INTERNATIONAL ASSOCIATION OF FORENSIC MENTAL HEALTH SERVICES

NEWSLETTER

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Photo by Peter Miller

Spring Edition Features

Letter from the Editor

Dear members of the IAFMHS community,

Welcome to the spring edition of the IAFMHS Newsletter. We hope it finds you all well in your various corners of the globe. COVID-19 has dramatically changed our professional and personal lives, and this issue aims to reflect upon these changes and share a new initiative in which international forensic mental health directives and policies relating to COVID-19 are being synthesized and compiled. Moreover, while the conference is cancelled, this issue contains information on how we plan to reschedule for 2021.

It is also with sadness that I announce my departure from the position of Newsletter Editor. It has been my pleasure to serve the IAFMHS community in this capacity. I have learned so much from working with the many scholars and professionals that contribute to this newsletter, and I look forward to continuing to collaborate with you all in other forums.

As always, we would like to encourage members of IAFMHS to submit content to the newsletter. Furthermore, we are currently soliciting applications for the new editor of the Newsletter. Please feel free to reach out with comments or questions.

Alicia Nijdam-Jones, Editor

SPRING UPDATE

IAFMHS President Anne Crocker

Dear Colleagues,

I hope this Newsletter finds you healthy and safe. This editorial was meant to address preparations for our annual conference in Krakow, Poland, the 20th anniversary celebrations, the great schedule of talks and workshops that was being put together and beautiful and historic places to discover in Poland. As with many other events and conferences, we were faced with the inevitable decision to cancel. However, with the collaboration of the local organising committees for the 2020 and 2021 conferences as well as the Association's Board of Directors and Student Board, we were able to reschedule Krakow for the 2021 conference and Sydney, Australia for 2022. Many thanks to our past president Professor Barry Rosenfeld for all of his legwork on this, from his locked down apartment building in New York City. We will keep monitoring the situation closely over the next few months and continue to keep our forensic mental health community appraised. I also wish to thank Inga Markiewicz the chair of the Krakow LOC for her availability and willingness to stay on to chair for next year. Finally, our appreciate goes out to our chair and co-chair of the scientific program committee, Dr. Michael Martin and Dr. Yanick Charette for the work they put into to the call for submissions and review process. Yanick will be taking over as chair for next year, with our colleague Dr. Ashley Dunn from Australia as co-chair.

With Covid-19, our lives have dramatically changed and the future still holds many uncertainties. We have seen tremendous examples of community solidarity, heroic work from our healthcare workers around the globe, creativity and community engagement from many businesses – even Gaia seems to be breathing better these days. Coronavirus is keeping us contained in our homes, changing our relationships with each other and to our outside world. This pandemic is truly testing global resilience, capacity to creatively reorganise and adapt. It is also as well as directing our attention to the importance of questioning our current state of affairs at the social, healthcare, economic and environmental levels alike. Maybe this crisis will also present opportunities to adopt change for the better?

Anne Crocker, PhD

Director, Research & Academics, Institut national de psychiatrie légale Philippe-Pinel; Professor, Department of Psychiatry, Université de Montréal

Coronavirus will inevitably change the world. It has certainly strongly affected the lives of persons with mental illness who are already confined in institutional settings. What the medium and long-term practices and effects will be are of course unknown. A few weeks ago, we sent out a call to IAFMHS members to share their experiences, policies, practices regarding the management of this pandemic in relation to justice-involved person with mental illness. Many of you have generously sent along important documentation to share with the community that we have attempted to collate in a living compendium of some sorts, available here (also see the summary on page 3 of this edition). Please continue to send along your comments, suggestions and further documentation on policies, practices, and research so we can keep this resource document alive and evolving for the benefit of all. My deepest thanks to Dr. Ashley Lemieux and Jean-Philippe Gagnon, M.A. (Philippe-Pinel Institute in Montreal), Tamara De Beuf (PhD candidate, Maastricht University, Netherlands & senior communications officer, IAFMHS Student Board), and Dr. Tonia Nicholls, (BCMHSUS, University of British Columbia, Canada & Editor of the IJFMH) for their hard work in helping put this together!

Again, maybe some innovations for forensic mental health services will emerge from this crisis. Many researchers have had to reorient some of their work to addressing COVID-related issues in our field. We have been hearing about many great research initiatives around the world and would like to invite you to share these, if you wish, with the global community to better understand the effects of this situation for persons with lived experience of mental illness on longer-term practices and measures and maybe be better prepared for future global crises situations. Again, you can do so by emailing iafmhs@sfu.ca.

Editorial Team

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Marichelle Leclair, *Editorial Assistant*, Université de Montréal (CAN)

PRESIDENT UPDATE

Other IAFMHS News

I would also like to take this opportunity to congratulate our Spring 2020 Derek Eaves Research grants awardees: Anthony Battaglia, BA (Hons), York University, Canada, *Towards a Social-Cognitive Understanding of Aggression Perpetrated by Forensic Psychiatric Patients* (Dr. Mini Mamak, supervisor) & Jennifer Krentz, BA (Hons), Simon Fraser University, Canada, *Risk Factors and Protective Factors for NCRMD Patients: Has Clinical Practice Kept Pace with Evidence-Based Practice?* (Dr Tonia Nicholls & Dr Ron Roesch, supervisors). Anthony and Jennifer received a $500 CA research grant. Congratulations to both! The next call for proposals will be for October 31st, keep a look out!

Newsletter – Call for Editor!

After 3 years and doing a tremendous job, Alicia Nijdam-Jones, will be editing her last IAFMHS Newsletter. Alicia has generously accepted to coach the next person for the summer edition. Furthermore, our efficient editorial assistant (Marichelle Leclair, Université de Montréal) is there to help! We are therefore seeking candidates to fill this position quickly. Please see the call for details on page 6, this is a great experience for upper graduates and early career professionals to develop networks and stay appraised of what is happening in forensic mental health internationally. In times like these, it is all-the-more important to stay in touch and keep communications available in the association, so we strongly encourage anyone interested in contributing to come forward (iafmhs@sfu.ca).

Member at Large - Board of Directors - Call for Nominations!

The Association is seeking nominations for 2 positions as Member at Large on the Board of Directors (see page 16 for a description). This is a three-year term and candidates must be members in good standing. It involves a few meetings a year and potential work groups related to conferences, awards, newsletter, membership etc. This is a great opportunity to get directly involved in shaping the Association's future!

We are also currently exploring the possibility of setting up online talks and panels for the IAMFHS community. We are planning on setting one up on the COVID-19 theme in forensic mental health services in line with the resource document that is being put together. If you have suggestions of themes you would like to see addressed and if you would like to be involved in helping organise such activities, do contact us!

On that note, I wish you good physical and mental health and let us know what is happening in your region!

Anne Crocker. IAFMHS President

Addressing the COVID-19 Pandemic Among Justice Involved Persons with Mental Illness

This initiative aims to compile and synthesize directives and policies that have been implemented in forensic mental health settings around the globe in response to the COVID-19 pandemic. In collaboration with our international community, we are gathering policies, procedures, legislation, and research that covers the field's response to COVID-19.

More specifically, this initiative is focusing on the following issues:

- Legislative or justice procedure changes (mental health act changes, tele-psychiatry, tele-court appearances, changes in review board hearings etc.)
- Changes in institutional practices (visits, hygiene, restrictions, staff to patient ratios, kitchen, clinical practices and activities, screening etc.)
- Empirical studies, reviews, and opinion pieces
- Information watches (e.g., agencies/websites providing rapidly updated forensic information related to COVID-19)

Over 70 resources have been documented to date and many more are waiting in our mailboxes to be processed. Nevertheless, we are soliciting additional resources, in particular from countries situated in the Middle-East; (Southeast) Asia; South-America; & Northern, eastern, and southern Europe.

We need your help to further strengthen this compendium! Please, share your information with us via this form or let us know what information you are looking for via this information request form.

The document will be shared on our IAFMHS COVID-19 webpage, as we try to keep our field informed on the global reaction to COVID-19 in forensic mental health services. Updates will be share regularly via our social media accounts: Twitter, Facebook, and LinkedIn.

STAY TUNED!

IAFMHS and the Safety, Justice and Mental Health Technology Assessment Unit (Philippe-Pinel Forensic psychiatric Institute)

Do you want to be part of this project?

Email us at ashley.lemieux.pinel@ssss.gouv.qc.ca to learn ways to become involved!

INTERNATIONAL FORENSIC MENTAL HEALTH SERVICES HIGHLIGHT

FORENSIC MENTAL HEALTH SYSTEM IN POLAND

Inga Markiewicz, MA

Forensic Psychiatry Clinic of IPiN, Warsaw; Member of the Psychiatric Board for Preventive Measures at the Ministry of Health, Poland

Historical note

Polish forensic psychiatry has a long tradition. Its origins date back to 1580, when the Third Lithuanian Statute of King Sigismund the Old introduced the question of the responsibility of “insane” perpetrators of murders and bodily injuries, recognising their impunity. As early as 1932, the penal code was amended to include the legal concept of "diminished responsibility" and so-called "precautionary measures" to treat and isolate people who had committed crimes and were found both with mental illness and dangerous. Specialized medical secure facilities were created to receive this population. Already at that time, attention was drawn to the importance of psychiatric opinion in the application of these measures and the need to provide care after leaving the hospital.

In the post-war period, Polish forensic psychiatry emerged unscathed from the attempt to subordinate it to the political influence of communist doctrine. Unlike in some socialist countries, no reports suggested that the forensic psychiatric system was used to repress political opponents under the guise of alleged mental illness.

The forensic psychiatric system was further developed in parallel of the development of the post-war state. Political changes entailed law reforms, which in turn determined healthcare reforms. The dates and events that had the greatest influence on the shape of today's forensic system in Poland include:

1) 1951 - the establishment of the Forensic Psychiatry Clinic at the Institute of Psychiatry and Neurology in Warsaw as a scientific and research unit dealing with the issues of forensic psychiatry

2) 1989 - the Round Table deliberations, the fall of the communist doctrine and the development of the democratisation of the state

3) The reorganisation of the healthcare system, increased availability of modern diagnostic and treatment methods, advocacy for community psychiatry

4) The introduction of control bodies and organisations representing patients' interests, including the institution of the Patient Ombudsman

5) 1994 - adopting, as one of the first countries in Europe, the Mental Health Protection Act, which introduced new solutions to protect people with mental disorders

At the beginning of the 1990s, Poland opened up to new solutions resulting from closer cooperation with other Western European countries (mainly Germany and the Netherlands), where the forensic psychiatry system was already more developed. Training cooperation was established with Westfalisches Zentrum für Forensiche Psychiatrie, Van Hoeven Clinic, and Veldzicht, among others. Also, joint scientific conferences were organised to exchange experiences, which continues to this day.

INTERNATIONAL FORENSIC MENTAL HEALTH SERVICES HIGHLIGHT

The 1990s and the first years of 2000 were also a period where several changes were brought to the criminal law. Provisions regarding precautionary measures were amended, special forensic wards and separate hospitals were established to treat persons with mental illness who had committed the most serious prohibited acts. At that time, a 3-stage model of forensic psychiatry facilities was also developed, with wards of minimum, enhanced and maximum security.

Forensic Psychiatry in Poland - Current Status

The forensic psychiatry system in Poland is responsible for several aspects, including providing forensic and psychiatric opinions and providing both secure and outpatient treatment for justice-involved people with mental illness.

Legal opinion in criminal matters

Judgement on perpetrators of offences is made by an order of the court or the prosecutor. Opinion in criminal matters is obligatorily issued by two expert psychiatrists who can request the opinion of, among others, an expert psychologist, neurologist or sexologist. The opinion may be issued after an outpatient examination or several weeks of observation in a hospital ward. Experts formulate opinions in writing, but may also be called upon to appear in court in person and give an oral opinion. They answer questions asked by the judicial bodies, which are usually regarding the issue of the sanity at the time of the act of the person being examined, the risk of repeated offending, the ability to participate in court proceedings, and the need to take precautionary measures.

Precautionary measures

The Polish Penal Code provides for four types of precautionary measures to be applied to perpetrators who were insane at the time of the act or whose sanity was significantly reduced: 1) electronic control of whereabouts; 2) therapy; 3) addiction therapy; 4) stay in a psychiatric institution. The first three measures are not restrictive of liberty, with isolation being mandated only in specific cases. Placement in a psychiatric hospital is only possible if it is necessary to prevent the perpetrator from committing another serious criminal act and if other legal measures are not sufficient to achieve this goal. The duration of stay in a forensic facility is not determined in advance. To determine whether a patient must continued to be kept in isolation, psychologists and psychiatrists of the ward must draw up, every six months, a written opinion on the current state of the patient's health and progress in treatment. The opinion is then sent to the court. It is the court that ultimately decides whether the patient is to remain in the ward or to be released.

Psychiatric Board for Preventive Measures

One of the elements of the system that implements safeguard measures, which is unique compared to other European Union countries, is the Psychiatric Board for Precautionary Measures, an institution that reports directly to the Ministry of Health. They are responsible for directing patients to specific facilities, for specifying the degree of security required, as well as for improving the general operation of the precautionary system. The final decision is always made by the court.

Forensic psychiatry facilities in Poland

The process of treating justice-involved people with mental illness is still being implemented mainly in hospital settings, although for many years there has been talk of the need to develop an outpatient model. Currently, there is a network of psychiatric wards with three security levels: high (3 facilities), medium (24 wards) and low (36 wards). In total, Poland has approximately 2,800 beds in forensic facilities. The facilities are located throughout the country, usually in the form of wards in psychiatric hospitals. Wards with the highest level of security are separated as independent hospital units. All forensic psychiatry facilities are state institutions and report to the Ministry of Health.

Stay in a forensic wards

The rules that apply to patients inside forensic psychiatry facilities depend on the security level of the ward. Legal regulations mainly apply to the ward admission criteria, the type of security devices used and the number of staff. Patients are assigned to specific wards based on the presence of aggressive behaviour or the risk of escaping from the facility. Wards with medium and high security are more restrictive. It is not possible to grant passes, except for medical consultations (each time with the court's consent). Patients can obtain a pass only in wards with a low security level.

Forensic Psychiatry Facility in Branice

Forensic Psychiatry Clinic, Institute of Psychiatry & Neurology, Warsaw

INTERNATIONAL FORENSIC MENTAL HEALTH SERVICES HIGHLIGHT

Smoking is prohibited in all Polish hospitals, including forensic psychiatry wards. Despite such legal regulations, some wards, especially those of low security level, offer separate smoking rooms.

Patients have access to telephones, including cell phones, computers, and other electronic devices. These issues are governed by internal regulations respecting patient rights and therapeutic principles prevailing in the wards.

Location of forensic facilities in Poland:

Low security Medium security High security

Therapeutic programme

The therapeutic programme is varied. In addition to pharmacotherapy, all facilities provide occupational therapy, social worker support, and psychological care, most often in the form of individual contacts and therapeutic groups. They also offer addiction therapy, cognitive and social skills training, stress reduction, and exercise therapy. Patients have also the opportunity to participate in religious practices.

Perspectives and challenges for forensic psychiatry in Poland

Changes in forensic psychiatry over the years have brought the Polish forensic psychiatry system closer to world standards by adapting it to the needs of the modern world. Cooperation and joint research between facilities in the country and abroad allow the opportunity to exchange experiences, draw inspiration, and optimise treatment.

However, Poland has observed practical difficulties in applying legal regulations regarding the treatment of patients in forensic wards. No executive regulations define the outpatient care model. Also, in many facilities, the housing conditions do not meet the expectations of patients and staff. The facilities are not therapeutically profiled, but only divided by levels of security. In many cases, there is also no access to all recommended therapy methods. The increasing average age of employees of forensic psychiatry facilities and the lack of systemic support for the recruitment, training and motivation of employees are also worrying. The legal status of court experts is still not fully regulated.

The coming years will show to what extent psychiatric health care is prepared to carry out new and difficult tasks and whether the current forensic psychiatry system can deal with present problems and new challenges.

Become the Newsletter Editor for IAFMHS

The IAFMHS Newsletter is dedicated to disseminating information on behalf of IAFMHS. Its quarterly issues reach out to membership and beyond to address contemporary issues in the field, highlight important research, circulate job opportunities and CFPS, engage professionals, students and early career professionals, and distribute information on the annual IAFMHS conference.

The IAFMHS Newsletter is currently recruiting for a new Editor or Editorial Team to start in Summer 2020. Becoming Newsletter Editor is a rewarding experience. You will extend your professional and academic networks, highlight research that you are passionate about, and grow to be an important member of the IAFMHS community.

Interested in applying? Here are the skills and qualifications we are looking for:

- Active in the IAFMHS community with strong networks or the desire to build connections;
- Confidence to engage with authors and researchers to solicit contributions;
- Strong organizational skills to ensure timely and professional submissions;
- Ability to cultivate positive working relationships with colleagues, professionals in the field, and students.

The Role

The Newsletter Editor(s) is responsible for editorial oversight, handling the submission process, making decisions on content as well as working with the other members of the Editorial Team and compiling the content in the newsletter format.

Submission Information

To apply, please forward your CV and a statement of interest, highlighting your personal and professional qualifications by email to iafmhs@sfu.ca. Please submit your application by **30 June 2020**.

RISKY BUSINESS

Exploring Biases in Violence Risk Assessment: The Need for Systematic Research

Jennifer Murray, PhD
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Violence Risk Assessment is a key competency and work-a-day task in the life of a clinical-forensic psychologist. While there have been vast improvements in the process in recent years, empirical investigations to understand the psychology behind clinicians' judgements has remained comparatively under-developed within the academic literature. There are a wealth of theories within the decision sciences literature which attempt to explain and map human judgement and decision making. These theories generally posit that people who are working under conditions of increasing complexity and uncertainty will rely on heuristics – cognitive shortcuts – to support their judgements, and that, with these, bias may occur.

Given that this field of research is still very small, this presents an exciting opportunity for the academic community to work together with our practitioner partners in an interdisciplinary way to develop applied research to systematically explore bias in violence risk assessment. Since 2007 I have been researching decision making and judgement in violence risk assessment. For example, I have explored "attribution bias." Attribution bias is the observable effect where we tend to overemphasise the cause of another person's behaviours as being caused by something internal to them (e.g., personality) and/or within their control. We also underemphasise the impact of external and situational causes on their actions. We do the opposite to explain our own negative behavioural outcomes – overemphasise the external causes and underemphasise the internal ones. In risk assessment this is a relevant and potentially important bias. We know from past research that when we emphasise internal causality for offending behaviours, we also see them as more serious and the person as more dangerous and responsible for the crimes (e.g., Quinsey & Cyr, 1986). This in turn may increase perception of risk posed.

In my research I used a series of vignettes based on real cases which were attributionally manipulated to either focus on internal causality or external causality. In the first study (Murray et al., 2011), we investigated the impact of internal versus external attribution on unaided clinical judgements of risk across experts, lay-people, and semi-experts. For the expert and lay groups where an internal attribution was applied, the crime (which had the same description across conditions) was considered more serious, and the person was judged to be more responsible and at a higher risk than when an external attribution was applied. A longer sentence length was also recommended in this condition. In the follow up study (Murray et al., 2014), participants were given a longer vignette (again either internally or externally manipulated) and asked to complete the HCR-20v2. Once again, some differences occurred in judgements. Attribution effects were present within the Historical Scale, Clinical Scale, and overall scoring of the HCR-20, but not in the Risk Management Scale. Ratings were higher within the internal attribution condition compared to the external one.

In a final study (Murray et al., in prep.), we investigated the potential impact of attribution effects on violence risk communications. We explored this using a thematic analysis of the risk communications produced by ten clinicians and then a quantitative evaluation of these using a large sample of lay assessors (N > 500). No attributional biases were observed.

The principal findings of this series of studies are therefore that attributional manipulations affect both unaided and aided judgements of violence risk assessment, with higher judgements of risk being afforded to internally manipulated offender scenarios than externally manipulated ones. However, this difference is not apparent in investigations of risk communication. It seems that attribution bias may therefore be present in the judgements made when assessing violence risk, but perhaps not the decisions or outcome of these judgements.

The first two studies' findings are potentially concerning at face value. However, are these internal attributional factors actually meaningful or beneficial when assessing risk for violence? The mere presence of heuristics and associated biases in judgements don't tell us anything about the way that these are used to inform judgements and decisions; simply that they do. The studies that I have carried out cannot answer this, and so future research could focus on the potential utility of heuristics and biases in clinical assessments of violence risk. Essentially, why are people using these and are they problematic or are they possibly helpful? This feels counterintuitive, but it is always best to investigate rather than jump to assumptions.

Taking the final study into account, it may be the case that even when biases are present in judgement, they

RISKY BUSINESS

may not impact decisions/outcomes. So, are these observed effects something that happen in real practice or are they products of research methodology and experimental manipulation? Again, we simply don't know the answers based on the studies described, and so I would argue that we now need to move this research into a more applied, ecologically valid research design. Working together across the intersection of decision sciences, forensic psychology, psychiatry and beyond to systematically explore bias across the spectrum of risk assessment, using different methods from the experimental and theoretical to applied methods is key. Through this can we properly understand the process underpinning clinical judgement and decision making in violence risk assessment and its impact on real practice.

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For more information, contact Linda Hand - lhand@phsa.ca

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
Provincial Health Services Authority

SPOTLIGHT ON MENTAL HEALTH DIVERSION

Second Judicial District Court's Mental Health Court: 2001 to the Present

V. Ellsworth Lewis, Ph.D., Northern Nevada Adult Mental Health Services, Division of Public and Behavioral Health

Nevada's Second Judicial District Court's Mental Health Court (formerly known as the Washoe County MHC) is now in its 20th year of operation. Originally one of five judicial learning sites, it was the subject of Frailing's (2011) study, "Referrals to the Washoe County Mental Health Court" in the International Journal of Forensic Mental Health, which examined key predictors of referral and selection. This 20-year update focuses on four systemic shifts affecting specialty courts in northern Nevada: (1) proliferation, (2) risk assessment, (3) legislation, and (4) funding.

The proliferation of specialty courts stems from the success of court-monitored therapeutic interventions. The Second Judicial District Court created Family Drug Court (1994), Adult Drug Court (1995), Prison Reentry Court (1999), Diversion [Drug] Court (2000), Mental Health Court (2001), Felony DUI (2007), and Veterans Court (2009). In 2015, the Nevada Legislature further endorsed diversion by earmarking $4.4 million from the general fund to expand and enhance such programs throughout the state. As a result, diversion has been applied to broader classes of crimes at multiple judicial levels. The multijurisdictional MHC has counterparts with special populations (e.g., Family Treatment Court, Medication-Assisted Treatment) and limited jurisdiction (e.g., municipal and community courts). There are now 20 specialty courts in Washoe County.

Risk assessment, an extension of the Risk-Needs-Responsivity (RNR) model to courts and community supervision, is increasingly used with diversion populations. The Nevada Risk Assessment System is now administered to all probationers and parolees—which constitutes about half the MHC caseload. RNR shifts programming to a less voluntary and less compliant clientele. If a high-risk score becomes a criterion of program selection (which has not yet occurred in MHC), then MHC could prioritize selection of individuals with higher criminogenic risk and mental illness for participation.

In June 2019, Nevada Governor Sisolek signed "watershed" legislation (AB 236), following recommendations from the Justice Reinvestment Initiative supported by the Pew Charitable Trusts and the CSG Justice Center. The new legislation includes broadening of the criteria for referral to mental health and veterans courts. Defendants whose crimes (or prior crimes) involved "use of force or threatened use of force" are no longer excluded. Discretion regarding eligibility rests with judges, but there is clearly a sea change favoring alternatives to incarceration. Veto of a referral by the prosecution is no longer allowed. Mental illness is broadly construed; any psychiatric condition that "seriously limits the capacity" to function in "the primary aspects of daily living" (personal relations, living arrangements, employment, recreation) qualifies.

Funding issues impacting MHC include both the growing impact of the Affordable Care Act (ACA) and the expiration of federal grants. Nevada is one of only a few states that provide outpatient mental health services to indigent and uninsured clients. ACA increased coverage for underserved populations, which has led to expansion of community resources. When Frailing studied the MHC, almost all programming was coordinated and provided by the state (Northern Nevada Adult Mental Health Services). As insured patients are transitioned to community providers, treatment coordination and monitoring becomes more challenging. Meanwhile, funding for housing under an existing grant is expiring. Since higher risk defendants also face greater challenges finding jobs and housing, there are logistical limits on the acceptance of high-risk referrals.

The above factors have created a period of dynamic growth in specialty courts in Washoe County. During Frailing's study (2006-09), MHC referrals were likely to be rejected if their criminal charges or history were "serious," or if they were not "severely mentally ill." Public safety and the limited charter of state services to treat serious mental illnesses were constraints on acceptance to MHC. With the proliferation of specialty courts and the transition to community providers, the role of the Division of Public and Behavioral Health is diminished. With the implementation of risk assessment and the broadening of eligibility, former reasons for rejection are undercut. Public defenders have firm footing for arguing that more referrals should be made and accepted. But is not yet clear who will coordinate and monitor services for courts and clients who fall outside the umbrella of state services.

About Our Special Interest Group

The MHC & Diversion Programs SIG focuses on addressing the overrepresentation of adults with behavioral health disorders in criminal justice settings through diversion initiatives. Our members include academics, behavioral health practitioners, and legal professionals interfacing with many aspects of criminal case processing. Mental health courts and broader diversion initiatives have continued to grow over the past three decades. Our SIG members share an interest in the future growth and expansion of such programs as well as new directions for research and practice. For more information about this SIG, please contact Evan Lowder at elowder@gmu.edu.

FORENSIC MENTAL HEALTH NURSING

Responding to the Clinical Supervision Needs of Nurses in a High Secure Hospital

Mhairi Ward, RNMH, BSc, MSc
Senior Nurse, The State Hospital Board for Scotland

A review at the State Hospital on the uptake of clinical supervision by ward-based nursing staff in 2018 highlighted that between 4-20% (average 12%) were engaged in clinical supervision. The main reasons for the low uptake resulted from "forced non-participation and deliberate rejection" (Buus et al, 2018, p. 787). The former referring to organizational issues and the latter referring to an individual's thoughts, expressed views, and feelings which influence their decision not to engage in clinical supervision.

Regular clinical supervision and reflective practice are important in forensic mental health nursing where there are higher levels of stress and burnout due to the complexity of the client group. Therefore, an improvement project was established to create a sustainable process for the delivery of clinical supervision/reflection along with an environment that encouraged nurses to participate in a meaningful way. Creating a robust framework to support this in practice requires organizational resources and commitments, and professional engagement.

The professional standards of proficiency (NMC, 2018) advise nurses that to promote improvements in practices and services they require to regularly contribute to clinical supervision and reflection activities. The Chief Nursing Officer in Scotland proposes within the "Nursing 2030 Vision" (Scottish Government, 2017) that all nurses, in all settings will have access to supervision and reflective practice within the next decade. Nevertheless, there is a lack of clear explanation as to how this might be achieved.

At the State Hospital our project had two aims:

1. Explore with the nursing staff (registered nurses and nursing assistants) what their views are about the current provision of clinical supervision and preferred approaches to receiving clinical supervision/reflective practice moving forward.
2. Provide opportunities for ward-based nursing staff to engage in clinical supervision and reflective practice based on their feedback.

A questionnaire survey was carried out, asking nurses (*N* = 300) their views on the current provision of supervision and reflection activities within the hospital. There was a 31% response rate and the feedback from staff included a request for 1:1 clinical supervision (with a supervisor of choice), reflective practice facilitated by nursing staff, and clinical supervision/reflective practice to take place out with the handover period.

There are several factors which enhance supervision, such as having a choice of clinical supervisor and leadership which promotes involvement in, and protected time for supervision and reflection.

Therefore, the project team considered the key parts of the system which needed improvement and what was required to contribute to the overall project vision for all nursing staff to have access to and engage in regular clinical supervision and reflective practice.

The clinical supervision for nursing staff within the wards focused on their professional role and daily nursing care rather than specific psychological interventions/therapies. A 2-day training package was developed for nurse supervisors using Proctor's three function interactive model (formative, normative and restorative) and Els van Ooijen (2003) 3 step method. Values Based Reflective Practice (VBRP®) developed by NHS Education for Scotland (2017) was the approach agreed for group reflection activities. Staff were required to complete an initial 4 days training prior to facilitating groups then follow the process for registration set out in the national handbook for best practice.

A pilot project was commenced on one ward.

- Nursing staff chose a supervisor from a list of trained nursing clinical supervisors and were encouraged to arrange regular bi-monthly clinical supervision.
- VBRP® facilitators scheduled fortnightly sessions in the ward during a time that could be protected and was out with the nursing handover period.
- All supervision and reflective practice sessions were recorded on a spreadsheet to allow easy identification of which sessions took place or were cancelled (with a reason why).

The results and outcomes of the project reflected an increase in the number of staff engaging in clinical supervision (from 20% to 72.5%) and reflective practice over a 6-month period (from 33% to 92%). The main themes drawn from the qualitative feedback from nursing staff engaged in VBRP® included: staff benefitting socially, emotionally and professionally from the group; the facilitators created a safe and supportive environment.

Due to the success of the pilot study there is a plan to roll out the model of clinical supervision and reflection activities across the hospital site.

FORENSIC MENTAL HEALTH NURSING

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RESEARCH UPDATE

ON CONSENT AND EXPLOITATION AMONG INCARCERATED RESEARCH PARTICIPANTS

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More often than not, when it comes to discussing the procedures in research that are the best and most ethical, the actual participants are left out of the conversation. This dearth of literature highlights how for all the talk regarding the high ethics of research practices, more work remains to be done to give a voice to the very people impacted by a study design. This is especially true for those belonging to vulnerable populations, like incarcerated individuals.

Dugosh and colleagues (2010) developed and validated an instrument that measures an incarcerated participant's experience of coercion to participate in research. Specifically, the Coercion Assessment Scale (CAS) was designed for incarcerated individuals with a substance use disorder. The results of this study are enough to give pause to anyone engaging in research with incarcerated persons. Almost 15% of the participants confessed feeling as if they could not say 'no' to participation while others cited coercive influences like financial gains, with more than 30% of the participants endorsing entering the study mainly for financial reasons (Dugosh et al., 2010). Moreover, highlighting the presence of indirect coercion, more than half of the participants endorsed that they believed entering the study would help with their court case or felt the judge would like it if they entered the study (Dugosh et al., 2010).

In a second study, researchers set out to investigate whether participants viewed their participation research exploitative (Christopher et al., 2016). The participants were all incarcerated individuals who had also participated in a different clinical study (Christopher et al., 2016). This included studies on substance dependence, a clinical trial for reducing HIV risk behaviors, and a clinical trial for psychotherapy for major depression (Christopher et al., 2016). Similar to the study by Dugosh and colleagues (2010), the results were striking. For instance, about a quarter of the participants agreed with the statement that the study they had originally participated in took advantage of the fact they were incarcerated and 10% felt the researchers used them to get what they wanted (Christopher et al., 2016). Additionally, more than half of the participants agreed that joining the study was the only way for them to get access to the treatment they needed and almost a quarter of them agreed that the only reason they joined the study was to get access to treatment resources. This once again highlights the indirect coercive powers that can be at play when it comes to clinical experimental work with incarcerated individuals. Nonetheless, on a more positive note, only a single participant confessed feeling that they were taken advantage of. Moreover, the vast majority (96%) of the participants agreed that incarcerated persons should have the chance to join more research studies if they wish to do so (Christopher et al., 2016).

In sum, the sparse research available on the feelings of incarcerated participants suggest that the participants themselves may perceive certain aspects of the research process as – at least indirectly – coercive and/or exploitative. This might be especially true for clinical trial studies where participants enrol to get to treatment or other resources they normally would not have access to. As a community, we can do more to protect the voluntary and informed consent. For example, it would be easy for all incarcerated participants to complete a measure like CAS to gauge any direct or indirect coercive pressures they may feel. At the same time, more work needs to be done on how research participants, especially those belonging to a vulnerable population, perceive the procedures. All in all, at the core of scientific work is a regard for others, and therefore, research procedures should reflect that.

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STUDENT SECTION

Spotlight: Interview with Kasia Uzieblo

Student Section Editors: Maria Aparcero, Student President, Fordham University, USA | Sarah Schaaf, Student President-Elect, Fairleigh Dickinson University, USA | Silvia Fraga, Student Secretary, Royal Holloway University of London, UK

Kasia Uzieblo is a senior researcher at the Forensic Care Specialists (Van der Hoeven Clinic, The Netherlands). Her main research interests are psychopathy, sexual and domestic violence, and forensic psychological assessment. As a visiting professor, she teaches Forensic Psychology at Ghent University and Criminological Psychology at Vrije Universiteit Brussel (Belgium). She serves as an expert witness and conducts psychological evaluations at the Van der Hoeven Clinic, a high-security, forensic psychiatric clinic. She is the founder and coordinator of the Forensic Division of the Flemish Association of Clinical Psychologists. She also served as the president of the Dutch Chapter of the Association for the Treatment of Sexual Abusers (NL-ATSA). At present, Kasia functions as the secretary for the Society for the Scientific Study of Psychopathy (SSSP). She has published and presented her research nationally and internationally and organized many training sessions in her areas of expertise.

Kasia Uzieblo, PhD

Senior researcher at the Forensic Care Specialists in The Netherlands

Q: Can you tell us a little bit about how you became interested in the field of forensic psychology?

A: I think it all started with my fascination for World War II and the X-files. Given that my Polish family had suffered horrific ordeals during WWII, I was eager to learn more about what had happened back then. So, I began reading books about WWII at a very young age. I was mainly intrigued by questions, such as "Why are people capable of committing such gruesome acts?" and "Are all of us able to commit such crimes?" At the time, I didn't realize that there were jobs that directly focused on these questions. However, this changed when X-files aired on TV. I was fascinated by the careers of the protagonists which primarily focused on the investigation of the criminal mind and I became really interested in pursuing a career that would allow me to do so as well. This was how I found my way into (forensic) psychology.

Q: Could you share a few important moments in your career that ultimately shaped you as a woman in science, and in forensic psychology in particular?

A: Both the highs and lows have shaped me throughout the years. I think my PhD project was a true eye-opener. It was challenging to work in an environment that expects so much of you and where positive reinforcement is relatively scarce. This really influenced my self-image and self-esteem for some time. Academia is a fascinating world, but it can also be harsh and callous. However, it is a good learning experience. For instance, it made me realize that it is important to never give up, and that opportunities shouldn't be taken for granted. I also think it's important to have people in your work environment (i.e., head of department, mentors) that believe in you, encourage you, and acknowledge your work and efforts. It's so much more stimulating to have a team that you can trust and rely on, that allows you to succeed and fail; people you can share your highs and lows with. And indeed, although times have changed, being a woman in science remains a challenge. It's my experience that women must shout louder and put their feet down more often just to be heard compared to men. You have to be very stubborn to succeed in science, and even more so as a woman, but that's probably the case in many other professions as well.

Q: Before you started as a senior researcher, you founded a postgraduate course on applied forensic psychology. What moved you to take on this challenge and how do you think the program impacts the current state of forensic psychology in Belgium?

A: I think my own frustration about the lack of opportunities to study forensic psychology motivated me to take on this challenge. Back then, topics related to forensic psychology only received little, if any, attention in psychology programs in Flanders; and unfortunately, this is still the case. Consequently, people who wanted to specialize in this field, only had very few options: 1) attending a postgraduate course that mainly focused on forensic psychiatry and tended to neglect psychological theories and practice, 2) moving abroad to study forensic psychology, or 3) gaining insights through clinical practice. I strongly believed we could do a better job in providing psychology students and clinicians the necessary tools and theoretical insights to optimize their forensic psychological work. Hence, when I had the opportunity to establish a postgraduate course, I didn't think twice about it. My hope was, and still is, that this course encourages evidence-based practice in Flanders.

STUDENT SECTION

It's important to have people in your work environment that believe in you, encourage you, and acknowledge your work and efforts.

Q: Could you name some of the most pressing challenges for the Belgian government regarding the field of forensic psychology?

A: There are many pressing challenges, but I think the most important one concerns the training of expert witnesses and their recognition by the courts. Anyone can be an expert witness in Belgium. Consequently, many have not been properly trained in forensic psychology or forensic psychological assessment, which is often problematic. For instance, the use of unstructured clinical judgment for predicting recidivism is still very common in court, and I have also seen expert witnesses assessing psychopathic traits solely by using the Rorschach or the MMPI-2. Due to the lack of knowledge and adequate training, these witnesses often unintentionally perpetuate common myths about phenomena such as sexual violence and psychopathy. They often provide advice that is not evidence-based and can be counterproductive. Over the years, some efforts have been made to improve the quality of expert evaluations, but it is still not enough. We now have a register for expert witnesses, but this doesn't ensure quality. Obviously, not all expert witnesses are doing a bad job, but the number of flawed assessments that my colleagues and I encounter remains appalling.

Q: Throughout your career, you have organized several conferences in which you invited international experts to Belgium. The beers, chocolates and waffles perhaps make it a little easier to bring these experts to Belgium. How do their visits impact the field in your country?

A: Many colleagues ask me why I organize so many trainings, workshops, and conferences. They often say that in order to boost my CV, I should rather be focusing on writing papers and grant proposals. And they are right, you don't get a lot of academic recognition for organizing educational events. But I consider facilitating evidence-based practice as an important task of scientists. One of the most effective ways to do this – at least that's my experience – is to bring scientific experts closer to practitioners. Practitioners often don't have the time to read the literature and/or don't have access to scientific journals. New theoretical insights are not being implemented right away; however, they slowly but steadily trickle down into practice. I believe that educational events play an important role initiating these changes.

Q: Psychopathy and sex offending, two of your main research interests, are topics that receive a lot of public and media attention. Have you experienced any challenges communicating research findings on these topics to the public?

A: Yes, I experience many challenges, but I think they are quite common. I'm often facing a lot of myths about psychopathy and sexual violence in the general public, media, among policy makers, and even practitioners. When you try to bring some nuances into the debate, you're often ignored because nuances are difficult to understand and don't sell headlines. I'm definitely not an expert in overcoming these challenges, but I believe it's important that we, as scientists and practitioners, engage in conversations with politicians, the media, and the general public, and continue to disseminate our knowledge until it is heard.

I consider facilitating evidence-based practice as an important task of scientists.

Q: What advice do you have for graduate students or early career professionals who are interested in following your professional footsteps?

A: I always say that it's important to find out what you are truly passionate about. It's also crucial to understand that there are many roads that lead to your goals and they can sometimes be bumpy. One advice that has resonated with me since grad school is to seek out opportunities and take them. Don't take no for an answer, at least not at first. And most importantly, stay true to yourself and be kind to others. It's easy to get blinded by ambition and forget about these values.

Visit our Spotlight page for the full interview and to read more about Dr. Uzieblo's experiences as a forensic psychologist in Belgium and the Netherlands, as well as her perception of the different approaches to forensic psychological practice in both countries. Furthermore, Dr. Uzieblo discusses how international organizations such as IAFMHS can help to improve forensic services across countries.

STUDENT SECTION

Stopping *Would You Rather* Culture By Choosing Community-Care

Courtney Wade, M. Ed.

Sometimes, graduate school feels like a long game of *Would You Rather*. However, instead of choosing between a fate as an unknown superhero or that of a famous villain, graduate students navigate choices such as "consistent, quality sleep or a complete dissertation" and "eating regularly scheduled meals or attending all meetings on time today." As graduate students are intimately aware, *no one* wins when choosing between basic needs and professional or academic responsibilities. For solely journalistic purposes, I surveyed a convenience sample of graduate students about their experiences with such either/or scenarios.

The most frequently cited impacts of choosing responsibilities over basic needs ranged from forgetful to near-fatal, such as:

- running red lights;
- finding eggs and milk in the pantry;
- finding a cell phone in the refrigerator;
- tension with friends, family, and partners;
- wearing clothing inside out or backwards in public;
- accidentally leaving the car running while filling up the gas tank;
- routinely falling asleep at restaurants and gatherings with friends;
- routinely needing to take a nap in the car before driving ten minutes home;
- and taking pre-class naps in the lab in order to be able to participate in discussion.

Graphics: @courtney_erin_w

Other responses touched on longer-term impacts, such as:

- worsening of chronic health conditions;
- developing physical and/or mental health problems;
- missing deadlines due to declining physical and/or mental health;
- needing to take one to three weeks off of work at a time to prioritize health;
- attending doctor appointments during business hours with increasing frequency;
- and managing the stress of invisible disabilities, navigating disclosure, and requesting accommodations.

In the case that you do not fall asleep before telling it, an anecdote of finding your cell phone in the refrigerator may do well at end-of-semester lab meetings and parties. The laughter, knowing nods, and chorus of been-there's that inevitably follow expose the organizational and cultural climates that allow the game to continue. Though the actual game of *Would You Rather* operates in an alternate reality where consequences are imaginary and, often, not well thought out, the lives of graduate students operate within a universe where context matters. There is no question that everyone is impacted by the either/or decision-making style of *Would You Rather* culture. However, accepting the reality of the graduate student experience often involves accepting many factors over which the student does not have control, such as supervisory relationships, program requirements, and funding allocation. These and other similar factors perpetuate either/or decision-making by turning the right to prioritize health into a privilege.

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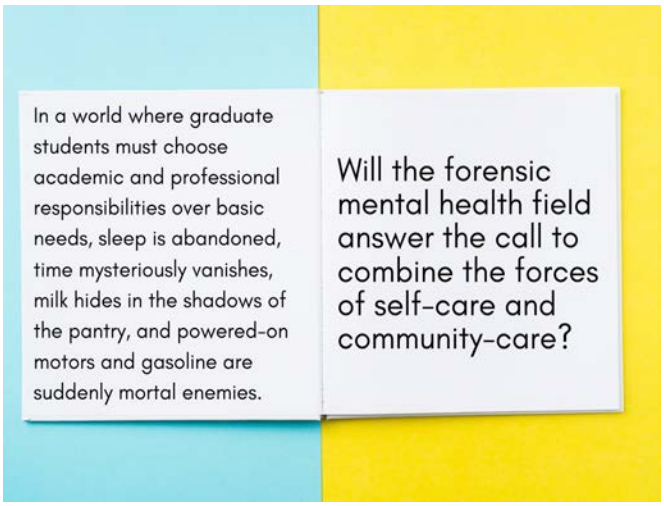
When tasked with writing a newsletter article about self-care strategies for graduate students, I was ecstatic. Self-care is a topic I am extremely passionate about as a first-generation doctoral student in applied social and community psychology, counseling professional, and person navigating neurodiversity and disability within academia. Yet, as the coronavirus pandemic evolved, I felt it would be remiss to situate any self-care strategies outside of our current collective reality. It then occurred to me that it is remiss to do so in any version of reality. As a field, how can we work to escape the real-life game of *Would You Rather?* We can start by collectively recognizing that action cannot be separated from context. Acknowledging the contextual impact of institutional and sociopolitical climates allows us to take a holistic and intentional approach to viewing the reality of the graduate student experience; a reality where factors such as a global pandemic, extracurricular responsibilities, transitions to working remotely, institutional policies, and structural inequality inform graduate students' priorities, productivity levels, and wellness. We promote cultural change by elevating contextual factors and shifting from self-care to community-care. We win *Would You Rather* using both/and decision-making: caring for *both* the community *and* ourselves.



Graphics: @courtney_erin_w

Winning Strategies of Community-Care

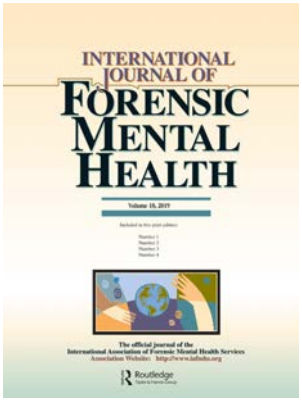
Recognize the synergy between self-care and community-care. Consider the complimentary benefits of individual self-care and interpersonal community-care. Acknowledging the validity of the struggles of others does not invalidate our own.

Leverage your privilege. Self-care does not solve systemic issues, nor should it have to. Community-care calls us to use our own privilege to fight stigma and challenge the status-quo in the face of inequity for the benefit of the entire community.

Show and tell. Use both words *and* actions. Think creatively about aid you can provide within your means. When in doubt, *ask* who you are trying to help. Reaching out and showing authentic respect for autonomy, agency, and indigenous knowledge may itself serve as a healing act.

INTERNATIONAL JOURNAL OF FORENISC MENTAL HEALTH

Feature Article



Mental Health Nurses' Experiences of Risk Assessments for Care Planning in Forensic Psychiatry

Marielle Nyman[a], Björn Hofvander[b] , Thomas Nilsson[c] , & Helle Wijk[a]

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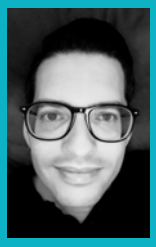
The risk of patients committing violence implies major challenges throughout the care process in forensic psychiatry and brings risk assessments to the fore. The aim was to explore nurses' experiences of risk assessments for their care planning and risk management in forensic psychiatry. Data were collected through focus groups with 15 nurses. The qualitative content analysis followed a deductive approach guided by the person-centered philosophy. When exploring nurses' reasoning on risk assessment, units related to person-centered principles were identified. The findings showed that nurses made great efforts to confirm the unique person behind the patient, even when challenged by patients' life histories of violence. They also regarded therapeutic alliance as crucial, although this needed to be balanced between caring and restricting actions. A fruitful strategy to preserve therapeutic alliance may be to increase the use of a structured focus on protective factors in treatment plans towards promoting recovery-oriented policies and practices.

Associate Editor Highlight



Jamie Livingston, PhD

Associate Professor,
Department of Criminology
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Jamie Livingston is a criminologist who studies and teaches about issues of social justice and social inclusion for people at the intersection of the mental health, substance use, and criminal justice systems. The specific areas in which his scholarship has concentrated includes stigma (especially at a structural level), forensic mental health recovery, correctional mental health system design, compulsory treatment, and participatory and narrative research methods. More recently, his research has engaged with the desistance field, exploring its application to forensic mental health. His current studies in his research program examine various topics, such as: the needs and experiences of people victimized by crimes resulting in a NCRMD verdict, the role that peer support plays in formerly incarcerated people's lives, and the outcomes of people following discharged from forensic mental health hospitals.

Call for Nominations: Member-at-Large

The Association is seeking nominations to fill two Member-at-Large vacancies on the Board of Directors. Those wishing to stand for office should be members in good standing of IAFMHS. Self-nominations may be submitted. The Nominations Committee is chaired by Past President, Dr. Barry Rosenfeld.

The member-at-large will serve in this role for a term of three years. The MAL will attend meetings of the Association and of the directors, and will participate actively in discussions and decision-making regarding Association mandates and operations. The member-at-large may be assigned specific duties or work groups within the Association's activities.

The deadline for submission via email to iafmhs@sfu.ca is 5.pm Eastern time, **Thursday June 25, 2020.**