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# On The Edge

The Official Newsletter of the International Association of Forensic Nurses

On the Edge is owned and published quarterly by the IAFN. This newsletter is distributed to membership directly, and available to the public domain via [www.iafn.org](http://www.iafn.org).

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More Information

## Author Guidelines

### Submission Deadlines

Winter 2007	10/24/2007
Spring 2008	1/26/2008
Summer 2008	4/27/2008
Fall 2008	7/27/2008

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### Attention Members

Have you renewed your IAFN membership for 2007? Most memberships expire on 12/31.

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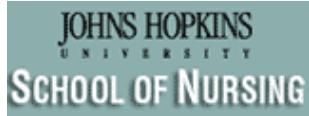
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## From The President

By Susan Chasson, JD, M.S.N., RN, SANE-A, President



Dear IAFN Members,

As the end of my presidential term nears, I am reflecting on all the things that I wanted to achieve, and have not yet accomplished. With a single year in office as President, it is important to see any changes that occur do so with the full support of the Board and with accompanying institutionalized policies. We have already revised and created many policies that further define structure, communication and responsibility within the Association. There is one change though that I have not yet implemented and I fear that I will be unable to complete before my term ends December 31st. I will need your help.

Anyone who knows an IAFN member realizes that Forensic Nurses are many things. IAFN members are entrepreneurs, creative innovators, and compassionate helpers. With that in mind I ask the members of IAFN to become the change agents that start the ball rolling. **My challenge and request** for you is to reach out and grow the membership of IAFN to make us a more **diverse organization**. As nurses, I believe we will witness major changes and upheavals in health care over the next few years. I am afraid that seeking funding for victims of violence will be shortchanged as hospitals and other health care organizations fight for critical operations funding. Diversity can mean many things and for our membership it includes seeking new members who are nurses of color, nurses who serve people relegated to a marginal position within societies, and nurses who live and practice outside the United States. For those of you who have been long time members of IAFN, many of you have received crucial support from your colleagues when times were tough. Many of these nurses are working in communities where times are always tough and could use support from a community of nurses.

I encourage you as members and chapters to seek out nurses who are not members and give them some encouragement and financial assistance to join the field of forensic nursing and IAFN. Are there Tribal or First Nations nurses in your state or province who need help to get started or to join? Is there a community health nurse in your country, state, or province who is working for lower wages and serving a marginalized community? Can your chapter sponsor a membership for a forensic nurse in a developing country?

My long-term vision is for IAFN to assist you in your giving to others by offering a way to give financial support to these nurses who may not have enough resources to join IAFN and receive its benefits, when you renew your own membership. I am eager to start this campaign for giving and I hope we can start today to work together to make sure our organization truly represents and provides support to forensic nurses throughout all communities of the world.

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## From The Editor

By Janean Fossum, RN, BSN, CDDN



Dear Friends and Colleagues of the International Association of Forensic Nurses,

As the managing editor of *On The Edge (OTE)* I am thrilled to have the opportunity to provide IAFN members a quality publication just as former editor Lynda Benak, accomplished for so many years.

I invite members from **all over the world in every area of forensic practice** to submit an article for publication. Your contributions are essential to the success of *OTE*. I extend my sincere appreciation to those who have already contributed. Our Feature Articles include:

- An interesting perspective with well-illustrated views of the forensic nurse working in multiple settings and a job description from doctoral candidate Patricia Pasky McMahon.
- An overview of the recent conference held by the American Nurses Association on disaster planning and how a disaster may affect the forensic nurse. Joyce Williams poses some tough questions.
- A unique perspective on forensic nursing in a mental health care setting with a special focus on an intervention and success to reduce restraints and isolation. Donna Reimer and Carla Corwith present readers a true success story from one setting.
- East Meets West is an opportunity for forensic nurses to celebrate our specialty in nursing. In this issue Carmen Henesy relates her experience sharing forensic nursing while creating new friendships and exchanging ideas and culture with forensic nurses in Japan.
- A Global Expansion Update from IAFN founder Virginia Lynch and her recent travels to help inaugurate the newly formed United Kingdom Forensic Nurses Association.

I share President Susan Chasson's hopes for the IAFN and the membership. I would like to take this opportunity to express my high regard for Susan's work. I appreciate her endless commitment, wit and her great sense of humor. Susan has an incredible knowledge base and I always look forward to reading her comments, as they are so well thought out and apropos. Thank you, Susan!

From the IAFN Membership Committee, Bonnie Barsa has great news about the increase in IAFN members. Our campaign to encourage members with special incentives helped accomplish this. I challenge all current members to reach out to the special people you know who should be members and invite them to join the IAFN.

Utilize *OTE* to post updates involving your Council, submit a book review and/or recognition of a colleague's accomplishment. Please see the web page for author guidelines and deadlines for submission.

Regularly in *OTE* you will find the message from our president, articles from other forensic nurses and research briefs. The staff at IAFN also contributes with updates about grant projects such as SAFEta, membership, and elections, as well as information about upcoming events such as our 15th Annual Scientific Assembly in Salt Lake City.

Members who have attended the last few scientific assemblies may remember me as the IAFN booth coordinator selling publications, pins and other items. IAFN Staff will now be in that position. I will miss seeing you at the booth but I will be looking for you to talk about submitting your articles to *OTE*.

I recently graduated from Oregon Health Sciences University with my BSN. I plan to continue working for my Doctorate of Nursing Practice with the ultimate goal to teach forensic nursing.

Currently in my professional career my central area of practice is with individuals who have cognitive and developmental disabilities. Most of the clients I serve are victims of past assault, neglect and abuse. Unfortunately they are without voice. Often they are unable to advocate for themselves due to their lack of communication skills, severe cognitive deficiencies, and at times overlying psychiatric issues, making them incredibly vulnerable. Providers caring for disabled individuals advocate for them and are often not believed. The forensic nurse can provide the credibility and the evidence. My goal as a forensic nurse examiner is to serve this population.

My father was a police officer killed in the line of duty. I am keenly aware of how violence can impact your life. Daily as forensic nurses we continue this tradition of addressing violence. As I care for clients I wonder, "what can I do to prevent this?" To each of you I extend my appreciation for your dedication in the care of this population. It is my hope that through primary prevention efforts we, as a community of forensic clinicians can work ourselves out of jobs.

I extend my condolences to the children of Michelle Milstead RN, SANE and her team-members at Wichita Falls, Texas. Michelle was recently killed in an apparent murder/suicide at the hands of her estranged husband. Her dedication to forensic nursing and humanity will be missed.

I look forward to hearing from each of you and reviewing your manuscripts for future articles.  
Take good care,



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## From The Executive Director

By Carey Goryl, MSW



From the Desk of the Executive Director,

I hope you have begun to notice the positive changes happening at IAFN. There are only more to come. I am delighted to share some of the Association's most recent accomplishments and new partnerships.

On August 22, 2007 the Association's membership **reached 3000 members!** This is a historic moment as it demonstrates the growth of the Forensic Nursing profession and an agreement from 3000 forensic nurses and allied professionals on the benefits of IAFN membership.

It is also with great excitement that I announce a **change in Publisher** for IAFN's official journal, the *Journal of Forensic Nursing*. Beginning January 1, 2008, Wiley Periodicals, which just recently merged with Blackwell Publishing, will publish the *Journal of Forensic Nursing*. This will allow the Journal to see more growth in new International and Academic markets. As an added benefit, members and subscribers will be able to access the Journal in full text on line, including all past issues! IAFN will continue to offer online continuing education credits through articles in the Journal, and there is only more to come. A sincere thank you to our current publisher, Anthony J. Jannetti, with Editorial staff Janet D'Alesandro and Linda Alexander for all their hard work in making the Journal what it has become today.

We hope to see many of you in Salt Lake City, Utah at the *15th Annual Scientific Assembly*. I know that staff is eager to put a face to the voices and emails that we communicate with so often. Registration has been strong. Please make sure to register during regular registration as to avoid the late registration rate increase! And while we will take registrations on site at the Assembly, we strongly encourage you to sign up before the event so we can plan for your attendance accordingly.

The IAFN Home Office is located in Arnold, Maryland, USA and any of the staff can usually be reached Monday through Friday, from 9:00am to 5:00pm Eastern Standard Time.

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## Forensic Nursing in Multiple Settings

By Patricia Pasky McMahon, M.S.N., CRNP, SANE-A

A description of the duties related to a clinical forensic nurse examiner varies with the setting in which the forensic nurse functions. Inherent to the clinically based role is similarities from which specific function flow. The focus of the following position description is to provide comprehensive forensic nursing care to a victim of crime in an advanced practice nurse capacity in settings such as in the field, community-based nursing, emergency departments and inpatient hospitals.

### *Clinical Forensic Nurse Examiner: Position Description*

The position description for a clinical forensic nurse examiner should include educational and skill requirements, specific duties, and related responsibilities. The forensic nurse is expected to interact with other professions and must be prepared to demonstrate an advanced level of expertise in the practice of forensic nursing. The portrayal of the following position includes merging of the nurse practitioner role with that of the forensic nurse role, direct victim and suspect interaction, and managerial responsibilities applicable to a variety of settings.

### **Details of Position Requirement**

While educational requirements may vary according to locale, consideration of masters and doctoral level preparation is an important aspect of this evolving position, especially in the administrative role. Professionals outside of nursing with whom the forensic nurse will have contact and be evaluated among for forensic nurse abilities have degrees beyond the entry level of the respective profession as a forensic scientist (Lynch & Duval, 2006). Further enhancement and solidification of the relatively new specialty of forensic nursing among the other areas of nursing requires sound scientific research and publication of this research. Requirements for research and publication support the need for advanced degrees and advanced practice certifications in forensic nursing.

Dependent on the area of practice and needs within the community, the forensic nurse may consider attaining a nurse practitioner certification in addition to the advanced requirements necessary for forensic nursing. The nurse practitioner is able to extend the care and treatment of victims beyond that of a forensic nurse. Settings that provide ready consultation to the clinical forensic nurse examiner may render the need for the additional licensure of the nurse practitioner as unnecessary.

Skills required in a managerial position that include clinical duties necessitate experience as it relates to the setting. Presently, forensic nurses affiliated with hospitals must be capable to work with various teams inside and outside the hospital setting (Sekula, 2005). Proficiency is essential in areas as detailed history taking, evidence collection, and administrative skills which integrate grant writing and budget management. Leadership skills that demonstrate an acute awareness of the support needed among team members is critical due to the often psychologically straining situations in which the team members regularly work.

Protocols directed at evidence collection and specific design of expectations of the forensic team are best outlined and regularly reviewed within a manual that is accessible to the entire team. Documentation of the work performed by the team, interactions with departments inside and outside the hospital, and outreach within the community should be clearly described within monthly reports. The reports should be substantive and designed to further educate hospital and community leaders and to support the importance of the forensic role within nursing. Equally important is sharing this information with the team at monthly meetings. Team meetings should include chart review and an opportunity for members to share difficulties and gain support from within the team. Provisions for members in need of critical incidence stress debriefing should be readily available.

The clinical forensic nurse examiner practices in a specialty unlike any before in nursing. Thus, as it is important for nurses within other specialties to be involved with related organizations, it is essential for the clinical forensic nurse examiner to be active with the International Association of Forensic Nurses. Involvement should also include participation within the clinician's state forensic nurse organization. The clinical forensic nurse examiner must purposefully undertake steps that demonstrate the expertise within the position and the ability to function as a resource to the hospital, community organizations, and legal arenas. Educating the community about the role of forensic nursing can be supported by establishing a positive rapport with the local media. Demonstrating expertise within the community is as important as on the witness stand (Lynch & Duval, 2006).

Successful support for the well being of those who have been a victim of violence to achieve resolution of the trauma is within the perspective of forensic nursing (Hammer, Moynihan, & Pagliaro, 2006). Support for the healing of the wounds, psychological and physical, enables the individual to transform from victim to survivor; this is the ultimate goal of the clinical forensic nurse examiner.

## Clinical Forensic Nurse Examiner

**Objective:** Provide comprehensive forensic nursing care to victims of crime in an advanced practice nurse capacity in a variety of settings including in the field, community-based, emergency department and inpatient hospital.

### Educational Requirements:

- Current licensure as a registered nurse in the state of practice
- Current licensure as a family nurse practitioner in the state of practice
- Minimum Masters degree in Nursing with a Forensic Nurse or Family Nurse Practitioner focus
- Post Masters Certificate in forensic nursing from an NLN accredited school of nursing or Post Masters Certificate as a family nurse practitioner from an NLN accredited school of nursing
- Current certification as an adult sexual assault nurse examiner
- Current certification as a family nurse practitioner
- Documentation of continuing education supporting above certifications
- Documentation of attendance and completion of requirements as a pediatric sexual assault nurse examiner; Pediatric certification preferred

### Skill Requirement:

- Keen analytical and investigative ability
- Proficient in evidence collection of victims and suspects
- Able to perform forensic nursing duties in the field, emergency and inpatient hospital, and community-based settings
- Proficient in forensic photography
- Ability to maintain objectivity and confidentiality
- Strong team work ethic while also able to work independently with minimal supervision
- Experience as an administrator or coordinator of a forensic team
- Ability to work in stressful environments while maintaining a professional attitude in communication with potential victims and perpetrators of violent crimes, law enforcement, and other members of the team
- Strong oral, written, and interpersonal communication

- Refer patient for further care in the medical, emotional, and legal arenas as dictated by the presenting situation
- Assess patient follow-up of referrals by contacting patient 48 hours after initial contact
- Communicate effectively with other departments concerning the care of the victim
- Conduct evidence collection as outlined in an investigative warrant on a suspect
- Accept five non-consecutive days of 24 hour call per month
- Conduct forensic nursing investigation in the field when requested by the state or local police authorities as established by joint protocol
- Act as a consultant to staff within the hospital when areas relating to the forensic needs of a patient are required
- Comply with subpoenas relating to testimony of involved forensic cases
- Maintain monthly statistical and written reports designed to summarize relevant information on victim contacts
- Administer budget for the forensic department
- Assess clinical competencies of forensic nursing staff once yearly and at a more frequent interval if necessary
- Conduct monthly meetings for the forensic team
- Attend monthly meetings designed to enhance the cooperation between law, legal, crime lab, victim support, and forensic nursing professionals
- Communicate monthly with state crime lab director concerning quality of samples of evidence collection as submitted by team
- Provide quarterly updates to emergency and other departments of nursing staff concerning the area of forensics via live presentations and articles in the institution's newsletter
- Observe for areas that need improvement related to enhancing forensic services and formulate a grant

**skills**

- Experience as an expert witness and fact witness in forensic cases involving domestic violence, sexual assault and other violent crimes that involved participation in evaluation and care of a victim or perpetrator of a crime
- Experience in successful grant writing
- Experience with administering a departmental budget

**Specific Duties:**

The Clinical Forensic Nurse Examiner's duties will include the following, but will vary according to the presenting situation.

- Obtain a complete patient history as it relates to the presenting situation
- Document the entire encounter with the patient including the history, physical findings, interventions, and referrals
- Obtain forensic evidence according to protocol including digital imagery, use of toluidine blue dye, microscopy, and colposcopic photos
- Obtain required laboratory tests of victim as dictated by presenting situation according to protocol
- Maintain complete chain of evidence on all forensic materials obtained as outlined in the Clinical Forensic Nurse Protocol Manual

proposal to be submitted to the community foundation or national related organization

- Inform community of forensic services through community presentations and working with the institution's Corporate Communications Department

**Related Responsibilities:**

- Association with area Critical Incident Response Team
- Active participation and enrollment in the IAFN
- Active participation and enrollment in the state forensic nurse organization
- Resource for nursing community
- Resource for the local community including law enforcement, Rape Crisis Services, community legal services, educational institutions, and other organizations as related to the duties of this position
- Goal setting to include publication related to duties within position with local news media and submission for scholarly publication
- Design and conduct research directed at supporting the functions of the forensic nurse role

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 Sekula, L. K. (2005). The advance practice forensic nurse in the emergency department. *Topics in Emergency Medicine*, 27(1), 5-14.

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## Modifications to Care in Disaster Situations

By Joyce Williams, MFSA, RN

Disaster response necessitates personal preparation prior to deployment to a professional setting. Standards of care place healthcare providers in situations that require modifications to provide care and allocate scarce resources in order to save the largest number of lives in contrast to traditional focus of saving individuals. The *ANA Quadrennial Policy Conference* in Atlanta convened experts this past summer to establish guidelines for disaster response. It is essential to remember that disasters are not business as usual.

How many of you are prepared to respond to a disaster in your community? A widespread disaster places significant strain on the public. The impact is felt personally and professionally causing breakdown in expected routines. Individual and family burdens increase stress leading to violence and assaults. Healthcare facilities face surges causing limitations in medical and human resources. Difficult decisions are necessary to provide care to meet the greatest needs.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) updated their standards revising the approach to the evaluation of Emergency Management effective July 2006. Environment of Care Emergency Management Drill Standard 4.20 (ED 4.20) states that during planned exercises the organization must monitor core performance in patient management including provision of both clinical and support care activities, patient identification and tracking processes.

The American Nurses Association (ANA) organized a quadrennial policy conference on June 22, 2007 with the purpose of determining appropriate alterations to care during disasters. Topics discussed were response to nuclear, biological, chemical, radiological, and explosive situations. Knowledge of appropriate preparation is paramount to ensure competency of staff and resources necessary to provide optimal care. The legal implications including federal laws and regulations during care of mass casualties are of great importance. What if a forensic nurse is asked to do something different than they typically do? During a mass casualty event modifications to care are necessary to treat the immediate needs and utilize available resources. Modifications to care will occur according to the size and type of event. Natural disasters may result in loss of structures to care for individuals seeking medical care. Communities must prepare in advance to provide treatment in the midst of flooding, disruptions in infrastructure, and loss of utilities. The services forensic nurses provide are very much needed in disaster situations. Effective care to victims of violence was absent in the initial phases of Hurricane Katrina. Selecting locations for temporary structures to provide forensic services should be organized among governmental agencies, disaster teams and community

resources. Prearranged go-kits will reduce the time to treatment for victims. Organizing a forensic specialty team to respond to disaster situations locally regionally and nationally will fill this requirement.

The purpose of this conference was to challenge the nursing community to prepare now for an event that will disrupt services and cause delays from a mass casualty event. Collaboration among healthcare providers demonstrates the need to appreciate adjustments in care when resources are stretched.

IAFN presented a poster describing the complexities faced and lessons learned during Hurricane Katrina. Lessons learned stressed the need to provide all levels of prevention for victims. A community assessment checklist will help prepare for possible, probable, and worst case scenarios. Forensic nurses must act now to ensure safeguards to protect essential functions, relocation of services, resumption of services, and preservation of evidence.

The results of disasters have political and societal impact. Forensic Nurses can respond proactively to establish a ready response team that is deployed to disaster areas and reduce disruption in services for those injured. Some questions to consider determining the readiness of your facility are; if a disaster were to disrupt your community, what is your forensic model of care to serve disaster victims of violence? Are your protocols updated to include all types of forensic services? Do you have a plan to screen for victims of violence with a strategy for those identified? Where will you preserve healthcare records and evidence collected? What do you do with 500,000 casualties?

#### References:

American Nurses Association 2007 Quadrennial Policy Conference: Nursing Care in Life Death and Disaster.  
<https://nursingworld.org/meetings/2007/quadpolicy/>

Joint Commission on Accreditation of Healthcare Organizations. *The 2004 Joint Commission Comprehensive Accreditation Manual for Hospitals, Environment of Care Standard 4.20* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2004.

Joyce Williams is a forensic nurse examiner, forensic investigator and disaster response nurse in the United States. Mrs. Williams works as a wound analyst at the Armed Forces Medical Examiner System. She works with children of abuse and neglect at a Child Advocacy Center and investigates unattended deaths in Maryland. She responded to 9/11 and Hurricane Katrina. She is the legislative chair for the governmental affairs committee for IAFN and the past chair of the 13th Scientific Assembly. She is the immediate past president and founder of the Maryland/DC Chapter of Forensic Nurses.

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## Application of Core Strategies: Reducing Seclusion & Restraint Use

By Donna Riemer, ADN, LNC, Certified Traumatologist and Carla Corwith, RN, BA, MBA, LNC

The level of violence in psychiatric hospital settings presents ongoing challenges for both patients and staff. Hospitals and institutions continue in their efforts to both meet JACCHO standards and make their institutions safe for patients and staff. This paper illustrates how one forensic nursing unit has experienced a substantial reduction in violence. Subsequently, the need for seclusion and restraints was also reduced by greater than 90% over three years.

There has been extensive research, examining the risks and benefits of seclusion and restraint (S/R) use for patients and staff. Although complete elimination of S/R use in a forensic hospital may not be feasible, the need for more restrictive interventions can be greatly reduced. Focusing on reducing the use of S/R should not distract from the focus of meeting the basic, holistic needs of patients: promotion of safety and reduction of trauma risk. The American Psychiatric Nursing Association Seclusion and Restraint Standards of Practice (APNA) clarify that the key to S/R reduction is prevention of aggression by thorough assessment with early intervention using less restrictive measures. This goal can be accomplished by making unit changes that add structure and calmness, and by utilizing a treatment team approach that facilitates partnership with the patient, rather than control over the patient. (Seclusion and Restraint Position Statement and Standards of Practice, 2000). Utilizing these approaches has resulted in a substantial reduction in violence and the need for S/R in a forensic nursing unit. This paper illustrates how one forensic nursing unit reduced the need for S/R by focusing on core strategies that include teaching patients how to meet their needs using therapeutic, nonviolent communication skills.

The Intensive Treatment Unit (ITU) at Mendota Mental Health Institute (MMHI) in Madison, Wisconsin is a medium security 21-bed forensic unit designed to provide a safe therapeutic milieu for long-term intensive treatment of acute psychiatric, somatic, medical or behavioral symptoms. The male patients have diagnoses of psychotic, personality, mood, anxiety, and cognitive disorders and many have dual diagnoses.

The core strategies introduced into the ITU at MMHI are presented below:

### Core Strategy #1: Leadership toward Organizational Change

The ultimate goal of MMHI's Seclusion and Restraint (S/R) Policy was to create a treatment environment in which the use of physical interventions, seclusion, and restraints was not necessary. The Administrative Support Committee reviewed all S/R incidents and assigned a formal debriefing facilitator as needed. The committee assisted in consultation on patients who were repeatedly secluded or restrained and changes in S/R policies and procedures were made as appropriate.

### Core Strategy #2: The Use of Data

The MMHI administration reviewed trends in the institute S/R data. The ITU treatment team tracked, reviewed and analyzed unit data. Each patient's specific behaviors were documented each shift on a behavior flow sheet to identify behavior patterns and the triggers to the behaviors. Also, patients were assisted with problem solving when triggers occurred, utilizing healthy, safe skills. The ITU staff tracked the S/R incidents and critically reviewed the treatment plans to assess if changes were required. Prior to the revision of ITU programming, S/R use was not uncommon on ITU. Both the patients and staff expressed feelings of insecurity and a lack of safety. There were patients and staff boundary issues, staff splitting behaviors, transference and counter transference issues, excessive loss of work days due to staff injuries. One staff was not able to return to work at all, and most of the patients were on the lowest possible security level. One patient exhibited threatening behaviors that required one-to-one staffing around the clock for over a year at substantial

extra cost.

### Core Strategy #3: Patient and Staff Education

The Unit Manager interviewed all ITU treatment team members to develop a unit improvement plan. The treatment team consisted of a Unit Manager, Psychiatrist, Psychologist, Registered Nurse, Licensed Practical Nurse, Social Worker, Registered Occupational Therapist, and Resident Care Technician (RCT). Routine team educational meetings were implemented that focused on conflict resolution and enhancement of team building skills to promote cohesion of the ITU team. Current approaches to managing threatening behaviors were reviewed by the ITU treatment team resulting in the implementation of additional staff education that included therapeutic communication skills, nonviolent communication skills, the nursing process, SOAP format documentation, trauma-informed care and utilizing the treatment plan as a working document. Patients were encouraged and prompted to contribute and actively participate in the development of the treatment plans. Staff and patient thinking errors that previously led to counterproductive reactive use of S/R were identified. Education was also provided to help reverse thinking errors that led to barriers to program goals. Examples included: beliefs that interventions could not occur until either physical aggression occurred. In addition, staff believed that aggression was inevitable, and even acceptable in a forensic nursing unit.

Intervention Options Continuum (IOC) training for staff was mandated for all MMHI staff and updated biannually. IOC training provided education on crisis prevention, management and safety utilizing respectful and therapeutic approaches. Consumer advocates provided staff education on such topics as respect, therapeutic approaches to providing care, trauma informed care, and reducing the risk for violence. These initiatives helped staff and patients to understand and clarify each person's roles and responsibilities in reducing violence. It also has increased staff awareness of the importance of avoiding controlling type interactions that can trigger patients who may have trauma issues (Champagne, Stromberg, 2004). Using the public health model, reactive interventions for managing threatening behaviors were replaced with proactive interventions. One tool utilized was promotion of effective communication by promoting mutual patient-staff respect and offering empathy before education (Stewart, 2005).

The ITU team began working with patients at the time of admission to develop a proactive positive rapport and therapeutic relationship that promoted respect and trust. Patients were taught alternative healthy, safe ways to cope with strong emotions utilizing stress reduction techniques, self-esteem building, and non violent communication of their needs to staff. Staff encouraged them in practicing these alternatives. Poor self-esteem can lead to an increased risk for relapse and interfere with progress towards recovery (Shiraldi, 2005), so self-esteem building groups were added to patient treatment. Identification and reversal of cognitive thinking distortions that affect self-esteem and self-esteem enhancement were taught. It was required that staff and patients understand that threatening behaviors include physical aggression and behaviors that increase acuity such as, types of eye contact, verbal threats, provocation, manipulation of lower functioning peers, threats to "go off", gesturing, posturing, and grandstanding. The MMHI zero tolerance policy for threatening behaviors was constantly enforced with patients and staff. Most people never "just lose it" and there may be an element of premeditation and planning, or an unidentified trigger. Patients were taught that threatening behaviors cannot be displayed in the milieu. They were to exit the milieu with one verbal prompt from staff. Staff consistency in enforcing the zero tolerance policy became the expectation. Nonviolent communication skills were taught to all patients and staff on ITU. This therapeutic communication tool (Rosenberg, 2003) supports basic nursing standards of care and has helped to promote respect and empathy, and enhance conflict resolution skills among patients, peers, and staff. Use of empathy with a patient in crisis will help calm them while keeping the lines of communication open (Sears, 2006).

Education was provided to patients and staff that included the treatment plan process and each person's responsibility in that process. "Well written care plans are key to providing consistent, high-quality care, especially in the forensic setting. They are a primary means of communicating, coordinating, and organizing both preventative and treatment strategies. (Encinare, McMaster, McNamee et al, 2005). Patients were also expected to be an active part of the team. The RCT interventions for patient care were added to the treatment plans. Education was provided for staff on working successfully with the developmentally delayed patients, transference and counter transference, and different types of relaxation skills. Patients were taught to self-manage with meditation, qigong and grounding exercises. Role-playing was a major part in the staff education and training.

### Core Strategy #4: The Use of S/R Prevention Tools

The most challenging patients may be those with a long history of verbal and physical threatening behaviors. One such patient provoked peers and threatened or assaulted staff often. He caused major staff splitting and boundary issues. He refused to participate in treatment or meet with the treatment team. When he communicated it was only one-to-one with one staff person. Eliminating the patient control of the unit was a priority, and required frequent review, additions and modifications of the treatment de-escalation plan, and consistent implementation by a cohesive treatment team.

The nursing process was the basic building block used for clinical decision making and included the actions taken by the nurse to provide psychiatric mental health care (Stuart, 2005). Using the nursing process of assessments, planning care, implementing therapeutic interventions, and evaluating the results, the de-escalation plans were added to each ITU patient treatment plan. The plans began by identifying the treatment plan title, and the treatment goal. In addition, they also identify each patient specific behavior, triggers for the behaviors, early warning signs of increasing stress, threatening behaviors and interventions for signs of stress and threatening behaviors. With early warning signs for increasing stress and early interventions identified on the de-escalation plans, treatment sabotaging behaviors such as anger, provoking, poor coping skills, or failure to redirect could be interrupted and the patients were defused before threatening behaviors were displayed. This has led to a substantial decline in threatening behaviors. Staff became able to assist patients in managing their symptoms before they were out of control. Nursing interventions have become proactive instead of reactive, and the staff spends their time leading treatment groups and activities instead of reacting to violence.

Unit rules and procedures have been improved. Patients are now expected to clear the halls and be seated while waiting for meals, medications, activities, and treatment team meetings to decrease risk of conflicts. The unit milieu became a safe place and unit activities were enhanced by adding RCT led activities on the unit. Exercise groups and exercise machines were added as options to help the patients burn energy and safely manage stress. The result was a calmer milieu with an increase in feelings of safety and security for everyone.

### Core Strategy #5: Consumer Roles in Inpatient Settings

Consumer groups and advocates are pressing for new policies to make S/R use safer, encouraging reduction and eventual elimination (Bluebird, 2004). A Consumer Rights Advocate was hired at MMHI in order to provide support to consumers and families in their healing. Family members and significant others were encouraged to participate in treatment team meetings to provide support and participate in patient recovery. Education and support were provided to family members. The existing Community Meetings were expanded to include reinforcement of educational topics such as the zero tolerance policy, and nonviolent communication and problem solving skills. Reminders were given to patients about unit rules and rationale for the rules. Such initiatives have helped to change weekly meetings from "gripe" sessions to healthy problem solving sessions. Patients were encouraged to voice concerns with empathy and respect using the steps of nonviolent communication skills that were posted on walls of ITU. Patients were praised for their efforts in choosing nonviolent behaviors and making progress towards our goal in making ITU a violence free unit.

## Core Strategy #6: Patient and Staff Debriefing Tools

During the S/R experience, education was provided to the patient regarding why S/R was needed and when it can be discontinued, to help patients process emotionally charged incidents, distress, problem solve and decrease risk of traumatization. Patients have an opportunity to debrief as soon as they are in control of their behavior. Immediate post-event debriefing was completed with staff when the patient was stable. The nurse assessed staff for signs of physical or psychological trauma and to allow staff to de-compress and problem solve. Referrals were made to Employee Health and or Employee Assistance programs. Issues that were identified in the immediate post event debriefing were referred to the next treatment team meeting, at which time the patient was encouraged to participate in a review of the treatment plan, to identify and problem solve triggers, and to process the event with the team. The team provided education on healthy, safe ways to manage emotions and stress, and also reinforced healthy choices and the zero tolerance policy. The threat of violence to health care employees is 16 times other service workers (Zimmer, K.K., & Cabelus, N. B., 2003). Both witnessing and being directly involved in violence places staff and patients at risk for developing post trauma symptoms. This is one reason that routine debriefing was commenced after an S/R and during each shift on ITU. Staff was encouraged to participate in debriefing to voice their feelings and use nonviolent communication skills. Staff had an opportunity to process the events of the shift, assess level of team work and identify needed improvements. Each debriefing allows opportunities to address small and large problems, and recognize successful proactive interventions. The debriefing assisted the staff in disengaging so as not to take home work-related stress. The goal was to decrease staff risk of developing compassion fatigue or secondary victimization symptoms. The Unit Manager reviewed the debriefing reports to identify problems or concerns that required intervention by the treatment team.

## Results

Since 2004, core strategies were implemented as part of the MMHI Violence Free Initiative and ITU has successfully reduced S/R incidents from 33 hours in 2003 to 6 in 2006. There has been a reduction in S/R hours from 92.57 hours in 2003 to 6.4 in 2006. Time lost from work due to serious staff injuries was reduced from several months to zero.

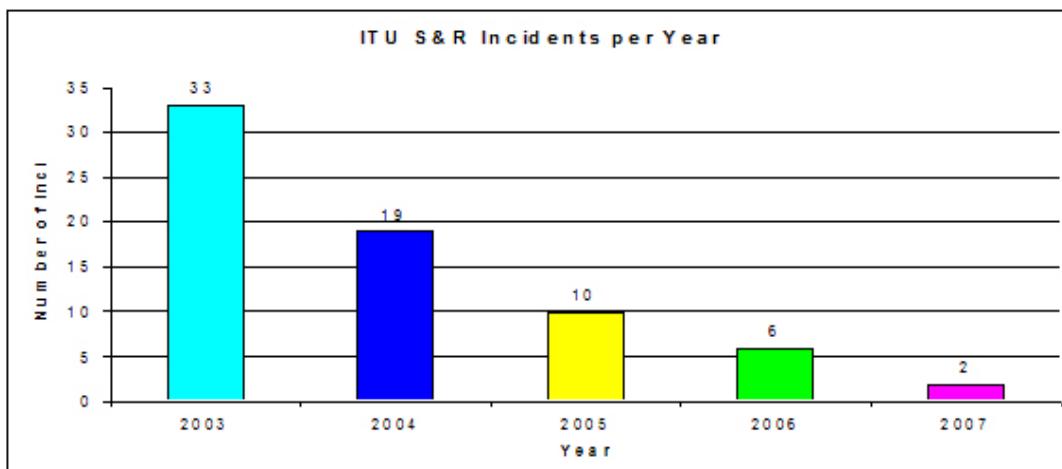


Table 1 reflects the reduction in S/R each year since the revision of the ITU programming began in March of 2004.

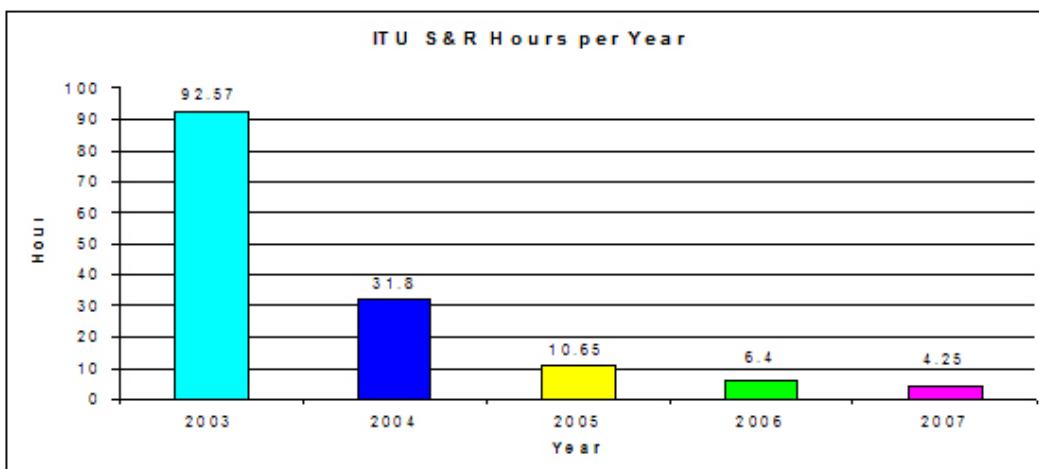


Table 2 reflects the reduction in S/R hours each year since the revision of the ITU programming began in March 2004.

The initiatives were based on Huckshorn's recommendations (2004) and meet APNA standards. The initiatives included ongoing assessments, early intervention, patient and staff education, adding structure to the milieu, and empowering patients to take control of their recovery. The outcomes of successfully meeting these standards included:

1. Reduction of injuries to staff and patients

2. Reduction of threatening behavior from patients
3. Elimination of the need for one-to-one staffing
4. Acquisition of patients' earning grounds privileges
5. Increase in patient transfers to minimum security
6. Increased acquisition of conditional release rather than S/R

The core strategies that have been utilized with other interventions have made a positive impact on the unit. The goal was to have a violence free hospital setting that promoted healing and recovery with the least restrictive interventions. The use of data helped to paint a clear picture of behavioral patterns and triggers that necessitated the implementation of proactive interventions. Education was a key factor in empowering patients and staff, and helping to enhance skills. Education for patients has helped increase their feelings of control over the journey to recovery. The use of S/R prevention was critical for a safe and healthy staff and work setting. Consumer roles in inpatient settings have provided extra support to patients and families. Patient and staff debriefing was valuable as an opportunity for processing, empathizing, decompressing, and problem solving, educating and decreasing the risk of trauma to anyone involved or witnessing violence.

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## From Around the World East Meets West

By: Carmen Henesy RN, SANE-A



Working as a forensic nurse for many years in San Francisco I have had the opportunity to welcome delegations from India, Japan, and China, and share with them the comprehensive services offered for child and adult Sexual abuse and treatment. It is rewarding to visit forensic professionals in their practice settings in other countries and to host them in the US.

Sherry Arndt and I had the opportunity in late 2005 to visit Tokyo, where we contacted Naomi Kanou, an IAFN member who is a nurse midwife and assistant professor of nursing at Ibaraki Prefectural University of Health Sciences. Naomi and eight colleagues welcomed us for a beautiful shabu shabu and kaiseki meal in elegant Asian style. They then asked to interview us regarding forensic nursing, SART, funding, on-call coverage and other common sense questions about the profession and practice issues we often encounter. We parted with offering them an invitation to visit the US.

Along with Naomi, other Japanese colleagues visited San Francisco in March 2006. They included Dr. Izumi Takase, the medical examiner and a forensic pathologist at Shiga College of Medical Science, Shiga, Japan, Nanako Yoneyama, RN, PHN, MS Associate Professor of Psychiatric and Mental Health Nursing at Akita University, and Shizuko Murayama, RN, MS, Wound and Ostomy Specialist, Akita University. These and other forensic nursing colleagues joined us for an intensive 6-day tour of multiple forensic agencies in the San Francisco Bay area. These agencies are: Redwood Children's Center in Sonoma, CA, the Child Interview Center for Contra Costa County in Martinez, CA, the Keller Center for Family Violence Intervention in San Mateo, CA, the San Francisco Rape Treatment Center, the Bay Area Women Against Rape (BAWAR), and Child and Adolescent Sexual Abuse Resource Center (CASARC).

To complete the interdisciplinary tour we visited the Family Justice Center of Alameda County in Oakland, CA where a massive framed picture made up of origami proved to be



L>R Dr. Izumi Takase, Kris Bleything, Silvia Baez, Diana

a most fitting welcome for Japanese guests. Sherry Arndt and I were subsequently featured in an article in a Japanese nursing journal about "Sexual Assault Nurse Examiner" easily recognized in the midst of all the Japanese characters.

Dr. Takase came back to attend the CA Medical Training Center pediatric SART training in San Diego and the CA Medical Training Center adult SART training in Sacramento. At that time she invited Patrick Besant-Matthews, Sherry Arndt and I to Japan in June 2007. We were asked to lecture on forensic photography, forensic interviews with children and the history of forensic nursing and SART, respectively. Patrick and I also presented at Akita University where we were treated like visiting dignitaries, and feasted on the exotic sites of Kinkakuji, the Golden Pavilion, a World Heritage site. We were presented with seasonal Japanese costumes for dinner. Richard Kaczynski, a California Ph.D. student in forensic medicine translated all our material and served as interpreter.



Japanese guests at Tattinger's Champagne Winery, March 2006 L>R, Dr. Takase, Naomi Kanou, Nanako Yoneyama, and Shizuko Murayama.

dedicated IAFN member and avid world traveler.

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Dr. Katsuji Nishi of Shiga University of Medical Science and Dr. Yoshihiro Asanuma of Akita University are so supportive of forensic nursing and were instrumental in bringing us to Japan. Dr. Izumi Takase, Nanako and Shizuko worked hard to make this trip and our presentations a great success. It was, indeed, an honor to be invited to Japan to share our knowledge, and to hear yet again, "... I was completely unaware of the "forensic nursing" arena...but its assuring to know that there are people like you around to help the victims and the judicial process". As in many countries, forensic nursing is an uncharted region, and the skills and expertise that can be shared through education and collaboration are essential for establishing the foundation in other countries and the advent of SART programs. Although sex crimes are underreported in Japan, the dedicated professionals in forensic nursing and medicine will educate and initiate new services in the land of the rising sun.

Carmen Henesy has been a registered nurse for thirty-nine years and has worked as a forensic nurse in San Francisco for twenty years. She is a



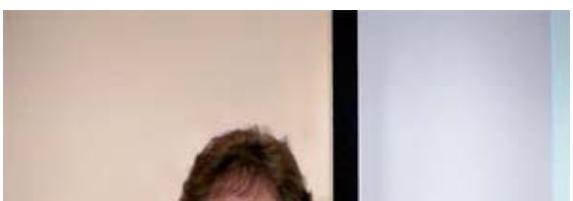
Shrine at Lake Tazawa-ko, Akita, Japan, June 2007-08-10  
Sherry Arndt, Nanako Yoneyama, and Carmen Henesy  
-All recipients of an IAFN Achievement Award

## Global Expansion Update: The United Kingdom Association of Forensic Nurses

By Virginia Lynch, M.S.N., RN, FAAN, FFAFS



Exciting events for the science of forensic nursing are happening within the United Kingdom and a new association in partnership has evolved. The founding of the United Kingdom Association of Forensic Nurses (UKAFN) was official on March 22, 2007 in London at the King's College Hospital, an NHS Foundation Trust.



Jo Delaforce, Chair of the UK AFN, a Forensic Clinical Nurse Specialist (FCNS) at the Haven Camberwell, Kings College Hospital, NHS Foundation Trust, London, has founded the association and made inroads into the science of forensic nursing since its inception in the United Kingdom. The association is developed to raise the profile of forensic nurse examiners, improving quality care and best practice'. Jo has spent many years working in a variety of acute medical and surgical specialties including sexual health, with eight years in a busy South London Accident and Emergency (A&E) department. She has helped achieve the title *Centre of Excellence* in providing care for



**Jo Delaforce, Chair of the UK AFN and a Forensic Clinical Nurse Specialist (FCNS).**

holistic manner.'

Among those who presented perspectives from each discipline were; Jacqueline Docherty, Executive Director of Nursing Operations, King's College Hospital, Dr. Catherine White, Clinical Director of the Sexual Assault Referral Centre at St. Mary's Hospital, Manchester, England, Assistant Commissioner John Yates, Metropolitan Police Service and Kathy French, Sexual Health Adviser at the Royal College of Nursing. Attesting to the quality of services offered by the forensic nurse examiners (FNE's) at the Haven, was a former service user, a victim of violence who praised the staff for their professionalism, support and encouragement for recovery.

Further testimony came from the nurses who provide these services in London and in Manchester. Jacqueline Hilder, Forensic Nurse Practitioner (FNP), who works with the Sussex Forensic Medical Services as liaison with the Sussex Police, and will be setting up a Sexual Assault Referral Centre there. Christine Donohue, a Forensic Nurse Examiner (FNE) was one of the first nurses to work as a FNE in the sexual assault Referral Centre in Manchester established in January 2004. She performs the forensic medical examination on male and female victims who make a report of rape or sexual assault. Her background in women's health and acute gynecology, family planning and sexual health services provides a strong foundation for the role of the FNE. Christine is also involved with both women and men's health research.



**Jo Delaforce with UK Forensic Nurse Examiners.**

custody nursing soon brought recognition to the forensic skills of the nurse

Nurses came from across the UK and abroad. IAFN member Jonas Lundgren, Sweden, attended with great interest in view of establishing an organization in his country. He is the head of the Office of the Medical Examiner in Gothenburg, Sweden and will be filling the office of IAFN Board Member in a new term starting in January, 2008.

Virginia Lynch is the founding president of IAFN. She represents the IAFN and the American Academy of Forensic Scientists as their International Liaison. Currently she is teaching in Africa. Virginia has been recognized as one of the American pioneers in nursing and founder of forensic nursing as a scientific discipline. Since 1993, Virginia has served on the faculty of Forensic Nursing and Forensic Health Science, Beth El College of Nursing, University of Colorado, Colorado Springs as well as adjunct faculty of the University of Rochester in Rochester, New York.

Virginia A. Lynch, M.S.N., RN, FAAN, FFAFS

victims of sexual violence. Her role has evolved from Practice Development nurse to her present position, which includes many roles at the Haven with staff training in sexual health and A&E departments in South London. Jo received a Commendation by the Metropolitan Police for outstanding dedication and commitment to improving the services of victims of sexual assault in 2004, and she was awarded the Nursing Standard, Sexual Health Nurse of the year in 2007. She has been one of the driving forces in the creation of the UKAFN. Ms. Delaforce opened the ceremonies with a prestigious crowd representing nursing, medicine and law enforcement agencies, bringing together the major professionals essential for a successful Multidisciplinary team approach to improved forensic services.

The purpose of the association is stated as: 'The United Kingdom Association of Forensic Nurses is committed to raising the awareness and profile of Forensic Nurses, while working together to develop, improve and maintain a high standard in forensic evidence collection, while providing high quality nursing care for all individuals in a



**Virginia Lynch Founding President IAFN.**

Virginia Lynch, founding IAFN president in America represented the International

Association of Forensic Nurses. Virginia was invited by the UKAFN to address this founding group as they joined with us in the global effort to reduce and prevent sexual violence. She presented congratulations and assistance from the IAFN as she closed the ceremonies, inviting all to participate with the IAFN in a joint movement currently spreading forensic nursing science in Europe as well as in other developed and developing countries. She spoke on the historical perspective of forensic medicine in the UK and how it reflects the full circle of the forensic nursing role as one component of clinical forensic practice and death investigation. Calling attention to the earliest documentation of midwives in the 15th century, the only aspect of nursing at the time, who provided forensic services in confirming pregnancy, rape, or virginity as well as testifying in the King's court.

Kenneth Pratley, Director of the Department of Forensic Medicine at Scotland Yard, supported the transition to contemporary forensic nursing in 2000 by initiating funds to establish a pilot program in Kent. From this program, the role of the forensic nurse in



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L/R Lindsey Ferguson, Forensic Nurse from Scotland  
 with IAFN founding President Virginia Lynch.

## Regional News

### Connecticut

The CT IAFN Chapter has been networking with legislators and other agencies, such as the Connecticut Sexual Assault Crisis Service, to develop and sponsor a bill, which would establish a statewide forensic nursing program. This program would include a statewide regional program for sexual assault nurse examiners in hospital emergency departments. An amendment to Senate Bill 1013 to convene a working group to develop recommendations for this establishment passed in the CT Senate, but did not make it through the House in this legislative session. Lynn Price, CT IAFN Chapter President and Quinnipiac University professor was actively involved in supporting this bill, as were several chapter members and Quinnipiac forensic nursing students who testified on behalf of the bill.

The 6th Annual CT IAFN educational conference was held April 3, 2007 at Quinnipiac University in Hamden, CT. Debbie and Rob Smith were the keynote speakers at the conference, entitled, "A Pebble in the Water." The Debbie Smith Act, named for Ms. Smith, a survivor of sexual assault, authorized funding to process the backlog of DNA collected in sexual assaults, and established funding for sexual assault nurse examiner programs and training. Chapter member Jennifer Hiscoe gave an update on the development of SANE programs in CT.

Chapter member and Quinnipiac University professor Barbara Moynihan received the prestigious Florence S. Wald award for her outstanding contributions to nursing practice. Chapter board member and past president Nancy Cabelus was featured in an article in the New England edition of *Nursing Spectrum*. Nancy's work in human trafficking was the subject of an article by Debra Ansccombe Wood. Nancy also presented her doctoral research on sex trafficking at the New Hampshire Attorney General's conference on Domestic Violence in June. Chapter board member Denise Covington spoke on forensic nursing at the Rhode Island Chapter of the Association of Peri-Operative Registered Nurses' (AORN) dinner meeting. Denise's presentation introduced the group to forensic concerns in patient care and heightened awareness to the discipline of forensic nursing.

This fall the CT chapter will have a new web site, which is currently under construction. Those interested in a preview can log on to [www.ctiafn.org/os](http://www.ctiafn.org/os).

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## Member News

### Member-Get-A-Member Campaign Results

By Bonnie Barsa

Congratulations to all those members that participated in the 2007 Membership Campaign! We received a total of 110 new members from June 15 – August 15, 2007 that actually stated a member as referring them to the IAFN. This is great news for your association, as it shows the value that our members see in the IAFN. That is almost 2 members every day that joined because a member shared the news about IAFN.

We would like to extend additional kudos to those members that referred sufficient new members to receive a small token of our appreciation. The following individuals referred a total of 5 members, earning an IAFN pin, during the 60 days that the campaign ran.

**Michelle Clifton from Berlin, MD**  
**Judy Pinson from Memphis, TN**

The following individuals referred a total of 3 members, earning them an IAFN tote bag, during the campaign.

**Mike Holt from Jackson, TN**  
**Virginia Lynch from Divide, Colorado**  
**Dan Sheridan from Baltimore, MD**

Thank you to all of you that participated. We appreciate all of our members continued support of your association!

## Research Briefs

By Barbara W. Giardin, Ph.D., M.S.N., RN

Sexual Assault Nurse Examiner Chesapeake Forensic Services

The objective is to show that a clinical brief should be corroborated in research and by sending inquiries to the author of a clinical article.



### Vulvar microfissures

**Susan Kellogg-Spadt (2007, May), Coitally related vulvar fissures The Female Patient 32, 26-29.**

This clinical overview describes the genital findings observed in well woman care. Vulvar vestibular microfissures are commonly at the 6 o'clock region of the vaginal introitus, a poorly keratinized region with the fourchette medial to Hart's line having only 1 mm of keratin. Inflammation and splitting is common. This article reviews common causes for increased fragility of tissue at the vaginal introitus: vaginitis, vulvitis, dermatitis, anatomic variants, and disease. All of the causes may result in females experiencing psychological aversion to sexual intimacy. Treatments are discussed.

Implications:

1. Practitioners performing female genital examinations may benefit from knowledge regarding common problems, and nursing care addressing referral and treatment.
2. This is not research, but noteworthy trend from gynecology perspective.
3. Sexual history is not considered in relation to microfissures, and may complicate findings.
4. They are impetus for analyzing research findings that corroborate or refute the significance of the clinical finding of microfissures.

So consider a couple other briefs about fissures below:

Wincelaus J, Jones PA (1997, Aug.). Genital herpes masquerading as anal fissures.

*JR Coll Surg Edinburgh* 42(4), 276-7

This is a case report (a single patient) of a single woman with relapsing anorectal symptoms. Gonococcal and chlamydial infection of the rectum may have been the source of her symptoms, which resulted in anal fissures and proctitis-commonly seen in surgery clinic.

Implications:

1. SANEs should not imply that GC or chlymydia has caused the anorectal fissures that we might find on a medical-legal exam.
2. When asked about this study, "Might STIs can cause fissures (superficial tears)?", it would be important to explain that this article presented findings in a single patient and the sexual history was not taken. A sexual history might have revealed the practice of anal intercourse as the cause of anorectal fissures.
3. SANEs describe the findings, not guess how they got there.

Edwards I. (2004). Vulvar fissures: causes and therapy. *Dermatology Therapy* 17(1),

111-16. contact: [ledwardsmd@aol.com](mailto:ledwardsmd@aol.com)

Edwards discusses the two main patterns of vulvar fissures: 1)at the posterior fourchette, and 2)within skin folds and creases. The cause of posterior fourchette splitting is not known. Skin-fold fissures occur in response to several inflammatory dermatoses or infections.

Implications:

- o This article is not a research study or single patient case review, but a description of a variation: vulvar fissures.
- o Even though the article is in the literature, it is not appropriate to suggest to police that microfissures are common-recall this was not even a case review let alone a survey of 100 charts, which would strengthen the power of the findings.
- o When you see a journal article and have questions, query the author. In asking Edwards about fissures, she responded by saying, "I have no numbers to support the frequency of vulvar fissures, and most **women do not fissure with most acts of penetration**".

Barbara Giardin, Ph.D., M.S.N., RN

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### More Information

#### IAFN Mission Statement

The mission of the IAFN is to provide leadership in forensic nursing practice by developing and disseminating information internationally about forensic nursing science.

#### Be an Author!

We welcome your article submissions to *On the Edge*. Consider it one of our primary avenues for networking and expanding the focus of forensic nursing practice and development. Please share your forensic nursing expertise with interested readers and colleagues around the world.

If you are a first time author or are simply not attune to writing do not let this be a deterrent from sharing your expertise. We make every attempt to ensure your article reaches the appropriate audience and provide support and assistance whenever possible. [See Author Guideline posted on IAFN web page](#).

When you send in an article, whether it is a case study, a research study, regional news or anything else, we want to be sure you are appropriately recognized. To this end, please include your name, credentials, type of work place, city and state along with three or four lines about yourself, as we include a brief bio at the end of every feature.

Your contact information should include your name, address, and telephone and fax numbers, email address. Please be certain the information is accurate, as we may need to contact you for additional questions or clarification on your submission and its publication.

#### **Guidelines and Style**

The newsletter follows the style guidelines of the Psychological Association Publication Manual, 4th Edition. For assistance or additional questions, please contact the managing editor.

#### **Content**

If you would like to discuss content or ideas, or if you already have an article prepared, please contact:

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