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NEWSLETTER

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Letter from the Editor

"*Winter forms our character and brings out our best.*" – Tom Allen

Welcome to our first newsletter of 2023, IAFMHS Members! Behind the scenes in our organization, we have many dedicated people working on organizing our first in-person conference since 2019, which will be held in vibrant and stunning Sydney, Australia. Stay posted for updates as the days in June draw nearer!

In this edition of the newsletter, I would like to highlight a contribution and call to action from Dr. Piel and Dr. Sheehy discussing the possible role of attorneys in suicide prevention, and the complications and challenges they may face from professional and legal restrictions or lack of training.

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

Sarah Coupland, Editor

FORENSIC MENTAL HEALTH NURSING

From a model to a practice change to reduce seclusion and restraint: where are we now?

Marie-Hélène Goulet, Ph.D. & Clara Lessard-Deschênes, Ph.D.

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While some aim for their reduction and others their elimination, there is an international consensus on the need to reduce the use of seclusion and restraint in mental healthcare. These restrictive practices have negative consequences that no longer need to be demonstrated and several programs have been proposed to decrease their use (e.g., Six Core Strategies (Wieman et al., 2014), Safewards (Bowers, 2014)). So why are seclusion and restraint still used frequently? It is now time to reflect on how to change practices.

For this purpose, we conducted an integrative review of 136 articles that led to the proposal of the Model of prevention of seclusion and restraint in mental health (Goulet& Lessard-Deschênes, 2022). Interventions were categorized using Bronfenbrenner's ecological model. Six categories are proposed in terms of systems mutually involved in the prevention of seclusion and restraint use: the person (individual), the professionals and the therapeutic environment (microsystem), the psychiatric care unit culture (mesosystem), organizational initiatives (exosystem), national policies and international organizations (macrosystem), and evolution of the discourse or resistance to change (chronosystem).

First, government policies have been found to exert a form of pressure on mental health professionals to reduce the use of seclusion and restraint, while they feel powerless when it comes to alternatives that consider the safety of all parties involved. Thus, according to Happell and Koehn (2010), as the professional group most likely to initiate seclusion, nurses' attitudes toward these policies will influence the extent to which they are implemented in practice. According to Duxbury (2015), there are three myths that contribute to the resistance to change in practices related to restraint that must be deconstructed: 1) restraint keeps people safe; 2) restraint is a clinical intervention; and 3) restraint is only used as a last resort.

Second, some say that a fundamental change in the culture of psychiatry is needed to reduce the use of seclusion and restraint (Sashidharan, Mezzina, & Puras, 2019), which fits into the chronosystem of our model. In 2004, Secker exposed the failure of the "zero tolerance" policy where no expression of aggression is tolerated, because it does not allow professionals to interpret the meaning of the aggressive behaviour and thus intervene in accordance with the need expressed by the person. **(Continued on next page…)**

FORENSIC MENTAL HEALTH NURSING

From a model to a practice change to reduce seclusion and restraint: where are we now? (continued…)

Moreover, we are witnessing an evolution of practice standards and discourses advocating participatory and inclusive approaches: from a paternalistic approach where the professional is considered the specialist to a partnership approach where the responsibility for risk management should be shared by all. But, once again, the change in discourse is slow to reflect in practice.

A reduction in the use of seclusion and restraint can only occur if professionals do not feel that their safety is threatened by the new practice. According to the sociologist Giddens (1987), reflexivity is the constant revision of practices in light of new information and implicit knowledge. In this context, feeling safe being a fundamental need, there can be no change if the professional feels that their safety is at risk. The professional will then follow the laws that they consider to be right. Since nurses have a decision-making responsibility over the use of seclusion and restraint, they need to have the necessary space and support (from their organization and colleagues) to implement alternative interventions. The responsibility of the use of seclusion and restraint must be shared by the many systems involved.

References

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards [Article]. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499-508.

Duxbury, J. A. (2015). The Eileen Skellern lecture 2014: Physical restraint: In defence of the indefensible? [Health & Mental Health Services 3370]. *Journal of Psychiatric and Mental Health Nursing, 22*(2), 92-101.

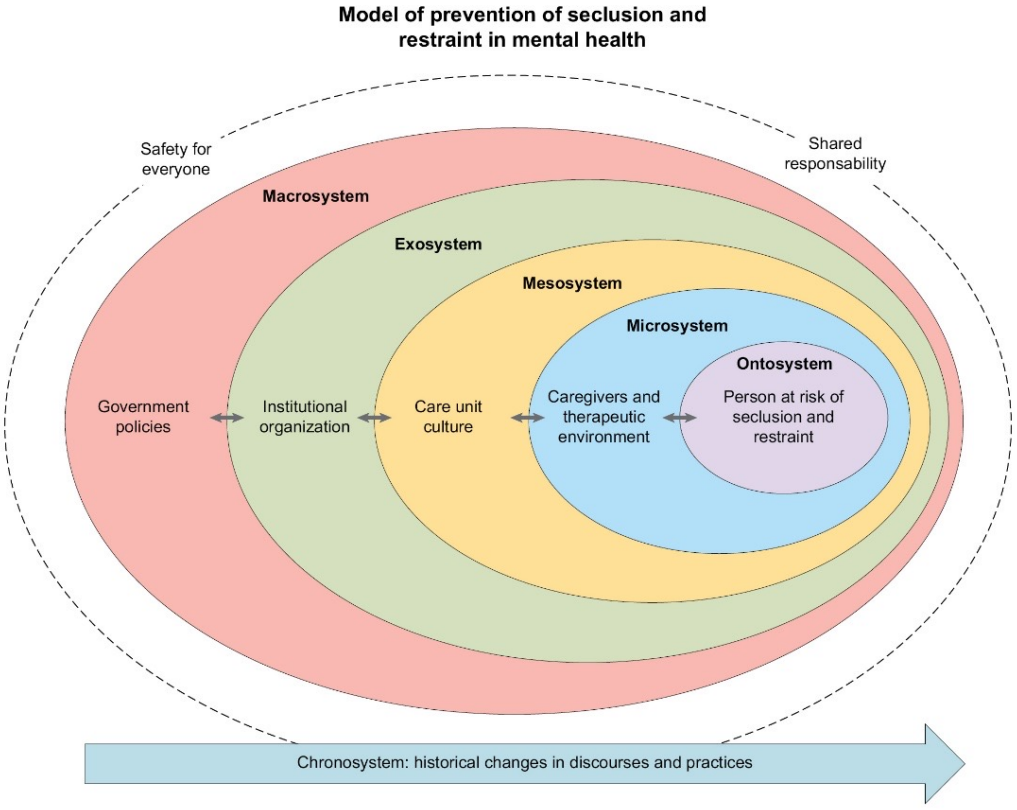
Giddens, A. (1987). *La constitution de la société*. Presses universitaires de France.

Goulet, M.-H., & Lessard-Deschênes, C. (2022). Le Modèle de prévention de l'utilization des mesures de contrôle en santé mentale: une revue intégrative. *Santé Mentale au Québec, 47*(1), 151-180.

Happell, B., & Koehn, S. (2010). Attitudes to the use of seclusion: has contemporary mental health policy made a difference? *Journal of Clinical Nursing, 19* (21-22),3208-3217.

Wieman, D. A., Camacho-Gonsalves, T., Huckshorn, K. A., & Leff, S. (2014). Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric impatient facilities [Inpatient & Hospital Services 3379]. *Psychiatric Services, 65*(3), 345-351.

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**



MENTAL HEALTH DIVERSION

A Summary of the Saskatoon Mental Health Strategy Court Evaluation

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The Saskatoon Mental Health Strategy (MHS) Court brings together a multidisciplinary team of community stakeholders and legal professionals to assist justice-involved individuals living with mental illness and cognitive impairments (Barron et al., 2015). The Saskatoon MHSCourt, like other mental health courts, is designed to divert justice-involved persons with mental health concerns away from the traditional court system into community-based treatment by providing personalized treatment in order to disrupt the cycle of recidivism for justice-involved individuals living with additional mental health concerns (Baillargeon et al., 2009; Lurigio &Snowden, 2009; Rankin & Regan, 2004; Schneider, 2008; Schneider et al., 2007; Wiener et al., 2010; Winick, 2002; Winick & Wexler, 2003). With colleagues at the University of Saskatchewan's Centre for Forensic Behavioural Science and Justice Studies, we embarked on a comprehensive evaluation of the Saskatoon MHS Court to determine the effectiveness of the MHS Court and the extent to which it is achieving its intended outcomes.

The full evaluations of the Court are available here, here, and here, but this summary will focus on summarizing the results of the process and outcome evaluations. In an outcome evaluation of the first-year cohort of the Saskatoon MHS Court, results indicated that arrest recidivism was low for clients involved with the Saskatoon MHS Court although court cases and convictions increased for participants. Notably, a large proportion of the recidivist cases and convictions resulted from system generated or non-compliance issues. Given the increased detection of non-compliance due to greater supervision by the MHS Court compared to the traditional justice system, there was also evidence of over-supervision and over-punishment by the MHS Court.

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Due to these increases, defence counsel may advise clients to take their chances with the traditional criminal justice system, meaning that the Court may not be fully accomplishing its goals of diverting clients out of the traditional criminal justice system. Fewer clients experienced a mental health episode 1-year post-Court entry; however, these episodes lasted significantly longer post-Court. Further, more clients accessed services post-Court entry, with access to group counselling, individual counselling, and detox increasing.

In a qualitive process evaluation with 9 multi-disciplinary professionals involved in the functioning of the Court, results were divided into three main themes (balancing priorities and viewpoints, resources, and connections) with corresponding subthemes. Despite challenges, professionals thought that the Court was meeting its goals by treating the underlying causes of offending behaviour rather than simply criminalizing the behaviours. There were several areas of improvement identified for the Court including increasing capacity and preventing burnout among professionals, providing more clarity about the aims and goals of the court, and increasing collaboration among various professionals and community agencies. Specific recommendations for addressing these challenging areas include an increase in funding for the MHS Court and mental health services, the creation of a dedicated coordinator position for the MHS Court, an increase in collaboration among community agencies and the Court, a restructuring of the pre-court meetings to promote open dialogue, and an increase in the number of professionals providing their services to the Court. **(Continued on next page…)**

MENTAL HEALTH DIVERSION

A Summary of the Saskatoon Mental Health Strategy Court Evaluation

(Continued…) While these evaluations are specific to the Saskatoon MHS Court, they provide a valuable case study that can be used as an example for similar programs. Despite some difficulties, MHCs seem to provide much needed support to a vulnerable population and may help to alleviate some of the difficulties seen in the traditional justice system.

References

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*, 103–109. https://doi.org/10.1176/appi.ajp.2008.08030416

Barron, K., Moore, C., Luther, G., & Wormith, J. S. (2015).*Process evaluation of the Saskatoon Mental Health Strategy*. Centre for Forensic Behavioural Science and Justice Studies-University of Saskatchewan, Saskatoon, SK. https://cfbsjs.usask.ca/documents/research/research_papers/Process%20Evaluation%20of%20the%20Saskatoon%20Mental%20Health%20Strategy.pdf

Lurigio, A. J., & Snowden, J. (2009). Putting therapeutic jurisprudence into practice: The growth, operations, and effectiveness of mental health court. *The Justice System Journal,30*, 196–218.

Rankin, J., & Regan, S. (2004). *Meeting complex needs in social care: The future of social care*. Turning Points/ Institute of Public Policy Research (IPPR).https://www.ippr.org/research/publications/meeting-complex-needsthe-future-of-social-care

Schneider, R. D.,Bloom,H., & Heerema, M. (2007). *Mental health courts: Decriminalizing the mentally ill*. Irwin Law.

Schneider, R. D. (2008). Mental health courts.Current Opinion inPsychiatry, 21, 510–513

Wiener, R. L., Winick, B. J., Georges, L. S., & Castro, A. (2010). A testable theory of problem solving courts: Avoiding past empirical and legal failures. *International Journal of Law and Psychiatry, 33*, 417–427. https://doi.org/10.1016/j.ijlp.2010.09.012

Winick, B. J. (2002). Therapeutic jurisprudence and problem solving courts. *Fordham Urban Law Journal, 30*, 1055–1103.

Wexler, D. B., & Winick, B. J. (2003). Putting therapeutic jurisprudence to work. *ABA Journal, 89,* 54.

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

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH

Feature Article

Trajectories and Outcomes of Those Not Criminally Responsible on Account of Mental Disorder through a Canadian Forensic System

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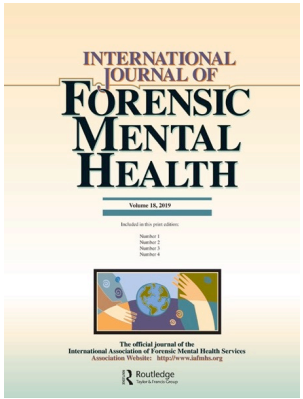

Canadians adjudicated Not Criminally Responsible on Account of Mental Disorder (NCR) are detained in forensic psychiatric hospitals under a jurisdictional review board (RB) governed by the Canadian Criminal Code. The custody and management of NCR populations are administered independently across jurisdictions despite being federally legislated, and research is limited on how RBs may vary in their efforts to balance public safety and social reintegration across cases, settings, and provinces. To this end, the trajectories and outcomes were investigated in one understudied Canadian RB system on a sample of NCR individuals (n = 109) and compared to other provincial practices. A retrospective longitudinal design was employed to track an NCR cohort between 2005 and 2010 until 2015. Results demonstrated that the provincial RB aligned their operational and management practices with federal legislation, but unique deviations contributed to novel NCR trajectories and outcomes under RB supervision that were conservative relative to provincial partners. Dispositions varied as a function of risk level and were informed by clinician recommendations. Detention length differences were observed between ancestral lines, as the White ancestral group spent an average of three years less in custody than the Nonwhite ancestral group despite limited differences in demographic, clinical, and criminogenic profiles. Further research is required on NCR trajectories and outcomes across other understudied provinces and the role of forensic risk instruments in assisting with the consistent application of federal law.

SPOTLIGHT ON FORENSIC TREATMENT

A specialist secure service for people with autistic spectrum disorders

Dr. Harinder Bains, MBBS, FRCPsych, LL.M.
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The secure autism spectrum disorder (ASD) specialist inpatient service has been developed in partnership with South of England - National Health Service (NHS) with the aim of meeting regional needs of patients in line with the national Transforming Care programme (Department of Health, 2012). The service has been rather unique in that it was developed with NHS under a programme of bed closures, in order to meet a regional need to repatriate patients closer to their 'home' areas and successfully discharge patients into their local communities. Most of these patients have been seen as 'difficult to discharge' patients. The aim of the service has been to achieve this through collaborative care pathway management with community care stakeholders.

The 14 bedded service aims to provide a high-quality specialist service focussing on engagement in individualised outcome-focussed treatment and rehabilitation programme in a suitable environment. The physical environment is 'autism friendly' (National Autistic Society) within a therapeutic milieu conducive to addressing specific autistic needs, risk management and enable patients to work towards living safely, with appropriate support, in the community.

All patients have a multi-disciplinary therapeutic treatment plan which is outcome-based. The care plans address any comorbid mental and physical health conditions, which along with other psychosocial considerations, form the framework for care plan outcomes. Patients have access to a range of individual and group rehabilitation activities that include educational, leisure, vocational, sporting and community skills development.

The patients admitted to the service have been relatively young (below the age of 35 years) and this is consistent with previously described target age group for such services (Alelly, 2018).

The service has had an overrepresentation of individuals who have committed sexually-based offences and an adapted programme for those who committed such offences has been developed. Treatment plans include communication, functional and sensory assessments.

Multidisciplinary input includes psychiatry, specialist nursing, psychology, occupational therapy, speech and language therapy, art and drama therapy. Patients have individualised risk management plans that are based on philosophy of positive risk-taking (Department of Health, 2014) and proactive approach to reducing use of restrictive interventions.

Carer and family involvement is an essential component of the collaborative model and this is done through formal clinical processes (such as Care Programme Approach meetings and Clinical Treatment Reviews) and promoting a culture of communication in the team, with families and carers, and managed through the team's social worker.

A monthly ward audit reviews the use of restrictive approaches to managing patients. The use of physical restraint, segregation, and seclusion is monitored by an organisational restrictive intervention reduction programme. This service in particular has the challenge of working with enhanced external framework such as sexual harm prevention court orders due to larger than usual number of such orders in this service.

All patients are detained under the Mental Health Act with some having restriction orders (Mental Health Act, 2007) including a larger than usual number of patients under 'hybrid' orders (s.45A of Mental Health Act). This reduces likelihood of indefinite restriction and introduces a predictable timeframe, which is helpful for patients with ASD.

(…Continued on next page.)

SPOTLIGHT ON FORENSIC TREATMENT

A specialist secure service for people with autistic spectrum disorders (…continued)

The primary outcome measure for the service has been successful and suitably supported discharge into community. Outcomes in relation to progress includes qualitative and quantitative measures that are monitored by the multidisciplinary team and external stakeholders through involvement of commissioning case managers through formal processes (NHSE, Clinical Treatment reviews) and informal liaison with the clinical team. This has resulted in development of transparent collaborative clinical practice which in addition to providing external scrutiny and assurance, has also helped expedite involvement of community services for discharge at relatively early stages.

A particular challenge with the patient group is that there tends to be lack of clarity in community as to which community mental health provision can most appropriately meet needs of people with ASD. This has led to delays in discharges due to lack of clear guidance as to whether general adult psychiatric or learning disability community provisions are the commissioned service for adults with ASD without intellectual disability. It is therefore not surprising that regions with specialist forensic teams (Devapriam & Alexander, 2012) have been able to facilitate and support discharges more quickly than regions where such a provision does not exist. Where such community services exist (NHS, 2017) they have been able to support community discharges by providing specialist expert consultation to community services. Eight of the 10 community discharges from the service have been to regions with such specialist community support.

Acknowledgement: Prof. Quazi Haque, Executive Medical Director Elysium Healthcare, UK for his contribution and review of this article.

To provide feedback on this article, please contact **Dr. Bains** directly (harinder.bains@elysiumhealthcare.co.uk) or the editor, Dr. Coupland (sarah_coupland@sfu.ca).

References

Allely, C. S (2018). A systematic PRISMA review of individuals with autism spectrum disorder in secure psychiatric care: prevalence, treatment, risk assessment and other clinical considerations. *Journal of Criminal Psychology 8*(1), 58-79. http;//DOI:10.1108/JCP-06-2017-0028.

Care Quality Commission, Guidance for providers Success factor 8 <https://www.cqc.org.uk/guidance-providers/all-services/success-factor-8-courage> accessed 7th January 2023

Department of Health (2012). Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report. London, UK.

Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions. London, UK.

Department of Health et al (2015) Transforming Care for People with Learning Disabilities – Next Steps. London, UK.

Devapriam, J. & Alexander, R. J. (2012). Tiered model of learning disability forensic service provision. Journal of Learning Disabilities and Offending Behaviour 3 (4), 175-185.

Melvin, C. L., Barnoux, M., Alexander, R., Roy, A., Devapriam, J., Blair, R., … Langdon, P. E. (2022). A systematic review of in-patient psychiatric care for people with intellectual disabilities and/or autism: effectiveness, patient safety and experience. *BJPsych Open, 8*(6), e187. http://doi.org/10.1192/bjo.2022.571

Mental Health Act 2007.
(https://www.legislation.gov.uk/ukpga/2007/12/contents)

National Health Service England (NHSE), Care and Treatment Reviews
(https://www.england.nhs.uk/learning-disabilities/care/ctr)

National Health Service England, (2015). Building the right support-A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.
(https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf)

NHS England, (2017). Community Forensic Support for people with a learning disability and or autism -a national perspective. http://www.iow.gov.uk/azservices/documents/2910-workforceCompetencyv6.pef

National Institute of Clinical Excellence.
(https://www.nice.org.uk/guidance/cg142)

National Autistic Society, *Accessible environments*
(https://www.autism.org.uk/advice-and-guidance/topics/autism-friendly-guide/accessible-environments)

SPOTLIGHT ON LAW INTERSECTIONS

Criminal Defense Attorneys and Suicide Prevention

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Steve was recently detained at the local jail following a fight after a night of drinking. He was booked for second-degree assault. This was his first time in jail. He repeatedly said that he had never been arrested before and questioned whether this would cause him to lose his job. Steve displayed some agitation, but cooperated with booking. He was taken to a cell, where he isolated from others. He did not want his family to know about his arrest. On the second day, he met with his lawyer. One hour after returning to his cell, he was found dead by hanging with a bed sheet around his neck. The following day, the lawyer mentioned that, in their meeting, Steve said he would "rather die than lose everything" important to him.

Suicide in corrections is a well-documented issue. Jailed inmates are twice as likely to die by suicide than the general U.S. population and suicide is the leading cause of death in jails (Carson, 2021). Recent arrest is a particularly vulnerable time and confers increased suicide risk (Bryson et al, 2021). Nearly 80% of suicides in jail are by those awaiting trial and over 40% are within the first week of incarceration (Carson, 2021). Recent research indicates that violent offenses are associated with elevated risk compared to non-violent offenses (Carson, 2021). Consistent with the general population, mental illness is a significant risk factor for suicide among people in correctional settings. Among those with recent arrest, intoxication and substance use are common risk factors (Carson, 2021).

Although there has been increased attention to suicide risk in correctional settings, questions remain as to how to identify those at elevated risk for suicide who are not recognized by current screening measures and how to identify additional measures to mitigate risk. An under-examined area is the role that the criminal defense attorney could play in risk mitigation for some defendants involved in the criminal legal system. Some research indicates that over a third of suicides occur close to the date of a court hearing, and nearly a quarter occur close to the date of a phone call or visit, sometimes with the defense attorney; roughly two-thirds of suicides occur in less than a day after the call or visit (Hayes, 2010).

For many arrested individuals, entering into the corrections system is a frightening and isolating experience. As in the case of Steve, persons may not be in close contact with family and the shame associated with arrest can leave them feeling even more alone. For some people, their attorney may be the only person they are in meaningful communication with during their incarceration, and lawyers may be privy to a clearer picture of their client's changing mental status. An attorney will know when someone has received bad news about their case and how well they take it. We speculate that bad news from an attorney or family member may be an acute stressor that precipitates suicide in some detained persons, especially when already vulnerable.

But, involving non-clinical professionals into the discussions of suicide prevention is not without complications. Although some lawyers pursue some basic training in recognizing psychological symptoms, this is most commonly focused on lawyer-wellbeing, not recognition of symptoms in their clients. Studies have demonstrated a desire for more training among attorneys working with clients with mental illness or suicidal thoughts (Flood & Kelley, 2019). In addition, even when a lawyer identifies a client's suicidal thinking or behaviors, lawyers may not know how to access services for their client while preserving their duties to their client.

Lawyers may be concerned about breaking attorney-client privilege. Whether they alert the correctional staff or mental health providers, attorneys in the U.S. risk breaching their code of professional ethics in some jurisdictions if they disclose a client confidence without their client's consent. Although the American Bar Association's Model Rules of Professional Conduct permits breaking confidences "to prevent reasonably certain death or substantial bodily harm" (ABA Rule 1.6), this is an exception to attorney-client privilege that has not been adopted in all states. Where it has been adopted, the practicalities of defining what "reasonably certain" means is not clear cut, may vary by state, and has serious professional implications.

(…Continued on next page.)

SPOTLIGHT ON LAW INTERSECTIONS

Criminal Defense Attorneys and Suicide Prevention

(continued…)

We have observed several cases similar to Steve, and posit that the attorney may be an underutilized intervention point for suicide prevention. Attorneys working with clients with mental health and other risk factors for suicide and may be in a position to help preserve the safety and life of their client. We call for the availability of more professional education for lawyers, particularly criminal defense lawyers, on basic behavioral health symptoms; suicide, including risk factors and association with criminal arrest; and trauma-informed services. For states that have yet to modify their attorney professional codes to permit disclosure to prevent serious risk of harm to the patient or another, we encourage state bar associations and others to advocate for and support such changes. Not only is there a chance to preserve life, but the opportunity exists to better support our legal colleagues as they grapple with their client's mental health conditions and suicide risk, sometimes doing so alone.

To provide feedback on this piece, please do not hesitate to contact Jennifer Piel, JD, MD, Director Center for Mental Health Policy and the Law, Department of Psychiatry & Behavioral Sciences, University of Washington, Seattle, WA, USA. Email: **piel@uw.edu**

References

American Bar Association. (2020). Model rules of professional conduct: Rule 1.6: Confidentiality of Information. *American Bar Association*

Bryson, W. C., Piel, J., & Thielke, S. M. (2021). Arrest and non-fatal suicide attempts among men: Analysis of survey data from the National Survey on Drug Use and Health. *BMC Psychiatry, 21*(1). https://doi.org/10.1186/s12888-021-03544-0

Carson, E. A. (April 2021). Mortality in local jails, 2000-2018-Statistical Tables. *Bureau of Justice Statistics*. NCJ 256002.

Carson, E. A. (Oct 2021). Mortality in state and federal prisons, 2001–2018–statistical tables. *Bureau of Justice Statistics*. NCJ 300731

Flood, F. (2019). Noncustodial client suicide. *Criminal Justice, 34*(2), 10-17.

Hayes, L. M. (2010). National Study of Prison Suicides: 20 Years Later. *US Department of Justice National Institute of Corrections*. Accession number 024308.

STUDENT SECTION

SPOTLIGHT: Interview with Dr. Lindsay Malloy

Student Section Editors: Lillian Bopp, President, University of Nebraska- Lincoln, USA | **Lindsay Healey**, Secretary, Carleton University, CAD | **Mimosa Luigi**, President-Elect, McGill University, CAD

Dr. Lindsay Malloy is an Associate Professor of Psychology at Ontario Tech University, specializing in developmental and forensic psychology. She is the Director of the Development, Context, and Communication Lab, and her research addresses how, why, and to whom children and teens disclose negative or traumatic experiences; factors that influence children's memory, deception, and narratives; and investigative interviewing and interrogation techniques. Her scholarship is widely cited in both forensic and developmental psychology, has appeared in amicus briefs submitted to the U.S. Supreme Court, and has resulted in multiple prestigious early career awards (e.g., from Divisions 37 and 41 of the American Psychological Association). Dr. Malloy's research has been funded by several U.S. and Canadian federal agencies. She also regularly provides expert testimony and consultation related to children's and adolescents' communication about and memory of events.

Lindsay Malloy, PhD

Associate Professor in Psychology, Ontario Tech University, CAD

Q: Can you tell us about your past/current research and professional activities?

A: I did my PhD at the University of California, Irvine, finishing in 2008. Then, I started a dream postdoc at the University of Cambridge in England. From there, I spent 7 years as an Assistant and then Associate Professor in the Legal Psychology program at Florida International University in Miami, FL. I loved the program and university but having had two babies in two years and hot weather not really being our thing, I was fortunate to be offered a position at Ontario Tech University, where I started about 5 years ago. Despite it being another country, this brings me the closest that I have lived to my family in Michigan since I moved to California in 2002.

Currently, my lab is pursuing projects on topics ranging from children's testimony via language interpreters, to how parents perceive abuse disclosures, to sibling influences on children's lie telling, to how school resource officers interact with teens – all with a common thread of intersecting developmental psychology and forensic psychology. I also teach undergraduate and graduate courses in our Forensic Psychology program (e.g., Developmental Psychology, Children and the Law, Expert Testimony). And I am quite heavily involved in program, university, and professional service, having served on the American Psychology-Law Society's Executive Committee for several years now. Occasionally, I consult on legal cases or serve as an expert witness.

Q: How did you become interested in the field of forensic psychology?

A: The short answer is Dr. Debra Poole at Central Michigan University. The longer answer is that I started university 110% certain about what I wanted to do with my life. I was going to be – drumroll – the first female Program Director at KROQ, Los Angeles.

What I really wanted to be was a rock star, but I sadly did not have the musical talent to make that dream come true, so at age 16, I started a career in radio at a modern rock radio station in Michigan. I have to say that besides academic work, it was the only other thing that I've ever been pretty good at. I thought about leaving university in my second year when I got offered full-time middays at this radio station, but I had a full academic scholarship, so I decided to finish what I had started. In my second year, I also had a small undergraduate seminar course with Dr. Debra Poole, who would occasionally mention expert witness cases that she had worked on. I became aware that there was this interesting intersection of psychology and the law. She gave me an article that had just come out entitled "So what is forensic psychology anyway?" Ultimately, she took me (also a first-generation college student) under her wing, mentored my undergraduate honours thesis, and guided me through the graduate school application process. It was through that exposure – in a course that was required for my scholarship – that my education, career, and life changed quite dramatically. Coincidentally, I ended up moving to southern California to complete my PhD with Dr. Jodi Quas. While I listened to KROQ in graduate school, I can't say that I ever came close to my goal of being the first female program director of this station, though!

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

A: There are so many different, relevant responses that I could give and so many moments – most of them positive, thankfully, but some not – that I could use as examples. Ultimately, there are hundreds of small moments of kindness, generosity, and encouragement from mentors and colleagues that have shaped me as a woman in science and in forensic psychology. I am grateful to everyone who has taken the time to share their knowledge and time with me over the years.

One rather funny moment stands out to me. I was in a conference hotel room with Jodi Quas (my mentor) and Gail Goodman (her mentor) early on in my graduate school career. We were having a working lunch having just received reviews back on a manuscript submission at a prestigious journal. They shared the reviews with me there, and I remember thinking, "Well that's that then. Too bad we got such terrible news!" And then I saw that they were excited about the reviews…even encouraged by them. I was quite confused at first but learned that this was just the way that "revise and resubmits" were worded. It was quite eye-opening and definitely helped shape my approach to future rejections (of which there have been many, of course). Persistence in the face of rejection feels so crucial in our field, and I think that's why this moment stands out to me (and as a reminder of how much I didn't know or understand about academia when I started out).

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

A: I interviewed quite a few academics in the "children and the law" field (broadly speaking) when I taught my Child Witness graduate seminar online in 2020, and one thing that really stood out to me was how remarkably different all of our backstories were ***(…Continued on next page).***

STUDENT SECTION

SPOTLIGHT: Interview with Dr. Lindsay Malloy (continued)

How very different the paths were that got all of us to essentially the same spot – at least in terms of being a faculty member at a university researching some aspect of children and the law. Most of these people I had known for many years, yet I and still hadn't known the ins and outs of their path to get here and, so several things surprised me. This really demonstrated, to me, that there is no one path to follow. It makes me think of one of our big comprehensive exam concepts from graduate school – equifinality, or many different pathways leading to the same outcome. I'm not sure you can or want to follow in someone else's professional footsteps per se. But one common thread that came up in all of these interviews with my colleagues was mentorship. Each one of us had a fabulous mentor (or two or three) who sparked our initial interest in the field and helped our education and careers grow and develop. So, I suppose my advice would be to try to find a supportive community of mentors and peers. And then try to be that for others as well because kindness goes a long way in our field.

Q: How did you become interested in academia? Do you have any tips on balancing commitments (e.g., teaching, research, providing training, etc.)?

A: I don't know that I developed an interest in academia per se, as in I did not intentionally pursue that career from minute one or even from minute 60. I just kind of went to school and…never left. It was what allowed me to keep doing what I loved – research, mentoring students, teaching, etc. But now I see via Twitter that there are other career paths in which people are able to do these things – and not necessarily in academia.

In terms of balancing those commitments and others, I may not be the best person to ask about this because I have not figured out a magic solution. I will say to try to be strategic about what to say "yes" to. Service will always take up time, for example, but are there service opportunities where you can learn something or build an important relationship? I remember being told early in my career that I was "wasting my time" by giving talks to practitioners and that I should be spending my time only on research that would be valued in my tenure portfolio. But those talks helped me develop some research ideas and collaborations with practitioners that I think were viewed positively when I applied for my first big federal grant as PI. They were not a "waste of time." Also, I have just started a term on the Research Ethics Board, and although I am nervous about the time this new role will take, I am already learning a lot that I think will come in handy when my students and I submit applications down the road. Finally, I also figured out (way too late) that my life was a lot easier when I just recognized that I wasn't going to "catch up" with my to-do list.

Q: What do you enjoy most about your career?

A: People will often cite the flexibility in academia. "I can choose to do this work at 4am or 6am! On Friday night or Sunday night!" Just kidding. Mostly. There is a lot of flexibility compared to other types of jobs/careers and I appreciate that. Now more than ever I appreciate that often what I need to do my job is just my laptop and an internet connection. The flexibility means that I can be present in some of the activities in my children's lives in a way that is likely easier than parents with other jobs. What I appreciate most of all is the flexibility of choice in terms of my research. I can develop an interest in something new and run off to study it and that can keep me excited and motivated when all else fails.

Q: Your academic career has taken you all over the globe, from the U.S. to the U.K. and now Canada. What has it been like developing your academic portfolio with this international experience?

A: It's been a LOT of immigration paperwork! After we moved from south Florida to Canada with a 2.5-year-old and a 6-month-old, I said that I hope we really loved Canada because I vowed that we were never moving again. Then our whole family spent my research leave year in the UK just a few years later. So, it is clearly something that I love. I feel very fortunate to have lived in three countries over the last 15 years, and I would do it all again. But multiple international (n = 5) moves, especially with kids, is no joke. It does take a toll. It does take time to get yourself established, to get your lab set up, to get your kids and family settled (if that is relevant to you). It can take a toll on friendships and family relationships. But it also can open the door to so many new friendships, collegial relationships, and opportunities. With all of the challenges can come a great deal of fun and experiences that would otherwise not be available. I loved that I got to spend my postdoc at the University of Cambridge working with Michael Lamb, for example, and living in such a remarkable place. It was the time of my life in more ways than one. That move was relatively easy compared to others as I did that one on my own. But each move since has gotten increasingly complicated. I recognize that it is a privilege to be able to make such moves and that many may not be able to because of a spouse, family obligations, or other reasons (e.g., immigration restrictions). So, I think we need to do away with the idea that people NEED to or SHOULD move internationally for their academic work, but I also would never discourage anyone from doing so if it worked in their circumstances. Just get yourself a good international accountant because taxes can be a huge pain!

Q: What kind of barriers do you face in conducting your research on children and the law, and what do you recommend for individuals conducting research with a similar population?

A: In my research I have worked with several populations, some more difficult to access than others (e.g., maltreated children, youth who are incarcerated). With greater vulnerability tends to come greater risk and so access or permission to do research can be very difficult. But even in the studies I do with children who are typically-developing and involved in our research via home visits or school visits, access and recruitment is often our biggest challenge. Parents must provide permission for kids to participate in research, but even well-meaning, interested parents are busy (I know because I have my kids do as many studies as possible, but life gets in the way!). Patience and relationship building are key here, and also building in time because recruiting kids/families may end up being 80% of the time it takes to do a study! For students interested in forensic developmental psychology, I also recommend considering other, related questions that may not involve working with kids directly but are still highly relevant to the issues of interest. For example, some of our studies have involved analyzing interview transcripts or conducting studies on adults' perceptions of kids – we have been able to ask interesting, timely research questions without needing to rely on collecting data from kids directly. This is a particularly important consideration for honours thesis students or Masters students who typically have less time than a PhD student or postdoc.