and treatment of illness or safety of the institution (ANA, 2004; Scott & Gerbasi, 2005). The PMHNP focuses on meeting the offenders’ needs by maximizing the use of advanced nursing knowledge and skills to improve primary mental health care within the unique and distinct environment of the criminal justice system (ANA, 2004). These secure environments are among the most controversial and stressful environments in society in which public and political animosity prevail. For a variety of reasons they have become sanctuaries for a large portion of vulnerable and at risk-populations (Pertemelj-Taylor, 2005).
The civil rights movement of the 1960s brought attention to the standards of health care within the criminal justice system. During the 1970s, spurred on by prison riots, hundreds of class action suits were filed (Anno, 2001). Prior to the 1960s professional nursing was non existent in correctional facilities and limited research efforts investigated the health status of the prison population (ANA, 2004). In 1976, the United States Supreme Court declared that failure to provide health care to confined individuals in correctional facilities violated their constitutional rights (Estelle v. Gamble). Enforcement of these rights forced correctional health care systems to restructure their delivery of care (ANA, 2004; Weiskopf, 2005). In the next two decades significant changes had been made to the correctional health care delivery system, although between 1980 and 1995, the state and federal prison systems more than tripled, leading to overcrowding and increased demands for offender health care services (Weiskopf).

In 1985 the American Nurses Association recognized correctional nursing as a specialty when ANA developed the *Scope and Standards of Nursing Practice in Correctional Facilities*. In 2004 the American Nurses Association developed guidelines for advanced practice nursing in correctional facilities in their proposed draft document, *Corrections Nursing: Scope and Standards of Practice*. Although these standards apply to all nurses and advanced practice nurses within correctional facilities, the PMHNP additionally follows the guidelines of the *Scope and Standards of Psychiatric-Mental Health Nursing Practice*, outlined by the American Nurses Association, the American Psychiatric Nurses Association, and the International Society of Psychiatric-Mental Health.
Health Nurses to address mental health issues and outcomes for correctional mental health (ANA, 2000).

Correctional health is one of the fastest growing specialties and opportunities exist to strengthen the role of the PMHNP as leader in managing the health and wellness of the mentally ill offender within correctional facilities and community corrections (ANA, 2004; Goldkuhle, 1999). Correctional health care providers according to *Correctional Mental Health Care Standards & Guidelines for Delivering Services* (NCCHC, 2003) must facilitate credentialing in accordance to licensure, certification, and registration requirements of the state. The PMHNP as an advanced practice nurse is educationally prepared at least at the master’s level. After graduation 44 states require national certification for advanced psychiatric nursing practice and licensing is regulated by state requirements (Staten et al., 2005). Certification and advanced certification is available through the National Commission on Correctional Health Care (Anno, 2001).

The PMHNP incorporates knowledge of the correctional field through planning, implementation and management of the individual, group or community (ANA, 2000, 2004). Coordinated and comprehensive mental health care is necessary to address psychiatric and medical needs of the mentally ill incarcerated along with appropriate referrals upon release (NAMI, 2001). Given correctional systems are under increasing pressure to provide humane levels of healthcare with limited resources (ANA, 2004) the PMHNP can deliver holistic and integrative treatment, act as a resource for non-psychiatric providers, and is a logical choice as a cost effective, efficient and effective provider for primary mental health care within corrections.
ENVIRONMENT

Because of sensational headlines and high profile incidents the public and some policy makers are misinformed about the majority of the mentally ill offenders committing serious violent crimes. In fact a large number have been incarcerated because they displayed in public symptoms of untreated mental illness. Calls for crackdowns on quality-of-life crimes and offenses such as illegal substances have netted many people with mental illness (Council of State Governments, n.d.). Some of the mentally ill who are fortunate enough to have financial resources receive treatment. Others are unable to take care of their basic needs. They are homeless, impoverished, too disabled, fearful, or deluded to keep appointments, have committed crimes, and end up in the criminal justice system (Abramsky & Feliner, 2003). When the mentally ill offender reaches the incarceration stage, the provision of services has always been somewhat of a contentious subject. When services are limited, psychotic and suicidal behaviors disrupt the orderly running of the facility, but when a broad range of services are offered, cries of coddling are sounded in some of the public arenas, and yet others wonder why services are given to offenders that are difficult for the average law abiding citizen to receive (Fagan & Ax, 2003).

The specialization of correctional health care arises from the fact that the patients being treated have offended, and their continuing risk to themselves or others requires particular legal systems, institutions, services and professionals to care for and treat (McGauley & Campbell, 2004). The offender population is composed of male and female, from youth to elderly, of multi-cultural and ethnic descent, who are victims as well as perpetrators of crimes (ANA, 2004; Peternelj-Taylor, 2005). The majority is of
minority status, have a limited education, and come from poverty and unemployment before incarceration (Goldkuhle, 1999). Reflecting their disadvantaged background, the health service needs of the incarcerated population are multifaceted, complex, and often acute, especially upon entry (Goldkuhle; Weiskopf, 2005). Offenders from lower socioeconomic status have not had the benefits of adequate health care, and tend to engage in unhealthy behaviors such as substance abuse, tobacco use, poor nutritional habits, multiple sex partners, and sedentary life styles, that place them at high risk for diseases such as acquired immune deficiency, heart disease, hypertension, hepatitis, and renal disease (Anno, 2001).

The incarceration experience can be a significant stressful life experience event, even for those who do not have a mental illness. Quality of life is affected by separation from family and friends, limitations on privacy, fear of assault, and overcrowding (Petemelj-Taylor, 2005). Offenders with mental disorders are vulnerable to the adversities of incarceration. They have difficulty understanding and following the expectations of the institution and commit more rule infractions in which they spend time in segregation, complicating their symptoms of mental illness through isolation and barriers to services. They are often ostracized by other inmates, stigmatized through punishment by prison staff for symptoms of their illness as being noisy, refusing orders, self-mutilating and attempting suicide (Abramsky & Feliner, 2003; Aufderheide & Brown, 2005; Ditton, 1999). These experiences overwhelm the resources of mentally ill offenders (Petemelj-Taylor) and create a comprehensive range of medical and mental health care needs.
Correctional facilities are mostly viewed as places of punishment and nurses who deliver care to offenders are challenged to do so in caring relationships which facilitate their health and healing (Weiskopf, 2005). Mentally ill offenders are stigmatized doubly by a mental disorder and socially proscribed acts. The PMHNP must remain neutral and avoid projection of feelings that are found unattractive or shameful on to the disadvantaged, including feelings of incompetence, dependency, despair or aggression (McGauley & Campbell, 2004). He or she must learn to work within strict security regulatory environments that are often over crowded, with consideration of the legal and public health considerations of providing mental health care to offenders, while maintaining professional boundaries, and respect for the patient’s dignity, autonomy, cultural beliefs, privacy, and confidentiality (ANA, 2004; Weiskopf).

It is a challenge to care for offender populations, who have committed crimes against society in which the PMHNP is a part of, to turn a life around in spite of the patient’s past and present behaviors (Goldkuhle, 1999). Because a history of alcohol and drug use is so prevalent among the prison population and in common with particular offenses, it is essential to address addictive behaviors during incarceration. Failure to capitalize on opportunities to treat substance abuse or communicable diseases imposes risk to offenders, communities, and public safety upon re-entry (Anno, 2001; Re-entry Policy Council, 2004). The PMHNP is bound by the Code of Ethics for Nurses with Interpretive Statements (ANA, 2001) to deliver ethical care. Correctional health work requires patience and perseverance, to be non-judgmental, compassionate, respectful of the patients as human beings, and treatment as such, undaunted by the circumstances
surrounding corrections, to help them recognize their intrinsic value and worth in society (ANA, 2004; Weiskopf, 2005).

The U.S. health care delivery system, the rate of incarcerating, and the fact that offenders have substantial health needs has created a crisis in correctional health care (Anno, 2001). Correctional health care costs account for 3.7 billion or ten percent of all state correctional costs (Council of State Governments, n.d.). Correctional health care costs have escalated and health administrators are being pressured by funding agencies and their own correctional administrators to control and reduce expenditures, although controlling costs is warranted because increases were necessary initially to bring the standards of health care delivery up to acceptable minimums (Anno). The primary goal of correctional health care is to provide quality care, on a timely basis, in a cost effective manner. The most widely accepted health care policy is to provide offenders with community standards of care, or “medically necessary” treatment. Two driving forces behind correctional health care are the offenders’ constitutional right to health care services and legal suits are costly for state and federal budgets (Council of State Governments).

According to the Human Rights Watch report (Abramsky & Feliner, 2003) many correctional health care systems continue to be deficient, crippled by understaffing, insufficient facilities, and limited programs. Expenditure of staff represents the biggest portion of most health care budgets. Correctional health has assumed much importance in the past few years due to court involvement. Medical malpractice and professional legal costs demand services to be professional and meet acceptable standards of practice. Improved efficiency can be accomplished by managed care techniques as exampled by
communities to control costs through utilization of case management practices (Anno, 2001). A demand for the provision of effective, efficient, timely services for underserved populations in accessible community settings has drawn attention to the advanced practice psychiatric mental health nurse as an ideal provider. Easily accessed, safe and high quality mental health care is difficult for many to secure and the PMHNP with their scope of practice is critical in addressing these gaps in services (Staten et al., 2005).

The PMHNP practices in the case manager role by supporting the patient’s highest level of functioning through interventions to enhance self sufficiency. The PMHNP uses population-specific nursing knowledge and research, knowledge of the legal system, and expertise in supportive psychotherapy to obtain services needed for the patient. Case management services are based on a comprehensive approach, in terms of the patient’s needs, resources, and cost-effectiveness of care (ANA, 2000). Interventions identified for successful re-entry include risk assessment, supportive counseling, problem solving, teaching, medication management, and comprehensive care planning (Re-entry Policy Council, 2004). These interventions are mirrored in the advanced psychiatric nursing case management practices resulting in mobilization of therapeutic resources, maximization of positive outcomes of safety, reduced recidivism, and cost-effective savings for the public tax payer (ANA, 2000; Re-entry Policy Council).

Different organizational models of health service delivery are used within our nations’ jail and prison systems. Health service delivery programs for staffing in jails and prisons may hire their own employees, contract to private for-profit vendors, to a public health department or university, or a combination of the above (Anno, 2001). Regardless of who provides services the government agencies are responsible for services
provided. Whether a PMHNP is employed by the government agency or contractual agreement, organizational issues such as practice privileges, collaborative practice agreements, placement of the PMHNP within the organization, supervisory issues, and authority and accountability need to be addressed (Hamric & Hanson, 2003).

Psychiatric mental health nursing practice requires a coordinated ongoing interaction between patients and clinicians to deliver comprehensive services (ANA, 2000). The PMHNP as part of a multidisciplinary effort identifies the needs assessment of the mentally ill offender and participates in developing a comprehensive plan of correctional programming. Collaboration between administration, social services, counselors, employment agencies, and education systems is an integral part of managing the service needs of the mentally ill offender (Re-entry Policy Council, 2004). As part of the health care delivery service team the PMHNP manages acute and chronic mental health and psychiatric disorders and has knowledge of medical disorders to develop a differential diagnosis or evaluation of co-morbidities. It is crucial the PMHNP possess skills to assess and diagnose common medical problems and refer them appropriately when needed due to the complexities of psychiatric disorders and co-morbidities, especially within the prison system (Wheeler & Haber, 2004).

Supportive professional relationships are essential for correctional employees surrounded by an unpredictable environment, exacerbated by dysfunctional behavior and poor adaptation by inmates with mental disorders. The health needs of the offender population have high visibility within the correctional environment and can be a source of negative attitudes contributing to unrest amongst the offenders. Untimely response, perceptions of uncaring attitudes of health staff, or frustration with unmet needs can
result in offender control problems for custody staff (Anno, 2001). Understanding the worldviews of custody and nursing are important for creating effective communication and maintaining a safe environment for staff and offenders in which to live and work (Schlosser, 2006).

Although custody is more exposed to the violent and aggressive side of corrections, the PMHNP will encounter mentally ill offenders with psychopathological histories of acute violence and aggression who have suffered deprived and abusive childhoods in which multidisciplinary work is particularly important in correctional psychiatry (McGauley & Campbell, 2004). Professional boundaries must be identified between custody and correctional nursing, but collaboration is essential. PMHNPs must adhere to prison rules, be able to function positively and confidently with custody staff within a secure environment, and in a manner that does not place themselves or others at risk. Professional boundaries must be maintained while developing therapeutic relationships with mentally ill offenders (Smith, 2005).

Therapy improves behaviors, in turn, helps custody maintain order. Custody is instrumental in identifying abnormalities of behaviors within the correctional population. They have frontline insight into sleep patterns, appetite, energy levels, social interactions, and significant changes in baseline behaviors (Schlosser, 2006). They are invested in advancing their knowledge of the incarcerated population by including education in chronic and infectious diseases, mental illness, addictions, and suicide prevention (Anno, 2001). Even the offenders have an investment in the safety and orderly fashion of the way an institution is run. When facilities are safe and secure, less anxiety is felt and more pro-social behavioral changes are made, where as offenders, are less willing to
attempt pro-social changes in antisocial settings (Schlosser). The nursing profession works in partnership with custody to provide medical and mental health services to confined individuals (ANA, 2004). Although mental health providers may be the only employees hired to work in therapeutic relationships with offenders, everyone who works in corrections is part of the mental health team (Schlosser).

Correctional nurse researchers are concerned with the limited educational and training opportunities for all level of nursing students within correctional health care (Mason, 2002). Education in correctional health is urgently needed to shift the professional isolation of practice to a community-based health service with links of multifaceted health and judicial programs. Neither medical nor nursing schools have made a commitment to develop a broad-based understanding of health-related issues surrounding crime, including health risks and needs of the offenders, victims of crime, or the influences on their families (Goldkuhle, 1999). The PMHNP collaborates with others in the research process and uses the best available evidence to develop comprehensive care planning, interventions, and anticipates expected outcomes in managing the health of this vulnerable population (ANA, 2004).

It is important to monitor the legislative changes related to the PMHNP and their practice in regards to maintaining the ability to provide accessible, safe, and high-quality care while optimizing the contributions the PMHNP can make to the delivery of mental health (Staten et al., 2005). As an advanced practice nurse it is imperative for the PMHNP to be involved in political action structures that deal with policy issues that constrain advanced practice at local, state, and federal levels (Hamric & Hanson, 2003).
Membership in professional organizations such as the American Nurses Association, the American Psychiatric Nurses Association, the American Correctional Association, the National Commission on Correctional Health Care, or the International Association of Forensic Nurses, can assist the PMHNP to keep informed on current trends in advanced practice, certification and regulatory issues, political forces that affect their practice, educational opportunities for advanced practice nursing or patient wellness, and the development of supportive networks.

The role of the PMHNP is gaining visibility within correctional mental health care, although correctional nursing continues to be illusive within statistical reporting and there is a paucity of nursing research (ANA, 2004). The public and other nursing professionals are unaware of the challenges encountered by correctional nurses or their accomplishments. Correctional nurses must become aware of the limits they are imposing upon themselves (Goldkuhle, 1999). By publishing their knowledge and experiences within correctional health, they promote themselves as a valid and credible organization worthy of the recognition and respect they deserve. As the development of the PMHNP continues to evolve, strategies are necessary for negotiating their roles within the complexities of the health care delivery system. Communicating the role of the practitioner, collaboration with key colleagues and correctional administration, partaking of leadership responsibilities, participation on research committees, and demonstration of commitment to policies and practices that support advanced nursing practice help promote the role of the PMHNP in the field of corrections (Bryant-Lukosius & DiCenso, 2004).
According to Beck and Maruschak (2001) a staggering 41% of all inmates released from jails and prisons are incarcerated within three years. Lack of access to outpatient treatment and adequate community support are two of the factors cited as causes of the mentally ill individuals entering the criminal justice system. The mentally ill offender may be stigmatized by their history of arrest, substance abuse, homelessness, and non-compliance and be seen as a “problem patient” or as “treatment resistant” by community healthcare and residential service staff. Community mental health centers often lack the capacity to provide assertive community treatment centers or intensive outreach programs that are necessary to promote engagement in outpatient services (Weisman, Lamberti, & Price, 2004).

Bridging or re-entry into the free world is a major challenge to the correctional system. The PMHNP has a responsibility to assist individuals to interpret their environment, define role behaviors, and determine how to maintain wellness within the correctional environment. As they become eligible for release, inappropriate health maintenance behaviors acquired to survive in the correctional environment need to be identified to assist in transitioning into the community. The PMHNP advocates for mentally ill offenders by encouraging the development of special intermediate treatment units, facilitating collaboration between corrections and community health systems to access supportive services and identify effective substance abuse treatment programs to provide continuity of care after release (Yurkovich & Smyer, 2000).

Nursing represents the largest group of health care professionals practicing in correctional health care and clearly has a significant role to play in influencing the mental health and well being within the correctional health care environment. Nursing is the
backbone of correctional health and the PMHNP provides leadership in the coordination of multidisciplinary health care and synthesizes data to prescribe necessary systems and community support measures, in collaboration with administrators, educators, researchers, and policymakers, to work together to seize opportunities to build bridges between the public and private health sectors in the community (ANA, 2004; Goldkuhle, 1999; Peternelj-Taylor, 2005). This serious realization of our population, about 4 million, is stimulus enough to strengthen collaborative efforts between correctional health nurses, public health, and educators, so we may assume leadership and management of the correctional population (Goldkuhle).
ADVANCE PRACTICE NURSING

The PMHNP plans and implements services to meet the mentally ill offenders’ complex psychiatric problems and needs for a stable emotional and social support system through a depth of theory, knowledge, and advanced clinical nursing skills. The PMHNP applies critical thinking to guide psychiatric practice and other health care personnel (ANA, 2000, 2004). He or she is professionally qualified to practice autonomously and is accountable for their practice independent of other disciplines (ANA, 2000). Although there may be tension surrounding inter-professional politics between advance practice nursing and physicians, the impetus to develop heath-care teams, spurred by population-based health and increased chronic illness burden, require varied expertise in order to deliver effective and efficient care (Johnson & Paulson, 2005). The PMHNP collaborates as a member of the interdisciplinary mental health team and provides consultation to health care providers to enhance quality and cost effective services for patients (NONPF, 2002, 2003). Psychiatric advanced practice nursing includes the complete delivery of direct primary mental health care activities (ANA, 2000, 2004).

Professional organizations provide guidelines for delivering services within correctional institutions and are not to be mistaken for mandatory services. Court ruled minimum requirements for mental health services in correctional settings as cited in NCCHC (2003) must include:

- Screening and evaluation to identify those needing mental health care;
- A treatment plan for identified problems;
- Qualified mental health staff sufficient to treat the population;
• A health records system;
• A suicide prevention and treatment program; and,
• The appropriate use of behavior-altering medications

For the purpose of this paper the National Commission on Correctional Health Care’s, *Correctional Mental Health Care Standards & Guidelines for Delivering Services* (2003) has been utilized to guide the professional responsibilities of the correctional health care delivery system and the clinical duties of the midlevel provider or the psychiatric mental health nurse practitioner. Direct clinical practice by the PMHNP incorporates scientific knowledge from other disciplines into practice management and evaluates the mental health care that is provided through a comprehensive quality assurance system (ANA, 2000, 2004). Clinical practice is the hallmark of advanced practice nursing (Brown 1998; Johnson & Paulson, 2005). Practice areas include services provided in jails, juvenile detention facilities, forensic psychiatric hospitals, and correctional institutions with outpatient clinics and inpatient infirmaries (Judy Erickson, Advanced Psychiatric Nurse Practitioner, personal communication, August 2006).

All offenders receive mental health screening, with an evaluation for a positive screen upon admission to a correctional facility, for the essential detection and diagnosis of mental illness. Identification of mentally ill offenders with serious mental health needs, including developmental disabled and/or addictions, prevents deterioration and ensures they receive treatment as soon as possible. Early identification of mental health needs can prevent unnecessary human suffering, suicidal and violent behaviors. A history of suicidal behavior and offenders’ behaviors are examined, along with the potential for substance abuse withdrawal. In jail settings suicides occur within the first
48 hours after incarceration and the majority involves the influence of alcohol or drugs (NCCHC, 2003) The PMHNP provides health promotion and disease prevention, provides anticipatory guidance and counseling to reduce risk factors, and follows up appropriately. He or she recognizes environmental factors affecting patients and provides interventions and referrals to promote healthy environments (NONPF, 2002, 2003).

Comprehensive health assessments and exams are performed on all offenders after arrival to the institution. Early detection of mental illness decreases health care costs (NCCHC, 2003). The PMHNP performs a comprehensive psychiatric evaluation which includes: Interpretation of the history; evaluation of mental status; assessment of symptoms and physical findings; evaluation of diagnostic information; and through critical analysis and diagnostic reasoning skills, develops appropriate differential diagnoses. The PMHNP will prioritize the health problems and intervene appropriately to emergency care if needed and or employ appropriate diagnostic and therapeutic interventions with attention to safety, cost, invasiveness, and acceptability (NONPF, 2002, 2003). The PMHNP completes a nursing diagnoses based on the North American Nursing Diagnosis Association (NANDA) taxonomy and the medical diagnoses in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV).

All offenders have the opportunity to request daily to be seen. Sick call is conducted on a timely basis and in a clinical setting. Special care is needed for mentally ill offenders with a serious mental illness in a correctional setting. Individual treatment plans are required for mentally ill offenders with basic psychotic disorders or mood disorders, self-mutilators, the aggressive mentally ill and suicidal offenders. Alcohol and
other substance abuse disorders may be another condition that warrants individual
treatment planning. For patients with co-occurring mental health and substance abuse
disorders, integrated treatment planning to address both disorders is recommended.
Treatment plans are individualized, typically multidisciplinary, based on an assessment of
the patient’s needs, with goals and methods to achieve desired outcomes, inclusive of
cultural preferences. A range of supportive and rehabilitative services may be necessary
for referral (NCCHC, 2003).

The PMHNP develops an ongoing treatment plan which focuses on the patient’s
goals and outcomes to manage their mental health concerns. He or she diagnoses and
manages acute and chronic conditions and the patient’s response to the illness experience
by using a follow up system to ensure that patients receive appropriate services. The
PMHNP assess for a patient’s unstable and complex health care problems through
collaboration and consultation with the multidisciplinary health care team and initiates
referral when the problem exceeds the nurse practitioner’s scope of practice or expertise.
The PMHNP implements diagnostic strategies and therapeutic interventions and performs
psychopharmacology interventions which include the prescribing of psychoactive
medications, intentionally seeking specific therapeutic responses, and observes for side
effects or adverse drug reactions. The PMHNP participates in various forms of
psychotherapy with the mentally ill offender for the explicit purpose of effecting
negotiated outcomes that are intended to alleviate emotional distress, reverse or change

Infirmary care is provided to mentally ill offenders with an illness or psychiatric
disorder that requires daily monitoring, medication or therapy. Supervision is provided
by mental health clinicians for aggressive therapeutic intervention, but not limited to, the use of appropriate medications when indicated, individual and group therapies, and psychosocial activities. The goal is to stabilize conditions and improve activities of daily living. Documentation and discharge planning is initiated pending release (NCCHC, 2003). The PMHNP differentiates between exacerbation and reoccurrence of a chronic psychiatric disorder or medical disorder and coordinates treatment as necessary. He or she continuously evaluates the risk of danger to self or others, and secures restrictive environments for ensuring safety (NCCHC, 2002; NONPF, 2003). If a mentally ill offender is housed in segregation, arrangements are made for mental health care in appropriate clinical settings (NCCHC, 2003).

The PMHNP participates in the health emergencies specific to mental health as well as general disasters and major incidents. The PMHNP works closely with the medical health team as a valuable resource by virtue of their experience to respond to emergency situations (NCCHC, 2003). As part of a correctional facility the PMHNP may function on the Critical Incident Stress Management debriefing team that intervenes through supportive and educational service after such incidences as hostage, post riotous situation, death or serious injury, use of lethal force, involvement or witnessing of an inmate death, suicide, attempted suicide of an inmate, or staff member (Fix, 2001).

Offenders with psychiatric disorders should be referred to follow-up clinics or community assistance programs. Referral to community services that protect behavioral change and programs such as Alcoholics Anonymous, Double Trouble, should be a high priority. Collaboration with correctional and parole assists with effective releases and appropriate placements (NCCHC, 2003). The PMHNP participates in community and
population-focused programs that promote mental health and reduce risks of psychiatric
disorders. He or she coordinates care among mental health care settings and community
agencies to provide continuity, by referrals to other health care professions and

Health education is offered to all offenders to empower them to manage their own
illness, gain better control over their lives by learning coping mechanisms, and to keep
their symptoms under control to reduce stress (NCCHC, 2003). The PMHNP assesses
the patient's on-going and changing needs for guidance associated with growth and
developmental stages. He or she assesses the mentally ill offender's motivation, ability,
learning style, and cultural influences and creates an environment in which effective
learning can take place. Areas of education important in the correctional environment
include stress management, coping with mental illness, anger management, conflict
negotiation, psychotropic medication use and side effects, and coping with life in prison
(NCCHC, 2003). The PMHNP provides psycho-education to promote knowledge,
understanding, and effective management of mental health and psychiatric disorders
OUTCOMES

The PMHNP engages and collaborates with others in the research process to discover best approaches to practice. The research data presented is utilized to develop plans of care, interventions, and expected outcomes (ANA, 2000). An outcome is defined as the changes in functioning, morbidity, or mortality that resulted from the relation to the input or resources put into the health care system and the process or intervention delivered by personnel in the system (Repper & Brooker, 1997). Outcome evaluation and management is an accountability strategy toward balancing quality and cost of clinical health care that demonstrates efficacy and legitimacy for psychiatric-mental health nursing practice (American Psychiatric Nurses Association, 1998). The PMHNP contributes to nursing knowledge by conducting or synthesizing research that examines and evaluates knowledge, theories, and criteria, to improve healthcare. He or she disseminates research findings through activities such as presentations, publications and consultations (ANA, 2004). In relation to Brown’s Framework (1998), outcomes are consequences to individual patients, to the health care systems, to the profession, and to individual advanced nursing practitioners.

Evidence-based health care is essential and called for (US Department of Health and Human Services [US DHHS], 1999) in the delivery of mental health services. The Healthy People 2010 report (US DHHS, 2000) addresses the need to increase treatment for mentally ill persons in juvenile justice facilities and jails. In a study by Peter D. Hart (2002) the American public now favors addressing the causes of crime over strict sentencing by a two to one margin. Thirty seven percent agreed that prevention should be the highest priority and together prevention and rehabilitation (54%) garner far more
support than do approaches of punishment and enforcement (39%). Offenders through education may become personally responsible for health maintenance, disease prevention, medication management, and dietary intake, improving wellness and reducing health care costs (Anno, 2001).

At some point in an offender's life, we can assume that he or she was considered healthy. From their background histories, some type of trauma event(s) occurred: physical, biological, emotional, psychological, social, spiritual, or other unknown factors that led to behavior(s) in which they disconnected from the communities' values and norms (Goldkuhle, 1999). Goldkuhle calls this the health-trauma cycle in which the crime/disease process began. The consequences for some were incarceration or criminal behaviors that become a way of life in which destruction of self, others or the health of the community was affected. The goal of nursing within correctional health is to close the health trauma cycle, restoring the offender's health, and the offender to an integrated whole person within the community. The PMHNP accomplishes this through: Identification of the problem; participating in data collection; collaboration with other members of the research team; analyzing and interpreting research for application to practice; using research findings in the development of policies/procedures and standards of practice in patient care; and incorporating research as a basis for learning. The PMHNP applies research skills and knowledge to utilize best available evidence to guide practice (ANA, 2004).

A substantial body of literature exits for the role of the nurse practitioner outside of mental health. Research directed towards consumer satisfaction suggests that care provided is at least equal to care provided by a medical practitioner. Although advanced
Psychiatric nurse practitioners are becoming more visible in the mental health field, there still exits a paucity of research examining outcomes of the role of the advanced psychiatric nurse practitioner (Baradell & Bordeaux, 2001; Puskar & Bernado, 2002; Wortans, Happell, & Johnstone, 2006). Nurses must be able to define and measure their contributions, maximizing their resources toward the improvement in the health of the population (Repper & Brooker, 1998). In a study by Wortans et al. the role of the psychiatric nurse practitioner candidate on a Crisis, Assessment and Treatment Team, measuring the quality of services provided, the findings supported consumer satisfaction provided by the nurse practitioner as high. The study highlighted communication, relationship, longer consultations, and provision of information as beneficial and enhanced their perception of the quality of care and treatment they received (Wortans et al.). More research is called for to assess positive clinical outcomes associated with the PMHNP in correctional mental health regarding effects on infirmary admissions and lengths of stay, stabilization of symptoms, improved socialization and coping skills, decreased suicide rates, and overall cost-effective care.

Psychiatric mental health nurses are a specialty group with unique contributions that provide collaborative, integrative and multi-level clinical care service delivery (American Psychiatric Nurses Association, 1998). The involvement of the American Nurses Association and other professional organizations has done much to elevate the qualifications and professionalism of the practitioners who work in correctional health (ANA, 2004; Anno, 2001). However, advance practice nurses in psychiatric mental health nursing may be missing opportunities to take a leadership role. Clinical leadership by advanced practice nurses in today’s health care climate is essential to provide
direction for administration since their expertise in direct patient care and their interactions with patients along the continuum of care are invaluable for redesigning care delivery (Nevidjon & Knudston, 2005).

As advocates and leaders for the needs of individuals with psychiatric disorders the PMHNP can improve health outcomes by influencing health policy through lobbying efforts that support the mentally ill offender to reduce the stigma on services for the prevention and treatment of this vulnerable population. It is dangerous to reduce costs without having a commitment to improve quality. Adequate health care must be provided by all Department of Corrections by making the health care delivery systems more efficient (Anno, 2001). Individual outcomes for the PMHNP will be improved through active participation in consultation, collaboration, continuing education, certification, and evaluation. By monitoring one’s own practice as well as engaging in interdisciplinary peer review and utilizing relevant research to improve the quality of care, the PMHNP becomes a valuable and integral part of the mental health care delivery system (NONPF, 2003).

In preparation of future nursing staff, correctional nurse educators must set up partnerships with academic institutions and department of corrections to establish student placement (Weiskopf, 2005). Access to care is a major concern for the mentally ill offender. As a policy response to assess problems for those in rural and underserved areas the role of the advance practice nurse has evolved. The Department of Health and Human Services’ Division of Nursing, which implements the funds appropriated by Congress to support nursing education and special projects through Title VIII of the Nurse Practice Act (Johnson & Paulson, 2005) needs to support educational endeavors to
promote the role of the PMHNP as a viable and credible candidate for this underserved population.

Educational and training guidelines may include effective ways of interacting with mentally ill offenders; ways to develop therapeutic relationships that maintain safety, security and the importance of maintaining professional identity that is treatment oriented; the development of ethical caring models to delineate the boundaries of nurse and offender clinical relationships; education as to the legal implications of professional and autonomous correctional nursing practice; scope of practice issues; and education to provide nurses with skills needed to objectively assess the real needs of offender populations versus malingering (Smith, 2005). These areas of research can improve outcomes for correctional nurses and ultimately patient care.

The PMHNP needs to share information and personal knowledge about their experience working with the mentally ill offender in correctional health care. Qualitative research is called for to identify themes related to the role development of the PMHNP in correctional health and further quantitative research to validate the findings. It is clear there is a paucity of journal articles by correctional nurses compared to the volume of work published in other specialties. Publishing provides opportunities for peer review to exercise scrutiny of practice for credibility and viability (Evans & Wells, 2001). With the recent advances in the advanced psychiatric nurse practitioner role, and abundance of evidence that nurse practitioners have been successful in other areas of the nursing arena, it is surprising so little research exits in the advanced psychiatric nursing field. It is crucial this issue be addressed (Wortans et al., 2006).
SUMMARY

The most devastating crisis affecting corrections today is the ever-increasing numbers of mentally ill offenders. The war on crime, drugs, fixed sentences, mandatory sentencing, reduce use of alternatives and abandonment of early release has resulted in the explosion (Anno, 2001). Today’s inmates are older, sicker, and remain imprisoned longer (ANA, 2004). The mentally ill have long been among the most vulnerable and underserved population. Psychiatric patients, especially those with psychotic symptoms are often so impaired by their illness they are incapable of seeking treatment (Bjorklund 2003; Puskar & Bernardo, 2002). Prisons and juvenile detention centers, by default, have become repositories for individuals with mental illnesses (Peternelj-Taylor, 2005).

The focus on improving correctional health care began in the 1960s and is credited to the legal system and the health professional themselves. Much remains to be accomplished and in some areas correctional health care is still 20-30 years behind its community counterparts (Anno, 2001). Adopting a mental health promotion strategy in correctional environments is frayed with challenges. Mental health initiatives should be a primary concern when one considers the diversity of health challenges and marginalized status of the mentally ill offender (Perternelj-Taylor, 2005). Team work between mental health, security, classification, medical staff, and legal departments is needed. Offering treatment to mentally ill offenders promotes the core mission in corrections which is public safety and less violence directed toward staff and other offenders, ultimately creating a reduction in recidivism and improvement for communities (Aufderheide & Brown, 2005; Maue, 2001). The care and treatment the mentally ill offender receives
reflects the professionalism of the organizations that have set standards to delivery quality services and by the hallmarks of a civilized society (Anno).

The lived experience of nurses working in correctional health is both complex and conflicting. The environment is restrictive and different from other health care areas in which nurses walk a tightrope between providing therapeutic treatment and providing a secure environment. Despite the odds, nurses manage to establish caring relationships in which offenders are treated as human beings, with dignity and respect (Weiskopf, 2005). The emerging role of the PMHNP has gained momentum over the last ten years (Wheeler & Haber, 2004) and is a valuable asset to the correctional mental health delivery system. Advanced practice nursing is different from nursing and medical practice even when the advanced practice nurse is providing services similar to either of the two groups. The advanced practice nurse subsumes a variety of health care functions within larger environments that produce identifiable outcomes toward a more effective, humanistic and efficient health delivery system (Brown, 1998).

In a rapidly evolving industry, continually adjusting to changes in public opinion and shifts in judiciary rulings and legislatives mandates, administrators must be mindful of the mentally ill offender and the services they require (Aufderheide & Brown 2005). Judy Erickson who works as a PMHNP in corrections sums it up quite nicely:

Although legislatures and the public are becoming more aware of consequences of the mentally ill offender within the criminal justice system, it is time we stop warehousing this population and develop rehabilitative programs that focus on mental health treatment. The mentally ill offender has difficulties coping in the general prison population and some may need specialized psychiatric facilities or housing within institutions that identify and treat the needs of their serious psychiatric disorders. Others need qualified staff to address their issues while incarcerated that will teach them coping mechanisms, give them insight to their disease process, reunite them with support systems in the community, and reduce the revolving door syndrome that is so often recognized in the current system.
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