

A First-Person Reflection of Learning from The International Association of Forensic Mental Health Services (IAFMHS) 15th Annual Meeting and Conference

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Abstract

As concerns involving students with mental health issues continue to come increasingly to the attention of campus administrators and Behavioral Intervention Teams, this article outlines and explores some of the major themes that emerged during the 15th Annual Meeting and Conference of the International Association of Forensic Mental Health, held in Manchester, U.K., this past June. It also explains how the information presented around these themes can impact and support our day-to-day work with students of concern.

Author's Note:

More and more often, myself, my U.K. peers and NaBITA peers encounter or are likely to encounter students with a mental health disorder who are deemed a threat or are capable of carrying out unlawful, violent acts. Earlier this year, I was invited by NaBITA to write a paper that reflected my learning from a conference I attended focusing on this topic, which featured some of the best academics and practitioners from Europe, the U.S., and Canada, and to share some key themes of universal interest, namely:

- Improvements in risk assessment
- The dynamics and theory behind intimate partner violence;
- How law enforcement professionals manage mental health risk in custody;
- The rise in numbers of ex-military personnel who break the law; and
- The forensic assessment of juveniles and people with intellectual disabilities;

and how the information I listened to around these themes can impact and support us in our day-to-day roles.

All references will be listed numerically at the end of this paper.

The International Association of Forensic Mental Health Services (IAFMHS) Conference "Risks — Rights — Responsibilities: Innovations in Forensic Mental Health Services" took place in Manchester, U.K., on the June 16–18, 2015. [1]

1. Moving from Risk Assessment to Management: Searching for Causes of Violence and The Relationship Between Delusions and Violence

With the experience of being asked to risk assess students deemed to be a risk to either themselves or others, specifically in threatening behaviours targeted at others, I was keen to listen to evidence-based and evidence-generating theory around this tricky subject. The two speakers of most interest on this topic were Professor Jeremy Coid, the director of the Violence Prevention Research Unit and a forensic psychiatrist at Queen Mary's University, London; and Dr. Simone Ullrich, also of the Violence Prevention Research Unit.

What is the main purpose of risk assessment? Surely, the key purpose of undertaking a risk assessment is to provide a formulation that will inform us and hopefully prevent something awful from happening. Very often, we find ourselves being asked to undertake a risk assessment on a person deemed to be dangerous, and for many of us, we just hope that we "call it" right.

Professor Coid was clear in his message that no risk assessment should ever be carried out without a risk management plan or strategy

being in place. He expressed the opinion that good risk assessment should consist of a combination of evidence-based risk assessment tools, and within his session, he highlighted the benefits of tools used in the U.K., Western Europe, and Canada, such as the PCL-R (for detecting psychopathy and predicting violent behaviour) [2], the VRAG (Violence Risk Appraisal Guide) [3], and the HCR-20 (Historical Risk Management 20) [4], commonly used in forensic psychiatry in combination with clinical judgement based on experience.

For the benefit of my NaBITA colleagues, it might be helpful to reflect and to compare and contrast the items in the above tools with that of The Structured Interview for Violence Risk Assessment (SIVRA-35), a 35-item inventory designed by Dr. Brian Van Brunt [5].

Furthermore, Professor Coid observed that risk assessment as a standalone activity is not necessarily effective in reducing the chance of something happening, and only one study comes to mind — The Brøset Study — that successfully predicted a violent incident. The Brøset Violence Checklist (BVC) is a six-item inventory that posited that risk assessment alone reduces violence. The BVC specifically assesses three patient characteristics (confusion, irritability, and boisterousness) and three patient behaviours (verbal threats, physical threats, and attacks on objects) as present or absent. It is hypothesized that an individual displaying two or more of these behaviours is more likely to become violent within the subsequent 24-hour period than the patient who does not display these behaviours. A patient scoring 0 is at very low risk for violence, whereas a score between 3 and 6 (the maximum) would indicate immediate need for preventive measures. The instrument has been shown to be more reliable in predicting violence than clinical judgment or intuition in inpatient populations for the first 72-hour, post-admission [6].

However, Professor Coid asserted that predictive models of risk assessment have been found to be wrong 30–40 percent of the time, and that more work should be done in the field of developing causal models of risk assessment.

Listening to Simone Ullrich's exploration of the relationship between delusions and violence was fascinating. Particularly noteworthy was her observation that there is little to no evidence base supporting the generally-held belief that people who are experiencing a psychotic episode are violent unless there is a co-morbid alcohol/substance misuse state in the mix. In other words, we should not assume that when we come into contact with a person experiencing a psychotic episode, the individual will be violent. Instead, we should revise our assumptions and be wary of violent behaviour if we know that such individuals are additionally misusing alcohol or illicit substances [7].

2. Intimate Partner Violence (IPV)

Three speakers in particular stood out for me within this theme. First was Dr. Jennifer Storey of Mid Sweden University, who presented a session titled, “Investigating the Influence of Victim Vulnerability and Gender on the Assessment of Intimate Partner Violence.” Dr. Storey explained that Sweden has put in place legislation to mandate their police forces to routinely use the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) [8] when IPV is suspected at any incident to which the police is called.

Interestingly, while there seems to be a rise in the numbers of female perpetrators of IPV in Western Europe, there are no gender-specific assessment tools for female perpetrators of IPV in existence. This leads me to consider that there is a gap in the market for such a tool to be created, perhaps one with similarities to SIVRA-35.

In Sweden, incidences of IPV in same-sex relationships are not coded as IPV, but as “between friends,” which led me to reflect on the fact that same-sex couples perhaps do not receive the same standard of recognition as their heterosexual counterparts when it comes to the reporting and mitigating of risk in relation to IPV.

Also of particular interest was “Anxiety and Intimate Partner Violence: Can their Association be Explained by Coexisting Conditions or Borderline Personality Traits?” by Dr. Mary Davoren of the Violence Prevention Research Unit at Queen Mary’s University. Dr. Davoren’s presentation was probably one of the highlights of this conference for me. She asserted that in IPV perpetrators, antisocial personality disorder (ASPD), anxiety disorders, and drug/alcohol dependency are common, and recommends that if you are assessing an IPV perpetrator, you should also be assessing them for anxiety.

In self-report studies, male perpetrators who reported incidents of IPV were found to be violent men generally. In other words, their violence is not restricted to the IPV context. This left me with a future research idea: exploring the causal pathways of IPV (e.g., rejection, abandonment, and jealousy), and I would encourage anyone interested in collaborating with me on this subject to contact me.

Finally, in “Differentiating Intimate Partner Homicide — a Swedish Register-Based Study of Homicides in Sweden, 2007–2009,” Dr. Shilan Caman from Karolinska Institute in Sweden explained that in Western Europe, between 25 and 30 percent of all homicides are coded as Intimate Partner Homicide (IPH). In the study that Dr. Caman presented, of 264 incidents of homicide (36 unsolved), 56 were coded as IPH (25 percent) with 80 percent of the victims being female and 86 percent of the perpetrators being male. Homicide Suicide is highly prevalent within IPH scenarios, Dr. Caman noted, and again I

was left considering the potential for a rigorous investigation of this. Anyone interested in discussing this area of research interest is also encouraged to contact me.

3. U.K. Developments in Police-Based Mental Health Assessment and Treatment

This was a particularly interesting subject to share, particularly for those colleagues who have law enforcement officers on campus or who regularly escort students to a place of custody or investigation. “Mental Health Screening in Police Custody,” by Dr. Jane Senior, the director of the Offender Health Research Network at the University of Manchester, primarily focused her attention on mental health screening tools currently being used in custody suites in the U.K. Citing Lord Bradley’s 2009 report [9], she observed that figures available are variable but range between 2 and 20 percent of detainees in U.K. custody suites have a mental illness.

The figure is still seen to be high and therefore, there has been a resurgence of attention to this subject of how mentally ill “offenders” are treated while in custody. It is vital to remember that in the U.K., a custody suite is not a prison. The person detained at a custody suite may never actually be charged. A custody suite is a place of secure detention following arrest on the suspicion of a crime while being questioned.

Historically, mental health screening in the custody setting has been patchy at best in the U.K., and it is typical that the mental health screening tools used may not have been validated and are being used by police personnel who have received no mental health training. The most commonly used screening tool used in custody suites had been the “Prison Screening Questionnaire” (PriSnQuest, Shaw et al, 2009), an eight-item, yes/no questionnaire. If three or more questions are answered affirmatively, then further assessment is deemed to be warranted. By its name, you can surmise that this tool was created for use within prison populations, and was not designed for pre-charged or pre-sentenced detainees.

To address this matter, Senior et. al (2013) produced “The Police Mental Health Screening Questionnaire” (PolQuest,) [10], the new generation and successor to PriSnQuest, which was designed for the specific use of custody sergeants. PolQuest is a 13-plus-one-item mental health screening questionnaire that can be administered in five minutes and links into local mental health referral pathways.

The questions are colour-coded, whereby red questions require an urgent and immediate response to the risk posed, while amber questions are routine. Red questions relate to risk posed by psychosis or suicidal ideation/harm to others.

Interestingly, the rules of administration state that PolQuest must only be administered to individuals over 18 years of age who are sober during interview. This left me with a question: What happens to 16–18 year olds? The U.K. government has issued guidelines on young people's custody rights in the U.K. [11], but these guidelines make no mention of mental illness and so how young people are to be screened. This may present an opportunity for a gap to be bridged and for an age range-specific mental health screening tool to be designed for use prior to police interviews.

In "Health Screening of People in Police Custody: HELP-PC Project," by Dr. Iain McKinnon, a consultant psychiatrist at Newcastle University's Institute of Health and Society, explained that under U.K. PACE (Police and Criminal Evidence Act, 1984), a custody sergeant is legally responsible for the welfare of detainees, and owes a duty of care to detainees while they are in a custody suite of which s/he is in charge. On arrival at a custody suite, it is usual practice for a detainee to be assessed for physical and mental health conditions, intoxication/withdrawal, injury, and what is termed a "mentally vulnerable" state. Although there is no clear definition of this term, it is usually thought to include intellectual disabilities.

This assessment/screening/risk assessment is undertaken in a public area, very often with other people in very close proximity, and with little or no privacy and little or no concern for the dignity of the detainee [12] [13] [14] [15]. This led me to reflect on the human rights violations and the lack of dignity often demonstrated within detention settings universally, not just in the U.K. Even within an educational setting, how mindful are we to the privacy and dignity rights of someone suspected of having committed an unlawful act, when Western democracy dictates that individuals are innocent until found guilty by a jury of their peers?

In "Service Users' Experiences of Detention in Police Custody," Dr. Heather Noga of Simon Fraser University in Canada was keen to point out that for vulnerable people taken into police custody, of primary importance was that their interactions with people in authoritative roles be ones where they were afforded respect, dignity, trust, legitimacy, and a voice. She went on to observe that, "better (more respectful, empathic, and dignified) treatment of detainees usually leads to adherence to treatment protocols further upstream." Does this principle of Dr. Noga's not also relate to how we interact with vulnerable students who require our assistance in times of trouble? How many times have we been asked to interview or assess vulnerable young adults who have been labelled as "trouble-makers" or "resistant" by figures of "authority," and when you take the time to get to know them and understand their perspective, turn out to be neither troublesome nor resistant, but usually just scared and

confused as to what is happening? And to which approach is the so called "trouble-maker" more responsive to — the authoritarian or the caring and empathic?

4. Military Personnel Who Offend: Understanding the Needs of a New Forensic Population

"Offending within the Military," by Dr. Deirdre MacManus, a consultant psychiatrist and senior lecturer at Kings College London, pointed out that ex-military personnel are the largest single occupation group in prisons in England. To help understand how and why ex-military personnel offend, Dr. MacManus advised us to consider the possibility that many may have had a predisposition to anti-social behaviour before joining up.

In U.K. recruitment studies, 47 percent of males who join the military (particularly the Army) have deficient literary skills. The King's Centre for Military Health Research [16] was timed to start with the second Iraq war and has provided the only longitudinal study in existence in the U.K. evidencing higher violent offending in a military cohort than in a general public cohort. I asked Dr. MacManus if there is any significance in the public perception of deployment? For example, might the controversy surrounding the Iraq war and the perception that it is considered by many in the U.K. to as an illegal war, perhaps have a detrimental effect on military personnel morale? She responded that it appeared to be a complicating factor. It appears that alcohol and anger are the most commonly cited issues and common co-morbidities, which lead to externalised offending behaviours.

In her 2013 paper, "Veteran Mental Health: Are We Headed in the Right Direction?" [17], Dr. MacManus suggests that instead of focusing on short-term alcohol treatment or anger management courses, efforts should instead be focused on protective factors (e.g., employability, secure housing, debt management, and civilian transition) to reduce the levels of risk of offending.

In England today, there are 4.9 million military veterans and military dependents. Up until 2010, there were no specialised health services for ex-military personnel, despite an upsurge in reported PTSD and domestic violence within this population. Then came a report by the British Parliamentary Member Dr. Andrew Murrison in 2010, "Fighting Fit" [18], which campaigned for more and better specialised mental health services for ex-military personnel.

National Health Service England (which funds and provides specialised commissioned services in England) now funds these services. There are currently 10 regional specialised NHS services for ex-military personnel. However, only some of the services have in-reach to prisons, as this role falls mainly as a burden to the voluntary sector.

Dr. MacManus was adamant that there still remains a very real need for collaboration to support ex-military personnel in relation to their mental health, welfare, and housing needs (protective factors).

In “The Health Needs of Ex-Military in Prison,” Dr. Verity Wainwright of the University of Manchester, stated that early leavers from the military often cite mental ill health as being their primary reason for leaving. Studies undertaken by Dr. Wainwright identify violence (e.g., murder, manslaughter, and grievous bodily harm), drug offences, and sexual offences as the most common offence charges committed by ex-military personnel. The majority of men that Dr. Wainwright interviewed were first-time prisoners.

Mental health continues to have stigma surrounding it; this is thought by the research team to compound and maintain offending behaviour, as there are very few avenues open through which to speak of mental illness or seek out support, both in the military and in the penal system.

I was immensely saddened by Dr. Wainwright’s closing observation that many of the young men interviewed had experienced a profound sense of loss when leaving the “institutionalised” setting of the military and described a sense of “fitting in again” in a prison setting. “Military personnel make ideal prisoners,” because they “respond to a sense of order, discipline, and authority” commented a prison governor (warden) who appears in one of her studies.

Listening to Dr. MacManus and Dr. Wainwright, I found myself reflecting on the increase in numbers of ex-military personnel enrolling in colleges and universities, many of whom have multiple and complex needs, sometimes complicated by undiagnosed PTSD or other mental health conditions. How often is it the case that something has gone wrong before some of these vulnerable adults are brought to our attention? I am aware of a role at the University of Birmingham in England with the title “Vulnerable Students Officer.” More roles such as this one could go a long way in supporting ex-military personnel who enroll with risk factors rendering them vulnerable.

5. Forensic Assessment: Knowledge Exchange with Third Parties Such As Prosecutors and Judges

In “Prosecutorial Decision-Making Regarding Forensic Mental Health Assessments and its Relevance in Holland,” Dr. Maaike Kempes, who chairs the Netherlands Institute for Forensic Psychiatry and Psychology, described that in Holland, if individuals under the age of 18 offend, they are tried in accordance with juvenile law. However, since 2014, if it is deemed that development is “delayed,” then a person will be tried in accordance with juvenile law up to the age of 23. That led me to ponder the question of who assesses those

who may be “delayed.” Whose expert opinion is that? In Holland, there are around 4,000 forensic assessments completed per year, of which approximately 600 are for 18–23 year olds. A psychiatrist and a psychologist are both responsible for “applying juvenile law” assessment and advise judges accordingly.

This left me with another future research idea: Can criteria be developed to assess for the application of juvenile law in cases where “delayed development,” or what might be termed “intellectual disability,” is suspected? Again, anyone interested in this topic or collaborating with me on this is encouraged to contact me.

References

- [1] IAFMHS “Risks — Rights — Responsibilities: Innovations in Forensic Mental Health Services” Conference Programme. Retrieved from www.iafmhs2015.com.
- [2] The Hare Psychopathy Checklist — Revised (PCL-R). Retrieved from www.minddisorders.com/Flu-Inv/Hare-Psychopathy-Checklist.html.
- [3] The Violence Risk Appraisal Guide (VRAG). Retrieved from www.fotres.ch/index.cfm?&content=9010&spr=en.
- [4] Historical Risk Management 20 (HCR-20). Retrieved from www.minddisorders.com/Flu-Inv/Historical-Clinical-Risk-Management-20.html.
- [5] The Structured Interview for Violence Risk Assessment (SIVRA-35). Retrieved from <https://nabita.org/resources/sivra-35/>.
- [6] The Broset Violence Checklist (BVC). Retrieved from www.researchgate.net/publication/229078207_The_Brset_Violence_Checklist.
- [7] Profile on Dr. Simone Ullrich. Retrieved from www.wolfson.qmul.ac.uk/a-z-staff-profiles/simone-ullrich#profile.
- [8] Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). Retrieved from www.justice.gc.ca/eng/rp-pr/fl-lf/famil/rr05_fv1-rr05_vf1/b1.html.
- [9] Lord Bradley’s Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. Retrieved from www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf.
- [10] The Police Mental Health Screening Questionnaire (PolQuest) Retrieved from www.ohrn.nhs.uk/OHRNResearch/PolQuest.

- [11] The UK Government, "Being Arrested: Your Rights." Retrieved from www.gov.uk/arrested-your-rights/when-youre-arrested.
- Other Articles of Interest by Dr. Iain McKinnon:**
- [12] "Health Screening in Police Custody." Retrieved from [www.jflmjournal.org/article/S1752-928X\(10\)00007-7/abstract](http://www.jflmjournal.org/article/S1752-928X(10)00007-7/abstract).
- [13] Evaluation of Above Project (<http://eurpub.oxfordjournals.org/content/23/3/399>). "Screening for Psychiatric Morbidity in Police Custody: Results from the HELP-PC Project." Retrieved from <http://pb.rcpsych.org/content/37/12/389>.
- [14] "Evidence-Based Risk Assessment Screening in Police Custody: The HELP-PC Study in London, U.K." Retrieved from <http://policing.oxfordjournals.org/content/early/2014/04/04/police.pau010.abstract>.
- [15] "Advances in Mental Health and Intellectual Disabilities." Retrieved from www.emeraldinsight.com/doi/pdfplus/10.1108/AMHID-04-2015-0015.
- [16] The King's Centre for Military Health Research. Retrieved from www.kcl.ac.uk/kcmhr/index.aspx.
- [17] McManus and Wessley, 2013, "Veteran Mental Health: Are We Heading in the Right Direction?" Retrieved from www.kcl.ac.uk/kcmhr/publications/assetfiles/veterans/Macmanus2013veteran.pdf.
- [18] Andrew Murrison, 2010, "Fighting Fit" Report. Retrieved from www.gov.uk/government/uploads/system/uploads/attachment_data/file/27375/20101006_mental_health_Report.pdf.