INTERNATIONAL ASSOCIATION OF FORENSIC MENTAL HEALTH SERVICES

NEWSLETTER

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Winter Edition Features

Letter from the Editor

Dear members of the IAFMHS community,

Welcome to the first edition of the 2021 IAFMHS newsletter! What a strange start to the year it has been, as we find ourselves with moments of hope mixed with on-going uncertainty. In light of our on-going COVID-19 pandemic, we would like to solicit contributions pertaining to the impact that the pandemic has on the practice of forensic mental health. To this end, we are featuring a recently published article by Dr. Lemieux and colleagues provides a review regarding best practices, challenges, and recommendations of managing COVID-19 in secure settings.

In this issue of the newsletter, I would also to highlight the research update provided by the EU-VIORMED International Collaboration, which aims to improve the quality of forensic psychiatric care across Europe.

As always, we would like to encourage graduate students, early career professionals, and other members of IAFMHS to submit content to the newsletter or to join our team.

Sarah Coupland, Editor

RISKY BUSINESS

Videoconferencing Technologies in Assessment: Get on Board or Get Left Behind

Ashley B. Batastini, Ph.D.
Assistant Professor
University of Memphis

With massive shortages in mental healthcare providers, especially in rural communities, remote delivery mechanisms have been hailed as a sort of savior in this crisis (see e.g., Frueh, 2015; Matthews, 2017). Among the most common of these mechanisms are videoconferencing technologies (e.g., Polycom, Cisco WebEx, Zoom, etc.), which use audiovisual monitors or screens to connect agencies (e.g., hospitals, jails) or individual clients to service providers who are located elsewhere. While much of the research to date is based on U.S. practices and clientele, the fast-growing use of videoconferencing technologies can be observed internationally. Across the globe, healthcare systems are making room for this trend (e.g., American Psychological Association, 2013; American Telemedicine Association, 2013; Digital Health & Care Scotland, 2018; United Kingdom National Health Service, 2019; Australia's National Digital Health Strategy, 2018). In the wake of an unprecedented, worldwide pandemic, there has been a near overnight shift in practitioners turning to virtual services, needing to quickly acquire training and establish infrastructure to connect with clients.

In forensic mental health assessment (FMHA), the use of videoconferencing technologies had been gaining attention, even before the pandemic hit. In a 2019 survey, about 34% of forensic examiners reported having used them before (Batastini et al. 2019). Notably, however, the empirical literature is limited in this area. One of the earlier (and only) known experimental studies to examine the reliability of competency to stand trial evaluations found little differences in examiners' clinical forensic opinions using the Georgia Court Competency Tool between in-person and videoconference administration (i.e., via a local area network [LAN] and a Polycom system; Manguno-Mire et al., 2007). Given this rise in videoconferencing technologies, my team and I conducted a smaller-scale meta-analysis on telepsychological services with both justice-involved and substance abuse clients (Batastini et al., 2016). Although the focus was broader than FMHA, including measures of mental health symptoms, therapeutic processes, program engagement, program performance, and service satisfaction, we similarly found little compelling evidence that video-based services were underperforming compared to in-person methods. As such, we concluded that being physically present in a room with a client is likely not as important as we might believe it to be. Of course, our findings were based on only a small set of studies. Further, violence risk and threat assessments are notably absent from this literature. Given its prevalence and the problem of significant wait times for evaluations, much of the discussion about videoconferencing technologies has centered on adjudicative competency (Luxton & Lexcen, 2018; Luxton et al., 2019).

In addition to establishing the extent to which videoconferencing technologies may lead to different forensic clinical judgments and under what conditions, it is also relevant to examine the opinions of psychological and legal experts, as perceptions are directly linked to use. Especially now, remote options for FMHA may increase the rate at which individuals can move through the judicial system without violations to their rights or creating potential threats to public safety. In our 2019 survey, evaluators expressed moderate concern over the ethics and legality of using videoconferencing technologies in FMHA. Importantly, the use of videoconferencing technologies in FMHAs has, thus far, not been challenged in court. As a group, these examiners most frequently cited reduced costs for courts as a benefit of these technologies, while challenges in administering psychological testing and potential technological problems were seen as the most significant problems. Interestingly, however, early career practitioners and those with prior experience endorsed more positive attitudes about videoconferencing technologies than their counterparts. In light of the increased exposure to these technologies during the COVID-19 pandemic, it is quite possible that examiners' opinions have since shifted. (*Continued...*)

RISKY BUSINESS

Videoconferencing Technologies in Assessment: Get on Board or Get Left Behind

While little research and best practice commentary have addressed remote violence risk and threat assessment specifically, many of the same general recommendations and cautions apply. These include, but are not limited to:

1. Ensuring data transmission systems are secure (e.g., using encrypted email, HIPAA compliant virtual platforms);
2. Working with agencies and clients to minimize the risk of disruptions and distractions and maintain documentation when incidents occur;
3. Testing network connectivity and optics (e.g., lighting, physical positioning, appearance of attire) in advance;
4. Identifying a reliable on-site or local contact person in case of an emergency (clinical or medical) or some other issue requiring immediate response (e.g., an examinee damaging computer equipment);
5. Assessing examinees' ability to engage in a video interview (e.g., hearing or visual impairments, paranoid ideation);
6. Determining whether assessment tools can be modified in a clinically justifiable and legally defensible manner (i.e., does the modification make sense and is it still likely to yield valid results?); and,
7. Clearly explaining the rationale for using technology and the implications of any associated limitations in reports and testimony. As Luxton and Lexcen (2018) argue, in cases that are likely to be subjected to intense legal scrutiny (e.g., contentious or high-profile cases), examiners may want to exercise greater caution when choosing VCT.

VCT is unlikely to replace in-person assessments, but it is almost certainly here to stay. Practitioners who fail to adapt risk getting left behind.

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*.

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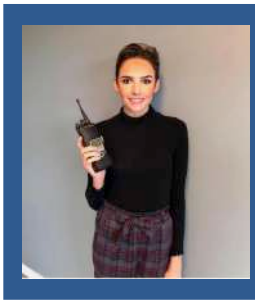
Annual IAFMHS Conference

For updates about the 2021 IAFMHS Conference, please check our conference website here.

SPOTLIGHT ON MENTAL HEALTH DIVERSION

Randomizing Dispatch Calls for Service for a Police Mental Health Co-Response Team in Indianapolis, IN, USA.



Emily Sightes, MPH

Data Assistant
Center for Behavioral Health and Justice
Wayne State University

Co-response teams have gained popularity in recent years for their focus in diverting individuals with a mental health illness away from the criminal justice system (Bailey et al., 2018). Co-response teams partner a police officer with at least one social or medical services provider (e.g., mental health clinician, social worker, paramedic, psychiatrist) to respond to emergency calls for service involving behavioral health concenrs. By way of background, the Indianapolis model consists of a Mobile Crisis Assistance Team (MCAT) that responds to mental health, substance-use, and co-occurring emergencies in addition to a Behavioral Health Unit (BHU) that provides follow-up services. Both the MCAT and BHU include a Indianapolis Metropolitan Police Department (IMPD) crisis intervention-trained officer and an Eskenazi mental health clinician. The MCAT team responds to immediate mental health dispatch calls for service while the BHU team provides follow-up care to the MCAT clients within 48 hours after the initial call for service.

Researchers from the Center of Health and Justice Research at the Indiana University Public Policy Institute and the Center for Behavioral Health and Justice at Wayne State University have partnered with IMPD and Eskenazi Health to conduct one of the first randomized controlled trials of a co-response team. The study was designed to examine the effectiveness of the MCAT-BHU model in reducing criminal justice involvement among persons in mental health and substance use-related crises relative to police response as usual. This research effort has necessitated creative strategies to conduct random assignment of participants to condition.

To achieve the goals of this study, our research team decided to implement randomization at the level of an emergency 9-1-1 call for service. As a member of the research team, I am one of two Indianapolis-based researchers who is responsible for determining call eligibility and then randomly assigning 9-1-1 calls to study condition. This process involves listening to an IMPD dispatch radio five days per week from 10:00 am to 5:30 pm. When an MCAT-eligible call for service comes in via the radio, we randomize the call for service using TrueRandom.org's coin flip application; a *HEADS* results indicates MCAT can respond to the call, and a *TAILS* result indicates MCAT cannot respond to the call. We then communicate this result to the MCAT officer via Zello, a mobile application that acts as a walkie talkie. In the case of a *HEADS* result, once the MCAT team is finished responding to the call for service, the team will communicate their availability to respond to further calls.

Although our research team has established a comprehensive list of MCAT-eligible dispatch call types, there are instances in which it is unclear if a call for service meets the MCAT criteria. In these cases, I will reach out to the MCAT officer on Zello and ask his opinion, and we will decide together if a call constitutes an MCAT call. Since the start of the study, I have established great trust and rapport with the MCAT team which facilitates such a collaboration. Indeed, throughout the entire creation and implementation of the study, we have relied heavily on the feedback and expertise from members of the MCAT team as they have valuable experience responding to various types of dispatch calls. Fortunately, IMPD has been more than willing to collaborate with researchers to facilitate study implementation.

Overall, working closing with the MCAT-BHU team in order to establish this randomization protocol has allowed me to gain insight into the potential impact that co-response teams can have on the community. Members of the IMPD co-response team have a passion for their work, and we've found this to be a key factor impacting the success of these teams.

References

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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.

FORENSIC MENTAL HEALTH NURSING

The Case for Normalizing Physical Health Care in Forensic Mental Health Services.

Brian McKenna, RN, Ph.D., Professor of Forensic Mental Health, Auckland University of Technology and the Auckland Regional Forensic Psychiatry Services

When I trained as a nurse in the early 1980's (yes, a long time ago), we learned about Cartesian Dualism, Descartes' 17th century theory of the mind-body split. Broadly, he theorized that the mind and body were distinct and separable entities. Cartesian Dualism has been replaced in favour of holism, which suggests that an individual's parts (e.g., physical, psychological, social, cultural and spiritual) can only be understood in relation to their whole. And yet, we were confronted with the practice reality of how busy institutions focus exclusively on the part and not the whole, and struggled to hold true to the holistic vision.

Our "modern world" has several physical health epidemics, some of which have been exacerbated by poor lifestyle choices. We are eating too much of the wrong foods, we are physically inactive, and we over-indulge in the lifestyle choices perceived as quick fixes to the stresses of modern living (e.g., alcohol and other substance use). The health implications are immense: obesity, cardiovascular disease, diabetes, cancer, and the list goes on.

Our severely mentally ill populations have even poorer health outcomes when compared with the general population, that results in staggering implications and reduced life expectancy. Specifically, studies have suggested that mortality is more than doubled for individuals with any mental illness, and that most commonly deaths result from conditions like diabetes, cardiovascular disease, metabolic syndrome and respiratory illness (Walker, McGee, & Druss, 2015). The underlying reasons are complex and multifaceted. These reasons include poor healthy lifestyle choices (like us all), the experience of institutions (which limit choice and motivation), the symptoms of mental illness (which cloud effective response), medications to relieve such symptoms, (which further compromise physical health), and reduced access to and quality of healthcare delivery due to financial and structural barriers, stigma and discrimination (see Te Pou o te Whakaaro Nui resource).

The solution? Normalising physical health alongside mental health. Systemically, international initiatives such as "Equally Well" embrace the challenge through supporting the combined efforts of the health, social care services, communities, and education providers. Yet my personal perception is that normalising physical health care remains a challenge in secure forensic mental health services. Contracting out physical health care to external general practitioners, or having it addressed through short term new graduate doctor internships does not provide continuity of care. It is only a partial solution to the everyday experience of service users.

Person-centred physical health care support requires a seven-day-a-week service, embedded into our secure services. In my own profession, it is exciting to see the possibility offered by the evolving roles of nurse practitioners. Nurse practitioners combine their advanced nursing knowledge and skills with diagnostic reasoning, therapeutic knowledge, and skills, including prescribing rights. Nurse practitioners work autonomously and in multi-disciplinary teams to promote health, prevent disease, and improve access and population health outcomes for a specific service user group or community. Specifically, their focus is on this unmet need.

If we acknowledge that physical health care need within our forensic mentally ill populations is an unmet need, the opportunity to embed nurse practitioner skills within forensic mental health services is an exciting possibility. It now requires bold leadership to articulate such unmet meet and consider planned innovation as a way forward.

Resources and References

Te Pou o te Whakaaro Nui.

New Zealand Ministry of Health

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If you are a nurse working in a forensic mental health setting and would like to contribute to this section, please contact Helen Walker at *helen.walker6@nhs.scot*.

Institut national de psychiatrie légale Philippe-Pinel
Université de Montréal

Université de Montréal

POSTDOCTORAL RESEARCH FELLOWSHIP OPPORTUNITY

A full time postdoctoral position in the area of Forensic mental health (mental health, justice and safety). The fellowship is for 12 months with a possible second year appointment and provides a research and academic training.

Description

The postdoctoral fellow will lead and participate in the development of a series of scientific papers on trajectories of individuals receiving forensic mental health services as well as coordinate research activities and supervise research assistants and students.

The goal is to expand and enrich the candidate's knowledge of forensic mental health and the scientific method, and to extend the candidate's skills in conceptualizing and executing statistical analyses and writing manuscripts for publication in high impact scientific journals.

Qualifications

Applicants must have a recent Ph.D. in a related discipline (e.g., Psychology, Psychiatry, Epidemiology, Sociology, Criminology etc.), have a demonstrated record of experience in advanced quantitative statistical methods. Applicants must have demonstrated ability in preparing and publishing research papers. The applicant must be interested in pursuing a career that focuses broadly on mental health, antisocial behaviour, justice safety, mental health and the law.

Environment

The position is to be held at the *Institut national de psychiatrie légale Philippe-Pinel* research Center and the Department of Psychiatry & Addictions of the *Université de Montréal*. It is funded through a CIHR operating grant and a bursary from the *Centre international de criminologie comparée*. Supervision will be ensured by Professor Anne Crocker.

The postdoctoral fellow will be integrated into the national team and be offered the necessary supervision to develop all of the abilities necessary to become an independent scientist. Teaching and student (co)supervision opportunities will also be offered.

We are seeking to fill the position as soon as possible.

Application deadline: February 28th 2021

To apply, please send to Dr Anne Crocker: anne.crocker@umontreal.ca

- Curriculum Vitae
- Cover letter detailing research interests, experience and career goals
- Two letters of recommendations
- Two manuscripts

CICC Centre international de criminologie comparée 50 ans 1969-2019

Feature Article

Management of COVID-19 for Persons with Mental Illness in Secure Units: A Rapid International Review to Inform Practice in Québec

Ashley Lemieux[a], Audrey-Anne Dumais Michaud[ab], Jean Damasse[c], Julie-Katia Morin-Major[c], To Nhu Nguyen[c], Alain Lesage[c,d], & Anne G. Crocker[a,d,e]

[a]Institut national de psychiatrie légale Philippe-Pinel, Montréal, Québec, Canada; [b]Department of Social Work, Université du Québec en Outaouais, St-Jérôme, Québec, Canada; [c]Centre intégré universitaire en santé et services sociaux (CIUSSS) de l'Est-de-l'Île-de-Montréal, Montréal, Québec, Canada; [d]Department of Psychiatry and Addictions, Université de Montréal, Montréal, Québec, Canada; [e]School of Criminology, Université de Montréal, Montréal, Québec, Canada

The full article can be found here.

This rapid review was conducted in response to the growing needs of forensic and correctional institutions to care for patients in the midst of a global pandemic, which increased patients' vulnerability and turned their institutions into potential outbreak sites. Our goal was to identify best practices which would decrease transmission risks taking into account patients' mental health recovery. Because our review took place over the course of the first COVID-19 wave (from December to August 2020), most papers identified are derived from opinion pieces which either described: (1) the experiences of specific institutions and (2) lessons they learned or descriptions of potential hazards relative to previous research conducted on confinement. Nevertheless, the themes highlighted have helped identify potential areas that need to be taken into account when institutions implement new policies and procedures during a pandemic. Moreover, they have pointed towards research opportunities to identify best practices for implementation in the current pandemic and in the event of future health crises. Given extensive COVID-19 research funding, it is hoped that new empirical research will be published, in open access on an ongoing basis. One important conclusion to be mindful of is to increase the integration of individuals with lived experiences in both research and clinical endeavors. While this unprecedented health crisis has shaken the foundations of our health care and social services, it has also provided an opportunity for increased collaboration between patients, clinicians, and researchers to move towards evidence-based and person-centered care.

Abstract: Most countries have implemented guidelines and policies in response to COVID-19 that have had a direct impact on institutionalized or incarcerated persons with mental health problems. Although these strategies are essential to protect these vulnerable persons from the pandemic, they can also have significant consequences on recovery, well-being, as well as rights and freedoms. Accordingly, we conducted a rapid review to identify strategies, challenges and recommendations for dealing with the COVID-19 outbreak in secure settings for persons with mental illness. While most available publications are not empirical in nature, this knowledge synthesis can nevertheless guide managers of psychiatric and forensic psychiatric institutions, and correctional facilities in dealing with the COVID-19 pandemic.

CALL FOR COVID-19 SUBMISSIONS

As we enter 2021 and face the uncertainty, concern, and restrictions of the second wave of the COVID-19 pandemic, we invite contributions to share reflections, adaptations, and impacts that the global pandemic has had on forensic mental health practice. We hope to be able to showcase the differences and similarities between our countries. Please send submissions to the Newsletter Editor, Sarah Coupland at *sarah_coupland@sfu.ca*

RESEARCH UPDATE

The EU-VIORMED International Collaboration: Violence Risk Assessment and Treatment for Forensic Patients with Schizophrenia Spectrum Disorders

Giovanni de Girolamo, St John of God Clinical Research Centre, Italy | Giuseppe Carrà, University of Milan Bicocca, Italy | Heiner Fangerau, Heinrich-Heine-University Duesseldorf, Germany | Pawel Gosek, Institute of Psychiatry and Neurology, Poland | Marco Picchioni, King's College, UK | Hans Salize, Central Institute of Mental Health, Germany | Johannes Wancata, Medical University of Vienna, Austria | Margaret Walker, EUFAMI, Belgium

The EUropean Study on VIOlence Risk and MEntal Disorders (EU-VIORMED, www.eu-viormed.eu) is a European project that aims to improve the quality of forensic psychiatric care all around Europe. Different work packages (WP), including WP4 *Identifying violence risk factors* (coordinated by P2-KCL), WP5 *Evaluation of effective treatments* (coordinated by P4-MUW), and WP6 *Mapping of forensic services* (coordinated by P3-MANN) were linked to project *Management* (WP1, coordinated by P1-IRCCS Fatebenefratelli), *Evaluation* (WP2, coordinated by P5-IPIN), *Dissemination* (WP3, coordinated by P8-UNIMIB), and *Data analysis* (WP7 coordinated by P1-IRCCS Fatebenefratelli). Five countries contributed to work package 4: Italy (coordinating centre), Austria, Germany, Poland and the United Kingdom.

Objectives

The main aims of WP4 were:

- to test if new putative risk factors, such as social cognition deficits, contributed to the risk of violence in forensic patients with schizophrenia spectrum disorders and a history of significant violence (cases) compared to patients with no history of significant violence (controls) using a five-nation case-control study design;
- to describe the needs and unmet needs of patients with schizophrenia spectrum disorders and to compare patients' and staff members' views of those needs in forensic psychiatry settings;
- to establish for the first time in an international sample forensic patients' competence (capacity) to consent to their treatment, and explore what factors may contribute to lack of competence;
- to test and compare for the first time the validity of three violence risk assessment guides, the HCR-20 v3, and two novel risk assessment guides, the Forensic Psychiatry and Violence (FoVOx) and Mental Illness and Suicide (OxMIS) guides in patients with schizophrenia spectrum disorders and a history of significant violence.

Summary of progress

Overall, we succeeded in recruiting 398 patients in total, 221 forensic cases and 177 matched controls over a 22-month period (from June 2018 to April 2020). All patients provided written informed consent before entering the study.

Each subject was assessed using the study battery of standardized instruments, including the Positive and Negative Syndrome Scale (PANSS), the WHO Disability Assessment Schedule, the Modified Overt Aggression Scale (MOAS), and the Camberwell Assessment of Need (CAN). In addition, in Italy and Poland, both cases and controls underwent a sophisticated social cognition battery to explore if deficits in risk taking, decision making, and moral domains contributed to violence risk in patients with schizophrenia spectrum disorders. Analyses are currently underway, and we look forward to future publications exploring these areas. In line with the European Commission policy to make research data findable, accessible, interoperable and reusable (FAIR), we welcome the active collaboration of scientists and clinicians in the optimal exploitation of data collected in the framework of this project. For any information with this regard, please contact the project PI Dr. de Girolamo (gdegirolamo@fatebenefratelli.eu).

Two systematic reviews investigated the effect of distinct interventions on violent behaviors in patients with schizophrenia across large databases (MEDLINE, EMBASE, SCOPUS, Web Of Science, CINAHL, PSYNDEX, PsycINFO). They have been submitted to high impact journals in the field. (*Continued...*)

EU-VIORMED Project

Düsseldorf Unit

The task of the Düsseldorf Unit is twofold: 1) ethical assessment of the arguments for or against coercive measures towards forensic patients in the EU Member States; and 2) ethical analysis of the results of the MacArthur Competence Assessment Tool-Treatment (MacCAT-T) survey.

None of the issues above can be addressed independently of the national legal frameworks regulating detention and treatment of justice-involved persons with mental illness. These vary significantly across Europe, starting from competence over forensic psychiatry (the Ministry of Health, the Ministry of Justice, or both). We have approached the different regulations as dynamic systems with a double perspective: as the result of ethically-informed struggles over the balance between care of the individual and protection of society; and as frameworks within which further ethical dilemmas and conflicts may arise. Taking the move from an in-depth analysis of the countries involved in the EU-VIORMED study, we proceeded to an ethical mapping of the different jurisdictions under the following rubrics: definition of the criterion of criminal responsibility and its degrees (full, absent or diminished); its role in determining admission to a forensic psychiatric institution; stakeholders and experts involved in the decision-making; the process of review of detention measures; the maximal length of stay; service provisions; and rationales for treatment, including the use of coercive measures.

Special attention has been devoted to recent state interventions expected to strongly impact the institutional trajectories of the forensic patients, as well as the concepts of care. Such interventions range between single judicial acts and comprehensive structural reforms. An exemplary instance is the 2011 verdict by the German Federal Constitutional Court, declaring involuntary treatment unconstitutional. At the opposite end of the spectrum stands the long history of the Italian psychiatric reform, culminating in the 2014 closure of forensic psychiatric hospitals and the implementation of small-scale residential facilities (REMS), where internal management is exclusively medical and, consequently, the responsibility over confinement and treatment is decisively shifted from the judicial to the medical domain. In-between these extremes stand more complex and diffuse examples of interaction among national and transnational subjects, such as the efforts at a national level towards implementation of the European Psychiatric Association guidance on forensic psychiatry (case of Poland, 2018), or towards avoiding sanctions from the European Court of Human Rights (case of Belgium, 2016).

In order to allow a systematic and consistent nation-based evaluation of all these levels and aspects (and in view of a country-to-country comparison) we plotted the above-listed features against the four bioethical principles of Beauchamp and Childress: respect of autonomy (of the patient), non maleficence, beneficence and respect for justice. These are assumed as a basic and "culturally neutral" interpretative grid allowing us to structure and analyse situated tensions (patient vs. caregiver, forensic patient vs. society, forensic patient vs. patient in general psychiatry, forensic patients vs. their counterparts who have committed the same offence but have no mental illness). The picture emerging from this scrutiny, which is still on-going, is widely heterogeneous, not only across the different countries, but also within the single national jurisdictions. We could not identify one single ethical principle consistently informing the whole system, but rather dynamic equilibria among the individual principles cutting through the levels above specified. Finally, we have conducted a critical review of the literature on the MacCAT-T. We are eager to start the ethical evaluation of the data collected by our partners!

WP6: Mapping of forensic services

The EU-VIORMED project WP6 (PI: Prof. Dr. Hans Joachim Salize, Central Institute of Mental Health, Mannheim, Germany) included a survey among experts on forensic psychiatric care from all EU Member States in order to get information on the variety of forensic psychiatric models and approaches that are implemented across the European Union. The survey was based on a detailed questionnaire that each expert was supposed to fill in for their country. The questionnaire addressed essential aspects of forensic psychiatry such as basic juridical concepts for placing and treating justice-involved people with mental illness, assessment and treatment concepts, provided capacities (number of forensic psychiatric beds or places in the various sectors), prevalence or incidence data and much more.

After identifying, contacting and recruiting the experts, the survey started in autumn 2018 and ended in November 2019 when the last questionnaire was returned to the study centre at the Central Institute of Mental Health in Mannheim, Germany. The final list of participants of the survey included 22 countries plus Switzerland as a non-EU Member State who volunteered to contribute. The analyses and dissemination processes started afterwards and are currently ongoing.

(*Continued...*)

RESEARCH UPDATE

EU-VIORMED Project

Results so far confirmed an ongoing serious knowledge gap on basic characteristics and features of forensic psychiatric systems in European Union Member States that was found in similar studies already 15 or 20 years ago. In many countries, even national experts in the field were unable to report valid numbers or time series of the most essential indicators such as number of services, number of beds or mean length of stay in forensic psychiatric care. Similarly, national data on the incidence and prevalence of concomitant mental illness and justice involvement is fragmentary. Outcome data allowing for evaluating the effectiveness of the various systems such as the rate of recidivism or re-offending of former forensic psychiatric patients is completely unknown.

National reporting systems on these crucial topics and indicators seem to be grossly underdeveloped. This finding is even more striking considering the repeated criticism of this omission by experts in the field during the last decades.

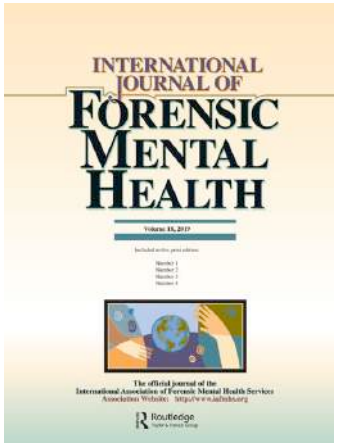
Available data and information collected by the WP6-survey suggest and confirmed a wide variety of in parts divergent approaches across the European Union. Many forensic psychiatric systems were implemented or reorganized on a very narrow or completely missing evidence base. Therefore, research and health care planning in this crucial field lack essential information for analysing the quality, outcomes or effectiveness of the systems in question. Currently, there is no routine data available to identify ineffective concepts, poor treatment, inappropriate settings, overcrowding of services or other weaknesses in the practice of placing and treating justice-involved persons with mental illness in Europe.

Although the analyses are ongoing, one major recommendation from the findings of WP6 will be to stimulate research on the issue on a national and an international level.

Also highly recommended is the co-ordinated and Europe-wide implementation of standardized national reporting systems in the field. Such registers - whose main indicators should be summarized annually in a Europe-wide forensic psychiatric report - are essential for having available valid and reliable indicators across countries and will enable to describe, to evaluate and to compare the various systems implemented in Europe – a pre-requisite for developing guidelines and standards of the placement and treatment of justice-involved persons with mental illness and promoting models of best practice in forensic psychiatry in the future.

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH

Feature Article



Voluntary and Forced Migrants in Forensic Mental Health Care

Stephanie R. Penney[a, b], Aaron Prosser[c], Teresa Grimbos[d], Egag Egag[a], & Alexander I. F. Simpson[a, b]

[a]Complex Care and Recovery Program, Forensic Division, Centre for Addiction and Mental Health, Toronto, Ontario, Canada; [b]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada; [c]Michael G. DeGroote School of Medicine, McMaster University, Hamilton, Ontario, Canada; [d]Child, Youth and Family Program, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Foreign-born migrants are at elevated risk for developing serious forms of mental illness, and are over-represented in criminal justice and forensic mental health settings. This study compares the clinical characteristics of forced (n = 60) and voluntary (n = 226) migrant patients in a Canadian forensic service to native-born patients (n = 234), and contrasts regions of birth represented in the current sample to the total adult migrant population in our catchment city (N = 2,537,410). Compared to Canadian-born patients, migrant patients were more likely to have a later-onset psychotic disorder as their only diagnosis, and less likely to have a personality disorder diagnosis. Migrant patients had more familial supports prior to illness onset, but were socially isolated near the time of forensic admission. Compared to the total adult migrant population, higher proportions of Caribbean, Central American, Eastern and Western African persons were represented in the forensic system, while fewer individuals from East and South Asia were represented. There was no effect of migrancy status on the duration of forensic hospitalization or community supervision. Findings suggest disproportionate minority representation among users of forensic services, and highlight what may be ineffective pathways to adequate mental health care among certain migrant groups.

STUDENT SECTION

Welcome from the 2020-2021 Student Board

Sarah Schaaf, M.S. - Fairleigh Dickinson University, USA | IAFMHS Student Board President

The year 2020 is slowly coming to an end and we are excitedly preparing for the upcoming term! As we reflect upon the challenges all of us had to conquer this year, we would like to give a special thanks to our past student board members and the relentless commitment, flexibility and thoughtfulness with which they have approached 2020's many changes and losses. Although most plans for IAFMHS's 20th anniversary year had to be put on hold, we would like to express our admiration for the student board's many accomplishments this year: increase of online presence, introduction of new student resources, newsletter contributions on a variety of topics, design of anniversary merchandise (stay tuned!), distribution of 2000 CAD in student awards and most notably the student board's efforts to raise awareness on diversity issues. The new student board is ready to continue the hard work and committed to making the upcoming year a rewarding experience for our student members. Without further ado, I am pleased to introduce to you the new 2020-2021 student board:

The new student board is more international than ever, with most members having moved around the world to complete their studies in a field relevant to forensic mental health. As an international group, we are eager to combine our diverse experiences and knowledge to foster student-led research, leadership opportunities and resources for our membership across the globe. Please review our current student opportunities and get involved!

- We are currently recruiting…
  - **Campus representatives** who will disseminate emails and opportunities to local students in their institutions. Campus representatives are important allies in raising awareness of our organization and recruitment of new members.
  - **Peer mentors** (i.e., senior grad students and early career professionals) and **mentees** (i.e., undergrad and grad students) for our Peer Mentorship Program.
- Visit us on our website and social media profiles (Twitter; Facebook; LinkedIn) for student resources and helpful tools to enrich your education and professional development.
- Stay connected and reach out to us with suggestions on how we can improve your experience as an IAFMHS student member. Your feedback is important to us! (students@iafmhs.org).

On behalf of the student board: Thank you for your trust! We look forward to creating new opportunities and making the most of the new year. Stay tuned for further announcements through email and social media.

Cheers to a fulfilling year!

Sarah Schaaf, M.S., IAFMHS Student President

Join a Team of Dedicated Professionals

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
An agency of the Provincial Health Services Authority
FORENSIC PSYCHIATRIC SERVICES COMMISSION

Are you a Clinical Psychologist with experience and a passion for working with individuals with complex mental health and behavioural needs? Join our team to make a difference in the lives of marginalized community members.

As a Forensic Psychologist with Forensic Psychiatric Services, you will provide individual and group psychological interventions for people ordered by the Court, certified under the Mental Health Act, or found unfit to stand trial or not criminally responsible on account of a mental disorder under the Criminal Code of Canada.

We currently have several exciting opportunities for Forensic Psychologists:

Forensic Psychiatric Hospital, Coquitlam BC

Regular full-time opportunity and regular part-time opportunity

What you bring

- A doctoral degree (PhD or PsyD) in Clinical Forensic Psychology OR
- A doctoral degree in Clinical Psychology (PhD or PsyD) with a minimum of two (2) years' experience in a forensic mental health context.
- Practicing clinical registration or eligibility for registration with the College of Psychologists of B.C.
- One (1) year of direct, clinical experience performing diagnostic assessment and treatment of adults in a Forensic Mental Health setting including risk assessment, cognitive behavioral therapy or other relevant assessment and treatment modalities.

For more information about these exciting opportunities, contact Linda Hand, Manager, Talent Acquisition at lhand@phsa.ca

What's in it for you

Forensic Psychiatric Services is part of BC Mental Health & Substance Use Services (BCMHSUS) bcmhsus.ca, a program of the Provincial Health Services Authority (PHSA) which cares for people with complex mental health and substance use challenges.

Every PHSA employee enables the best possible patient care for our patients and their families. Whether you are providing direct care, conducting research, or making it possible for others to do their work, you impact the lives of British Columbians today and in the future. That's why we're focused on your care too – offering health, wellness, development programs to support you – at work and at home.

Join one of BC's largest employers with province-wide programs, services and operations – offering vast opportunities for growth and development.

- Access to more than 2,000 in-house training programs.
- Enjoy a comprehensive benefits package, including municipal pension plan.
- 12 annual statutory holidays with generous vacation entitlement and accruement.
- Perks include onsite fitness classes and discounts to 350 BC-wide recreational programs, travel, technology, car and bike sharing, and more.
- Relocation assistance of up to $5,000 may also be available.
- Extended workday schedules (4-day compressed work week) are available for full-time psychologist positions.

What we do

The Provincial Health Services Authority (PHSA) plans, coordinates and evaluates specialized health services with the BC health authorities to provide equitable and cost-effective health care for people throughout the province. Our values reflect our commitment to excellence and include: Respect people – Be compassionate – Dare to innovate – Cultivate partnerships – Serve with purpose. Learn more about PHSA and our programs: jobs.phsa.ca/programs-and-services

PHSA is committed to employment equity and hires on the basis of merit, encouraging all qualified individuals to apply. We recognize that our ability to provide the best care for our diverse patient populations relies on a rich diversity of skills, knowledge, backgrounds and experiences, and value a safe, inclusive and welcoming environment.