INTERNATIONAL ASSOCIATION OF FORENSIC MENTAL HEALTH SERVICES

NEWSLETTER

VOLUME 6 | ISSUE 1
Winter 2021

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Letter from the Editor

"No winter lasts forever, no spring skips its turn."
Hal Borland

Around this time last year, IAFMHS made the difficult (though necessary) decision to cancel the in-person conference in Krakow. Though things are still a little different this year, I am happy to publicize the first IAFMHS virtual conference which will be taking place in June. We are fortunate to have Dr. Gina Vincent and Dr. Andrew Forrester as our keynote speakers. We will also also have a special panel on COVID-19 in forensic mental health services. Though the chance to catch up with you all in person will be missed, perhaps the silver lining of this year's conference will be the opportunity to attend sessions in sweatpants from the comfort of home.

In this issue of the newsletter, I would like to highlight more of our COVID-19 related content, including the work by Dr. Benassi and colleagues on virtual care in forensic settings and Dr. Martin and colleagues' observations of reductions in aggressive behaviour during the pandemic.

As always, we would like to encourage members and non-members to submit content to the newsletter or to join our team. Andrà tutto bene!

Sarah Coupland, Editor

RISKY BUSINESS

Observed reductions in aggressive behaviour in psychiatric inpatient care during COVID-19

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The COVID-19 pandemic has posed a severe challenge for governments as results from a survey conducted by the World Health Organization (WHO) in the summer of 2020 found that 93% of countries experienced negative impacts on mental health services (WHO, 2020). Previous research during the H1N1 pandemic in 2009 established an increase of patient aggression, for example in Australian emergency departments (Fitzgerald et al., 2012). Recent research has proposed that lack of freedom and movement may be risk factors that increase the likelihood of patients becoming irritable and upset amid the COVID crisis (De Sousa et al., 2020) and this may lead to increases in aggression within mental health hospitals.

Working in a tertiary mental health hospital, we anticipated that this phenomenon would also apply to our psychiatric inpatients, and consequently many drastic changes were implemented to proactively prevent any negative impact. In addition to measures designed to keep patients safe (e.g., unit sequestering), changes included suspending outpatient and non-essential services in order to streamline resources and redeploy staff to support inpatients, and opening of outdoor courtyards for scheduled cigarette breaks. We also established a patient engagement steering group designed to centralize decision making around engagement, customized unit activities, and celebration of patient successes on inpatient units.

Somewhat surprisingly, however, we had overestimated risk: there were fewer incidents of aggression leading to a significant reduction in our use of restraints and seclusion in the few months following the implementation of restrictions. For example, the average daily rate of the number of mechanical restraints reduced in our Adolescents, Forensics and Geriatrics programs by 56%, 49% and 100% respectively. For seclusions, the rate of incidences reduced for the Adolescents, Forensics, and Geriatrics programs by 76%, 35% and 19% respectively.

As such, we reflected on this naturally-occurring phenomenon to ascertain its potential causes and understand the factors that were mitigating the expected higher risk for aggression during the pandemic. The downward trend in incidents observed during the pandemic has suggested that aggression in mental health hospitals may be more situation-specific and less so a factor of mental illness. This is not a new concept however: previous scholars have argued that there are other – non-pathological – reasons why aggressive incidents are observed on inpatient psychiatric units (see McKeown et al., 2016).

Patient engagement has always been addressed within our hospital but usually in a very reactive way. When the outbreak occurred, the hospital – together with the family and patient engagement committees – proactively identified potential issues, gaps in service delivery, and factors related to self-directed day-to-day behavior. This resulted in the localized and customized creation of activities that were meaningful to patients. As a result, this shifted power from the service provider to the service user. This is congruent with previous research that demonstrates that trust, choice, and power are perceived as important for those receiving mental health services (Laugharne et al. 2011). Amid the COVID-19 crisis, it may be that the lack of perceived control over the course of the pandemic by both service users and providers, lessens the power imbalance between these two groups and also requires that both groups trust one another to adhere to their respective responsibilities amid this health crisis. *(Continued on next page...)*

RISKY BUSINESS

Observed reductions in aggressive behaviour in psychiatric inpatient care during COVID-19

Where choice is concerned however, the COVID-19 crisis may have demonstrated that the lack of choice (namely the lack of off-unit privileges) or more importantly the uniformity of choice (i.e., that all patients were faced with the same restrictions) may have alleviated patient-to-patient comparisons: if no one is afforded off-unit privileges, then there are no complaints regarding patients' own access relative to others' access. The concept of procedural justice stipulates that when people believe that a process is fair – even if they do not like the outcome – they will have respect for the process, thereby reducing any disputes. This possibility has important implications for the perceived subjective nature of our assessments. If this is the case, what if there was no subjectivity in allocating privilege access? Perhaps this could be achieved with introducing greater transparency in our risk assessment procedures.

Oftentimes the mental health system can be risk averse and rigid in its policies and practices. When the pandemic finally does come to pass and things go back to 'normal,' perhaps this would be a step back. To echo Brown and colleagues (2020) who state that there is "an opportunity now to find better ways of working with patients which we hope will out-live the COVID-19 pandemic" (p. 12), mental healthcare should learn from the lessons of what is possible in terms of patient engagement, flexibility, sharing power, and trust amid the pandemic and as such, not go back to 'normal' in our risk management approach. The phrase 'new normal' has often been used to speculate life after COVID-19 and it would seem mental healthcare can establish a 'new normal.'

To read more about our findings, please check out the original article published online, Martin, K., Arbour, S., McGregor, C., & Rice, M. (2021). Silver linings: Observed reductions in aggression and use of restraints and seclusion in psychiatric inpatient care during COVID-19. *Journal of Psychiatric and Mental Health Nursing*. doi: 10.1111/jpm.12752

If you are a practitioner or researcher engaged in risk assessment/management and would like to share your research, perspective, or ideas with readers, please contact the Risky Business editor, Krystle Martin at martink@ontarioshores.ca.

References

Brown, C., Keene, A.R., Hooper, C.R. & O'Brien, A. (2020). Isolation of patients in psychiatric hospitals in the context of the COVID-19 pandemic: An ethical, legal, and practical challenge. *International Journal of Law and Psychiatry, 71*, 101572.

De Sousa, A., Mohandas, E. & Javed, A. (2020). Psychological Interventions during COVID-19: Challenges for low and middle income countries. Asian Journal of Psychiatry, 51, 102128.

FitzGerald, G., Aitken, P. & Shaban R.Z., et al. (2012). Pandemic (H1N1) Influenza 2009 and Australian emergency departments: implications for policy, practice and pandemic preparedness. *Emergency Medicine Australasia, 24*(2), 159-65.

Laugharne, R., Priebe, S., McCabe, R., Garland, N. & Clifford, D. (2011). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-504.

McKeown, M. (2016). Stand up for recalcitrance! *International Journal of Mental Health Nursing, 25*, 481–483.

World Health Organization. (2020). COVID-19 disrupting mental health services in most countries, WHO survey. Retrieved online from: https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey

CALL FOR EDITORIAL ASSISTANT

The IAFMHS is currently seeking an editorial assistant for its newsletter. The editorial assistant works closely with the editor to develop the content and formatting of the quarterly newsletter. The role offers valuable editorial experience and opportunities for network development in the field of forensic mental health.

The role is open to all IAFMHS members and may be of particular interest for trainees. The position is a 2-year voluntary service position that will start on May 15. The current editorial assistant will assist the incoming editorial assistant for the Summer newsletter edition.

To apply, please submit a brief statement of interest and a CV to sarah_coupland@sfu.ca by May 1st.

Typical tasks

- Assists the editor in developing the content of the newsletter
- Maintains contact with the authors, along with the editor
- Edits and/or proofreads submissions for publication
- Designs and formats the newsletter

HIGHLIGHT ON COVID-19 IN FORENSIC MENTAL HEALTH

Virtual Care in a Forensic Service: Implementation, Evaluation and Next Steps.

Paul V. Benassi, M.Sc., MD, FRCPC,[1, 2, 3], Alexander Simpson, MBCb, BMedSci, FRANZCP,[2, 4] & Treena Wilkie, MD, FRCPC[1, 2]

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In face of a global pandemic of COVID-19, healthcare organizations have had to drastically rethink how they deliver care to keep clinicians and patients safe. Our facility, the Centre for Addiction and Mental Health (CAMH) is one of Canada's largest providers of forensic mental health care, serving over 500 forensic patients in hospital and in the community. Like many services, we rapidly moved to virtual care in March 2020. This entailed employing videoconferencing technology across nine inpatient units and three outpatient services, training of clinical staff and operationalizing the delivery of virtual care. The norm for clinical care and related activities had been centered around in-person encounters prior the pandemic, so this was a marked shift in practices. This rapid change to virtual care created a natural experiment to assess what factors influence the uptake, scale-up, spread and sustainability of such technologies in forensic psychiatry, and how provider and patient experiences have evolved over time (Greenhalgh et al., 2017). The following are some key themes we have drawn from our evaluations of virtual care that touch on implementation considerations.

Example of a Virtual Care set-up at CAMH

Accessibility

A key theme that emerged around implementation was accessibility of the technological infrastructure, which ranged from the quality of the internet to the usability of the software platform, to the availability of needed hardware. This was also closely tied to the need to train and build capacity amongst its users (clinician and patient). In the inpatient settings, it was initially challenging to adapt units to virtual set-ups, but over the first few weeks, the hospital was able to build the infrastructure. We observed that various staff informally adopted additional responsibilities to set-up, organize and facilitate virtual sessions for clients. In the outpatient setting, the quality and ease of videoconferencing was dependent on the patient's set-up in the community and their ability to operate the software independently. This presented a real challenge when working with people who have different means and abilities, and highlighted considerations of equity and accessibility with virtual care. This led to initiatives to connect clients with their own electronic devices in order to be able to participate in virtual care.

Paul V. Benassi, M.Sc., MD, FRCPC

Quality Improvement Lead and Forensic Psychiatrist, Law and Mental Health Division, CAMH

Assistant Professor, Department of Psychiatry and Dalla Lana School of Public Health, University of Toronto

One-Size-Does-Not-Fit-All

Once the technological infrastructure factors are addressed, it is important to look at the specific needs and characteristics of the adopter system (e.g. patients, staff). The usefulness, benefits and perceived value of virtual care are not the same for all, and differ based on the setting, task and user. In general, there are some medical conditions that were found to make videoconferencing challenging, including acute psychosis, agitated state, intellectual disability, or neurocognitive impairments. In inpatient settings, virtual care is generally more beneficial to clinicians than patients, with the latter viewing it either neutrally or as less than in-person care. *(Continued on next page...)*

Virtual Care in a Forensic Service: Implementation, Evaluation and Next Steps.

In addition, the inpatient setting continues to require some level of on-site staffing due the nature of the work and the patients residing there. In outpatient settings, there is greater benefit for all parties; many patients appreciated not needing to commute on public transport to attend outpatient clinic appointments. Virtual care was thus less intrusive and, during the pandemic, safer than in-clinic appointments. However there are more logistical/practical concerns (e.g. if you need to do a physical exam, how to address acute safety concerns). Finally, virtual care may be adequate for psychiatric follow-up care, but less desirable for tasks such as group therapy sessions, in-depth reviews or joint care planning.

Provider Experience & Forensic Consideration

From the early stages of virtual care implementation to a year later, clinical providers have become increasingly competent and comfortable using such technology. Prior to its implementation, forensic psychiatrists voiced concerns about being able to assess and manage forensic risk virtually compared to seeing patients in person. However, this did not appear to be a major concern when in practice. Most providers shared that the forensic aspect of their work did not solely rely on their encounter with the patient, but that their risk assessments and plans drew on many different sources of information (e.g. historical risk, input from other care providers, substance monitoring, medication compliance, etc.). In outpatient settings, conducting visits virtually could allow more frequent check-ins with patients due to the convenience. Providers reported that for regular and simple follow-up visits virtual care was similar to in-person. However, in person assessments were viewed as preferable when completing nuanced mental status examinations or initial assessments of patients. Overall, providers shared that a mix of virtual and in-person assessments is likely ideal when working with forensic patients.

Questions and comments about this piece may be sent to Dr. Benassi at paul.benassi@camh.ca.

References

Greenhalgh, T., Wherton, J., Papoutsi, C., Lynch, J., Hughes, G., A'Court, C., Hinder, S., Fahy, N., Procter, R., & Shaw, S. (2017). Beyond Adoption: A New Framework for Theorizing and Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability of Health and Care Technologies. *J Med Internet Res, 9*(11), e367.

IAFMHS 2021 Virtual Conference: Registration

Registration for the 2021 virtual conference will open on April 1. The conference will run June 16-17 (10am - 4pm ET; 7am - 1pm Pacific USA; 3pm - 9pm UK) and will include a mixture of pre-recorded presentations with live (via Zoom) Q&A.

2021 VIRTUAL IAFMHS CONFERENCE

Keynote speakers

Advancing from the "What Works" to "How to Make it Work": Applications of Implementation Science to Justice Supervision

Gina Vincent, Ph.D. is an Associate Professor at the Implementation Science & Practice Advances Research Center (iSPARC) and Co-Director of the Law & Psychiatry Program at the University of Massachusetts Medical School. She also is President of the National Youth Screening and Assessment Partners (NYSAP), a technical assistance center for assisting juvenile justice agencies with the selection and implementation of risk assessment and behavioral health screening tools.

Dr. Vincent has received funding from NIMH, NIDA, the MacArthur Foundation, and OJJDP for studies relevant to risk for reoffending, mental health problems, and substance abuse among youth involved in the juvenile justice system. She is author of the widely-used *Risk Assessment in Juvenile Probation: A Guidebook for Implementation* manual. She has assisted multiple juvenile justice agencies with the selection and implementation of risk assessment instruments for case planning and studies the effectiveness and impact on youth and the system.

She has over 70 publications and over 100 presentations to international, national, and local juvenile justice agency conferences in the areas of violence risk assessment, implementing risk/needs assessment in juvenile justice, adolescent substance abuse, callous-unemotional traits, and mental health symptoms.

Prison Mental Health: Past, Present, and Future

Andrew Forrester, MD(Res) FRCPsych is Professor of Forensic Psychiatry at Cardiff University, Wales, and a Consultant Forensic Psychiatrist with Swansea Bay University Health Board and Oxleas NHS Foundation Trust. He is Academic Secretary to the Faculty of Forensic Psychiatry, Royal College of Psychiatrists, and Editor in Chief of the SAGE journal Medicine, Science and the Law. He sits on the executive committees of the Forensic Faculty of the Royal College of Psychiatrists, the British Academy of Forensic Sciences, and the charity Crime in Mind, as well as sitting on the British Medical Association's Forensic and Secure Environments Committee. He is the former chair of the World Psychiatric Association's prison mental health task-force, a member of the Society of Expert Witnesses, a member of the Medical and Dental Defence Union of Scotland, an honorary member of the World Psychiatric Association, and a former member of the Royal College of Psychiatrists' Working Group on the Mental Health of Refugees and Asylum Seekers.

He has worked as a psychiatrist in prisons and other criminal justice settings for over 20 years, and has written over 700 reports to the Courts, mainly in criminal proceedings. His clinical and research interests relate to mental health conditions as they present in the criminal justice system, including prisons, courts, police custody, probation, and other places of detention, with a focus on vulnerability and marginalisation.

SPOTLIGHT ON MENTAL HEALTH DIVERSION

Implementing Community Courts in High-Risk Communities: Ontario's Justice Centres.

Dayna Arron, Executive Director of Justice Centres for the Ministry of the Attorney General, CAN
Honourable Mr. Justice Richard D. Schneider of Ontario, CAN

Ontario's Ministry of the Attorney General is implementing the province's first community courts. This work is based on the internationally recognized community justice center model, first pioneered in Brooklyn's Red Hook Justice Center (elsewhere referred to as problem-solving justice). The Center for Court Innovation has identified six guiding principles underlying successful community court initiatives, which include: (i) Enhanced information; (ii) Community engagement; (iii) Collaboration; (iv) Individualized justice; (v) Accountability; and (vi) Outcomes (Wolf, 2007).

The Justice Centres project was conceived and planned prior to the COVID-19 pandemic. And while there may be some overlap, these Centres are not designed to supplant the operations of the existing Mental Health Courts, which have been operating since 1998. Nor does the project replace or alter the provincial Diversion Program (in operation since 1994) that is province-wide and provides pre-plea diversion for minor to moderately serious criminal matters where there is a logical nexus between a mental disorder and the alleged offence. The Justice Centres focus on communities rather than exclusively individuals.

Ontario's work is taking place in four distinct communities, beginning with initial pilot projects that test elements of the Justice Centre model. Despite the localized approach in each site, Ontario's four models share a commitment to addressing underlying criminogenic factors in high-risk communities. In particular, the province is investing in increased access to and integration of services aimed at justice-involved people with mental illness, problematic substance use disorders, concurrent disorders, and/or developmental and intellectual disabilities. The nature and extent of these supports differs between sites, based on their focus population.

Toronto-Downtown East: This site will target the adult recidivist population in Toronto's downtown core, which is home to a disproportionately high number of individuals who are under-housed, living in shelters, experience mental health and/or substance use disorders, as well as a number of other risk factors. This pilot reimagines how the health and justice systems interact. Using a recovery-focused lens, on-site case managers, primary care physicians, psychiatric and addictions specialists will work with Crown Attorneys and defense counsel to help clients stabilize and avoid future interaction with the justice system.

Toronto Northwest: This pilot will serve youth aged 12-17 living in a network of Toronto neighbourhoods that experience significant levels of community violence, including shootings, robberies and assaults. Local evidence suggests Black youth are overrepresented in the Toronto criminal justice system. In response, the pilot will provide youth accused with critical supports and services, including a tailor-made and culturally specific needs assessment process, created in partnership with a local youth forensic expert, as well as child and youth forensic psychiatric services. Additional interventions include service navigation, educational advocates, and expedited first appearances.

Kenora: The Kenora Justice Centre is being developed in partnership with Indigenous leadership and community organizations to ensure that it contributes to decreasing the overrepresentation of Indigenous people in the local criminal justice system. Many of these communities have faced challenges rooted in forced relocation, loss of culture, involvement in the child welfare system, systemic discrimination and racism. As a result, the Justice Centre project will seek to increase referrals to restorative justice programs, reduce the remand population, provide multidisciplinary trauma-informed supports, incorporate restorative practices into justice system processes, and facilitate access to culturally-appropriate services delivered by local Indigenous service providers and organizations.

(Continued on next page...)

CALL FOR INTERNATIONAL HIGHLIGHTS

The newsletter is currently looking to publish content related to the organization of forensic mental health services in various countries. If you are interested in submitting a piece, please contact the Editor at sarah.Coupland@sfu.ca.

SPOTLIGHT ON MENTAL HEALTH DIVERSION

Implementing Community Courts in High-Risk Communities: Ontario's Justice Centres.

London: The city of London is home to a high number of emerging adults aged 18-24 not currently in employment, education, or training. This population also experiences a high number of mental health emergencies. The London pilot is aimed at providing justice-involved emerging adults, aged 18-24-years, with targeted supports and services to help them exit the criminal justice system and reconnect with school and work. Operating out of a local youth services hub, the court provides case management support, as well as early and meaningful connections to skills and job training programs, education supports, and mental health and addictions services.

Since the onset of COVID-19, Ontario pilots have been adapted to ensure access to justice for marginalized and vulnerable populations, currently struggling to participate in remote judicial processes. In each site, participants will have access to digital technology in a safe and supportive environment. The London Justice Centre pilot launched in September 2020, while the Toronto and Kenora sites are anticipated to be operational in 2021.

For further information about the project, please contact Dayna Arron, Executive Director of Justice Centres for the Ministry of the Attorney General: dayna.arron@ontario.ca.

In addition, IAFMHS member, the Honourable Mr. Justice Richard D. Schneider of Ontario can be contacted: richard.schneider@ontario.ca.

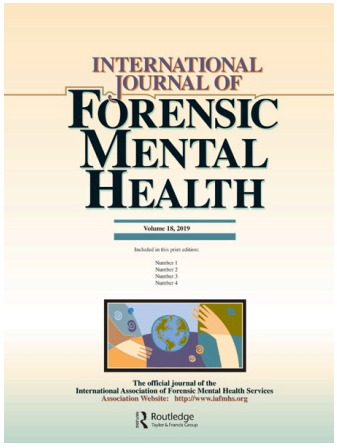
If you are a practitioner or researcher engaged in new or novel mental health diversion initiatives and would like to see this work highlighted, contact Evan Lowder at elowder@gmu.edu.

References

R. V. Wolf, *Principles of Problem-Solving Justice*, Centre for Court Innovation, 2007.

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH

Feature Article



eHealth Technology in Forensic Mental Healthcare: Recommendations for Achieving Benefits and Overcoming Barriers

Hanneke Kip[a,b], Kira Oberschmidt[c,d], and Joyce J. P. A. Bierbooms[e, f]

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While eHealth technologies such as web-based interventions, mobile apps, and virtual reality have the potential to be of added value for forensic mental healthcare, there is a gap between this potential and the current situation in practice. The goal of this study was to identify recommendations to bridge this gap. In total, 21 semi-structured interviews and 89 questionnaires were conducted in a Dutch forensic mental healthcare sample consisting of professionals, patients, and eHealth experts. Based on the broad range of identified recom- mendations, it can be concluded that attention should be paid to the characteristics of pro- fessionals, patients, technology, and the organization throughout the development, implementation and evaluation of eHealth.

FMH-Nursing Risk formulation and the 'Onward flight' of the Early Recognition Method

Frans Fluttert, Ph.D., M.Sc., RN. Senior researcher, FPC
Dr. S. van Mesdag NL, Research Supervisor, SIFER, Centre for Research and Education, Forensic Psychiatry and Psychology, Oslo University Hospital, Oslo, NO; Associate professor, Molde University College, NO; Associate professor, University of Southern Denmark DK

Forensic Mental Health Nurses face huge challenges in their care for patients with aggression problems (Renwick et al. 2016, v. Leeuwen & Harte, 2016). A large proportion of inpatient violence is precipitated by escalating interactions between nurses and patients (Renwick et al., 2016). Improvement of the interaction between staff and patients, for example, by collaborating on relapse prevention plans, may lead to a reduction of rates of inpatient violence (Duxbury & Whittington, 2005; Fluttert et al., 2010, 2020). Nurses may also become more confident in managing patients' aggression when they learn to apply risk management interventions and preventive strategies (Fluttert et al. 2008, 2020; Martin & Daffern, 2006; Mason, Coyle, et al., 2008).

Fluttert et al. (2008, 2010) developed the Early Recognition Method [ERM], which is a risk management strategy emphasizing the identifications and management of early warning signs of aggression. By means of the Aviation Black Box metaphor, Fluttert et al. (2008) explained how nurses unfold what often is perceived as the patient's 'black box' of aggression. By means of a protocolized ERM-interaction between nurse and the patient, the patient's so called 'black box' will be identified and represent their early warning signs that could occur as precursors prior to aggressive behaviors. These early signs can be defined as subjective perceptions, thoughts, and behaviors of the patient occurring prior to the incidence of violent behavior (Fluttert et al. 2011, 2013). The patient's objective behavior is usually quite easy to grasp; that is, a shouting patient clearly shows that they are angry. However, the source of the patient's anger may be more difficult tot grasp at times: Why are they shouting? Why are they so angry? What is going on in their mind? For the early detection of warning signs, considerable attention must be devoted to the recognition and exploration of the subjective factors underlying the patient's aggression or the precursors to violence. Within the ERM framework the FESAI (Forensic Early Signs of Aggression Inventory), a list describing 44 early warning signs, assists nurses in the identification of these signs (Fluttert et al. 2011, 2013). Most important is that ERM is a personalized strategy, fitting to the specific 'black box' or 'signature risk' of the patient's warning signs. This first ERM-intervention study (Fluttert et al., 2010) showed that the ERM strategy contributes to a significant decrease of inpatient aggressive incidents. Following this ERM-study, ERM was evidence-based developed and applied in other mental health institutes across The Netherlands, Belgium, Germany, Denmark and Norway.

The ERM risk management strategy is designed for forensic mental health nurses' practice and fits very well to the Structured Professional Judgement concept of risk assessment based on the Risk-Needs-Responsivity principles (Douglas et al., 2003). Structured Professional Judgement of patients focuses on 'risk formulations', wherein one describes risk scenarios as a means to managing the patients' violence risk (Bjørkly, Eidhammer & Selmer, 2014, Douglas et al., 2014). The Structured Professional Judgement and ERM endeavors to be a multi-disciplinary approach in order to have a comprehensive, patient-oriented, and individualized assessment and management of the patient's violence risk. Patient involvement in these practices is crucial in order to encourage patients to take responsibility for their violence risk and being involved in preventive actions accordingly (Stringer et al., 2008). Despite this, risk management strategies where patients systematically are being involved in risk formulation are scarce (Eidhammer et al., 2014, Ray & Simpson, 2019).

One of the core aims in forensic mental health nursing interactions is to build a sustainable relationship with patients by applying care activities, improving patients' social skills, reality orientation, and practical skills (Rask & Brunt 2006). This is also described in nursing theories explaining the essence of psychiatric nursing (Tanner. 2006). However, in case of risk formulation, forensic mental health nurses risk assessment/management actions are mostly on completing risk tools, such as the ratings on instruments, for example using the Brøset Violence Checklist (BVC) and the Dynamic Appraisal of Situational Aggression (DASA) (Almvik & Woods, 2009, Maguire et al., 2017). However, evidence-based strategies aimed at developing risk formulation by means of systematized dialogues between patient and nurse are scarce. This is remarkable given that within 'general' psychiatric nursing the Shared Decision Making collaboration between nurses and patients is established and acknowledged (Stringer et al., 2008). The specific context of forensic mental health nursing in dealing with patients' aggression, while also attending to the security and safety issues, may present challenging factors in systematically interacting with patients about their aggression and/or violence risk issues (Mason, King & Dulson, 2009). (*Continued on next page...*)

FMH-Nursing Risk formulation and the 'Onward flight' of the Early Recognition Method [ERM]

The ERM is specifically designed to assist forensic mental health nurses to apply interactional risk formulation dialogues. The patient's 'blackbox' could then be a 'brainbox' where the patient and nurse together assess, elaborate, and discuss the patient's personalized warning signs concerning aggression and/or violence risk. When forensic mental health nurses are responsible for the 24/7 care and security of patients having violence risk problems, they should be supported by research focusing on gaining a better understanding of *how* risk management interactions/dialogs could be applied. Against this backdrop, currently in Norway (Oslo University Hospital, Molde University College), the Netherlands (FPC Dr. S. van Mesdag) and Denmark (University of Southern Denmark) there are ongoing ERM studies on various topics such as: discourse analyses on the ERM-protocol (NO), inpatient clinical variables related to incidents and Early Warning Signs plans (NO), a single case narrative study of an aggressive patient in municipality care (NO), ERM in ACT-teams studying the effect on re-admissions and incidents in patients with Schizophrenia or Bi-polar disorder (DK). These studies are mostly 'nurse driven', however in design, appliance and reporting these studies are done within a multi-disciplinary context.

When these kind of studies contribute to opening the patients' 'black box' of aggression and violence risk scenarios, the nurse and patient could then access the patient's 'brainbox' dealing with aggression and/or violence risk. In aviation terms: 'the take-off' (meaning the identification of warning signs of aggression and/or violence risk) and 'the navigation' for forensic mental health nurses in their onward flights towards safe risk management strategies should be guided by sound empirical research to enable a safe 'approach and landing' at new 'destinations' for meaningful risk management.

References

Amvik, R., & Woods, Ph. (1999) Short term risk prediction: The Broset Violence Checklist. Journal of Psychiatric and Mental Health Nursing, 10, 231-238

Bjørkly, S., Eidhammer, G., & Selmer, L. E. (2014). Concurrent validity and clinical utility of the HCR-20V3 compared with the HCR-20 in forensic mental health nursing: similar tools but improved method. J Forensic Nurs, 10(4), 234-242.

Douglas, K. S., Ogloff, J. R., & Hart, S. D. (2003). Evaluation of a model of violence risk assessment among forensic psychiatric patients. Psychiatric Services, 54(10), 1372-1379. doi:10.1176/appi.ps.54.10.1372

Douglas, K.S., Hart, S.D., Webster, Ch. D., Belfrage, H., Guy, L.S. & C.M. Wilson (2014). Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3): Development and Overview International Journal of Forensic Mental Health, 13: 93–108, 2014

Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and aggression: Staff and patient perspectives. Journal of Advanced Nursing, 50(5), 469–478.

Eidhammer, G., Fluttert, F. & Bjørkly (2014), S. User involvement in structured violence riskmanagement within forensic mental health facilities – A systematic literature review. Journal of Clinical Nursing; 23,2716-2724

Fluttert F., B. Van Meijel, H. Nijman, C. Webster & M. Grypdonck (2008). Risk management by early recognition of warning signs in forensic psychiatric patients. *Archives of Psychiatric Nursing* Vol.22, No.4 (August), 208-216.

Fluttert F., B. Van Meijel, S. Bjørkly, M. Van Leeuwen, H. Nijman, M. Grypdonck (2013). Early signs of inpatient aggression in forensic psychiatry: an empirical investigation with the Forensic Early Signs of Aggression Inventory [FESAI]. *Journal of Clinical Nursing,*. Vol 22, 11-12, 1550-1558.

Fluttert F., B. Van Meijel, M. Van Leeuwen, S. Bjørkly,H. Nijman, M. Grypdonck (2011). The development of the Forensic Early warning Signs of Aggression Inventory [FESAI]: Preliminary findings. Towards a better management of inpatient aggression. *Archives of Psychiatric Nursing*, 25(2), 129-137.

Fluttert F., B. Van Meijel, H. Nijman, S. Bjørkly, M. Grypdonck (2010). Effect of The Early Recognition Method on the number of aggressive incidents and episodes of seclusions in forensic care. *Journal Clinical Nursing*, 19, 1529-1537.

Fluttert, F.A.J., Bjørkly, S. & K.Y. Dale (2020). The impact of a discarded diagnosis and focus on early warning signs of aggression on relations between user and municipal service providers - A narrative of a complex case. *Current Psychology.* DOI: 10.1007/s12144-020-01055-x

Leeuwen van, M.E. & J. Harte 2016). Violence against mental health care professionals: prevalence, nature and consequence. *The Journal of Forensic Psychiatry and Psychology*.

Martin, T., & Daffern, M. (2006). Clinical Perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. Journal of Psychiatric and Mental Health Nursing, 13, 90–99.

Mason, Y., King, L., & Dulson, J. (2009). Binary construct analysis of forensic psychiatric nursing in the UK: High, medium and low security services. International Journal of Mental Health Nursing, 18, 216–224.

Maguire, T., Daffern, M., Bowe, S.J. & B. McKenna (2017). Predicting aggressive behaviour in acute forensic mental health units: A re-examination of the dynamic appraisal of situational aggression's predictive validity. *International Journal of Mental Health Nursing,* doi.org/10.1111/inm.12377.

Rask, M., & Brunt, D. (2006). Verbal and social interactions in Swedish forensic psychiatric nursing care as perceived by the patients and nurses. International Journal of Mental Health Nursing, 15, 100–110.

Ray, I., & Simpson, A. I. F. (2019). Shared Risk Formulation in Forensic Psychiatry. J Am Acad Psychiatry Law, 47(1), 22-28. doi:10.29158/JAAPL.003813-19

Renwick, L., Stewart, D., Richardson, M., Lavelle, M., James, K., Hardy, C., Bowers, L. (2016). Aggression on inpatient units: Clinical characteristics and consequences. Int J Ment Health Nurs, 25(4), 308-318. doi:10.1111/inm.12191

Stringer, B., Van Meijel, B., Vree de, W., & Van der Bijl, J. (2008). User involvement in mental health care: the role of nurses. A literature review. Journal of Psychiatric Mental Health Nursing, 15, 678–683.

Tanner, C. A. (2006). Thinking like a nurse: a research-based model of clinical judgment in nursing. J Nurs Educ, 45(6), 204-211.

EQUITY, DIVERSITY, INCLUSION COMMITTEE

Introducing the IAFMHS Equity, Diversity, Inclusion Committee (EDIC)

IAFMHS is excited to announce the creation of the Equity, Diversity, Inclusion Committee (EDIC). EDIC holds monthly meetings and is committed to fostering equity and diversity in our organization and the field of forensic mental health. The committee aims to promote diversity in the Association's membership, as well as an inclusive environment that enables the contributions of all members. In order to enhance the standards of forensic mental health services in the international community, the committee will take a proactive response to ensure that organizational activities, protocols and structures are culturally sensitive, non-discriminatory and responsive to the needs of vulnerable, underrepresented, or marginalized communities. The IAFMHS Equity, Diversity, Inclusion Committee is also committed to strengthening IAFMHS research capacity and the delivery of best practice forensic mental health services by recognizing diversity of background, experiences, orientations, and abilities. As part of this mission, our goals are to:

1. Enhance the standards of forensic mental health services in the international community by ensuring that IAFMHS acts as an organization that is culturally sensitive, non-discriminatory and responsive to the needs of vulnerable, underrepresented, or marginalized, communities
2. Promote an international dialogue about diversity issues and considerations in forensic mental health
3. Promote education, training, and research in diversity issues in forensic mental health services
4. Support and create membership, leadership, and research opportunities for members of under-represented group
5. Inform professional communities and the public about current diversity issues in forensic mental health services

Current Members

The IAFMHS Equity, Diversity, Inclusion Committee is made up of a diverse group of clinicians, researchers, early career professionals and students representing eight countries working in the areas of forensic nursing, social work, psychology, and psychiatry:

- **Maria Aparcero-Suero,** Fordham University (USA/ Spain)
- **Hanie Edalati,** Canadian Centre on Substance Use and Addiction & Philippe-Pinel National Institute of Forensic Psychiatry, University of Montreal (Canada/ Iran)
- **Jourdan Jackson,** Simon Fraser University (Canada/ USA)
- **Brian McKenna,** Auckland Regional Forensic Psychiatry Services and Auckland University of Technology (New Zealand)
- **Sajid Muzaffar,** Birmingham and Solihull Mental Health NHS Foundation Trust (United Kingdom)
- **Alicia Nijdam-Jones,** University of California, San Francisco (USA/Canada)
- **Wendy Olson,** Saint Elizabeths Hospital (USA)
- **Sarah Schaaf,** Fairleigh Dickinson University (USA/ Germany)
- **Stephane Shepherd ,** Centre for Forensic Behavioural Science, Swinburne University of Technology (Australia)
- **Viola Vaughan-Eden,** Norfolk State University (USA)

Become Involved with EDIC

EDIC is currently recruiting new members. Participation in EDIC includes monthly Zoom video conferences and/or involvement in subcommittees that aim to further initiatives that foster equity and diversity in IAFMHS and the field of forensic mental health.

To apply, please submit your self-nomination, including your CV and a 300-word statement of interest highlighting your qualifications and interest in the committee, to edic@iafmhs.org by **April 30, 2021**. Both professional and student members of IAFMHS are encouraged to apply!

STUDENT SECTION

20th ANNIVERSARY SPOTLIGHT EDITON: Interview with our Former Student Board Presidents (Part 1)

Student Section Editors: Sarah Schaaf, Student President, Fairleigh Dickinson University, USA | Israa Altwaijiri, Student President-Elect, Swinburn University of Technology, AUS | Maartje Clercx, Student Secretary, Radboud University, NL

Dr. Alicia Nijdam-Jones is a clinical psychology postdoctoral fellow in the Clinical Psychology Training Program at the University of California, San Francisco. She has an MA and PhD in clinical psychology from Fordham University, as well as an MA in criminology from Simon Fraser University. Dr. Nijdam-Jones specializes in the area of violence risk assessment, assessment of malingering, stalking, and the use of forensic assessment measures with linguistically and culturally diverse (CALD) samples. She is experienced in conducting psychological and neuropsychological evaluations, as well as individual and family evidence-based interventions across inpatient and outpatient settings.

For her dissertation, Dr. Nijdam-Jones examined the accuracy of a culturally adapted version of a violence risk assessment measure in predicting institutional violence with offenders in a Mexico City prison. Dr. Nijdam-Jones is currently involved in several projects with collaborators at UCSF, Fordham University, University of Virginia, and researchers in Spain and Latin America.

Alicia Nijdam-Jones, PhD
Student Board President
2016-2017
"Congratulations, IAFMHS! We've come so far in the last 20 years, and I look forward to seeing all that we will accomplish in the next two decades!"

Q: What motivated you to become president of the IAFMHS student board?

A: I had been attending IAFMHS conferences since 2010, and the association had become integral to my growth as a student and professional in this field. When I came across the opportunity to become involved in the student board, I was excited at the prospect of developing student programming and professional development opportunities at the conference and throughout the association. I was also keen to grow my network by meeting graduate students with similar clinical and research interests.

Q: What are some of the projects the student board has worked on during the 2015/16 term?

A: I was fortunate to work with a wonderful team of fellow graduate students during the year I was student board president. Together we furthered the goals of the prior student boards, while creating several new initiatives, such as the IAFMHS Campus Representative Program, expanding the student presentation and travel awards, and developing the Derek Eaves Student Research Grant to support student research outside of conference attendance.

Q: What have you taken away from your IAFMHS student board presidency?

A: I learned invaluable leadership and mentorship skills while working with the IAFMHS student board. More importantly, however, I learned the importance of teamwork and collaboration, working together to build on each other's strength, while learning from each other's diversity of experience. Working with the student board also allowed me to develop important friendships with colleagues around the world, many of whom have come to influence my research and professional goals.

Q: What do you value about IAFMHS?

A: I have always found IAFMHS to be an incredibly supportive environment for students in the field of forensic mental health, and I look forward to the conference every year. Not only do these annual meetings provide the opportunity to share and learn about international research and clinical initiatives, but I also always return home inspired to ask new questions and approach my work in new ways. The association has also provided the opportunity to catch up with my colleagues and develop new professional relationships, which have been invaluable as I transitioned from a student to an early career professional.

Q: What advice would you give to the current IAFMHS SB?

A: Lean on and learn from each other. Each board member brings something different, unique and unexpected. The student board continues to impress me, developing new ideas and initiatives every year. It is foundational to the work of the association, so never forget how important and valued your contribution is.

Q: What advice would you give to students and young professionals interested in following your career path?

A: Take advantage of all the opportunities that present themselves to get more involved – be that through participation in conferences and workshops, contributing to newsletters, or through research collaborations with peers, colleagues, and other professionals. That said, protect your time and strive to strike a balance between your personal and professional life. This balance is essential in your success.

STUDENT SECTION

20th ANNIVERSARY SPOTLIGHT EDITON: Interview with our Former Student Board Presidents (Part 1)

Dr. Martin has worked with the Correctional Service of Canada since 2005, where he is now the Acting Director of Epidemiology. In addition, he is an Adjunct Professor at the School of Epidemiology and Public Health at the University of Ottawa. Dr. Martin received his PhD in Epidemiology and Public Health from the University of Ottawa in 2017, an MA in Psychology from Carleton University in 2011, and his BA in Criminology and Criminal Justice from Carleton University in 2007.

Dr. Martin's areas of expertise and research interests include: screening for mental illness; trajectories of mental illness and self-harm; risk and protective factors for mental health and behavioural outcomes; treatment of mental illness and self-harm behaviours; and system integration across jurisdictions and ministries responsible for providing health and social services.

Michael Martin, PhD
Student Board President
2015-2016
"Looking forward to (finally) celebrating the 20th anniversary of this fantastic organization with all of you soon!"

Q: What motivated you to become president of the IAFMHS student board?

A: I was involved in various leadership and volunteer organizations during my high school and university days, so giving back and building my leadership skills have always been important to me. Specific to IAFMHS, I was inspired by the work of previous student boards and saw this as an opportunity to help continue to grow the organization for students. The annual IAFMHS conference is often the only conference I attend because it is highly relevant to my work, and, most importantly because the members are so welcoming and generous with their time. Joining the board was not only a way to give back, but also to build stronger relationships with other leaders in the organization and experts in the field of forensic mental health.

Q: What are some of the projects the student board has worked on during the 2015/16 term?

A: As the board was still relatively new at the time, we primarily continued to grow a foundation for the organization and the student board. We focused on creating new incentives for membership such as running fundraisers to introduce new scholarships, creating a new website for the section, increasing the section's social media presence, and launching the peer mentorship program.

Q: What have you taken away from your IAFMHS student board presidency?

A: Most importantly, I took away some great new friendships and relationships with other student board and IAFMHS members. I often think back to the meetings that we held and how productive and enjoyable they were; I try and draw on some of the ingredients from these meetings to help run more effective meetings in my current job. It has also been incredibly rewarding to see many projects carry on through subsequent boards. The lessons I learned serving on a time-limited board have definitely helped me build more sustainable projects and processes in my work.

Q: What do you value about IAFMHS?

A: The generosity and expertise within the organization is second to none. I've joined various research and professional networks as a direct result of my involvement in the organization. I've had fantastic experiences within the organization, including my three years with the student board and two years on the conference Scientific Program Committee. Through these experiences I've learned about a wide range of topics and been exposed to the fantastic work that is being done by members around the world.

Q: What advice would you give to the current IAFMHS SB?

A: This is the beginning of your time to make a mark on the future of the organization, and the field of forensic mental health more broadly. But keep in mind that this is just a beginning; you don't need to achieve everything you can dream up in your short time on the board. Prioritize. Look after each other. Take self-care seriously. Enjoy the experience and the responsibility that you have been given by your fellow students.

Q: What advice would you give to students and young professionals interested in following your career path?

A: Whatever career path is of interest to you, think about what is essential to getting you there, and focus your efforts there. It seems that pressure to do more, faster, and better continues to grow, whether that comes from external sources, or ourselves. Look after yourself, and your colleagues, as people are the most important resource we have. Perhaps the best advice I was given at the start of my doctoral studies was to draft the cover letter I hoped to submit when applying for jobs, and work towards making that a reality. Having this as a road map helps identify which opportunities to pursue, and when to pass an opportunity on to someone else. Turning down an opportunity is difficult, but you'll be surprised how often you earn the respect of others in doing so, particularly if this means you are dependable and always follow through on your commitments.