



**AASW**

**Australian Association  
of Social Workers**

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*Submission to the Senate Community  
Affairs References Committee*

- *Indefinite detention of people with  
cognitive and psychiatric impairment in  
Australia*

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© Australian Association of Social Workers  
National Office – Melbourne:  
Level 7, 14-20 Blackwood Street  
North Melbourne 3051  
PO Box 2008  
Royal Melbourne Hospital Vic 3050  
T: 02 6199 5000  
F: 02 6199 5099  
E: [social.policy@aaaw.asn.au](mailto:social.policy@aaaw.asn.au)  
[www.aaaw.asn.au](http://www.aaaw.asn.au)

Enquiries regarding this submission can be directed to:

**Senior Manager, Policy and Advocacy:**

**Stephen Brand**

Email: [stephen.brand@aaaw.asn.au](mailto:stephen.brand@aaaw.asn.au)

Phone: 02 6199 5016

**AASW Chief Executive Officer:**

**Glenys Wilkinson**

Email: [ceo@aaaw.asn.au](mailto:ceo@aaaw.asn.au)

## Introduction

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### Who we are

The Australian Association of Social Workers (AASW) is the professional body representing more than 9,000 social workers throughout Australia. We set the benchmark for professional education and practice in social work and have a strong voice on matters of social inclusion, social justice, human rights and issues that impact upon the quality of life of all Australians.

### The social work profession

The social work profession is committed to the pursuit of social justice, the enhancement of the quality of life, and the development of the full potential of each individual, group and community in society. Principles of social justice, human rights, collective responsibility and respect for diversity are central to the profession and are underpinned by theories of social work, social sciences, humanities and Indigenous knowledge.

Social workers work with individuals, families, groups and communities. Professional social workers consider the relationship between biological, psychological, social, cultural and spiritual factors and how they impact on a client's health, wellbeing and development. Accordingly, social workers maintain a dual focus in both assisting with and improving human wellbeing and identifying and addressing any external issues (known as systemic or structural issues) that may impact on wellbeing, such as inequality, injustice and discrimination.

### Our submission

Social workers, and particularly mental health social workers and social workers specialising in intellectual disability, work with people with significant cognitive and psychiatric impairment both as skilled counsellors and as advocates. Their role is valued within multidisciplinary teams where there is a need to understand the complex relationship between the intra-psychic and the broader social and institutional systems. Social workers routinely need to work in environments where competing rights and risks need to be balanced and negotiated. Ultimately, the AASW takes the position that a human rights framework is the appropriate framework for addressing the complex issues relating to the indefinite detention of people with cognitive and psychiatric impairments.

In April an article entitled 'Forensic Patients and Forensic Mental Health in Victoria: Legal Context, Clinical Pathways, and Practice Challenges' was published in *Australian Social Work* the professional journal of the AASW.<sup>1</sup> This article addresses many of the issues raised in the terms of reference in this inquiry particularly as they relate to the State of Victoria. The article is added as an addendum to this report and constitutes a comprehensive and readable account from a social work perspective. Consequently the body of our report will be relatively short and highlight mainly points that have wider Australian relevance. It will also largely reflect on people with psychiatric impairment.

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<sup>1</sup> O'Donahoo, J. & Simmonds, J., (2016). Forensic Patients and Forensic Mental Health in Victoria: Legal Context, Clinical Pathways, and Practice Challenges. *Australian Social Work*, Vol. 69, No. 2, 169-180.

## Response

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- 1.1 The AASW supports the least restrictive practice possible with regard to persons with serious cognitive or psychiatric impairment. The AASW recognises that restrictive practices are not confined solely to detention, but also includes physical restraint, restraint by pharmacology and social isolation in community settings. Both indefinite detention and restrictive practices are harmful to the individual and can impinge on the human rights of that individual.
- 1.2 However the AASW recognises that there are situations in which the safety of the community and the human rights of others must also be considered when making complex decisions about indefinite detention of people with serious cognitive and psychiatric impairment.
- 1.3 The AASW wishes to emphasise that there are effective treatments available for the majority of people who are at risk to others. However, there is no single strategy or intervention that makes a person safe, either short- or long-term. As the Victorian experience shows, treatment needs to progress through a variety of stages from stabilising acute mental states, intensive bio-psychosocial treatment and rehabilitation, including intensively addressing offence-related issues through to supporting community integration and maintaining a stable mental state.
- 1.4 Multidisciplinary teams are necessary to make such approaches possible, as well as clear legislative frameworks that are supportive of therapeutic work and responsive to clinician feedback.
- 1.5 The Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (CMIA) seeks to balance community safety, the rights of victims, and the rights of mentally ill offenders. This legislation highlights that the rights of one individual cannot be viewed in isolation from the rights of others. This is the complex ethical and legal environment in which social workers practice. Social justice is a cornerstone of social work practice and as such social workers often find themselves advocating for human rights. Without a respect for human rights, therapeutic work and the welfare of the individual is seriously compromised.
- 1.6 The practical involvement of social workers is well summed up by O'Donahoo and Simmonds,  
*Social workers have a unique role assisting forensic patients at systemic, organisational, and individual levels. At systemic and organisational levels, they are involved in program development and advocate for needed services where gaps are identified. They promote the rights of patients and their families within an environment where these aspects of care can be overlooked in the patient's recovery. At an individual level, social workers undertake psychosocial and family assessments, run psycho-educational and therapeutic groups, and link forensic patients and their families to support services. As a recent initiative at Thomas Embling Hospital, social workers have assumed care pathway coordination, following forensic patients across units to enhance continuity of care and provide ongoing review of their recovery plans. Social workers therefore play a crucial role in facilitating a forensic patient's transition from one part of the system to the next, as well as their eventual transition back to the community. (2016, p. 174)*
- 1.7 Underlying the practical assistance that social workers provide is a person-centred, and strengths-based approach that is foundational for maximising recovery.

## Conclusion

Indefinite detention of people with cognitive and psychiatric impairment should be regarded as a last resort where the individual poses (or is assessed as posing) an unacceptable risk to him/herself or the community. Persons who are under a regime of indefinite detention continue to have human rights. This is important as a basic principle, but also because unless basic human rights are respected it is almost impossible to engage in therapeutic work that would lead to either recovery or reintegration into the community.

While legislative reform is essential to ensure a balance between conflicting rights and to continue to safeguard the community, such reform is unlikely to achieve its intended aims unless it is integrated with adequately funded services to assist recovery and reintegration of persons who have been indefinitely detained. An essential component of these services is the social work profession as social workers ensure human rights are preserved during the therapeutic process.

Submitted for and on behalf of the Australian Association of Social Workers Ltd



**Glenys Wilkinson**  
AASW Chief Executive Officer



**AASW**

.....  
**Australian Association  
of Social Workers**

T 02 6199 5000  
F 02 6199 5009  
E [social.policy@aaaw.asn.au](mailto:social.policy@aaaw.asn.au)

**National Office – Melbourne**  
Level 7, 14-20 Blackwood Street,  
North Melbourne Vic. 3051

**Postal Address**  
PO Box 2008, Royal Melbourne Hospital, Vic, 3050

Incorporated in the ACT  
ACN 008 576 010 / ABN 93 008 576 010



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Jamie O'Donahoo & Janette Graetz Simmonds

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## Forensic Patients and Forensic Mental Health in Victoria: Legal Context, Clinical Pathways, and Practice Challenges

Jamie O'Donahoo<sup>a,b</sup>  & Janette Graetz Simmonds<sup>a</sup>

<sup>a</sup>Psychology Programs, Faculty of Education, Monash University, Clayton, Victoria, Australia; <sup>b</sup>Community Forensic Mental Health Service, Forensicare, Clifton Hill, Victoria, Australia

### ABSTRACT

Forensic mental health services in Australia have evolved and developed considerably over the past two decades. To clinicians unfamiliar with them, the contemporary practice environments in which professionals deliver specialised forensic mental health services and the legislation governing offenders with a mental illness can appear extremely complex. This article outlines the legislation applying to individuals found not guilty of a serious offence on the grounds of mental impairment in the State of Victoria, describes the characteristics of the forensic patient population, and delineates the clinical pathway forensic patients typically take, using an illustrative case example. The competencies and attributes required by forensic practitioners are highlighted, along with the clinical challenges they face, including the inherent need to address risk in a service that has become recovery-focused in orientation. A central theme of the discussion is how social workers adapt their practice within these highly regulated settings to effectively meet forensic patients' needs.

### ARTICLE HISTORY

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### KEYWORDS

Clinical Pathways; Forensic Patients; Mental Impairment; Practice Challenges; Risk; Recovery Approach

Since the 1990s forensic mental health services in Australia have undergone significant reform and growth, bringing them out of the asylum era (Mullen, Briggs, Dalton, & Burt, 2000) and elevating their status to that of their mainstream equivalents. Parallel developments have occurred in Canada, the United States and Western Europe where, on average, the number of forensic beds has doubled over the past 15–20 years (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011). The increased need for forensic mental health services has resulted from rising rates of arrest, conviction, and imprisonment (Hanley & Ross, 2013) and the use of the criminal justice system to manage problematic behaviour in individuals with serious mental illness (Jansman-Hart et al., 2011). This demand also reflects greater recognition of the complexities of responding to mental illness in the criminal justice system (Victorian Institute of Forensic Mental Health, 2009).

Accompanying systemic changes, Australian state jurisdictions have introduced reforms to legislation governing the different orders that apply to mentally ill offenders. For example, an updated mental impairment defence has been available in Victoria

**CONTACT** Jamie O'Donahoo  [Jamie.ODonahoo@monash.edu](mailto:Jamie.ODonahoo@monash.edu)

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since 1997, making a plea of not guilty to a serious offence on the grounds of insanity a more attractive one (Ogloff, 2010) and leading to consistent increases in the number of individuals on this type of legal order (see State Government of Victoria, 2012; 2013).

Notwithstanding recent reforms, notable differences remain in forensic mental health service infrastructure and delivery, and there is still significant variation in the scope of the legal provisions that apply across the states and territories in relation to the defence of mental impairment (Hanley & Ross, 2013). This article outlines the legislative framework and clinical pathway for individuals found not guilty of a serious offence on the grounds of mental impairment in the State of Victoria. It discusses the nature of services provided to forensic patients and the skills and attributes required by professionals, in particular social workers, who deliver such services. Lastly, it focuses on the unique challenges posed by forensic mental health where balancing risk and recovery now form a part of everyday practice.

### Background

The Victorian Institute of Forensic Mental Health (known as Forensicare) is the statutory agency charged with assessing and treating adults who have a mental illness and who have come into contact with the criminal justice system. The organisation manages prison, secure hospital and outpatient settings in which professionals from a range of mental health disciplines provide clinical services to mentally ill male and female offenders on various legal orders, including remandees, security patients, and individuals on Involuntary Treatment Orders. Forensicare is also responsible for the management of all forensic patients in Victoria, that is, people who have been found not guilty of an offence on the grounds of mental impairment under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (CMIA) (Victorian Institute of Forensic Mental Health, 2013a).

### The Legislative Framework Governing Forensic Patients in Victoria

It has long been recognised that a person should not be held criminally responsible if at the time of committing an offence they lacked the necessary intent due to mental illness (Victorian Law Reform Commission, 2013a). The British M'Naghten Rules are the standard test for criminal liability for mentally disordered defendants in the majority of Western jurisdictions, including Australia, where they were first articulated in the 1930s (Allnutt, Samuels, & O'Driscoll, 2007). These rules set the parameters for the so-called "insanity defence," allowing a finding of not guilty if the evidence demonstrates that a person was psychiatrically impaired when the offence was committed. The presumed corollary of a proven insanity defence is that society will take a more compassionate approach, adopting the stance that its interests are better served by treating the mental illness than by punishing the individual.

Despite these principles, prior to the introduction of the CMIA in Victoria people who had been found not guilty of an offence on the grounds of insanity were being detained on indefinite orders under the former "Governor's Pleasure" regime with little review of their cases (Victorian Law Reform Commission, 2013b). Discharge from Governor's Pleasure status involved a complex decision-making process, which relied on agreement by the State Government cabinet, and ultimate endorsement by the State Governor, that the



patient could be safely returned to the community (Ogloff, 2010). This system was overwhelmingly concerned with the danger posed by the offender, favouring the community's expectations of safety over the rights of the person being detained (Ruffles, 2010). The CMIA was designed to uphold fairness for all parties, restoring the balance between community safety, the rights of victims, and the rights of mentally ill offenders.

The defence of mental impairment, which replaced the insanity defence, is outlined in Section 20 of the CMIA (Crimes (Mental Impairment and Unfitness to be Tried) Act, 1997). Mental impairment is not defined in the Act, but the M'Naghten Rules describe it as a "disease of the mind," a definition grounded in case law (Victorian Law Reform Commission, 2013b). Mental illness, intellectual disability, and conditions such as cognitive impairment fall within the scope of the defence (Victorian Law Reform Commission, 2013b), but in Victoria serious personality disorder and psychopathy do not (Mullen & Ogloff, 2009).

Upon a finding of not guilty by reason of mental impairment, an individual detained under the CMIA is known as a "forensic patient." The court places the person on either a Custodial or Non-Custodial Supervision Order, with the Act allowing for variation to be made between these two types of orders and for revocation of orders as the court deems appropriate (Holmes, 2000). When their legal status has been finalised, forensic patients on Custodial Supervision Orders are mandated to be sent to a secure inpatient mental health facility, which in Victoria is Thomas Embling Hospital.

Unlike sentenced prisoners who are usually given a fixed term of detention, a "nominal term" must be set by the court when a Custodial Supervision Order has been imposed. For the offence of murder, the nominal term is 25 years. Cases of attempted murder usually attract a nominal term of 20 years, while lesser offences such as assault might bring five years. The intended purpose of a nominal term is to provide a safeguard against arbitrary and indefinite detention of forensic patients who no longer pose a risk to the community (Victorian Institute of Forensic Mental Health, 2013a). At present, the legislation mandates a Major Review by the court if a person remains in detention at the end of their nominal term to determine whether or not the person should still be subject to an order.

The CMIA delineates the types of leave available to forensic patients on Custodial Supervision Orders and sets out a clear decision-making process for leave applications. A decision by the Forensic Leave Panel to grant leave must have strong rehabilitative grounds. The CMIA also provides for Extended Leave, which equates to releasing a person from the Hospital to live in the community for up to 12 months (Ruffles, 2010). In granting Extended Leave, the court must be satisfied that the leave will not seriously endanger the patient or the community (s 57). A forensic patient must progress through a series of short leaves before applying to the court for Extended Leave and they must return to the court for a further grant of leave at the end of each 12-month period.

### **Forensic Patients: Population Characteristics and Clinical Pathways**

An offender's pathway through the forensic mental health system varies according to their legal status, the severity of their mental illness, the environment in which the illness can best be managed, and the availability of hospital beds. However, forensic patients on Custodial Supervision Orders tend to follow a typical trajectory. When remanded into custody, male offenders are placed in the Acute Assessment Unit at Melbourne

Assessment Prison and female offenders are held in Marrmak Unit at the Dame Phyllis Frost Centre for women. Soon after committing their Index Offence, forensic patients are usually transferred from one of these prison units to Thomas Embling Hospital for an intensive program of bio-psycho-social treatment and rehabilitation. By the time they have reached the continuing care units at the Hospital, a forensic patient's mental state will have stabilised, their level of assessed risk will be low, and they will be undertaking a graduated program of leaves in preparation for their reintegration into the community.

Forensic patients normally transition back into the community well before their nominal term has expired, with a study by Ruffles (2010) showing that only 13% who had committed murder remained in detention beyond their full term. In 2013, the average length of custodial supervision for a forensic patient was 6–8 years (Victorian Institute of Forensic Mental Health, 2013a). A decision regarding a person's fitness to return to live in the community is made by either the County Court or Supreme Court, depending on where their case was originally heard. A forensic patient can submit an application to the court for Extended Leave at any time, but applications are usually only made when the treating team supports the application. The court's decision is based on written and verbal evidence presented by a hospital psychiatrist, the allocated community psychiatrist, and case manager. Evidence of the individual's progress incorporates their current mental state, assessed risk, how they have utilised their leaves, and their participation in hospital and community-based rehabilitation activities.

Once granted Extended Leave, a forensic patient is followed up by the Community Forensic Mental Health Service. At the end of June 2013 there were seven forensic patients living in the community on Extended Leave from Thomas Embling Hospital (Victorian Institute of Forensic Mental Health, 2013b). Community-based intervention for a forensic patient is comprised of regular psychiatric treatment, medication, and review by a psychiatrist, as well as assertive follow-up and support by a case manager at the Community Forensic Mental Health Service. At that stage the focus is on supporting community reintegration and maintaining a stable mental state rather than intensively addressing offence-related issues. Community oversight of a forensic patient on Extended Leave continues until they apply to have their order varied to a Non-Custodial Supervision Order, usually after 2–3 years of involvement by the community clinic.

### **Forensic Mental Health Professionals: Competencies, Attributes, and Challenges**

As a subspecialty of mental health, the forensic sphere demands a different skill set than general psychiatry. Mullen and Ogloff (2009) emphasised that forensic practitioners must have an understanding of the association between psychotic illness and criminal offending; knowledge in risk assessment, prediction, and management; the role of substance misuse in precipitating and sustaining psychotic disorders; and know-how in tackling psychological and social deficits prevalent in individuals with schizophrenia.

Coupled with these specialised competencies, forensic mental health professionals require distinct personal attributes to effectively carry out their roles. Those employed in the prison forensic units and the forensic hospital deal with a physical environment characterised by high walls, locked doors, and keys. They must be continually aware of

security imperatives and be prepared to appropriately respond when patients are violent, especially in the acute phase of their illness. Although there might be less perceived risk to community forensic practitioners due to the relative stability of forensic patients on Extended Leave, clinicians have comparably fewer protections than their prison and inpatient counterparts. Even when the assessed risk is deemed to be low, community clinicians frequently conduct solo home visits to clients or see them alone in an interview room, sometimes out of sight or earshot of other staff. They have to be constantly aware of the environment in which they interview clients and possess a repertoire of skills to de-escalate inflammatory or potentially risky situations.

Possibly even more challenging than the practice environment itself are the ethical demands placed on forensic clinicians. On the one hand, professionals must create a therapeutic milieu for patients and clients to foster their recovery and on the other they have to directly manage risk to ensure their own safety and that of their colleagues, patients, and the broader community. For instance, at Thomas Embling Hospital a clinician who has a strong rapport with a forensic patient and is doing therapeutic work with them might have to help physically restrain that individual and place them in seclusion if they have a violent outburst or display disturbed behaviour on the unit. A practitioner at the Community Forensic Mental Health Service who is case managing a forensic patient on Extended Leave might have to give evidence in court that the client is being guarded about their mental state or medication compliance.

The inherent tensions that lie in the provision of therapeutic care to forensic patients can create ethical predicaments for clinicians, challenging the value base in which their professional training grounded them. Paramount among these ethical challenges are situations where the duty to protect the wider community necessarily overrides patient autonomy, militating against an exclusively client-centred approach to which many practitioners subscribe (Carroll, Lyall, & Forrester, 2004). In the Victorian forensic mental health system, the daily reality for clinicians is striking a balance between ethically sound care that prioritises patient needs with the often competing need for public protection (Mullen, 1993). Providing excellent clinical care with compassion is challenging when the majority of forensic patients have committed a murder or attempted murder (Ogloff, 2010). Thus, the work involves a delicate balancing act, which makes it highly demanding, but equally rewarding.

### **The Nature and Provision of Clinical Care to Forensic Patients**

Victoria's forensic mental health system has historically subscribed to a medical model in the care it provides to forensic patients. In the prison and hospital facilities, this medicalisation of care occurs within a highly regulated custodial environment where staff use their clinical expertise to diagnose problems and prescribe treatments and then attempt to move patients forward towards an understanding of the treatment and eventual compliance (Smith & Bartholomew, 2006). The functions and tasks performed by professionals within these settings have tended to follow traditional lines, the consultant psychiatrist being the clinical leader of the multidisciplinary team, responsible for making final treatment decisions and recommendations regarding a forensic patient's movement.

In addition to the consultant psychiatrist, each multidisciplinary clinical team is comprised of psychiatric nurses, a clinical or forensic psychologist, an occupational therapist,

and a social worker. In the prisons and hospital, the consultant psychiatrist and the psychologist conduct clinical assessments, formulate diagnoses, and identify psychological areas of need. Psychiatric nurses have a primary role overseeing the day-to-day care of forensic patients and preparing clinical care documents such as treatment plans and patient leave applications. In contrast, the occupational therapist designs interventions to enhance patients' daily living skills and vocational activities.

Social workers have a unique role assisting forensic patients at systemic, organisational, and individual levels. At systemic and organisational levels, they are involved in program development and advocate for needed services where gaps are identified. They promote the rights of patients and their families within an environment where these aspects of care can be overlooked in the patient's recovery. At an individual level, social workers undertake psychosocial and family assessments, run psycho-educational and therapeutic groups, and link forensic patients and their families to support services. As a recent initiative at Thomas Embling Hospital, social workers have assumed care pathway coordination, following forensic patients across units to enhance continuity of care and provide ongoing review of their recovery plans. Social workers therefore play a crucial role in facilitating a forensic patient's transition from one part of the system to the next, as well as their eventual transition back into the community.

In the community setting, the same professional groups are employed as in the prison and inpatient services, and the consultant psychiatrist is again invested with ultimate clinical decision-making responsibility. A case management model is utilised to oversee the treatment and care of forensic patients. Case managers carry a caseload of forensic patients on Extended Leave with whom they have frequent in-person and telephone contact according to need. The case managers liaise with families and community support agencies to gather collateral information regarding a forensic patient's progress. Given that forensic patients living in the community are subject to less supervision, regular and comprehensive team reviews of each patient occurs to assess their risk, ongoing compliance with treatment, and progression towards a Non-Custodial Supervision Order.

The following fictitious case example depicts a forensic patient's treatment as they enter into and move through the forensic mental health system.

*Tim is a 25 year old man who was placed in custody at the Melbourne Assessment Prison after being charged with the murder of his mother. At interview with the prison psychiatrist, Tim presented as chaotic and disorganised with florid psychotic symptomatology. Tim's presentation led to his transfer to the Acute Assessment Unit for further assessment and stabilisation of his mental state with antipsychotic medication. He was given a provisional diagnosis of Drug Induced Psychosis. Prior to his Index Offence, Tim's girlfriend had ended their relationship and Tim had moved back home with his mother. He used large amounts of cannabis and amphetamines and his behaviour became increasingly erratic. His mother had told Tim's older brother that she feared for her own safety, particularly as Tim supposedly held her responsible for the breakup of his relationship.*

*Six weeks after being detained in custody, Tim's mental state showed little improvement and he was noncompliant with antipsychotic medication. The clinical team decided to transfer him to Thomas Embling Hospital where it was thought his illness could be better treated. On the acute unit at the Hospital his mental state gradually improved on a different medication.*

*On the basis of two psychiatrists' reports, in which Tim was described as having a final diagnosis of Paranoid Schizophrenia, he was found not guilty of his mother's murder on the grounds of mental impairment and given a nominal term of 25 years. Soon thereafter he was moved to the sub-acute unit at Thomas Embling Hospital where his insight improved and he began to participate in rehabilitation programs aimed at addressing his offence, his mental illness, substance misuse, and future goals.*

*Tim spent two years on the sub-acute unit and was then transferred to the transitional rehabilitation unit participating in a program of off-campus day leaves, which allowed him to build his independent living skills. He suffered a setback when he returned a positive random drug screen for cannabis, after which he underwent additional counselling with the unit social worker regarding his illicit substance use.*

*Tim was assessed as suitable for placement on the end-stay rehabilitation unit at Thomas Embling Hospital after three years. He engaged well with staff, seeing the psychiatrist regarding his mental state and progress towards his discharge, discussing offence-related issues with the psychologist, collaborating with the occupational therapist to find employment and working with the social worker to secure housing. Once Tim had found accommodation he commenced overnight leaves and he eventually obtained part-time employment.*

*After two years Tim was granted Extended Leave to reside at his community accommodation on a full-time basis with weekly case manager contact and fortnightly sessions with the community psychiatrist. Six months into his Extended Leave, Tim had maintained a stable mental state and was engaging with his community treating team with whom he regularly discussed relapse prevention measures. Tim's community psychiatrist had advised him that he would need to demonstrate two years of sustained stability before supporting a variation of his order to a Non-Custodial Supervision Order.*

Tim's case shows how forensic patients receive prison and hospital-based clinical services over several years, followed by outpatient treatment and care for another extended period. It reflects how a patient's progression through the forensic mental health system usually follows a linear path, unless their level of assessed risk increases through, for example, drug use. While factors such as drug misuse, relapse in mental illness, and poor engagement with the treating team can create obstacles, the case shows that it is unlikely for a forensic patient to serve their full nominal term, even if they do incur setbacks on their path to recovery. At the same time, Tim still spent a lengthy period in secure detention for someone found not guilty. He had to surmount major hurdles in order to gain Extended Leave, demonstrating the need for further research to clarify the CMIA's capacity to restore fairness to mentally ill offenders.

From a social work practice perspective, the Australian studies by Green, Thorpe, and Traupmann (2005) and Sheehan (2012), reference the distinct interventions social workers would have been likely to employ at each juncture of Tim's journey. For example, when he first came into custody the prison social worker would have advocated for Tim's rights, regardless of his offence and uncertain legal status; the hospital social worker would have undertaken substance misuse work with Tim and initiated contact with his family to ensure their needs and concerns were heard; a community case manager with a social work background would have prepared psychosocial reports and given evidence in court. All these interventions would have occurred with an understanding of Tim's mental disorder and its link to his Index Offence, ongoing assessment of his risk of endangerment



to himself and others, and with a continual focus on the interagency links and resources that would help support Tim's recovery and reintegration into the community.

As pointed out by Sheehan (2015), social work practice with a mentally ill offender like Tim happens in environments where significant social control is exercised and restrictive organisational policies and legal regulations apply. Additionally, social workers face community attitudes often marked by zero tolerance for offending behaviour rather than concern for the human rights of the person with a mental illness. Thus, for the social workers involved in Tim's case, forming a working alliance with him and his family, while being mindful of professional boundaries and organisational and community expectations, would have demanded a skilled and nuanced approach. For the hospital social worker responsible for Tim's care pathway coordination, navigating the logistical difficulties of his discharge, in particular accessing forensic-friendly supports and accommodation services, would have demanded considerable effort and persistence. Finally, Tim's community case manager would have had to deftly balance the therapeutic relationship with an obligation to give candid evidence in court, where legal procedure and the statutory thresholds of the CMIA take precedence over the social welfare needs of the individual.

### The Shift to a Recovery-oriented Model of Care

In the past decade, recovery-oriented care has become the guiding feature of mental health service delivery in Western countries (Burgess, Pirkis, Coombs, & Rosen, 2010). In Australia it has been embedded in the *National Standards for Mental Health Services* (Department of Health and Ageing, 2010), while Victoria has developed a *Framework for Recovery-oriented Practice* (Department of Health, 2011) and recognised recovery in the new Mental Health Act (2014) (s 10). Emerging from the consumer movement in mental health, the concept of recovery diverges from a traditional medical approach to care in which patients are expected to comply with treatment prescribed by professional "experts," to one in which the lived experience of service users is considered central to the care they receive (Gudjonsson, Webster, & Green, 2010). Underpinned by a humanistic ethos, other core concepts of recovery are hope, self-determination, rediscovering a positive sense of personal identity, and from a professional's perspective, supporting people to re-enter society as fully included citizens (Shepherd, Boardman, & Slade, 2008).

For a number of reasons it has been suggested that a recovery approach is incompatible with treatment in a forensic mental health service. Exerting choice and control over their own treatment is inevitably difficult when someone has been involuntarily detained, while maintaining hope and independence is a significant challenge when a forensic patient spends a prolonged period in a secure treatment facility and feel they are stagnating or even going backwards (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). Further, clinical management decisions within forensic services are dictated by the need to manage risk to the public (Maden, 2007), rather than by privileging the stated choices and wishes of the patient. This systemic focus on risk means the therapeutic orientation of clinicians is more one of "confronting and challenging patients' maladaptive behaviours" (Mezey et al., 2010, p. 684), and less about affirming their personal narratives.

Despite these barriers, recovery models have been adapted to meet the needs of patients in *forensic* environments. For example, in a women's admission ward in West London,

service users and carers became actively involved in clinical reviews, while staff participated in regular reflective practice groups to better meet the women's needs. The resultant gains were a marked reduction in incidents of self-harm, violence, seclusion use, and complaints (Drennan et al., 2014). On a long-stay medium secure forensic ward in East London, recovery principles were used to maintain hope and foster growth in individuals with severe mental illness, many of whom had been institutionalised for a long period of time (Smith & Garcia, 2012). Similarly, recovery-focused group interventions were shown to be beneficial for patients in a secure forensic psychiatric hospital in Nottingham (Skinner, Heasley, Stennett, & Braham, 2014).

In 2010, the recovery philosophy was formally introduced at Forensicare. Consistent with evidence from mainstream mental health services (Crowe, Deane, Oades, Caputi, & Morland, 2006), a training program heightened staff knowledge of recovery principles. Forensic patients were involved in delivering the training across the service, incorporating case examples of patients' "recovery journeys" through the system. A central component of the training was encouraging greater collaboration between clinicians and patients in the planning and delivery of patient care. At Thomas Embling Hospital, resultant examples of recovery-oriented practice included the formation of a recovery-focused patient working party (Davey & Dempsey, 2012); the planning and cofacilitation of an educational group by patients; and on one of the acute units, inviting patients to attend part of the weekly clinical review meeting to discuss their progress with the treating team (Dempsey, 2011).

### Reconciling Risk and Recovery

Recovery and risk are complex concepts, often seen to be at odds with each other. Sawyer (2008) highlighted how clinicians in Australian mental health services have tended to prioritise pathology-laden checklists and rating scales to manage and predict risk, at the expense of taking a therapeutic stance that engages the client in an open, inquiring interaction that attempts to understand their recovery needs. Likewise, in forensic mental health traditional approaches to risk assessment, reduction, and management have prevailed, with professionals imposing restrictions on patients and monitoring their behaviour, rather than actively involving them in the development of their own risk assessment and strategies for coping with risk (Boardman & Roberts, 2014).

Deficit-focused risk assessment instruments have been the principal means of formally assessing risk at Forensicare, including the Historical-Clinical-Risk Management-20 (HCR-20-V3) tool (Douglas, Hart, Webster, & Belfrage, 2013), which is employed by clinicians in the inpatient and community settings to build a forensic patient's risk profile. However, Barker (2012) has asserted that if risk assessments are to be done in the true spirit of recovery, they must reflect both the strengths and limitations of the individual and their circumstances. As such, risk appraisals should be written collaboratively with the patient, using not only the HCR-20-V3, but other tools and interventions that provide a more rounded view of the person's skills and abilities. In this sense, the social work perspective, with its intrinsic focus on client strengths and the person in their whole environment, has a role to play at Forensicare in counterbalancing the standardised, actuarial-based approaches to risk currently favoured.



## Conclusion

In Victoria, forensic patients are subject to the terms of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, which shapes the clinical care they subsequently receive and influences their trajectory through the forensic mental health system. Tasked with providing clinical services to forensic patients, social workers and other clinicians working in various forensic environments encounter a number of challenges in their daily roles, requiring distinct personal attributes and skills. Social workers adapt their practice to advocate for forensic patients and ensure their dignity is preserved, while at the same time acknowledging the constraints imposed by the treatment settings and the courts, in which they carry out their discipline-specific interventions.

The introduction of a recovery approach at Forensicare has created additional challenges, to which the organisation and its staff have responded with a thoroughgoing commitment to the involvement of forensic patients in the planning and delivery of their own care. The focus of social work on client-oriented, strengths-based practice has been important in ensuring that recovery principles are comprehensively implemented and in providing a different outlook on the assessment of risk. The viability of a recovery approach has yet to be formally evaluated at Forensicare, but the tangible benefits might include more streamlined clinical pathways for forensic patients and their timely movement through the system.

## ORCID

Jamie O'Donahoo  <http://orcid.org/0000-0002-1309-0776>

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