The Adaptation and Implementation of the Violence Reduction Program – Forensic Mental Health (VRP-FMH)

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Justice Health and Forensic Mental Health Network

NSW GOVERNMENT

Acknowledgment of Country

We would like to acknowledge the Wurundjeri Woi Wurrung people of the Kulin Nation and pay our respects to elders past, present and emerging. We acknowledge the over-representation of Aboriginal peoples in our care settings in NSW and affirm our commitment to closing the gap and moving steadfastly towards reconciliation.

Spirits and Aboriginal patients' journeys

Acknowledgments and special thanks

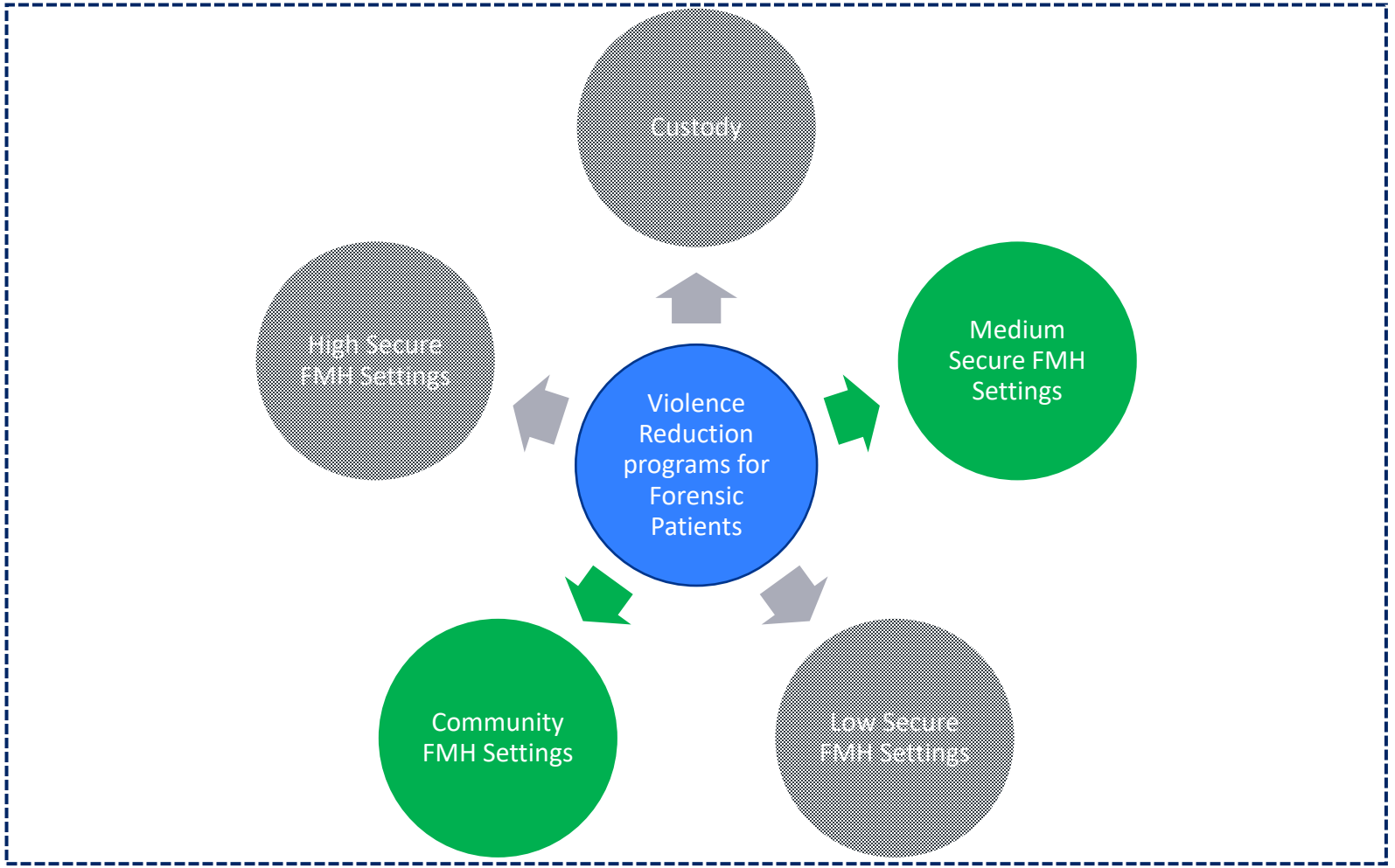
- Prof Stephen Wong, & Audrey Gordon, authors
- Sarah Wells and Yiota Zingirlis, co-authors, JHFMHN
- Dr Vindya Nanayakkara, General Manager FMH, JHFMHN
- Dr Tobias Mackinnon, Executive Director FMH, Forensicare
- VRP-FMH Governance Committee, JHFMHN
- Consumer Advisory Committee, NSW Forensic Hospital JHFMHN

Violent behaviour amongst adult Forensic Mental Health populations

- >90% of forensic patients (not criminally culpable due MI) in NSW have histories of serious violence, which have led to indictable offences.
- Over the course of a forensic patients time *in hospital*, those who score higher on violence risk assessment tools will be more likely to engage in aggressive acts when compared to lower scorers (Ogloff & Daffern, 2006)
- It has also been found that in NSW 6.3% of forensic patients went on to commit proven offences in the first 12 months *following release* (Dean et al, 2020)

Provision of Violence Reduction Programs across JHFMHN (predating 2021)

Only 2 services within NSW FMH offered rehabilitation specifically targeting violent offending, highlighting a lack of consistency in the provision of violence reduction interventions across NSW FMH settings (Nanayakkara, 2021)



Violence reduction programs in adult NSW Forensic Mental Health

There is an identified need for a single, validated violence reduction rehabilitation program across the entire NSW forensic mental health system to facilitate:

- Consistency in treatment approach
- Patients' progression in their pathway to recovery
- Reduction in episodes of aggression across settings
- Patient transition to lower secure facilities

"Speaking the same language"

Why the Violence Reduction Program (VRP)?

- The VRP developed by Prof Stephen Wong and Audrey Gordon in Canada, is a high intensity group treatment program for offenders with a history of violence, some of whom also have significant mental health concerns.
- The VRP integrates RNR principles with contemporary clinical and offender rehabilitation techniques such as using CBT, RP and MI approaches. Other programs can also be woven into the VRP.
- Incorporation of risk assessment through use of the Violence Risk Scale (VRS), a 26-item assessment tool which guides treatment targets in the program. VRS is used as a pre/post assessment for the participants of the VRP.
- The treatment efficacy of the VRP has been extensively evaluated internationally through empirical studies across offender populations in supermax, high and medium criminal justice as well as forensic mental health facilities.

Wong et al., 2005, Diplacido et al., 2006, Wong et al., 2007, Wong et al., 2012, Lewis et al., 2012., Olver et al., 2013, Wong 2018, Wong et al., 2016, Wong 2017. Horgan et al., 2019.

Adaptation of the VRP: A program for the treatment of violence prone forensic patients


Violence Reduction Program-Forensic Mental Health (VRP-FMH) Facilitator's Manual V1

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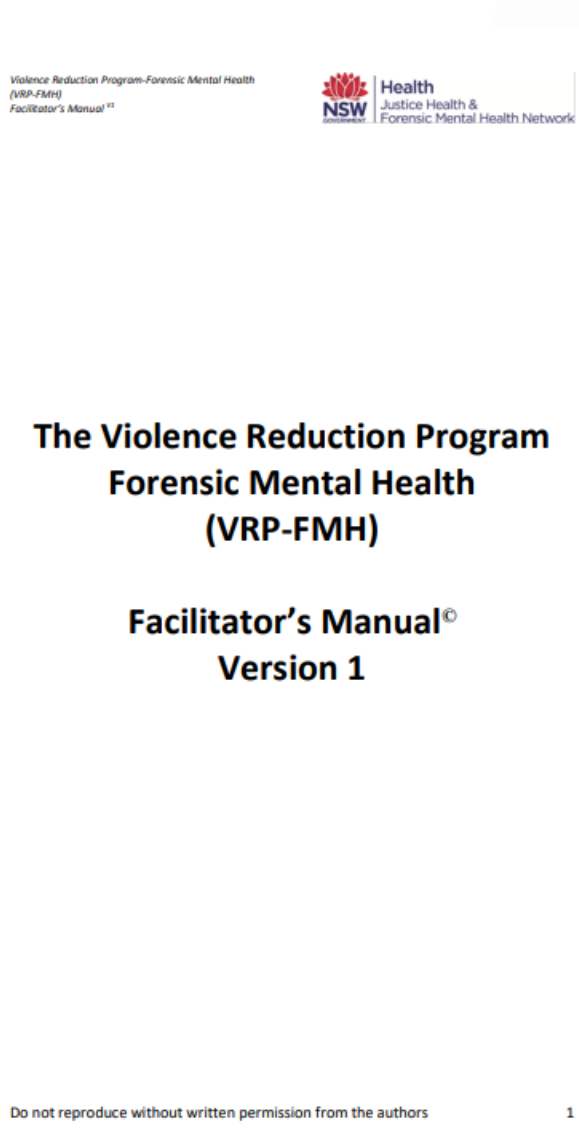
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The Violence Reduction Program
Forensic Mental Health
(VRP-FMH)

Facilitator's Manual©
Version 1

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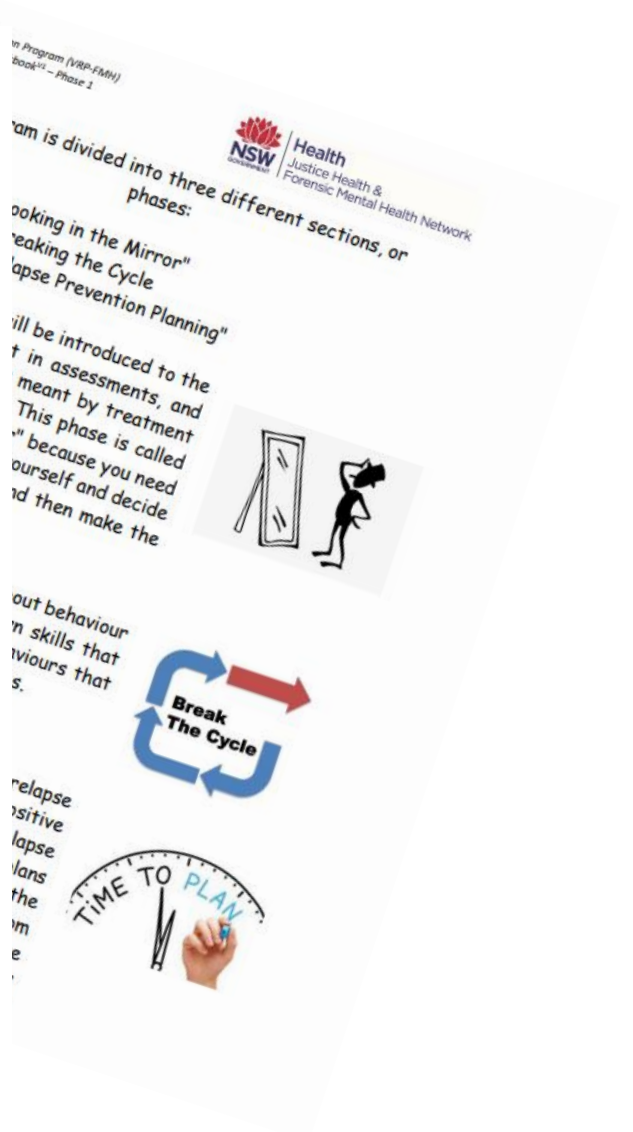
Program (VRP-FMH)
book V1 – Phase 1

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am is divided into three different sections, or phases:

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Break The Cycle

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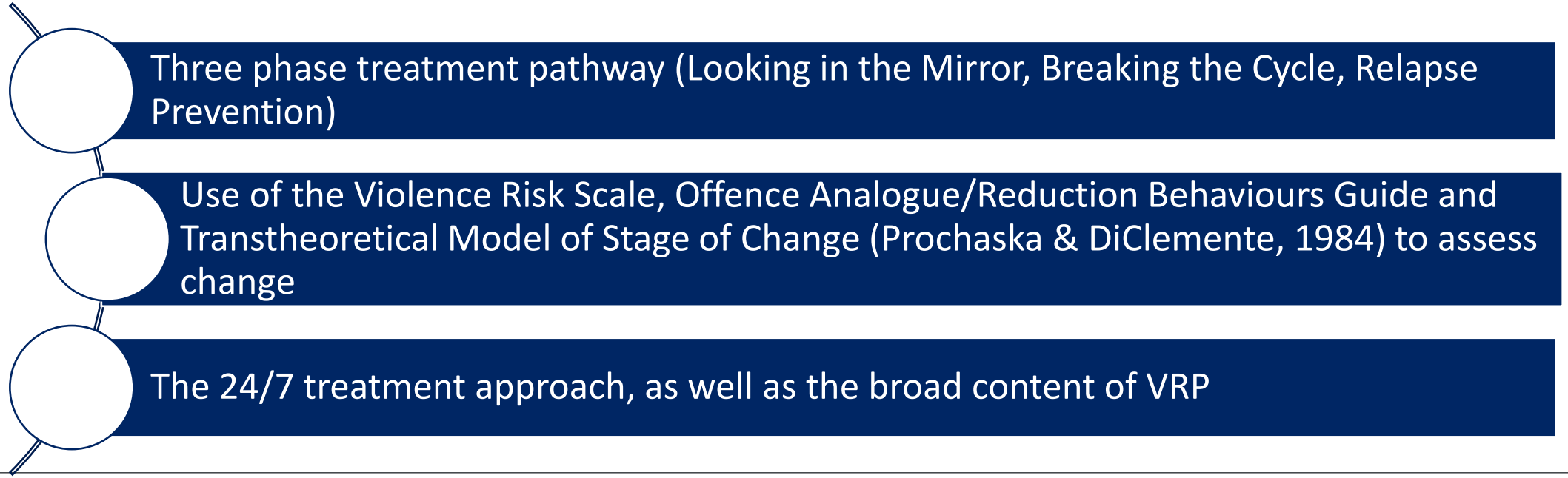
TIME TO PLAN

Adaptation of the VRP: A program for the treatment of violence prone forensic patients

- The VRP-Forensic Mental Health (VRP-FMH) is an adaptation of the original *Violence Reduction Program* led by Sarah Wells and Panayiota Zingirlis in consultation with the authors. The process was guided by Dr Vindya Nanayakkara
- The key principles of the VRP treatment approach have been retained including:



VRP to the VRP-FMH

Users of the *VRP-FMH* will see more similarities than differences between the original and the adapted *VRP*.

- A more (guided) scripted and session-based format to assist with program delivery across multiple settings within the Network
- 2 additional sessions were added to address mental health-specific needs
- Re-organisation of the material into 20 formal sessions and additional consolidation sessions for a duration of approximately 10 month
- A mental health lens was woven throughout the program
- Integration of the *VRP Supplementary Manual for Facilitators* and *Facilitator's Manual* into one **Facilitators Manual** for ease of access to the material
- Revision of the *VRP Participant's Workbook* to reflect the changes in the program
- The program is flexible enough to be delivered in an individual or group format

Implementation of the VRP-FMH

2016
- Adaptation of VRP to VRP-FMH (facilitator and participant manuals) commences, process of review by original authors and final approval in 2020

2020
- CFMHS successfully deliver VRP-FMH (individual) to Forensic Patients in community
- Development of VRP-FMH training program commences

2021
- VRP-FMH Governance Committee established
- Development and roll-out of staff (non-facilitator) training packages in Forensic Hospital

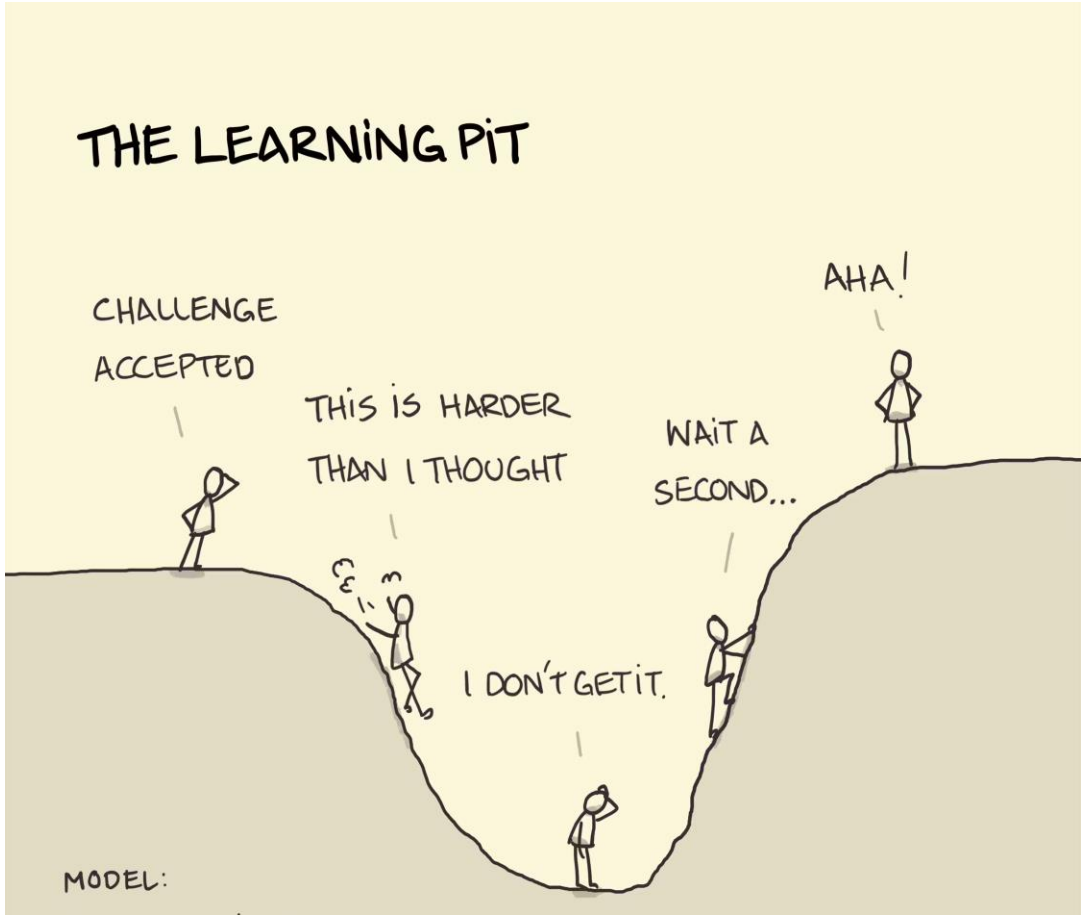
2022
- VRP-FMH Clinical Meeting established
- VRP-FMH Pilot group program - high secure hospital, rehabilitation unit NSW

2023
- Custodial MH employ first Psychologist for VRP-FMH
- Commencement of VRP-FMH (individually) in custody

2024
- VRS and VRP-FMH facilitator training (psychologists/psychiatrists) - H, M, L and Comm. forensic settings
- VRP-FMH pilot evaluation
- VRP-FMH Version 2 and women's version (in progress)

VRP-FMH Pilot Challenges

- COVID-19 – impact on location, staffing, patients
- 24/7 approach – demands on patients and staff
- Session length and frequency
- Patient flow
- Exacerbation in MI
- Multiple FMH settings at different stages in their development of treatment programs
- Maintaining program integrity in a climate of staffing shortages
- Gathering regular OAB/ORB data from MDT to assess change



Addressing challenges

- Senior management and broader JHFMHN support
- Governance committee
- International alliances with authors and VRP users
- Clinical meetings
- Presentations and in-services across different forums e.g. clinical governance, corrective services and FMH settings
- Collaboration with Consumer Advisory Committee
- Development of electronic forms and databases through the Health Intelligence and Analytics Unit
- Training staff on OAB/ORB guide

VRP-FMH Pilot Evaluation Outcomes

- **VRP-FMH Pilot**
  - 2 lead facilitators (Psychiatrist and Psychologist)
  - 9 participants commenced
  - 1 participant withdrew and 2 participants received early transfer to MSU
  - 6 completed
- **OAB/ORB change**
  - Anecdotally, change was observed across participants, although frequency of OAB/ORB reviews were inconsistent
- **Facilitator feedback**

'All (patient) feedback has been positive… patients reported significant impact on the understanding of themselves, their violence and patterns of behaviour'.

Participant feedback

Question	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. I got helpful feedback when I presented my history to the group.	✓				
2. The material in the program was easy to understand.	✓				
3. I thought the homework assignments were useful.	✓				
4. I thought developing my offence cycle was helpful.	✓				
5. I thought developing my relapse prevention plan was helpful.	✓				
6. I developed a good working relation-ship with my primary therapist.	✓				

Phase 1: Looking in the Mirror

(a) The most useful thing I learnt was: How I see myself in the mirror. Understand my mental illness and how mental illness affects me. Problems with alcohol, drug aggression, and hanging out with the wrong people and so on. However I need to change and then make the committments to change.

Phase 2: Breaking the Cycle

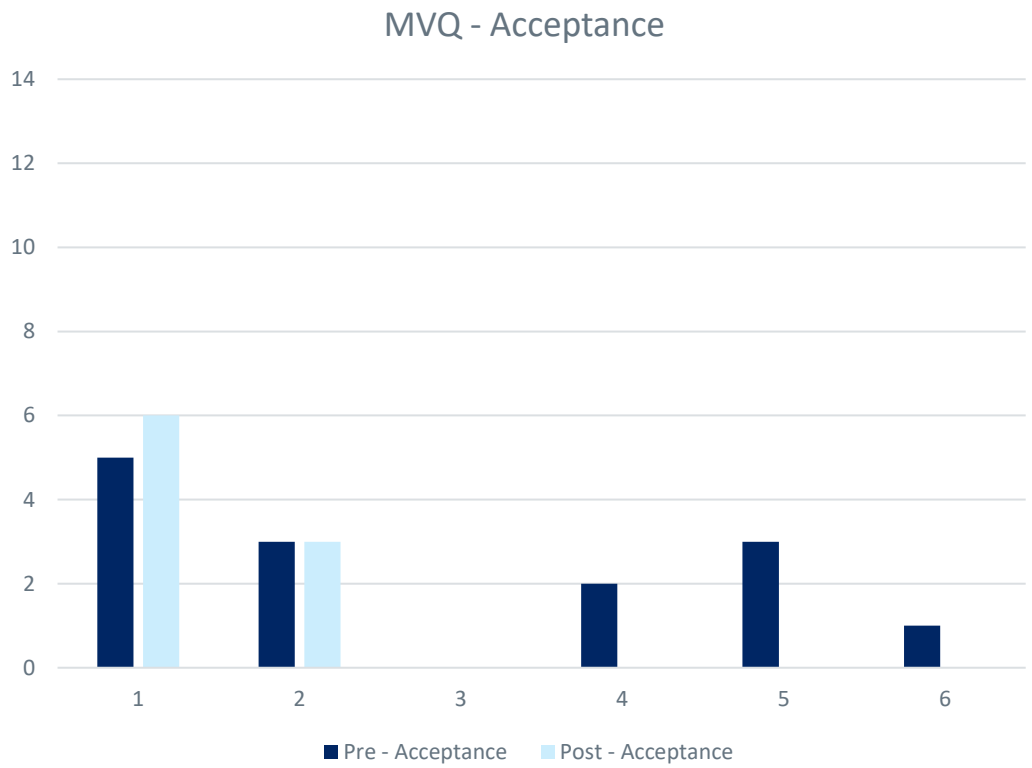
(a) The most useful thing I learned was: is to Manage My negative behavioural cycle and to change them so i don't go in the same path as before.

Phase 3: Relapse Prevention

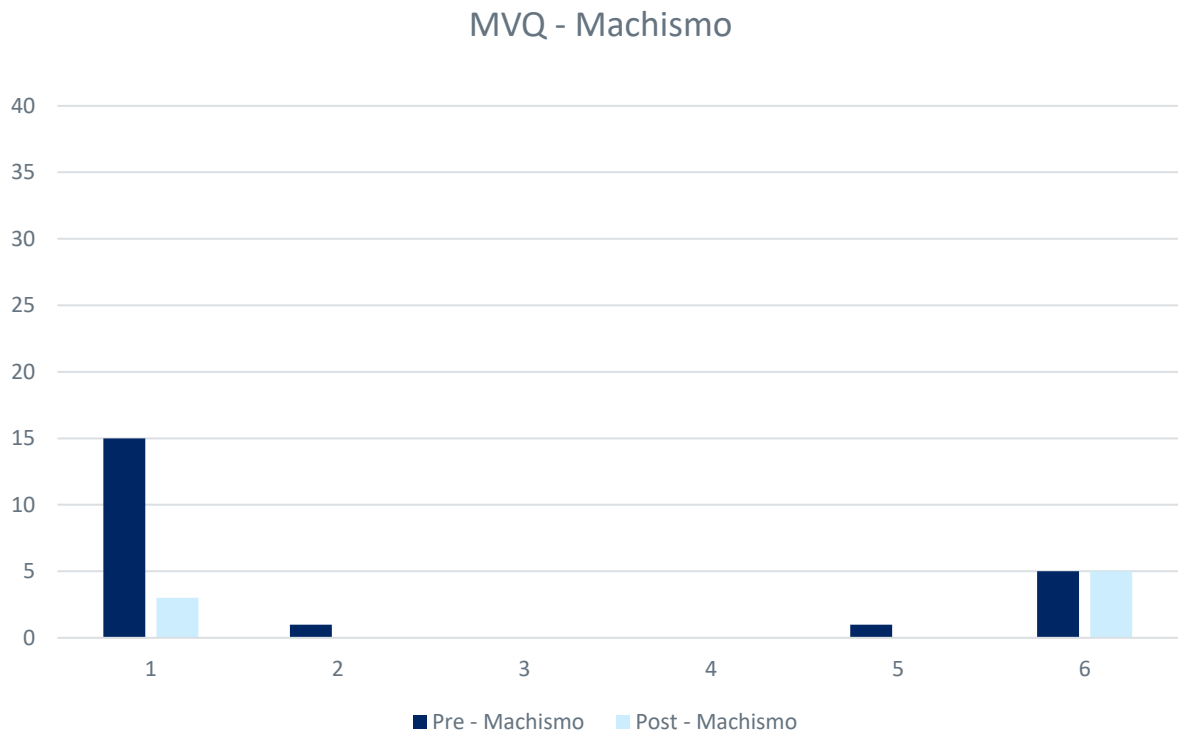
(a) The most useful thing I learned was: Static factors (concrete) that I Can't Change but I can learn from. Dynamic factors (Water) which I can change how I see new events and I can controll in a positive way.

Maudsley Violence Scale (MVQ) Outcomes

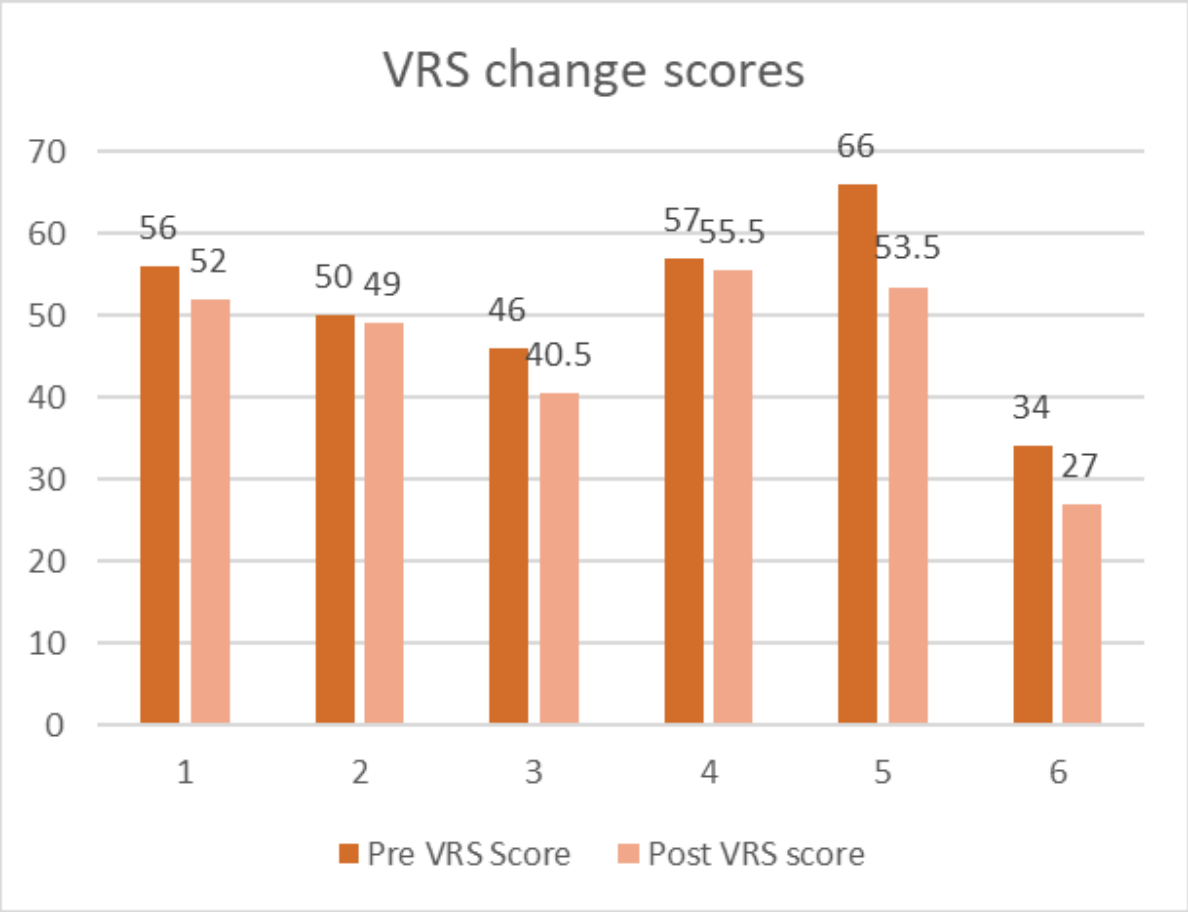
Acceptance - overt enjoyment and acceptance of violence. Holds attitudes and beliefs which condone violence.



Machismo -Justifies violence when threatened. Views violence as a sign of masculinity/ strength and fear and non-violence as weaknesses.



Violence Risk Scale (VRS) Outcomes



Where are they now?

Follow up of VRP-FMH completers;

83.3% were transferred to lower secure settings within 12 months of VRP-FMH completion

Since transfer;

None have returned to high secure settings

There have been *no formal breaches* to the conditions in their Forensic Orders

Since completion of VRP-FMH (>1.5yrs), there have been *no charges, proven offences or episodes of aggression.*

Next steps?

- Future proofing VRP-FMH into the digital world
- Co-evaluation of the VRP-FMH pilot program
- VRP-FMH facilitator/participant manual reviews
- Ongoing training of staff in VRP-FMH, VRS and OAB/ORB
- Support roll-out of VRP-FMH in medium, low and community FMH settings
- VRP-FMH manuals for different populations

Questions

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