

Treatment and Security Outside the Wall: Diverse Approaches to Common Challenges in Community Forensic Mental Health

Adam Brett, Andrew Carroll, Bob Green, Peter Mals, Scott Beswick, Marcello Rodriguez,
David Dunlop, and Cinzia Gagliardi

This article describes the Community Forensic Mental Health Services in Australia and their different service models. It discusses the service models used and why they have developed this way. The interface between CFMHS, mainstream mental health and secure inpatient forensic mental health services needs to be clear and common issues are outlined. The future directions for CFMHS are suggested, which include demonstrating that CFMHS are effective in delivering what they profess to do.

Forensic mental health services throughout the developed world have changed radically in their delivery over the last 20 years. From being the province of a few psychiatrists and psychologists who assessed and managed a relatively small number of mentally disordered offenders, services now have a much broader mandate. A forensic mental health service should now ideally provide a seamless service, offering a continuum of care across the mainstream mental health, court, correctional, inpatient and community arenas (Mullen, Briggs, Dalton, & Burt, 2000).

Although a relatively new development, services located in the *community*, rather than in secure hospital facilities, have been described as the “very core” of a modern forensic mental health service (Mullen et al., 2000). Such community forensic mental health services (CFMHSs) have to juggle a number of factors when assessing and managing mentally disordered offenders, including risk to others, provision of optimum psychiatric care, clinician-client safety, confidentiality and other ethical issues. In an era of evidenced based medicine, it is incumbent on the providers of such services to validate their models of service delivery. The first step in this process is to clearly describe existing

models of community forensic mental health service provision.

The federal political structure of Australia, together with its variegated demographic and geographical structure, has generated a wide range of such service models. Each of Australia’s States and Territories has its own health care system, mental health laws and criminal legislation. There are consequently subtle (and not so subtle) differences in the way each has developed its community-based forensic mental health services. Although some regions have operated CFMHSs for several decades, considerable reorganization and expansion has occurred nationwide since 2000. A consideration of the resulting ‘natural experiment’ – a diverse range of responses to the common challenges inherent in such work- can help to inform the development of such services elsewhere in the developed world. This paper therefore aims to qualitatively describe CFMHSs in Australia, demonstrating how different models of service delivery interact with local geography, legislation and needs. It will then discuss three key emerging themes in community forensic mental health: service delivery models; interface with mainstream mental health; and interface with secure hospitals.

Adam Brett, Community Forensic Mental Health Services, Western Australia; Andrew Carroll, Monash University and Forensicare, Victoria; Bob Green, Community Forensic Mental Health Services, Queensland; Peter Mals, Top End Mental Health Services, Northern Territory; Scott Beswick, Community Forensic Mental Health Services, Tasmania; Marcello Rodriguez, Community Forensic Mental Health Services, New South Wales; David Dunlop, Forensic Community Team, South Australia; Cinzia Gagliardi, Forensic Services, Australian Capital Territory

Direct correspondence to Dr. Adam Brett, Director Community Forensic Mental Health Services, U15/200 Wellington St. East Perth, Western Australia 6004 (Email: adam.brett@health.wa.gov.au).

Overview

Australia is a federation of six States and two mainland Territories (the ACT and Northern Territory). Table 1 presents data on the respective size, population, prison population and community forensic patient¹ caseload size of each State and Territory. The population of Australia, which totals approximately 20 million, is largely centered in urban areas in coastal regions. It can be seen that some regions have large areas but relatively fewer people (e.g., Western Australia) whereas others are small in area but with larger populations (e.g., Victoria).

These factors, along with resources for staffing levels have contributed to different responses to the common goal of CFMHS provision. The effect of legislation and public policy is evident in differences in the number of forensic patients in the community, ranging from 1 per 100,000 (NSW) to 8.5 per 100,000 in Queensland.

Table 2 presents data on referrals sources, services provided and assessment methods that are utilized. In addition to providing assessment and treatment services to forensic patients, CFMHSs generally also provide services to other high-risk civil clients of mainstream mental health services. Most CFMHSs also receive referrals direct from criminal justice agencies. CFMHSs may also offer court-liaison services, and link with secure inpatient and correctional facilities.

The use of structured risk assessments is a relatively recent development, particularly in Australia (Ogloff & Davis, 2005) but their routine application is one feature that distinguishes CFMHSs from most mainstream services. The HCR-20 (Webster, Douglas, Eaves, & Hart, 1997), the PCL-R (Hare, 2003) and the START (Webster, Martin, Brink, Nicholls, & Middleton, 2004), are the most utilized risk assessment measures. Also in use are measures of sexual offending risk- the Static 99 (Harris, Phenix, Hanson, & Thornton, 2003) and the SVR-20 (Boer, Hart, Kropp, & Webster, 1997), as well as measures of patients needs –the CANFOR (Thomas, 2003), substance use – the TCUDS-II

(Knight, Simpson, & Hiller, 2002) and competency – the MacCAT-CA (Hoge, Bonnie, Poythress, & Monahan, 1999).

An Australian Community Forensic Mental Health Services Network, involving senior staff from each service, was established in 2004 with involvement of all the States and Territories. The Network convenes monthly by teleconference to discuss issues pertinent to the practice of community forensic mental health and to present complex cases for peer discussion and review. For this paper, each State and Territory has contributed a synopsis of their service.

Victoria

Victoria is the smallest mainland State, but the most densely populated and urbanized, with over half of its population resident in the Greater Melbourne area. The CFMHS in Victoria is part of the Victorian Institute of Forensic Mental Health (*Forensicare*) and its clinical services are provided through two programs: the Mental Health Program (MHP) and the Problem Behaviour Program (PBP).

The MHP includes a case management team, which provides mental health care, assertive case management and outreach. Its target client group consists of high-risk mentally disordered offenders, many of whom have committed serious offences and have been successfully rehabilitated through its inpatient service (Thomas Embling Hospital) as forensic patients.

The MHP has a dual mandate in both providing comprehensive psychosocial care and also appropriate supervision to ensure that such patients comply with the conditions of their release into the community. The Problem Behaviour Program (PBP) was launched in early 2005 following a reorganization of the CFMHS. It brings a bi-disciplinary approach (i.e., psychology and psychiatry) to the assessment and management of problematic behaviors including interpersonal violence, uttering threats, stalking, fire setting and sexual offending (Warren, Mackenzie, Mullen, & Ogloff, 2005). Much of its role is in assessment, providing advice for primary treatment services on the etiology and management of such behaviors. Philosophically it attempts to integrate classical psychiatric approaches with psychologically based functional analysis and cognitive-behavioral approaches.

¹ The term forensic patient is used in this paper to describe those patients found not fit to stand trial or not guilty by reasons of unsoundness of mind- the criteria for these is subtly different throughout Australia.

Table 1
Size, Population, Prison Population and Community Forensic Patient Caseload Size of each State and Territory

	Population x 1,000 ¹	Prison Population ¹	Forensic Patients in community	Area X 1,000 sq km ¹	Caseload per case manager	Service model ²	Psychiatrists (registrars)	Nursing	Psychology	Social Work	Team Leader	Other
VIC	4917	4,140	70	227	10-15	P + I	1.0 (0.6) 0.6 (0.3)	3 0	0.2 3.3	2 0	1 1	- -
QLD	3796	5,243	322	1730	9-20	CL	2 0.5	2 1	2 1	2 0	2 1	1 2
WA	1952	2,899	20	2530	8	P + I	1	7	0.5	1	-	-
NSW	6,687	8,998	64	801	-	Ax	1(1)	4	1	-	-	1
ACT	323	132	NA	5	10	I	-	-	3	-	1	-
SA	1,527	1,455	105	983	10	P + I	-	7	-	1	1	-
NT	198	729	5	1349	11	I	0.1(0.2) 0	1.4 0.5	0.6 0	0.5 0	0.5 -	- 0.1
TAS	477	453	23	68	10	P + I	1(1)	3	4.5	4.5	1	1

1. Australian Bureau of Statistics (2005). 2005 Year Book Australia. Number 87. Australian Bureau of Statistics, Canberra.

2. P = parallel, I = integrated, CL = consultation liaison, Ax = assessment only.

Table 2
Referral Sources, Services Provided and Assessment Methods Utilized

State	Referral source ¹	Client group	CLS	Prison	Secure Liaison	Special programs	HCR-20	PCL-R/ PCL-SV	Other assessment tools
Vic	MHS/private Corrections Courts	MHS pts FP Criminal justice orders Voluntary pts	y	n	y	Problem Behaviour Program	y	y	START Range of measures for patients as required (e.g., SVR-20, RSVP, LSI-R).
Qld	MHS	MHS pts FP	y	n	y	-	y	y	STATIC99 SVR-20
WA	MHS Corrections	MHS pts FP Criminal justice orders	y	y	y	Anger management	y	y	Camberwell Assessment of Need – Forensic version (CAN-FOR) Texas Christian University Drug Screen II (TCUDS-II)
NSW	MHS, Probation & Parole	FP	y	n	n	Sexual offenders (in progress)	y	y	START Static-99/STABLE 2000 SVR-20
ACT	MHS	MHS pts FP	y	y	-	-	y	y	START
SA	MHS Corrections	MHS pts FP Prisoners	-	y	y	-	y	n	
NT Darwin	MHS Courts Corrections	MHS pts FP Criminal justice orders	y	y	y	-	y	y	McArthur Competency Assessment
TAS	MHS/CLS Corrections NGO	FP Criminal Justice orders pts on bail	y	y	y	Resource team Psychosis	y	y	START

1. MHS = mental health service, CLS = court liaison service and NGO = non-government organization

New South Wales

New South Wales is Australia's most populous State, with two thirds of its population living in the urban environs of Sydney. It has recently embarked on the initial stages of the development of a comprehensive and integrated forensic mental health service, a process that began with the development of court liaison services. Currently, the CFMHS team is assessing all forensic patients who have been conditionally released into the community. Comprehensive forensic reports are being completed and distributed to their respective treating mainstream mental health services. Following the completion of this task and utilizing data that are being collected, a broader service model appropriate to the State's needs will be implemented.

South Australia

With 1.5 million people, South Australia comprises less than 10% of the Australian population. The majority of its people reside in the State capital, Adelaide; much of the remainder of the State is arid and sparsely populated 'outback.' The core business of the South Australian CFMHS is the management of current forensic patients. It maintains a database and advises the relevant mainstream mental health treating teams of newly declared forensic patients with respect to license conditions, and of the pending lapse of limiting terms, so that continuity of treatment can be ensured.

The CFMHS refers clients to the appropriate regional mainstream mental health service in keeping with the philosophy of maintaining clients in their area of preference wherever possible. There is also a role for ongoing education to mainstream services regarding the legal issues relevant to managing forensic patients. In the future, the CFMHS plans to have more of a presence at the Supreme and District Courts level in identifying clients who are likely to receive a mental impairment defense and liaising with clients' current treating teams to ensure better continuity of care.

Australian Capital Territory (ACT)

The ACT, principally comprising the city of Canberra, is the political capital territory of the Australian Commonwealth. Geographically, it

comprises a small but relatively densely populated enclave in the New South Wales region. The CFMHS in the ACT was initially envisaged as providing full clinical management of all forensic clients as a stand-alone service: the impossibility of achieving such a goal with only three full-time staff members and no psychiatrist led to a shift in service direction. Consequently, the 'Forensic Community Outreach Service' has been set up to provide a tertiary level specialist forensic service, incorporated within the mainstream mental health service. It has three main functions: consultation/liaison; co-clinical management; and education/training.

For referred clients, initial assessments are conducted together with the mainstream mental health clinical manager and a management plan is devised to address both the mainstream mental health needs of the client and the factors associated with risk of offending. The CFMHS also assists mainstream services in implementing appropriate management strategies. Sometimes this involves providing assertive clinical management in conjunction with the mainstream mental health service for as long as it is clinically necessary.

Queensland

Queensland, with a land mass some six times that of the UK, has the fastest growing population of any State in Australia. Although its population is largely located in coastal areas, the population is somewhat less urbanized compared to other States. The geography and demographics of the State have clear implications for the development of statewide specialist forensic mental health service delivery.

An underlying principle of Queensland mental health policy is that mainstream services are responsible for the management of any community forensic patient in their area. As well as avoiding the expense and complication of providing an expanded parallel forensic community service across all districts, this is intended to provide equivalence of service and destigmatization of the forensic population. This policy provided a framework for the CFMHS to implement a consultation/liaison based model of service delivery, which is far more feasible than a parallel model given the vast size of the State and the limited specialist forensic mental health resources available.

The consultation/liaison service provides three levels of input, according to need:

- advice and information regarding forensic mental health issues;
- specialist assessments such as comprehensive risk assessments, second opinions, joint assessments and review of management plans;
- joint case management or other ongoing specialist intervention for complex cases, with the mainstream mental health service retaining overall treatment responsibility.

In this consultation based model the primary aim of CFMHS is to assist mainstream services in managing their clients who have both a serious mental illness and complex forensic issues. The CFMHS is one component of an integrated forensic mental health system that also includes inpatient, prison and court liaison services. An additional resource employed directly by thirteen mainstream services is that of 'Forensic Liaison Officers'. These positions were established to facilitate links and continuity of care between forensic services, criminal justice agencies and mainstream services.

Western Australia

Western Australia is the largest State in Australia in size (more than the land mass of the United States, including Alaska), but the vast majority of its landmass is uninhabited wilderness. Largely due to its mining industries, it is the richest state in the Commonwealth on a per capita basis. Most of its population lives in the area of Perth, its coastal capital city. The CFMHS is based in Perth but services the whole State. It runs three broad service streams: court-liaison; assertive case management; and consultation-liaison. The assertive case management service provides care to forensic patients and patients with serious mental illness who are at high risk of offending. The long-term aim for all case-managed patients is an eventual return to mainstream mental health services. This depends on a number of factors including risk assessment, severity of illness and willingness of the agency to take over ongoing care. If an admission to hospital is required, this is generally through mainstream mental health services. Exceptions include those whose risk level or legal

status is such that they require the security of the forensic unit.

The consultation-liaison service offers advice and education to a number of agencies (e.g., correctional services, mainstream mental health services) on a range of issues (including violence risk, fitness to stand trial, and diagnosis). This service is provided to remote and rural regions by means of videoconferencing.

The CFMHS also runs an anger management program for people with serious mental illness and anger issues, which occurs on an individual level. Other specialist programs such as sex offender programs are run by the Department of Justice.

Northern Territory

The Northern Territory has a total population of just 200,000, largely centered on the capital Darwin in the north, and the remote central town of Alice Springs.

There is no administratively separate Forensic Mental Health Service in the Territory. Instead, there is a multidisciplinary "Forensic Team" within each of the two regional mental health services ('Top End' and 'Central Australian'). The Top End Team, based in Darwin, provides three types of service: case-management of community-based clients; prison in-reach; and court liaison. For the most part, the team's community-based clients are subject to standard criminal justice system orders but a small and slowly expanding number are subject to the mental impairment and unfitness for trial provisions of the Northern Territory *Criminal Code*, introduced in 2002.

The Central Australian Forensic Team, based in Alice Springs, has a more limited capacity for community-based services and focuses primarily on prison in-reach and court-liaison. The Territory has several distinctive characteristics that impact significantly on the delivery of community forensic mental health services. Firstly, over a quarter of the population is Aboriginal (compared to 2.2% nationally). The challenges of servicing this politically and economically disadvantaged population, many of whom reside in remote settlements, are considerable. Aboriginal people are largely over-represented in the criminal justice system and they account for a large proportion of the case load. The

majority of such clients live in communities where traditional languages prevail and where many aspects of traditional culture remain intact. Inevitably then, forensic mental health clinicians have formidable cultural and linguistic barriers to contend with and are highly dependent on the assistance of interpreters and cultural consultants. Access to such workers is often limited and sometimes unpredictable.

Secondly, due to the small population of NT and the associated diseconomies of scale, the NT does not have an extended-stay forensic inpatient facility. This situation creates obvious difficulties for the rehabilitation of forensic patients. As a response to this situation, the Top End Forensic Team has begun to cautiously explore possibilities for graduated-release and community reintegration programs implemented directly from the prison setting.

Thirdly, there are significant problems arising from the dispersal of the population. There are only four population centers numbering more than 10,000. The remainder of the population live in small, isolated communities where even mainstream mental health services are in short supply: the norm in the larger communities is a visit by a mental health nurse every six weeks and by a psychiatrist every three or four months. Given this level of mainstream servicing, significant challenges arise when forensic clients return to such communities. In some instances, there may be a need for forensic input that goes beyond the usual bounds of consultation-liaison. In one recent case, the forensic team has adopted a more active coordination and oversight role, which commenced with the formulation of a comprehensive management plan, involving the remote mental health team plus a number of other local agencies. A pivotal element of this plan was an explicit reporting structure, in which all parties provide regular feedback to the forensic team, via email or telephone. The CFMHS relays important information to others in the network, recommends particular courses of action, and retains ultimate responsibility for applications to revoke or vary the terms of the supervision order.

Tasmania

The island state of Tasmania has a population of just under 500,000. The capital city is Hobart and 40% of the state is made up of reserves, National

Parks and World Heritage Sites. The Tasmanian CFMHS is a statewide service with offices located in Launceston in the north of the State and Hobart in the south. The community teams operate using an assertive case management model and also provide consultation and advice to other service providers, in collaboration with a CFMHS psychology resource team who conduct specialized risk assessments and court reports. A multi-disciplinary clinical review meeting is held weekly in each of the community teams to discuss new referrals, allocate client assessments and formally review case managed clients. The CFMHS also provides education to other services in the area of mental illness and risk assessment.

Service Models

Australian CFMHSs thus demonstrate a diverse range of service delivery, with differing models reflective of geographical, legislative and resource factors particular to each State and Territory. Gunn (1977) first used the terms *integrated* and *parallel* to describe forensic mental health services. These terms can be used in three different ways: to describe organizations; to distinguish models of patient care; or to describe patients (Snowden, McKenna, & Jasper, 1999). In general however, the term 'integrated' refers to forensic specialists working *within* community mental health teams (Mohan Slade, & Fahy, 2004) and 'parallel' to forensic specialists working on a *separate* specialist team.

The Forensic Assertive Community Treatment (FACT) programs in the USA (Lamberti, Weisman, & Faden, 2004) are a prime example of a parallel service. Such programs provide intensive service delivery with the additional use of legal leverage to ensure compliance.

In contrast, some have advocated the abandonment of separate forensic services in favor of giving enhanced resources to mainstream services so that risk assessment and management are at the heart of routine clinical practice (Turner & Salter, 2005). Such integrated services have also been said to minimize stigma, provide support and education for staff, and enable forensic expenditure to be provided for a wider group of patients and staff (Whittle & Scally, 1998). However, as baseline rates of serious violence are lower in mainstream mental health

services, which cover large populations, these services may not experience many serious adverse events and may not be fully attuned to the risks they run in some cases (Kennedy, 2002). The mixing of all patients in generic teams may therefore be sub-optimal risk management at the systems level. Whichever model is adopted, it is essential that service boundaries do not operate as barriers to the movement of individuals across levels of security when required (Kennedy, 2002).

The core business of CFMHSs is clear: optimizing the community management of high-risk individuals who have major mental illness. How this is best achieved has been the subject of debate among clinicians and service planners. Unfortunately, there is a lack of available information regarding the effectiveness of different models. At present, for example, there is not even any strong evidence that CFMHSs actually assess and manage risk any better than mainstream mental health services do. Additionally, there is the vexed question of how to measure 'effectiveness' in community forensic mental health. Is the reduction of reoffending a fair measure or is improved care a more realistic goal (Robertson, 1989)?

Clearly, there are difficulties comparing models developed for different historical reasons, in different legal, funding and geographic contexts. Establishing a parallel CFMHS in a remote community where there are inadequate general health and mental health services is clearly problematic. Current services in Australia are the result of such economic, philosophical and pragmatic considerations. There are however common desired outcomes, such as safe, effective management with reduced risk for the community and improved mental health for the individual. The need for evaluations or comparisons between different models remains an important clinical and research goal.

When considering Australian CFMHSs, it is clear that most States and Territories operate a hybrid system, consistent with the notion that parallel and integrated services are not mutually exclusive, but rather two ends of a continuum (Tighe Henderson, & Thornicroft, 2002). For example, Victoria, Western Australia and Tasmania have models incorporating parallel assertive case management in addition to offering a consultation/liaison service to mainstream mental health. In contrast, in Queensland all

community forensic patients are the responsibility of the mainstream mental health services: specialist CFMHS services are provided only via a consultation/liaison model, although this can include co-case management where required.

The variety of models employed by Australian CFMHSs allows for the possibility of validating and comparing different approaches by means of collaborative service evaluation research.

Interface with Mainstream Services

Regardless of where a CFMHS lies on the continuum of parallel to integrated models of service delivery, CFMHSs cannot operate in isolation from mainstream mental health services. Not only will mainstream services want to make referrals to a CFMHS, but all CFMHSs will also seek to eventually integrate patients back into mainstream services. The limited resources of both mainstream and CFMHSs make it inevitable that the demand for services exceeds the capacity to provide services. It is therefore not uncommon for issues to arise regarding whether individual patients or even class of patients (e.g., 'sex offenders' or 'ex-prisoners') 'belong' to a mainstream or to a specialist forensic mental health service. Other reasons for mainstream services' reluctance to provide treatment services include concerns regarding "dangerousness" and fear about people who have been violent (Roskes & Feldman, 1999), perceptions regarding personal responsibility if a patient reoffends (Lamb, Weinberger, & Gross, 1999), a perceived lack of skills to work with patients with complex needs who have been violent or involved with the criminal justice system (Vaughn Pullen, & Kelly, 2000) and additional administrative or clinical demands placed on busy clinicians. One example of this latter situation occurs with clients who have a history of homicide, who may be clinically stable, but who still require regular monitoring for risk-related issues. Based on acuity of symptoms alone, such persons may warrant a lower level of clinical supervision than is indicated by a broader conceptualization of their level of risk.

In addressing these issues, the question of what is "specialist" about CFMHS warrants consideration. CFMHSs are utilized most optimally in providing services to the mentally ill who present with issues

associated with higher risk and criminogenic need (Andrews & Bonta, 2003). Through experience and knowledge of the relevant literature, CFMHS clinicians bring a more comprehensive assessment of risk, most typically evidence based. CFMHS assessments are therefore more likely to focus on factors relevant to risk, not only in terms of psychiatric assessment but also monitoring of and interventions for, more broadly-based criminogenic needs (Andrews & Bonta, 2003).

Legal, ethical and political issues are also relevant to community forensic mental health. The importance of a philosophy that balances individual rights against public safety when working with mentally ill offenders is well recognized (Heilbrun & Peters, 2000; Lamb et al., 1999; Mullen, 1993). This is particularly important in politically high-profile cases, where a skilled CFMHS can bring an external perspective based on evidence rather than emotion. CFMHSs routinely work with high-risk patients and accordingly develop a more fine-grained understanding of the individual differences between patients who may have committed acts of major violence. Typically, CFMHSs will also be more experienced and knowledgeable regarding legal considerations and their application as they may pertain to specific patients.

Clearly, collaboration between CFMHSs and mainstream mental health services is essential for a variety of reasons. Firstly, even a fully parallel CFMHS would have difficulty duplicating comprehensive after-hour crisis or rehabilitation services. Such services play a vital role in providing optimal care and thereby reducing risk associated with mental illness. Secondly, as many patients who have had contact with the criminal justice system are neither under statutory criminal justice or psychiatric supervision, nor detained in institutions (Vaughan, 2001), mainstream mental health services are likely to have contact with such patients. Hodgins (2000) argues that the forensic and "traditional" patient populations are no longer distinct, since a high proportion of the mentally ill have had criminal justice system contact. In Victoria, for example, 25% of offenders have had previous psychiatric contact (Wallace et al., 1998). Thirdly, the specialist knowledge and skills of CFMHSs can be of assistance to mainstream services, not only in relation to designated forensic or high-risk patients but to

the broader group of patients who either have been or are at risk of criminal justice system involvement. Accordingly, mainstream mental health services can play an important role in preventing offending by providing effective mental health treatment (Hodgins & Müller-Isberner, 2004).

In addition to assuming direct clinical responsibility or offering co-case management, Australian CFMHSs have adopted a variety of approaches to working with mainstream mental health services. One example of an integrated approach involves locating specialist clinicians in mainstream services, who provide a link between forensic services and mainstream mental health services, as well as being a forensic 'specialist' within their service. Accessibility is a primary advantage of this model, while disadvantages include the risk that all forensic clients are referred to one clinician thereby de-skilling other staff. Isolation of the clinician and lack of contact with forensic peers to ensure the maintenance of knowledge and skills can also occur (Mohan et al., 2004).

Another major approach to providing specialist services is through consultation: from providing factual advice (e.g., on legislation) through to specialist risk assessments and management advice on specific clients. In most jurisdictions in Australia, consultation is one of a range of the services provided, whereas in Queensland it is the basis of the service delivery model. The provision of education and training are also important strategies employed by CFMHS to build mainstream service capacity and confidence in working with forensic issues.

Regardless of whether services are provided parallel to mainstream services or are integrated within mainstream services, an ideal system of care incorporates the CFMHS into a continuum of mental health service delivery, with clear links to the mental health and criminal justice systems, allowing for early response from and involvement of specialist forensic services as required (Blackburn, 2004; Lamb et al., 1999; Mullen et al., 2000; Vaughan et al., 2000). Systemic acknowledgment of these links can take a number of forms, ranging from the development of shared principles of collaboration, to service agreements, through to individual client-based memoranda of understanding between CFMHSs and mainstream mental health services.

Interface with Secure Forensic Inpatient Services

Throughout the developed world, the contemporary orthodox view is that psychiatric treatment should take place in a community setting whenever possible. A shift of resources away from the inpatient sector in recent decades has resulted in both very short average hospital stays and an increasingly high threshold for admission to hospital. The forensic sector, for a variety of reasons both clinical and political, continues to largely resist this trend: its financial resources are still heavily biased towards inpatient services; many of its patients are detained in hospital for periods of years, even in the absence of active symptomatology; for those who have been released into the community, the threshold for readmission to secure hospital care may be very low. One important but seldom discussed consequence of these peculiarities is the emergence of certain issues which commonly occur at the *interface* between community forensic mental health services and secure inpatient forensic mental health services.

The lack of a service-wide systemic approach to addressing the needs of long stay forensic patients has been recognized as a major deficiency in forensic services in England and Wales (Abbott, 2002) where the piecemeal approach to community forensic mental health service provision (Judge, Harty, & Fahy, 2004) has been one factor contributing to the “silting up” of the secure inpatient sector. In theory, it would seem perfectly possible to develop a seamless forensic mental health system, focused on the twin aims of service provision: optimising patient outcomes (*care*) and minimising risk to the public (*containment*) (Mullen, 1993). All too often, however, the differing locations of service elements – either side of a secure perimeter wall – result in ways of thinking and working which are disparate and even at times conflictual.

In general it may be that inpatient services are more risk averse than community services in their management style, although there is no empirical data to support this assertion. The common assumption, however, when there is an adverse incident involving an inpatient is that, since the hospital is responsible for patient welfare and behavior around the clock then, logically the incident must have been due to some systemic failure by the

hospital. Such assumptions are harder to maintain in the community locus where clinical contact may be limited to several hours a week at most and where it is acknowledged that much more power and hence responsibility is in the hands of the patients themselves. Given this, it is unsurprising and indeed, highly appropriate, that inpatient systems tend to be more risk averse.

Interface problems between the community and inpatient sector may arise around questions of client readiness for discharge into the community and of appropriateness for readmission into secure hospital care. Both arms of a service need to steer a middle way between an excessively cautious or an excessively liberal approach. On the community side, services may have a tendency to be overly precious and to only accept patients who are essentially symptom-free before they will concur with recommendations for release from hospital. Such an approach may deny appropriate community placement for a number of chronically symptomatic patients who may actually be safely manageable in the community. Conversely, community clinicians may fall into the trap of seeing re-admission to hospital, except in the event of a florid relapse of illness, as a failure of community care. The empirical work in the area (Heilbrun, 2000) suggests that a low threshold for readmission for forensic patients will actually have the benefit of reducing the risk of recidivism and consequently developing robust and politically defensible forensic mental health systems.

It is generally accepted (Heilbrun & Peters, 2000) that risk management in the forensic sector must go well beyond the control of symptoms of mental illness and look at broader rehabilitation aims such as social integration and attitudinal shifts; however, an excessively cautious approach that demands not only an absence of all active symptoms but also the inculcation of pro-social attitudes and the eradication of all ‘criminogenic needs’ may result in very protracted inpatient stays. Although release decisions are, in theory, taken by independent bodies, such bodies are generally loath to permit release in the absence of clear recommendations on the part of the treating team. In some parts of Australia at least, the culture of clients assertively seeking release, with the help of publicly funded legal assistance is, for good or ill, rare.

On the other hand, services may underestimate the potential for risk of violence after release by adopting an overly narrow cross-sectional approach to risk, which assumes that if all is well in the highly-structured setting of the hospital ward (where compliance with all conditions is closely policed) then the risk of recidivism after release is correspondingly low. This flies in the face of contemporary risk assessment methodologies, which emphasize consideration of future scenarios as well as current functioning (Webster et al, 1997).

To varying extents across the various services discussed in this paper, progressive and innovative steps have been taken to address the potential chasm between community and inpatient facilities. It is fair to say however that no service has achieved an ideal model of systemic harmony.

Better integration between inpatient and community forensic services is contingent on a service-wide philosophy which emphasizes active engagement between the two sectors, and eschews a view of community and hospital as passive impermeable silos. Operational management structures must adopt a service-wide vision.²

Paradoxically, effective integration also depends on a clear *differentiation* of roles, in order that the various sectors can properly understand and hence respect each other's endeavors, avoiding needless competition and duplication of effort. There are some very practical measures which can be taken to translate these notions into practice. One key step is to encourage similar, transparent, structured decision-making processes, which rely on objective data and which use a common 'language' across the different sectors. The usage across a service of the same empirically validated tools to assess risk and criminogenic needs can help to achieve this, and is now becoming routine in some forensic services in Australia.

Decisions around the recommended rate of progression of leave from hospital should be both transparent and determined on a case-by-case basis, taking into account the numerous relevant clinical (and political) risk factors. Similarly, on the community side, decisions regarding readmission, whether they be due to deterioration of mental state

or a perception that supervizability has broken down to unacceptable levels, need to be clarified and operationalized in order to facilitate appropriate discussions between inpatient and community sectors as well as other key stakeholders such as the courts.

The final transition from hospital to community should be a "gradual eliding not a sudden plunge" (Mullen, 1993, p. 217) to minimize the risk of psychiatric relapse and of reoffending at time of transition. There are several ways in which this can be achieved in practice, all of which depend on a healthy interface between hospital and community-based services. Planning for release from long-term secure care should commence as soon as the more florid manifestations of acute illness have settled down, with an increasing emphasis on broader rehabilitation goals such as addressing criminogenic needs. A graduated leave program giving patients increasing levels of responsibility is a critical part of this process for two reasons. Firstly, it is well established that effective rehabilitation should involve an *in vivo* component (Abbott, 2002) and that purely institutional programs have less established efficacy (Andrews & Bonta, 2003). Secondly, it is only by gradually lessening the level of control placed around a patient's day-to-day activities that their risk levels can be adequately assessed from the hospital setting: settled behavior in an environment which is fully controlled around the clock is a poor guide to how someone may react to the vagaries of everyday life back out in the community. The maintenance of social networks is another positive effect of leave programs. The latter stages of such leave programs, particularly when the patient no longer requires an escort, provide a good opportunity for community-based mental health services to become involved in client care. This involvement can include home visits (perhaps jointly with inpatient staff) and support groups involving current inpatients and recently discharged outpatients.

Discharge planning is hence best conceptualized as a long term process (months or even years) involving collaborative working between inpatient and community sectors, with the latter gradually taking on more responsibility as discharge approaches.

Another way in which the dichotomy between hospital and community can be reduced is by means

² The much derided service 'Mission Statement' may assist in this regard.

of specific “transitional” services. These can take various forms, including 24 hour staffed units in the community, or semi-supported accommodation supplemented with intensive outreach. Such services should be reserved for those whose level of psychosocial disability warrants this (Abbott, 2002).

It is envisaged that over the coming years Australian community forensic services will grow and develop in various directions in order to better meet the needs of the community. Clearly, such development will be more effective if a *service-wide* approach is adopted at the planning stages.

Conclusion

The vision of community services as the heart of forensic mental health service delivery remains far from realization. In part this may be related to the weak evidence base for such services: in order to flourish, CFMHSs will need to empirically demonstrate their effectiveness. Australian CFMHSs demonstrate an eclectic range of service delivery, with many common facets but also multiple differences reflective of geographic, demographic and other local factors. This diversity, together with the increasing collaboration between the services, provides fertile soil for the growth of the quality research which is required to enhance community confidence in the management of mentally disordered offenders in the community. Services need to optimize service delivery models, according to local needs and resources. They also need to build bridges with mainstream and secure inpatient services to ensure that the relevant boundaries are not impermeable. Such empirically based service development and evaluation will have wide applicability, since these goals are of course shared by community forensic mental health services throughout the developed world (Ogloff, Roesch, & Eaves, 2000).

REFERENCES

- Abbott, P. (2002). Reconfiguration of the high-security hospitals: some lessons from the mental hospital retraction and reposition programme in the United Kingdom 1960-2000. *Journal of Forensic Psychiatry, 13*, 107-122.
- Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct* (3rd ed.). Cincinnati: Anderson.
- Blackburn, R. (2004). “What works” with mentally disordered offenders. *Psychology, Crime and Law, 103*, 297-308.
- Boer, D. P., Hart, S. D., Kropp, P. R., & Webster, C. D. (1997). *Manual for the Sexual Violence Risk-20*. Simon Fraser University, British Columbia.
- Gunn, J. (1977). Management of the mentally abnormal offender. *Proceedings of the Royal Society of Medicine, 70*, 877-880.
- Hare, R. D. (2003). *Psychopathy checklist revised* (2nd ed.). Toronto: Multi-Health Systems.
- Harris, A., Phenix, A., Hanson, R. K., & Thornton, D. (2003). Static-99 coding rules: revised 2003. Ottawa: Department of the Solicitor General of Canada.
- Heilbrun, K., & Peters, L. (2000). Community-based treatment programmes. In S. Hodgins & R. Müller-Isberner (Eds.), *Violence, crime and mentally disordered offenders* (pp. 193-215). Chichester: Wiley.
- Hodgins, S., & Müller-Isberner, R. (2004). Preventing crime by people with schizophrenic disorders: The role of psychiatric services. *British Journal of Psychiatry, 185*, 245-250.
- Hodgins, S. (2000). Offenders with mental disorders. In C.R. Hollin (Ed), *The essential handbook of offender assessment and treatment* (pp. 219-238). Chichester: Wiley.
- Hoge, S. K., Bonnie, R. J., Poythress, N., & Monahan, J. (1999). *The MacArthur Competence Assessment Tool-Criminal Adjudication*. Odessa, FL: Psychological Assessment Resources.
- Judge, J., Harty, M., & Fahy, T. (2004). Survey of community forensic psychiatry services in England and Wales. *Journal of Forensic Psychiatry and Psychology, 15*, 244-253.
- Kennedy, H. G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment, 8*, 433-443.
- Lamb, H., Weinberger, L., & Gross, B. (1999). Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review. *Psychiatric Services, 50*, 907-913.
- Knight, K., Simpson, D. D., & Hiller, M. L. (2002). Screening and referral for substance-abuse treatment in the criminal justice system. In C. G. Leukefeld, F. M. Tims, & D. Farabee (Eds.), *Treatment of drug offenders: policies and issues* (pp. 259-272). New York: Springer.
- Lamberti, S.J., Weisman, R., & Faden, D.I. (2004). Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. *Psychiatric Services, 55*, 1285-1293.
- Mohan, R., Slade, M., & Fahy, T.A. (2004). Clinical characteristics of community forensic mental health services. *Psychiatric Services, 55*, 1294-1298.
- Mullen, P. (1993). Care and containment in forensic psychiatry. *Criminal Behaviour and Mental Health, 3*, 212-225.
- Mullen, P.E., Briggs, S., Dalton, T., & Burt, M. (2000). Forensic mental health services in Australia. *International Journal of Law and Psychiatry, 23*, 433-452.
- Ogloff, J.R.P. & Davis, M.R. (2005). Assessing risk for violence in the Australian context: In D. Chappel & P. Wilson (Eds.), *Issues in Australian crime and criminal justice* (pp. 301-388). Chatswood: Lexis Nexis Butterworths.

- Ogloff, J. R., Roesch, R., & Eaves, D. (2000). International perspectives on forensic mental health systems. *International Journal of Law and Psychiatry*, 23, 429-431.
- Robertson, G. (1989). Treatment for offender patients: How should success be measured. *Medicine, Science and the Law*, 29, 303-307.
- Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness. *Psychiatric Services*, 50, 1614-1619.
- Snowden, P., McKenna, J., & Jasper, A. (1999). Management of conditionally discharged patients and others who present similar risks in the community: integrated or parallel? *Journal of Forensic Psychiatry*, 10, 583-596.
- Thomas, S., Harty, M. A., Parrott, J., McCrone, P., Slade, M., & Thornicroft, G. (2003). *Camberwell Assessment of Need-Forensic Version: A needs assessment for forensic mental health service users*. London: Gaskell.
- Tighe, J., Henderson, C., & Thornicroft, G. (2002). Mentally disordered offenders and models of community care provision. In A. Buchanan (Ed.), *Care of the mentally disordered offender in the community* (pp. 89-110). Oxford: Oxford University Press.
- Turner, T., & Salter, M. (2005). What is the role of a community forensic mental health team? *Psychiatric Bulletin*, 29, 352.
- Vaughan, P., Pullen, N., & Kelly, M. (2000). Services for mentally disordered offenders in community psychiatry teams. *The Journal of Forensic Psychiatry*, 11, 571-586.
- Vaughan, P. (2001). Mentally Disordered Offenders: Everyone's responsibility. *British Journal of Forensic Practice*, 3, 16-21.
- Wallace, C., Mullen, P., Burgess, P., Palmer, S., Ruschena, D., & Browne, C. (1998). Serious criminal offending and mental disorder. *British Journal of Psychiatry*, 172, 477-484.
- Warren, L. J., MacKenzie, R., Mullen, P. E., & Ogloff, J. R. P. (2005). The problem behavior model: the development of a stalkers clinic and a threateners clinic. *Behavioral Sciences & the Law*, 23, 387-397.
- Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *The HCR-20: Assessing risk for violence version two*. Simon Fraser University: British Columbia.
- Webster, C. D., Martin, M., Brink, J., Nicholls, T. L., & Middleton, C. (2004). *START: Short term assessment of risk & treatment*. British Columbia: Forensic Psychiatric Services Commission.
- Whittle, M. C., & Scally, M. D. (1998). Model of forensic psychiatric community care. *Psychiatric Bulletin*, 22, 748-750.