Summer Edition Features

Letter from the Editor

It is with great sadness that we open this edition of the newsletter celebrating the life of Dr. Jodi Viljoen. Many of us knew Jodi both personally and professionally, and her legacy will live on through those that worked alongside her, were mentored by her, and through every single individual who builds on or is benefitted by the research she has conducted. Our field has lost a brilliant mind and a kind heart.

It was against this backdrop of loss that our organization gathered in Berlin for our first annual conference since the COVID-19 pandemic. Many reconnections were made and we all look forward to our next conference in Sydney in 2023.

As always we invite contributions but also feedback regarding our newsletter content.

Sarah Coupland, Editor

IN MEMORIAM

In Memoriam: Dr. Jodi Viljoen

It is with deep sadness that I am writing this In Memoriam for Dr. Jodi Viljoen, who died in June 2022. Despite her many accomplishments, Jodi was incredibly modest, and one of the kindest, caring, creative, warm, and thoughtful individuals I've ever known. I will miss her terribly and our field has lost one of its most outstanding humans.

I have known Jodi since 1998 when she started graduate studies at Simon Fraser University. I was her supervisor for her Master's and Doctoral research. She was an absolute pleasure to supervise. She was always prepared, took initiative on projects we worked on together, and was eager to take the lead on collaborations during her training. One example is that she is lead author on an article in which we challenged the Canadian laws that prevented psychologists from conducting pretrial criminal assessments.

Jodi's dissertation research was the beginning of her career-long interest in improving mental health and treatment services for adolescents in the justice system and the prevention of violence and offending. Through our collaborations, Jodi further developed competency to stand trial research through focusing on young offenders. Her study had an impact on our understanding of the cognitive elements of competency and incompetency, and the differences between adults and juveniles on the construct of criminal competency to stand trial. The exceptionally high quality of this research was recognized by the American Psychology-Law Society (AP-LS) when it honored her with its award for the best dissertation of the year in psychology and law.

Following obtaining her Ph.D. she took a position as an assistant professor at the University of Nebraska. To my delight, we were able to recruit her to return to SFU to join our faculty in the Law and Forensic Psychology program.

Jodi's promise as a young scholar was highly recognized during her academic career, and she leaves the field with a rich legacy that will continue to shape the field. By the time I nominated her for the AP-LS Saleem Shah Award for Early Career Contributions (an award she won), just five years into her career, she had published in the top journals of our field and begun the research that would lead to the development of two forensic assessment instruments for assessing adolescents. One of those instruments, the Short-Term Assessment of Risk and Treatability: Adolescent Version, illustrated her perspective that the assessment of risk must include an emphasis not just on the deficits and vulnerabilities of individuals but also their strengths, and that both characteristics are necessary to generate effective interventions to minimize future risk. She went on to create the Adolescent Risk Reduction and Resilient Outcomes Work-Plan (ARROW), which is based on her view that youth are less likely to reoffend when professionals select and implement case management

strategies that research has shown to be effective. The ARROW provides a structured process for justice professionals to develop evidence-based case management plans.

Jodi was also an outstanding mentor. She provided opportunities for her students in all aspects of research, from contributing to grant writing, presenting papers at conferences, and co-authoring publications. One student wrote on her tribute page that she was always full of positive energy, enthusiasm, and endlessly kind and supportive. Another wrote that she always had a smile or a kind word. Jodi was generous with her time, and the impact she had on her students was recognized by SFU when she received the Dean of Graduate Studies Award for Excellence in Supervision in 2011..

Jodi was passionate in her commitment to promoting social change. She served on the Broadening Representation, Inclusion, and Global Equity Committee for the American Psychology-Law Society and was the co-chair of its Diversity Awards. She was co-founder of the Indigenous Reconciliation Committee in SFU's Department of Psychology where she supported students and faculty in their journey to understanding the devastation of colonialism and genocide as she continued her own journey as a settler in Canada. (*Continued on next page…*)

IN MEMORIAM

In Memoriam: Dr. Jodi Viljoen

She worked tirelessly to link Indigenous students with Indigenous scholars and Elders.

Jodi was most recently honored with induction into the College of New Scholars, Artists, and Scientists of the Royal Society of Canada. Earlier this year, the Department of Psychology nominated her for a University Research Professorship. The university honored her with this prestigious award, but sadly it will now be given posthumously.

Jodi was always one to recognize those who supported her, including many of her colleagues and students who contributed richly to her research. Jodi will be missed by the many lives she touched at SFU and throughout the world. Jodi always expressed such joy when she talked about her loving family. She is survived by her husband Adam, her children Talia and Luke, and her parents Dale and Joanne.

A memorial donation may be made to Indspire (https://indspire.ca/) an organization important to Jodi that invests in the education of First Nations, Inuit and Métis people.

Ron Roesch

MENTAL HEALTH DIVERSION

Diversion First: Fairfax County's Approach to Developing a Cross-System Continuum of Care

Lisa Potter, Med, CSAC
Fairfax County Government, Fairfax, Virginia, USA

In 2015, leaders in Fairfax County, Virginia (United States) came together with a shared vision to address gaps in the intersection between criminal justice and behavioral health and transform the local system. That vision became Diversion First, a countywide initiative to offer alternatives to arrest and incarceration for people with mental illness, substance use disorders, and/or developmental disabilities who come into contact with the criminal justice system for low-level offenses. The goal of the initiative is to intervene whenever possible to provide assessment, treatment and needed support to prevent repeat encounters with the criminal justice system. Along with many other jurisdictions throughout the country, Fairfax County uses the Sequential Intercept Model as a framework for developing programs and services. This model helps communities to identify existing resources and opportunities to address system gaps to create opportunities for diversion at multiple points. The County was intentional in developing services at each intercept, recognizing that a comprehensive system would improve the lives of individuals and families at various stages of criminal justice involvement.

Lisa Potter, Med, CSAC

Director of Diversion Initiatives

Fairfax County Government

Diversion First has grown considerably in the past seven years and now includes a continuum of services for individuals involved in the criminal justice system who have behavioral health needs. (*Continued on next page…*)

MENTAL HEALTH DIVERSION

Diversion First: Fairfax County's Approach to Developing a Cross-System Continuum of Care (Continued…)

At the earliest stages, community-based teams, many comprised of public safety and clinical staff, provide services to address behavioral health crises. These teams offer services ranging from an immediate crisis response to outreach and engagement for individuals with unmet needs who have frequent public safety encounters. In addition, law enforcement officers can bring individuals to a 24/7 community-based crisis response center for services in lieu of arrest.

Diversion First also provides opportunities for intervention throughout the criminal justice system. Individuals booked into the local adult detention center are screened with standardized tools, and an array of behavioral health services, including an addiction recovery program and medication for opioid use disorder, are provided during incarceration. The court system is also a key Diversion First partner.

A Supervised Release Program provides intensive pre-trial supervision in the community, reducing the number of people who are incarcerated. Three specialty dockets, the Veterans Treatment Docket, Drug Court and Mental Health Docket, provide diversion though a structured process that integrates treatment and court supervision, providing a path out of the criminal justice system. Diversion First also includes a robust system of community-based behavioral health treatment, peer recovery support and housing to support stability, self-sufficiency skills, and long-term independence.

Fairfax County Courthouse

The momentum for Diversion First has not waned, and the County is committed to continually assessing for service gaps, quality improvement opportunities, and expanding programming based on data analysis and evolving community needs. Community crisis teams will expand in the coming months, and diversion efforts will align with the new nationwide 988 dialing code for crisis calls. The 988 code will provide a behavioral health alternative for 911/ calls for service in situations that do not require a public safety response, with trained call takers providing phone de-escalation and linkages to community resources. In addition, the County is planning for a future community re-entry center to serve as a central location to access a variety of resources to those currently involved in the criminal justice system, including employment, housing, health care, and assessment for treatment services.

Sharon Bulova Center for Community Health

The success of Diversion First is based on the partnership of multiple agencies working collaboratively to serve this complex and vulnerable population. Collaboration between non-traditional partners has resulted in tremendous culture change through a collective mission, co-located staff, shared policies and protocols, and data-sharing agreements. Broad County involvement from the onset of the initiative has also been essential, with County information and technology and legal agencies providing critical guidance, support, and willingness to advance innovative solutions to barriers such as disparate data systems. Frequent communication among stakeholders, including public and private partners, health care systems, and community members has led to increased resource efficiency and better outcomes. With sustained commitment and sense of purpose to serve those with behavioral health issues, comprehensive diversion programs are achievable and transformative, and ultimately strengthen communities.

If you have questions, comments, or feedback regarding this article, please do not hesitate to contact **Lisa Potter** at: lisa.potter@fairfaxcounty.gov

If you are interested in submitting a newsletter piece for the mental health diversion section of our newsletter, contact **Evan Lowder** at **elowder@gmu.edu**

NEW RESEARCH

Weight Gain in Secure Psychiatric Inpatient Settings: A Completed PhD Project

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Background

High obesity rates have been documented in psychiatric populations in the UK; on average inpatients gain three to five pounds a month during initial inpatient treatment (Shin et al., 2002; Wetterling, 2006). This is of particular concern for secure inpatients, who have higher obesity rates compared to the general population (Mills & Davies, 2022). Excessive weight gain in this population has long-term psychological and physical implications for the patient group. In the UK, individuals with schizophrenia have a life expectancy that is 20 years shorter than the general population (Laursen, 2011). Preventable physical illness is a leading cause of death in those with schizophrenia and these individuals are three times more likely to die from coronary heart disease compared to the general population (Hennekens et al., 2005). People diagnosed with this disorder are also at greater risk of developing type two diabetes and life-shortening respiratory diseases (Subashini et al., 2011; Tay, Nurjono & Lee, 2013). Obesity is a key contributing factor in all of the health conditions outlined above.

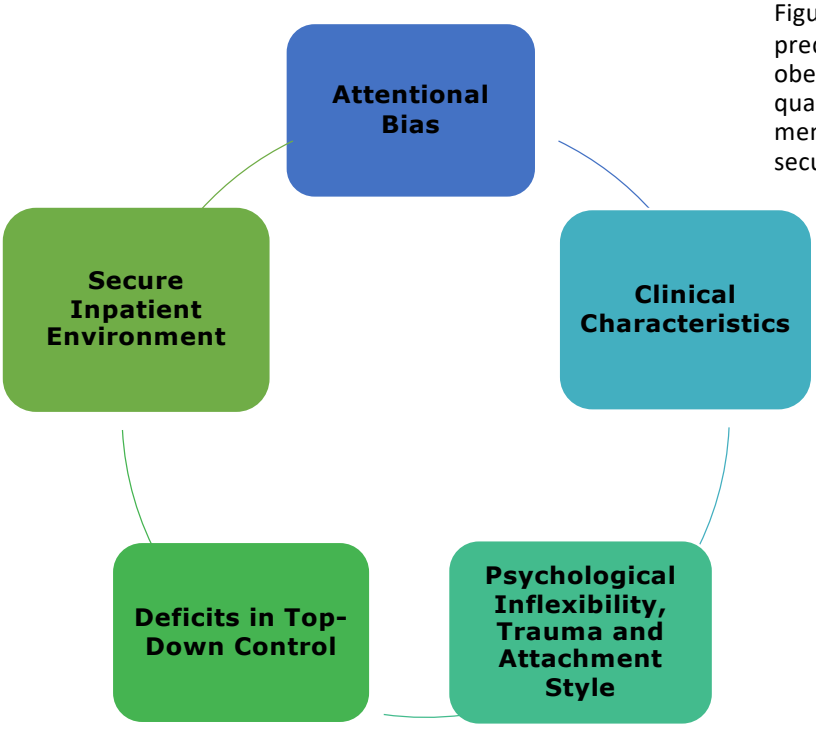

Figure 1. Conceptualisation of secure inpatient obesity

Aim

A review of studies identified a number of individual psychological, cognitive, behavioural and environmental factors that influence weight gain and obesity in the non-secure psychiatric literature. These are highlighted in Figure 1. A PhD project was conducted to assess the predictive power of these factors on weight gain and obesity in Welsh secure psychiatric inpatient services. A qualitative study was also conducted to explore staff members' views on why obesity is so common within secure services.

Project design

This PhD project is comprised of three studies. The first was a retrospective analysis of patient medical records, assessing the predictive power of pharmacological and clinical factors on weight gain over the first three months of inpatient treatment. Analysis was conducted on data from 209 inpatients from low and medium secure services in Wales. The second was an experimental study with 23 inpatients from medium and low secure services in Wales. The study involved a visual dot probe task to assess attentional bias towards high calorie food items and a questionnaire battery assessing levels of dysregulate eating behavior, top-down control, attachment style, Adverse Childhood Experiences (ACEs) and experiential avoidance. Initially a regression design was intended for this study to assess predictive power of these factors on weight gain over three and six months of inpatient treatment, however, due to lack of power because of the low sample size, a correlational design was used.

NEW RESEARCH

Weight Gain in Secure Psychiatric Inpatient Settings: A Completed PhD Project (continued)

The final study was a qualitative study that explored secure services staff views on inpatient obesity. Thirteen staff members from a range of professions were interviewed and a thematic analysis was conducted.

Findings

The initial findings within this PhD project were that the majority of inpatients were overweight or obese (70%). Contrary to the psychiatric weight gain literature, pharmacological or clinical factors did not predict weight gain over the initial three months of treatment. Weight on admission was the only significant predictive factor in this analysis, with lower weight individuals gaining more weight over 3 months.

With this, analysis from study two revealed that inpatients generally had an attentional bias towards high calorie foods, had high numbers of ACEs and greater levels of experiential avoidance compared to other clinical samples. Furthermore, higher scores of dysregulated eating behavior were associated with weight gain over three months. An anxious-preoccupied attachment style was associated with weight gain over six months. There were no other significant associations.

In a qualitative study, a thematic analysis identified a number of core themes that staff believed contributed to secure inpatient weight gain and obesity (see Table 1).

Table 1. Themes identified in study three analysis

Theme	Sub-theme
Secure Service Culture	Staff Shortages
	Restrictions
	Mental Health as Priority
Food Culture	Food Accessibility
	Hospital Food
	Normalisation
Poor Mental Health	Psychosocial Factors
	Effects of Medication
	Poor Motivation

Implications

Whilst it is important to acknowledge the limitations of this PhD project, the findings have important applications for practice. The findings suggest that there are individual cognitive, psychological and behavioural characteristics that are common amongst secure inpatients that may play a role in secure inpatient weight gain, factors independent of psychotropic drugs associated with high risk of weight gain. It is prudent that future research explores the predictive power of these factors across a broader sample and address the obesogenic nature of secure inpatient services.

Funding

This PhD project was funded by a Knowledge Economy Skills Scholarships (KESS2) studentship. This funding body is supported by the European Social Funds through the Welsh Government and links companies and organisations with academic expertise in the higher education sector in Wales to undertake collaborative research projects.

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ACROSS DISCIPLINES FEATURE

Possible differences between forensic psychiatrists and forensic psychologists in providing a diagnosis in criminal forensic assessments

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There has been debate as to whether a defendant's diagnosis should be included within a forensic mental health expert's report. The decision as to including a diagnosis may relate to the jurisdictional requirements in law, but also to the professional discipline of the evaluator. It is our hypothesis, based on clinical and administrative experience in the field, that forensic psychiatrists may be inclined to provide a diagnosis, whereas many psychologists may elect to not provide a diagnosis. Future research may help substantiate and quantify these possible differences. There are rational reasons for either including or excluding a diagnosis where permitted, and we suspect that there are cultural differences as well between the two disciplines which may influence their decisions.

Andrew Reisner, PsyD. & Jennifer Piel, JD, MD

Differences of opinion between Forensic Psychiatry and Forensic Psychology may be represented in their respective forensic guidelines and other relevant literature. The American Academy of Psychiatry and the Law (AAPL) suggests in its Practice Guideline for the Forensic Assessment that a diagnosis should be offered when "symptoms and signs allow a diagnosis that is in accordance" with the DSM or the International Classification of Disorders (ICD) (Glancy et al., 2015, p S26). Additionally, the AAPL practice guideline specific to competence to stand trial (Mossman et al., 2007) notes that inclusion of a diagnosis may substantiate that the defendant has a mental disorder in jurisdictions where this must be legally established and may help the court to better understand the basis for the defendant's functional incapacity and contribute to establishing the likelihood of restorability. In contrast, The Specialty Guidelines for Forensic Psychology emphasized the focus on legally relevant factors. The Specialty Guidelines state that forensic evaluators "are encouraged to consider the problems that may arise by using a clinical diagnosis in some forensic contexts and consider and qualify their opinions and testimony appropriately" (American Psychological Association, 2015, p 15). Both forensic psychologists and forensic psychiatrists acknowledge the cautionary statement in the DSM-5-TR establishing that a diagnosis does not essentially settle any given forensic issue, and that a functional assessment is needed in a forensic report (American Psychiatric Association, 2022). While acknowledging that at times providing a diagnosis is appropriate, an authoritative text on psychological evaluations for the courts cites arguments made for not providing a diagnosis, including problems in reliability of diagnosis, questionable relevance to the legal question being addressed, and the risk of time consuming cross-examination about which diagnosis is most accurate (Melton, Petrila, Poytheress, & Slobogin, 2007).

Although speculative, we wonder whether differences between forensic psychiatry and forensic psychology may have cultural roots as well as rational reasons. Psychiatrists may wish to maintain their identity within the field of medicine, which emphasizes the importance of diagnosis; psychiatry in general has become increasingly biologically oriented and adheres to a "medical model." The distaste for diagnosis among many psychologists may have its origin in the anti-psychiatry sentiments from the 1970's and earlier, where the medical model was reviled. There were times in the history of psychology when psychologists were not allowed to establish an official diagnosis in many clinical settings, and lacking the historical authority to diagnose, psychologists may have increasingly come to value assessment of personality and functional capacities.

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ACROSS DISCIPLINES FEATURE

Possible differences between forensic psychiatrists and forensic psychologists in providing a diagnosis in criminal forensic assessments (Continued…)

Although assessment of functional capacity is an undisputed essential element in both forensic psychiatrists' and forensic psychologists' assessments, we note that forensic statutory issues such as establishing mental illness, "severe mental disease," intellectual disability, and restorability to adjudicative competence, all involve psychodiagnostic assessment. In addition to describing the evaluee's functional abilities (or inabilities) and how the abilities relate to the psycho-legal question, we favor providing a diagnosis in forensic reports, although respect that others may not.

If you have questions, comments, or feedback regarding this article, please do not hesitate to contact **Dr. Andrew Reisner** at: forensicd9@gmail.com.

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RISKY BUSINESS

Supporting personal recovery for forensic mental health service users: The CHIME-Secure framework

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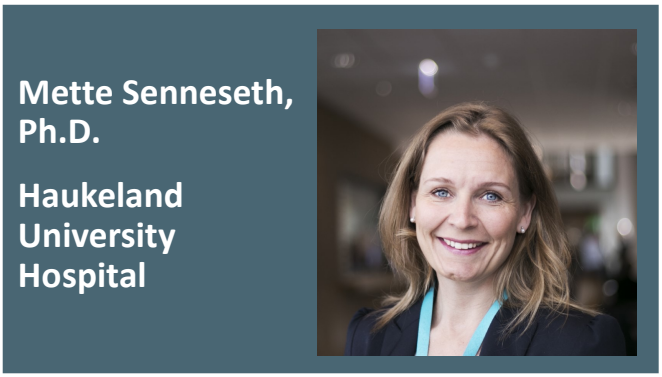

A recovery-oriented model of care has increasingly affected forensic mental health (FMH) services in the past decade. In contrast to other mental health service users, FMH service users include people whose behaviors represent a considerable risk to themselves and others. The potential conflict between the recovery paradigm and public security features of FMH services has thus been a subject of debate. However, there are strong arguments that the recovery model of care is as important for FMH service users as for other persons with mental illness and that FMH service users should receive best practice alongside other adult service users in mainstream psychiatric services (Simpson & Penney, 2011).

Although efforts have been made in making recovery a reality in FMH services, and previous work has shown that it is possible to implement recovery in a non-tokenistic fashion in forensic settings (Drennan & Wooldridge, 2014), there is no unifying or established framework for the concept of personal recovery for FMH service users to guide FMH services. When researchers studied the narrative accounts of non-forensic service users' recovery journeys, they found five common components resulting in the CHIME framework – connection, hope, identity, meaning and empowerment. A recent systematic review aimed to expand and adapt the original CHIME framework for personal recovery (Leamy et al., 2011) to make it suitable for understanding personal recovery in FMH service users (Senneseth et al., 2022). Twenty-one papers were included in the review and represented the views of 298 FMH service users, mostly inpatients (n=274). Based on these findings, the CHIME-Secure (CHIME-S) was presented. The CHIME-S is an acronym for the six personal recovery processes of FMH service users: Connectedness, Hope and Optimism about the Future, Identity, Meaning in Life, Empowerment and Safety and Security (Senneseth et al., 2022).

A prevalent finding in almost all papers was that service users needed to feel safe and secure, which meant being protected from hostile people and environments, as well as the active practice of self-management of risk.

(*Continued on next page…*)

RISKY BUSINESS

Supporting personal recovery for forensic mental health service users: The CHIME-Secure framework (Continued…)

These findings were categorized as the new key recovery process Safety and Security. The majority of findings in this new main category were related to self-management of risk of violence and/or relapse to criminality. To be able to support this recovery process one need to have specific strategies to educate and train FMH service users in how to manage their own risks and how to maintain their physical and mental health. Several papers also emphasized service users' needs regarding preparing for life outside FMH services.

Furthermore, the quality of relationships with staff and the ward environment played an important role in forensic service users' recovery. The key recovery process of Connectedness was concerned with service users being a part of the ward community for a long time. Developing Hope for a good life in the future and the belief in the possibility of recovery was also viewed as an essential recovery process. For Identity, analyses revealed three new subcategories related to rebuilding and redefining a positive sense of self: 'working with one's identity', 'coming to terms with past offences' and 'coming to terms with trauma and having been victimized'. Moreover, FMH service users needed to experience meaning in life, and to have an active and meaningful use of time while being an inpatient. Finally, findings highlighted the needs of FMH service users for a sense of Empowerment in a restricted life. Although all papers stressed the need for a mutual collaboration in forensic care, many service users experienced a lack of collaboration and involvement.

Several challenges and barriers for personal recovery for forensic service users were identified. All challenges and barriers appeared to represent the opposites of – or the lack of – the recovery processes defined by CHIME, each of which were placed into negatively loaded CHIME categories: Disconnectedness, Hopelessness, Negative Identity Experience – stigma as an offender, Lack of meaning and Disempowerment. While being a framework for understanding the recovery-processes and their associated barriers as viewed by FMH service users, the CHIME-S may be a useful framework to develop and guide recovery-oriented practices in FMH services.

To learn more about this study, see:

Senneseth, M., Pollak, C., Urheim, R., Logan, C., & Palmstierna, T. (2022). Personal recovery and its challenges in forensic mental health: Systematic review and thematic synthesis of the qualitative literature. *BJPsych Open, 8*(1), E17. doi:10.1192/bjo.2021.1068.

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 **Sarah Coupland**, Newsletter Editor at sarah_coupland@sfu.ca.

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Special Interest Group Conference Update

The Mental Health Courts and Diversion Programs Special Interest Group held a virtual meeting for its members. Topics discussed included the naming of specialty court programs, early intervention strategies more broadly, coordinated diversion initiatives, the role of stigma in accessing behavioral health resources, and criminal law reform. The SIG also discussed organizing diversion-related sessions for the 2023 annual conference in Sydney. Finally, the SIG solicited calls for short contributions to the "Spotlight on Mental Health Diversion" section of the IAFMHS Newsletter. Anyone who is interested in receiving more information can reach out to Evan Lowder at elowder@gmu.edu.

FORENSIC MENTAL HEALTH NURSING

Walking a Tight Rope: Maintaining Boundaries in the Forensic Milieu

Cindy Peternelj-Taylor, RN, HBScN, MSc, DF-IAFN, Professor Emeritus, College of Nursing, University of Saskatchewan

The ability to create and maintain therapeutic boundaries with forensic clients has been described as one of the most important competencies required by forensic nurses working with clients under forensic purview. Establishing and maintaining boundaries creates a relational space in which the client and nurse explore treatment issues within the safety of the therapeutic relationship. Boundary violations, however, are a distressing reality of clinical practice within forensic environments, which are often described as "hotbeds" for potential problems. The complex nature of the clients' psychopathology and treatment needs, the seductive pull of helping, professional isolation, and the failure of ethical reasoning by professionals (Adshead, 2012; Peternelj-Taylor, 2002; 2012), contributes to uncertainties surrounding professional boundaries. For many forensic nurses, navigating the therapeutic relationship in the forensic milieu is like walking on a tight rope. However, boundary violations that occur in practice are not unique to forensic nurses. As Collins (1989) notes "the very relationship that offers the promise of healing, also exposes practitioners of all disciplines to the hazards of overstepping their professional bounds (p. 153).

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The inability to differentiate the professional relationship from a social relationship by attempting to have one's personal needs met through the nurse–client relationship is consistently discussed as a precursor to boundary violations in the nursing literature. In forensic settings, nurses are often warned about getting "too close" to their clients, an edict that is rarely coupled with guidance regarding how to become engaged in a meaningful way that safely promotes the achievement of treatment goals for their clients. Yet when nurses transgress professional boundaries, they are often painted as "victims of circumstances, who were duped by the smooth-talking con artist." Clearly from an ethical perspective, the nurse is the one responsible for managing boundaries within the therapeutic relationship, not the client.

Forensic health care professionals, including nurses, are most vulnerable to transgressing boundaries when they are struggling with attachment issues, experiencing stressors in their personal lives (e.g., relationship problems, bereavement, personal caregiving responsibilities) which can easily lead to role reversal and inappropriate self-disclosure in the therapeutic relationship. During such times, they are at risk of being "targeted" by forensic clients who are looking to exploit the therapeutic relationship for personal gain (Cooke et al. al., 2019; Peternelj-Taylor, 2012). So, what can forensic nurses do to protect themselves and their colleagues from succumbing to the "slippery slope" by engaging in boundary violations? While a compete discussion of strategies to prevent boundary violations in practice is beyond the scope of this brief newsletter article, a few points are provided for thoughtful contemplation. (*Continued on next page…*)

FORENSIC MENTAL HEALTH NURSING

Walking a Tight Rope: Maintaining Boundaries in the Forensic Milieu

- Have a clear understanding of the therapeutic relationship, and one's roles and responsibilities
- Have a full and rich live outside of one's workplace
- Engage in self-awareness and self-monitoring, for example, "Would I say or do this in front of my colleagues or supervisor?"
- Ask yourself, whose needs are being met, yours or the clients?
- Do not share personal information about yourself, or other staff members, with clients
- Report clients' sexually inappropriate banter or gestures, even if it is embarrassing to do so.
- Look out for colleagues who may be struggling with managing professional boundaries.
- If you find yourself struggling seek the counsel of a trusted colleague or supervisor
- Make a point of discussing boundary maintenance on a regular basis during team meetings

When it comes to managing boundaries in practice, strategies need to be developed that address boundary violations before, during, and after they arise. Heightened awareness and understanding of the nature of boundary violations within the forensic milieu, will, regardless of one's professional discipline, contribute to effective risk management.

If you have questions, comments, or feedback regarding this article, please contact the author directly at or , please do not hesitate to contact **Cindy Peternelj-Taylor** at: **cindy.peternelj-taylor@usask.ca.**

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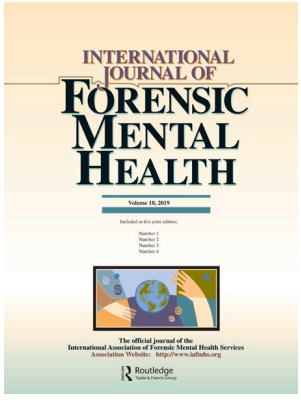
If you are a forensic mental health nurse who is interested in submitting a piece, please do not hesitate to contact **Helen Walker** at: **helen.walker6@nhs.scot**

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH

Feature Article



Patient Participation in Pro Re Nata Medication in Forensic Psychiatric Care: Interview Study with Patients and Nurses

Kirsi Hipp[a], & Mari Kangasniemi[a]

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Pro re nata (PRN, as-needed) medication is commonly used in forensic psychiatric inpatient care, but little is known about the participation of patients in its prescription and administration. This study describes patient participation in PRN medication treatment in forensic psychiatric inpatient care. Data were collected during interviews with 34 inpatients and 19 registered nurses in a Finnish forensic psychiatric hospital. The data underwent inductive content analysis. We found that patient participation in PRN was related to patients' individual needs and health conditions, and the use of PRN involved private decisions made in the social context of the ward. PRN was an integrated part of daily care, and it involved three stakeholders, namely patients, nurses, and physicians; however, the role of patients in this collaboration was undefined. The administration events for PRN were multiform, and depended on the level of agreement between patients and nurses on the need for PRN. In the future, more attention should be paid to how to motivate patients and provide them with equal opportunities to be involved in the planning of PRN, and to optimize shared decision making so that the expertise of both patients and nurses is utilized in the administration and evaluation of PRN.

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By joining together we will succeed

Te Kāwanatanga o Aotearoa
New Zealand Government

STUDENT SECTION

SUMMER EDITON: Annual Conference Highlights - Berlin 2022

Student Section Editors: Israa Altwaijiri, Student President Swinburne University of Technology, AUS | **Lillian Bopp**, President-Elect, University of Nebraska- Lincoln, USA | **Lara Schwarz**, Content Developer, Maastricht University, The Netherlands | **Lindsay Healey**, Student Secretary, Carleton University, Canada

Student Breakfast

Day one of the conference began with our annual student breakfast. The Student Board members were excited to finally meet each other in person, and it was an amazing experience to see some new and familiar faces of the Student Board. Student Board President, Israa Altwaijiri, welcomed student members and provided an overview about the Student Board's mission, goals and initiatives. Once the Student Board members introduced themselves, the Past President, Sarah Schaaf, and Content Developer, Lara Schwarz, provided some interesting fun facts about Germany to the attendees.

President – Israa Altwaijiri

President Elect- Lillian Bopp

Past President – Sarah Schaaf

Secretary – Lindsay Healey

Fundraising Coordinator
Elizabeth Jensen

Content Developer
Lara Shawarz

Communication Officer
Aiden Collins

Organizational Coins and pin

The student board merchandised the coins and pins as fundraisers, in order to support student led initiatives, grants, and scholarships. A huge thanks to those who purchased these items.

Student Panel Discussion with Prof. Corine de Ruiter and Prof. Michael Daffern

This year, the Student Board invited Professor Corine de Ruiter (Maastricht University, The Netherlands), and Professor Michael Daffern (Swinburne University of Technology, Australia) to speak at the student panel. Our Student Board secretary Lindsay Healey moderated the session and began by asking both speakers to provide some general information about themselves, their education, careers and their personal lives. Later on, Lindsay asked interview-style questions to both panelists touching upon different topics that students would find interesting and informative. Both our panelists are ambitious, enthusiastic forensic and clinical psychologists, who have a passion for research and teaching. Prof. Daffern and Prof. de Ruiter shared a lot of valuable thoughts with our students.

STUDENT SECTION

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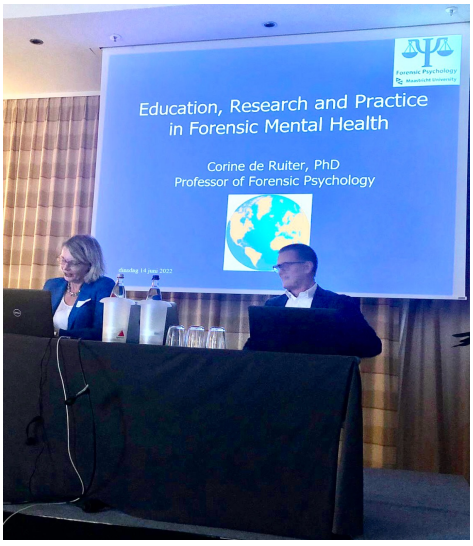
Student Panel Discussion with Prof. Corine de Ruiter and Prof. Michael Daffern

Prof. de Ruiter talked about how she didn't know at all what she wanted to do after graduating from high-school, "from studying English literature to becoming a pharmacist" everything seemed possible. While she describes herself as an "internally curious person", she decided to take a gap year, which really had an impact on her further life and career – among other things – she found her happy place in the U.S. Eventually, experiences and research outside the forensic field helped her to broaden and deepen her understanding of forensic-related issues.

One of her valuable pieces of advice to the students was: whatever you decide to do and wherever you decide to go – even through the work you do, the internship you need to conduct, or the uncomfortable experiences or feelings you have to go through – you will see how all of this builds character and a type of resiliency you would not build otherwise. Prof. Daffern agrees and adds that "building resilience and acceptance is key. You can use every place where you are as a place of learning".



These sentiments are especially helpful for our students who may be facing challenges in their current position, and who may feel anonymous or alone. One important thing that both our panelists appreciate is the opportunity to mentor. Prof. Daffern advised the students to find a mentor who is approachable, decent, and skilled. Someone who is humble and is passionate about teaching and working together, i.e., meeting at eye level. This will make life easier and is relevant for a good and respectful work climate. Furthermore, Prof. Daffern opined that clinical work can be much more contained than academic work. In the world of research, you really need to learn to manage your expectations; often people are never satisfied with the work they have done. "Be careful about having a specifically set plan of how you will develop a career" he says, referring to the fact that "things happen" and one should always be open to new and different possibilities in life.

One of our questions to the panelists was related to finding a good work-life balance. Prof. de Ruiter shared a simple sentence that is very valuable: "you need to learn how to manage your energy". She went on to encourage disregarding "time management" approaches, but rather focusing on and listening to your own individual body signs. If you don't do that, you will be stressed out and may in the long-term face mental health consequences. Also, she recommended not being anxious about the fact that there will be times in everyone's life where you need to focus more of your time on things outside of work and career – e.g., deciding to raise children or care for someone in your family. "Things will change again" and "don't be so hard on yourself" says Prof. de Ruiter.

STUDENT SECTION

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Student Panel Discussion with Prof. Corine de Ruiter and Prof. Michael Daffern

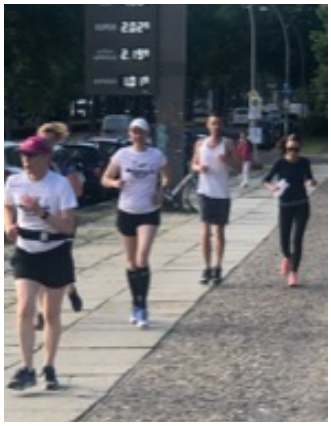
Lastly, we asked a question related to Prof. de Ruiters writing of books for the public. As she is a hard-working, inquisitive, and resourceful person, she revealed her ideas for future books she wants to write. She has a dream to write a nonfiction book that would target the biases the public holds about forensic mental health and forensic mental health patients. “There is always more behind what you can see. People are people” she says. “We need to start using our “System 2 Thinking” more than our automatic, fast and biased “System 1 Thinking.”

To sum up, bringing these two well-known Professors together in our Student Panel was a really good fit. Both panelists agreed on the fact that if one keeps being inquisitive and keeps on learning, one will stay motivated. Prof. de Ruiter adds: “If you feel you’re not learning, a place or a person is not good for you, then move on. Don’t remain stuck, and take your chances. Be on the lookout for new opportunities, which may be different.” Prof. Daffern says “be humble and kind, and find people who want to work with you and you enjoy working with. Recognize that you are a larger part of the community.”

The IAFMHS Student Board thanks Prof. Daffern and Prof. de Ruiter for their time and passion in sharing their life experiences with our students. It has been an extremely interesting and important panel and our student audience really enjoyed listening to and learning from you.

Fun Run

Day two of the conference began with our annual 5k Fun Run, where over thirty participants came out to support our student-led initiative and get their heart rates up! It was a beautiful morning in Berlin and runners, donning their 2022 Fun Run t-shirts, enjoyed a leisurely route through the streets of Berlin and nearby park, Volkspark Friedrichshain. Student volunteer, Daniel McFadden, did a terrific job leading the group from start to finish. Runners were welcomed back to the conference hotel with an array of light refreshments to start their day and got to take home an IAFMHS tote bag. We are grateful to everyone who participated and for their incredible enthusiasm so early in the morning. Finally, a special congratulations to Patrick Seal for being the first runner to arrive back!



SUMMER EDITON: Annual Conference Highlights - Berlin 2022

Patrick Seal Fun Run Winner

Student Social

On the second night of the conference, the Student Board hosted a successful student social event at BrewBog Berlin Mitte. Over the course of the evening, IAFMHS students from all over the world came together to share craft beer, an array of fire oven pizzas and dynamic conversation. The event created a relaxed and jovial space for old friends to reconnect and for new friendships to be formed. We sincerely thank all the students who joined us for this event, making it one of the most memorable moments of the conference.

STUDENT SECTION

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Students Awards

This year the Student Board offered one presentation and one poster award, as well as two travel awards. The selection process was difficult considering the range of high-quality student presentations this year! We were very pleased to support two well-deserving students who traveled internationally to attend the conference. Our presentation award runner-up Daniel McFadden received a book from well-regarded Professor Karl Hanson. A huge thanks to Professor Hanson for his valuable contribution.

Sanam Monjazeb
Winner of
Presentation Award

Jordan Cortvriendt
Winner of Poster
Award

Daniel McFadden
Presentation Award
Runner-up

Natasha Usenko
First Travel Award
Winner

Zhi Xiang On
Second Travel
Award Winner

Student Board –working together and socializing