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Models of Care in Forensic Mental Health Services

A review of the international and national literature

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Foreword

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (Paterson et al 2018) provides us with a blueprint to develop future service delivery. We are challenged to develop models of care which are co-produced, recovery-oriented and evidence-based and which place tāngata whai ora and their whānau at the centre of all that we do. Our shared goal is to make our forensic mental health services (FMHS) centres of excellence that are trauma informed and culturally responsive in addressing mental health and offending needs.

The number of tāngata whaiora requiring access for treatment in FMHSs has significantly increased over time; however, the size of our services has not. We recognise that now is the time to reflect and review all aspects of our FMHSs, to plan for future developments that better place tāngata whai ora and their whānau at the centre.

Forensic mental health services very often provide support and services for tāngata whaiora who are especially vulnerable, including those with very high and complex social needs, and those with multiple mental health and addiction needs. Tāngata whai ora who are Māori are alarmingly overrepresented, and the number of women accessing services is also on the rise. In addition, there has been a reduction in the prison population, and the increased demand for mental health and addiction services among this population results in even more pressure for our FMHS.

The Ministry of Health has commissioned this literature review as part of a two stage process to support future development in the Aotearoa New Zealand Forensic Mental Health Services. The other part of this work was to test the key findings from this document with tāngata whaiora, their whānau, the people who work in all parts of these services and those people who intersect with FMHS.

These two stages will then be woven into an implementation guidance document including being part of the System and Service Framework. This aspirational document will describe the current and future needs for service development, workforce development and models of care to support tāngata whaiora on their journey to achieve greater wellbeing.

We would like to acknowledge all those that contributed to this document including those psychiatrists and staff in the Aotearoa New Zealand mental health and corrections settings.

Me whakakotahi tatou ki te rapuhia i te huarahi pai mo te oranga pūmau.
We must unite in the pursuit of a better way of life.

Philip Grady
Acting Deputy Director-General, Mental Health and Addiction

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Executive summary

Forensic mental health services (FMHSs) were established in Aotearoa New Zealand in the early 1990s following the findings of the government Commission of Inquiry known as the Mason Report (1988). The five regional FMHSs (Auckland, Hamilton, Wellington, Christchurch and Dunedin) provide services in four main areas: inpatient, community, prisons and courts. Currently, each regional service follows its own model of care without an overarching framework that unifies FMHSs formally at a national level. Moreover, regional models of care often lack clear articulation (ie, they are not clearly documented) and may be divided or compartmentalised between the areas of service delivery, rather than designed holistically for all parts of the service. Consequently, service delivery and quality may vary within and between the regions, highlighting the need for a coordinated, cohesive model of care for FMHSs.

Forensic mental health services are used by the population of individuals with severe mental illness who are involved with the criminal justice system. Thus, FMHSs exist at the 'interface between the mental health and criminal justice sectors' (Ministry of Health 2010, p. 8). There are multiple pathways through which individuals may engage with an FMHS. In Aotearoa New Zealand, service users are typically referred to FMHSs via the courts or prisons due to their mental health needs or arrive in the service due to their legal status (eg, because they are unfit to stand trial, because they are not guilty by reason of insanity or under certain provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992).

This document details the findings of a set of scoping systematic literature reviews conducted to identify the national and international evidence on models of care governing adult FMHS provision. More specifically, the researchers sought to identify evidence-based best practices pertaining to models of care in the four areas identified above that broadly represent the main sectors of FMHS delivery. The researchers additionally conducted a review of regional, national, and international grey literature to examine further models of care as articulated in organisational documentation.

The researchers then used findings from these reviews to develop evidence-based summaries that the Ministry of Health can use to inform the development of a national implementation guidance document for FMHSs in Aotearoa New Zealand.

Scope and aims

The aim of this project was to conduct a review of national and international scholarly literature on models of care pertaining to the four main areas of adult FMHSs, as well as the regional, national, and international grey literature. Further objectives were:

- to identify evidence-based best practices relating to models of care for FMHSs
- to identify evidence-based best practices specifically pertaining to priority populations (Māori, Pacific peoples, and women)
- to identify relevant regional, national, and international guidelines in the grey literature (organisational documents)
- to identify how existing guidelines/models align with the evidence base
- to develop evidence-based summaries.

As 'model of care' has broad definitions and is often not discussed directly in the literature, the researchers examined research on approaches, models, frameworks, service provision and service delivery within adult FMHSs to locate discussion on models of care. Literature pertaining to non-forensic (general) and/or youth (child/adolescent) service users or practice-level forensic mental health interventions was beyond the scope of this project. As such, the researchers did not review in depth the body of literature pertaining to specific instruments, interventions or programmes used within FMHSs, including those relating to comorbidities, which may be relevant to the treatment contexts of FMHS users (eg, alcohol and other drugs (AOD)). Rather, the researchers examined the broader models of care that provide an overarching framework for the delivery of such services.

Methodology

The researchers conducted four scoping systematic reviews of the national and international literature on models of care for adult inpatient, community, prison and court FMHSs, respectively, between April and August 2019. They conducted searches using a set of predetermined keywords via several databases, namely Scopus, ScienceDirect and Google Scholar. They also obtained literature via recommendations from the Ministry of Health advisors overseeing this project. The researchers screened results first by title, then by abstract, then by full text to determine relevance to the project brief. Literature was limited to English-language works from 1990 to the present. Literature was not required to be peer-reviewed, to allow for a broader scope, though the majority of works located were peer-reviewed articles. In total, the researchers reviewed 9,701 titles, and retained 294 sources for in-depth analysis.

The researchers then conducted a fifth review of the grey (organisational) literature at the regional, national, and international levels to investigate (a) what guidelines exist concerning models of care in FMHSs and (b) how existing guidelines/models of care align with the evidence base. The researchers obtained documentation at the regional level via submissions from the regional FMHSs, and at the national and international levels via searches of relevant organisational websites and through contact with Ministry of Health advisors and international colleagues. In total, 66 additional documents were included in the grey literature review, yielding a total of 360 sources for the five reviews combined.

Review findings

Overarching findings

Therapeutic security – Forensic mental health services are typically structured according to stratified levels of therapeutic security, which must take into consideration environmental, relational, and procedural security. This is most readily apparent in the inpatient context, though considerations of therapeutic security apply to other contexts as well. Evidence suggests a need for integration of services between the various levels, to achieve continuity of care and increase service efficacy. Available regional documentation on FMHS delivery indicates alignment with this evidence, with varying degrees of implementation.

Rehabilitation – The function of FMHSs has increasingly shifted from a custodial to a rehabilitative one in recent decades, the primary outcome being community reintegration. Debate persists as to whether the key focus of rehabilitation should be alleviating mental illness or reducing (re-)offending behaviour; current best practices indicate it should be both. To address the latter, approaches such as the risk-need-responsivity (RNR) model have been developed that consider individuals' criminogenic needs. Within the organisational literature, recent shifts toward a rehabilitation focus are apparent in both health and corrections services, suggesting increasing adoption of best practices.

Recovery-oriented approaches – Contemporary FMHSs are increasingly shifting from a custodial model toward adopting recovery-oriented approaches, in keeping with international best practices, particularly in inpatient and community contexts. Recovery models (eg, the tidal model, the good lives model and Safewards) generally focus on the provision of person-centred, collaborative care to facilitate individuals' self-empowerment and self-determination. Recovery approaches are less developed for prison and court contexts, largely due to the unique nature of those environments, representing a potential area for future service development. Similar to rehabilitation, a recovery focus is apparent in the documentation provided by several of the regional services, with varying degrees of implementation.

Priority populations – Evidence suggests the importance of culturally responsive and gender-responsive services in the context of forensic mental health. Literature on the application of Māori-centred models of care is limited, in keeping with international trends relating to literature on other indigenous peoples. The most robust evidence has examined Māori inpatient and prison contexts. Perhaps ahead of the evidence base, recent organisational documentation at the regional and national levels within Aotearoa New Zealand emphasises the importance of co-designed service models that are engaged with, responsive to and equitable for Māori. Literature on Pacific peoples is even less developed, though the grey literature identifies this area as warranting future service development.

Literature pertaining to women in FMHSs has largely focused on specific intervention approaches, such as trauma-informed care, rather than broader models of care. Again, the grey literature has identified women as a priority population warranting future service development.

Individual review findings

Inpatient – In relation to service delivery approaches, the best-developed literature looks at inpatient FMHSs. This literature primarily centres around the themes of therapeutic security, rehabilitation and recovery-oriented approaches, as highlighted above. Generally, services are moving toward person-centred care that balances risk assessment and management with recovery-oriented principles. A variety of models have been used within inpatient FMHSs toward this end (though they tend to approach the issue from different ends of the spectrum). The two most prominent of these are the risk-need-responsivity model to address rehabilitative need and the good lives model to address recovery. There is limited literature on specific models of care within FMHSs to address the needs of Māori, Pacific peoples, and women.

Community – Community FMHSs provide a range of services, including consultation and liaison as well as various specialist interventions, which may be parallel to or integrated with general mental health services (GMHSs). The most robust evidence base within the literature is that for forensic intensive case management, and particularly forensic assertive community treatment, which indicates positive outcomes in reducing rates of rehospitalisation and recidivism and increasing service engagement.

Prisons – Prison FMHSs typically comprise in-reach services that collaborate with the primary mental health services provided by Ara Poutama Aotearoa Department of Corrections. Emerging evidence particularly focused on the Aotearoa New Zealand context suggests a model of care for in-reach services which comprises five key elements: screening, triage, assessment, intervention, and reintegration.

Courts – Court FMHSs internationally comprise three distinct yet overlapping roles: (a) consultation, whereby the court seeks expert advice for individual cases from psychiatrists, psychologists and/or nurses; (b) diversion, whereby FMHSs coordinate transfer of care most likely into inpatient services, but not necessarily out of the judicial system; and (c) liaison, whereby FMHSs provide complementary services (eg, screening, assessment, evaluation and coordination of care) to individuals moving through the court system, which may or may not include diversion. It is worth noting that diversion services are not currently offered in Aotearoa New Zealand.

Grey literature – Wide-ranging and somewhat disparate documentation is available at the regional, national and international levels concerning FMHS models of care. Within the existing documentation, it appears services and the FMHS sector more generally are moving – albeit with varying degrees of implementation – toward the adoption of a recovery-based approach organised according to principles of therapeutic security and recovery-oriented practice, in keeping with the best practices identified in the evidence base.

Notably, the national documentation highlights an emphasis on consultation, collaboration and engagement with te ao Māori, and the shift toward co-designed approaches in future service planning and development. Aotearoa New Zealand is a leader in this respect and has a unique opportunity to a set precedent internationally in the development of equitable, culturally responsive best practices.

Finally, trends within the international jurisdictions examined (England, Scotland, Ireland and Victoria, Australia), though specific to their local contexts, are generally in line with the evidence base and may be used as models of FMHS best practice. In the international documentation, overarching national governance structures to coordinate regional service responses, which include workforce development initiatives, provide potential solutions to regional disparity in FMHS provision.

Recommendations for models of care in Aotearoa New Zealand

Relevance of key findings

Relevance of key findings to the New Zealand setting

- The model of care should achieve equity of service delivery for Māori.
- The model of care should achieve equity of service delivery for ethnic groups specific to each region (eg, Pacific peoples).
- The model of care should achieve gender-specific equity of service delivery.
- The model of care should be proactive in focusing on early intervention and prevention strategies and interagency collaboration.
- The model of care should be collaboratively designed with all major stakeholders (eg, Māori, other relevant cultural expertise, gender-specific expertise, lived experience expertise, whānau/family expertise, inter-facing agencies such as prisons/police/courts).
- The model of care should reflect the reorganisation of FMHSs into an integrated, holistic service across the entire service user pathway (police, courts, prisons, FMHSs, community).

Therapeutic security, rehabilitation and recovery

- A national definition of the levels of therapeutic security should be developed and then consistently applied to models of care in each FMHS.
- A rationale should be provided for the inclusion (or not) of high secure facilities that exist in comparable jurisdictions.
- A holistic rehabilitation focus should be incorporated into all FMHS models of care, which combines an emphasis on mental health, addiction, criminogenic, physical, psychosocial and cultural needs.
- The FMHS model of care should include the integration of primary, secondary and personal health, including mental health and addiction needs.
- A strong recovery component should be central to the model of care in each FMHS.
- Both the rehabilitation focus and the recovery focus should reflect inclusive multidisciplinary, cultural and lived experience input.
- The model of care should incorporate a national response to tāngata whaiora with complex needs.
- All the above should be considered in the distinct models of care for the four components of FMHSs (inpatient, community, prisons and courts).

Recommendations for specific settings

Inpatient

- Although evidence exists for a number of recovery-orientated models of care in inpatient FMHSs, the national implementation of one model is suggested, to enable ongoing refinement.
- The DUNDRUM suite of measures should be introduced nationally, to assist in decision-making regarding service users' pathways through FMHSs.

Community

- Forensic mental health services should articulate either forensic assertive community treatment or forensic mental health case management as central to their models of care in the community, within a recovery-orientated paradigm.
- Forensic mental health services should articulate the nature of the consultation and liaison functions in their models of care in the community. In these community models of care, these services' integration or parallel operation with GMHSs should be clearly articulated.
- A well-resourced diversion model of care should be developed to relieve pressure from FMHSs.
- Forensic mental health services should develop clear relationships with agencies that have a preventative emphasis, to strengthen the diversion component of the model of care.

Prisons

- The STAIR prison in-reach model of care (developed in Aotearoa New Zealand) should be reviewed nationally to consider its culturally specific responsivity, gender-specific responsivity and recovery orientation.
- Once refined, this model of care should be endorsed as the prison model of care for all regional FMHSs.

Courts

- The model of care for courts should clearly articulate the core functions of assessment, consultation, diversion and liaison.
- Consideration should be given to proactive screening for mental health and addictions as a routine process in the models of care for courts.
- To increase responsivity to Māori, further consideration should be given to the use of Māori cultural assessments and provision of cultural support within the court liaison service.

Research

- Research needs to be embedded from the outset in all models of care.
- This research should be both formative (to flesh out progress in the embedding of the models of care) and summative (to consider the outcomes of the models of care).
- This research should be co-designed by all stakeholders, with an emphasis on kaupapa Māori research, given the populations FMHSs serve.

FMHSs in Aotearoa are at an exciting cross- roads. He Ara Oranga (Paterson et al 2018) challenges services to develop models of care which are co-produced, recovery-oriented, evidence-based and which place service users and their whānau at the centre. Furthermore, our health system is being transformed into a single National Health Service with a new Māori Health Authority (Ministry of Health 2021). If the findings of this literature review are endorsed alongside these changes, regional FMHSs should be able to achieve consistent service delivery and learn from the innovation of each other, in order to produce the best outcomes for those they serve.

Section 1: **Introduction and background**

Forensic mental health services (FMHSs) provide assessment and treatment to people whose mental health needs intersect with offending behaviours (when those behaviours are alleged, when they are proven or when a person is assessed at being at risk for offending). The people served by these services are among the most disadvantaged groups accessing mental health care. The clients have high and complex social needs; often have multiple mental health and addiction diagnoses, including substance dependence; come from backgrounds often characterised by high levels of deprivation and the experience of trauma; and have committed, or are at risk of committing, offences resulting in high levels of harm to others.

In Aotearoa New Zealand, forensic clients come into FMHSs via prisons, courts, police and, to a lesser extent, community services. A key source of referrals to the services is Ara Poutama Department of Corrections, particularly via the prison services. In sum, FMHSs provide inpatient treatment for offenders with severe mental illness, as well as in-reach assessment and treatment to prisoners who either do not need or are unable to access inpatient care. Forensic mental health services also assess people in the courts and follow up people transitioning from secure inpatient services into the community.

This report provides the findings of a set of five scoping systematic literature reviews conducted to identify the national and international evidence on models of care governing adult FMHS provision. The researchers sought to identify evidence-based best practices pertaining to models of care in the four areas that broadly represent the main components of FMHS delivery (inpatient, community, prisons and courts), as well as the regional, national and international guidelines articulated in the grey literature.

The researchers used findings from these reviews to develop a set of evidence-based summaries that the Ministry of Health can use to inform the development of a national implementation guidance document for FMHSs in Aotearoa New Zealand. To provide context for this report, the following sections within Section 1 offer background information, beginning with an overview of forensic mental health service users and services in Aotearoa New Zealand. This is followed by a discussion of what constitutes a 'model of care', a key premise to this report. Finally, a project brief is provided summarising the scope, aims and objectives, and methodology of the reviews.

It should be noted that the Ministry of Health commissioned this series of literature reviews three years ago; the literature search finished in 2019. Since that time, interest in models of care in FMHSs in jurisdictions similar to Aotearoa New Zealand has increased considerably. Since the conclusion of the literature search, models of care documents have been published in Ireland (National Forensic Mental Health Service 2019), the Australian Capital Territory (ACT Government 2019) and New South Wales (Dean 2020).

Even the definition of what constitutes a model of care is evolving. A recent article by Kennedy (2021) defines a model of care as detailing four components of service delivery: goals, pathways and processes, treatments, and evaluation. This definition explicitly moves away from a focus on the principles of a model of care. Yet this is the very focus of the literature reviews in this report. The intent of the focus on principles was to inform the development of a national implementation guidance document for FMHSs for Aotearoa. It is hoped that the detail of models of care for FMHSs (Kennedy 2021) will be developed through co-designed processes, which these literature reviews will inform.

Forensic psychiatry services in Aotearoa New Zealand

Forensic mental health services have the dual purpose of providing mental health care in a therapeutic environment while protecting and ensuring the safety of service users,[1] staff and the community. Services must continually negotiate the balance – or 'perceived tension' (Nicholls and Goossens 2017, p. 497) – between these two aspects, in what some refer to as the 'care versus control' debate or, in a less dichotomous view, the 'care–control continuum' (Gournay et al 2013). On the 'care' side of the continuum lies the mental health, wellbeing, safety and autonomy of the service user. On the 'control' side lies the challenge of ensuring the safety of the service user, other service users, staff and the wider community (ie, public protection) (Nicholls and Goossens 2017). Thus, key aspects of treatment and clinical decision-making within FMHSs involve assessing, mitigating and managing service users' risk to self and others, both immediate and long-term, to work toward the rehabilitation of the service user and prevention of recidivist offending if or when the service user returns to the community. While these two paradigms are often portrayed as 'being at odds with one another', as Nicholls and Goossens (2017) note, 'the two roles are in fact complementary and, arguably, unavoidable' (p. 497).

[1] Within FMHS literature and practice, various terms are used for 'service user', including 'mentally disordered offender', 'patient', 'consumer', 'client' or, in the Aotearoa New Zealand context, 'tāngata whai i te ora' or, more colloquially, 'whai ora' ('person in pursuit of wellness' in te reo Māori). Within the context of this review, 'service user' implies an individual receiving treatment within an inpatient forensic mental health facility. The circumstances of this treatment vary due to the wide-ranging nature of offending and the various legal pathways through which individuals are placed in inpatient units; typically, individuals are subject to compulsive or mandatory treatment within the legal and clinical frameworks governing care.

Within Aotearoa New Zealand, the origins of the current FMHS configuration stem from the recommendations of the government Commission of Inquiry known as the Mason Report (1988), which provided the blueprint for the development of FMHSs (Evans 2010, p. 369). Within these recommendations were a set of six principles to guide service delivery, as follows.

- 'Mentally ill offenders have the right to the same access to mental health assessment and treatment as non-offenders'.
- 'The health care system, not the corrections system, has the primary responsibility of mentally ill offenders'.
- 'The system needs to develop a wide range of components to be able to identify mentally ill offenders at any stage in the justice system'.
- 'Cultural understanding is an essential requirement – and it is constitutionally mandated in New Zealand'.
- 'Integration of many perspectives is required in the clinical care of patients, including psychiatry, psychology, social work, occupational therapy, spiritual understanding, education, and recreations'.
- 'Security and therapy must be integrated' (Simpson and Chaplow 2001, para. 2–5; see also Evans 2010).

The Mason Report further recommended the establishment of the five regional forensic psychiatric services currently operating in Auckland, Hamilton, Wellington, Christchurch and Dunedin,[2] which were to comprise of: '(a) a medium and a minimum security psychiatric unit; (b) a prison liaison service; (c) a court liaison service; (d) a community forensic psychiatry service, and (e) a consultation-liaison service to general psychiatric services' (Brinded 2000, p. 458). This structure has persisted with little change, informed by the principles above. However, some of the recommended principles have taken more time to be applied in practice, namely the development of culturally responsive (ie, kaupapa Māori) services.[3]

In Aotearoa New Zealand, a national high secure ('maximum secure') unit established at Lake Alice Hospital near Wanganui opened in 1965 and closed in 1999.[4] At the time of its closure, residents were transferred to regional medium secure facilities, ideally in those regions from which they came. It has been noted in Aotearoa New Zealand and in comparable jurisdictions that in terms of the use of restrictive practices, FMHS users experience higher rates, longer duration and greater frequency per person in comparison with users of other specialty mental health services (**Australian Institute of Health and Wellbeing 2020**; Ministry of Health 2017). The extent to which a discrete group of service users account for this variation and might require a high secure response has yet to be explored.

[2] Auckland Regional Forensic Psychiatry Services, Midland Regional Forensic Psychiatry Services (Puawai), Central Regional Forensic and Rehabilitation Services (Te Korowai Whāriki), Canterbury Regional Psychiatric Services and Southern Regional Forensic Mental Health Services.

[3] The development of formalised kaupapa Māori services did not start in earnest until the late 1990s, and began operating in inpatient FMHSs in 2006. Gaps in service provision within the forensic pathway and between the regions persist (Sweetman 2017).

[4] See the Lake Alice Hospital Website: **www.lakealicehospital.com/history.html** (accessed 11 October 2021).

Below, a brief overview of the forensic service user population is provided, followed by an indication of the typical structure of service delivery in each of the four main areas of FMHSs (inpatient, community, prisons and courts). It is important to note that, at present, each regional service follows its own model of care; there is no overarching framework that unifies FMHSs formally at a national level. Consequently, service provision, in practice, may vary from region to region – and the variations are not sufficiently described in the literature. As Skipworth and Lindqvist (2007) explain, FMHSs in Aotearoa New Zealand:

> exist at the interface between general mental health services and the criminal justice system, the boundaries between which are sufficiently indistinct to create a multitude of definitions as to who constitutes a forensic mental health patient as opposed to a general mental health patient, who should be providing services to these patients, and under what paradigms of care. Clarity is not assisted by the disparate approaches taken in different jurisdictions. In New Zealand, the Ministry of Health defines forensic services as 'mental health services delivered by a multidisciplinary team to mentally ill offenders, alleged offenders, or those who pose a high risk of offending.' (pp. 470–471)

As such, the following descriptions present a necessarily incomplete view of service provision, though they indicate trends within FMHSs.

The forensic service user population

Forensic mental health services are used by the population of individuals with severe mental illness who are involved with the criminal justice system, sometimes referred to in the literature as 'mentally disordered offenders'. In this way, FMHSs exist at the 'interface between the mental health and criminal justice sectors' (Ministry of Health 2010a, p. 8). There are multiple pathways through which individuals may engage with FMHSs. In Aotearoa New Zealand, service users are typically referred to FMHSs via court liaison or prison in-reach services due to their mental health needs or arrive in an FMHS due to their legal status (eg, they are unfit to stand trial, they are not guilty by reason of insanity or they are referred under certain provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992).

In terms of the adult inpatient service user population, the Ministry has not conducted a national census of FMHSs since 2005 (Ministry of Health 2007).[5] However, two stages of data collected by the Ministry (in 2008 and again in 2019) reveal a significant increase in the numbers of people supported by the five regional FMHSs support. In 2008, the services assessed and/or treated a total of 3,820 people; in 2019, this number had ballooned to 6,517 people. In addition, there were 4,409 episodes of care in 2008 compared with 7,580 in 2019. This increase is reflected by increased community contacts, as well as demand for court reports and prison in-reach services.

[5] See the Ministry of Health's (2010) review of forensic services for more detailed discussion of the specific subpopulations of FMHS users, including Māori, Pacific peoples, youth, women, people with AOD disorders, people with personality disorders and people with intellectual disabilities.

An equivalent increase has not been seen in access to inpatient treatment and, from there, step-down (community-based intensive recovery service) beds. These figures have remained relatively flat given the limited increase in beds and access to step-down beds.

Despite the significant increase in the forensic population, with further increases expected, the number of forensic beds increased very minimally over the same period. Since 2000, an additional 13 beds have been purchased for the Auckland Regional Forensic Psychiatry Services (the Mason Clinic) (five of which are located in the Central region).[6] Table 1 illustrates this widening discrepancy, using the prison muster as a baseline.

Table 1: Inpatient and step-down forensic beds by region, against changes in prison muster

Region	Beds 2013	Prison muster 2013	Prisoner to bed ratio 2013	Beds 2019	Prison muster 2019	Prisoner to bed ratio 2019[7]
Northern	103	2,323	22.5	111	3,914	35.3
Midlands	63[8]	1,837	29.2	63	2,171	34.5
Central	64	2,328	36.4	64	3,042	47.5
Canterbury	37[9]	1,118	30.2	37	1,946	52.6
Southern	13	547	42.1	13	691 (at least)[10]	53.1

The average age of people receiving assessment and treatment within FMHSs is 35. Regarding ethnic make-up, as a whole, Māori comprise roughly half of the prison population as well as the population of FMHS users (Mason Clinic 2011), though they comprise only 14.9 percent of the population (Statistics New Zealand 2013). Māori are thus substantially overrepresented in the forensic population and constitute a priority population for service development and intervention. Of the remaining portion of service users, Pacific peoples are notably overrepresented. The figures in this respect vary, however; the Ministry of Health reported in 2007 that Pacific peoples comprised 8–11 percent of FMHS users (Ministry of Health 2007) and the Mason Clinic reported this figure at 15 percent in 2011 (Mason Clinic 2011). Regional documentation indicates the distribution of Māori and Pacific peoples is most heavily concentrated in the North Island regional forensic psychiatry services (Auckland, Midland and Central), reflecting the general distribution of the Māori and Pacific populations within Aotearoa

6 The five beds for the Mason Clinic were taken out of the existing supply at the Porirua Campus. This was offset by an additional five beds being made available for forensic patients with long-term treatment needs at Stanford House in Wanganui, leaving the bed change in the Central region unchanged.

7 These figures do not include the additional 279 beds dispersed across the prison network via double bunking.

8 Includes district health board beds and 15 step-down beds run by non-governmental agencies.

9 Thirty-eight beds are funded, but this includes one seclusion bed which is rarely used.

10 The muster for 2018 was 691. It is unlikely, given data for the past five years, demonstrating a steady increase, that the muster fell between 2018 and 2019.

New Zealand. Especially noteworthy is the increase of FMHS clients who identify as Māori over time. According to recent Ministry of Health data, while Māori accounted for 41 percent of the FMHS client population in 2008, by 2019 this had increased to 49 percent. The Pasifika population has remained relatively unchanged, at 8 percent in 2008 and 9 percent 2019.

In terms of gender distribution, in keeping with the wider prison population, the majority of FMHS users are men. Indeed, Ministry of Health data shows that male clients significantly outnumber female clients (73.9 percent compared with 16.1 percent in 2019). Female Ara Poutama clients and female FMHS clients are an especially vulnerable population; they experience higher levels of all types of mental illness, including co-morbidity of severe mental illnesses such as post-traumatic stress disorder (PTSD), psychotic disorders and major mood disorders (Collier and Friedman 2016). As women are more likely to experience a mental health issue (75 percent, compared to 61 percent: Indig et al 2016), a greater portion of the female justice-involved population requires FMHSs than their male counterparts (McIntosh 2011; Indig et al 2016). Women experience significant mental health burdens, especially as they relate to trauma; for example, a recent study found 40 percent of female prisoners had met the criteria for PTSD in the prior 12 months (Indig et al 2016). It is also important to highlight here that the population of Māori female FMHS users is overrepresented to a much greater degree than the broader populations of Māori (both men and women) or women (all ethnicities) alone. For example, according to 2014 figures, Māori women comprised roughly 60–65 percent of the adult female prisoner population and up to 90 percent of the equivalent youth age group (16–22 years), where the Māori male population comprised approximately 50 percent of those groups respectively (Sweetman 2017). For these reasons, women comprise a second priority population within FMHSs for service development and intervention.

Regarding the clinical characteristics of FMHS inpatient service users, the 2005 census only recorded primary diagnoses. Schizophrenia was the most common diagnosis among inpatients (71 percent) and community FMHS users (73 percent; Ministry of Health 2007, p. 16). Some indication of the extent of mental health comorbidity can be gleaned from prevalence studies of prisoners (a pivotal catchment population for FMHSs). In a 2016 prevalence study of prisoners in Aotearoa New Zealand, 87 percent of prisoners had a lifetime prevalence of any substance use disorder, and 47 percent over the prior 12 months (Indig et al 2016, p. 23), while 33 percent of the same population had a personality disorder (Indig et al 2016, p. 51). Approximately one in eight (13 percent) reported at least one symptom of psychosis over their lifetime; there was little difference by gender in prevalence (Indig et al 2016). It is important to note that some FMHS users may have high and complex needs, including AOD comorbidity and/or personality disorder diagnoses, which may present additional challenges.

The complexity of the mental health needs of this population is further complicated by rates of 'brain and behaviour issues'. Although the particulars in the FMHS context are poorly articulated, it is conservatively estimated that 10 percent of the New Zealand prison population (the catchment population for FMHSs) has moderate to severe traumatic brain injury. Furthermore, there is an overrepresentation among the prison population of people with foetal alcohol spectrum disorder, cognitive impairment/ intellectual disability, communication disorders, attention-deficit/hyperactivity disorder, learning difficulties, dyslexia and autism spectrum disorder (Lambie 2020).

With reference to the index offence in the 2005 census, violent offences were the most common category for 59 percent of inpatient service users, followed by sexual offences, for 9 percent (Ministry of Health 2007, p. 12). More recent statistics indicate the legal status of inpatient FMHS users. During 2017, there were 378 people with special patient status in FMHS inpatient services, making up the overwhelming majority of service users. Of these, 139 were detained for lengthy periods having been found not guilty by reason of insanity, unfit to stand trial under the Criminal Procedure (Mentally Impaired Persons) Act 2003 or detained as restricted patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. A further 254 special patients were transferred to FMHSs from prison for compulsory mental health assessment and treatment (Ministry of Health 2019a, p. 58).

With the current pressure on demand with limited increase in resources and capacity, FMHSs have prioritised and continue to prioritise the treatment of those with psychotic disorders. Data collected from the Health of the Nation Outcome Scale (HONOS)[11] over a 12-month period (2017–2018) indicate that 80–90 percent of people treated in prison and forensic inpatient units have a primary diagnosis of a psychotic disorder,[12] a fact supported by anecdotal evidence provided by FMHSs across Aotearoa New Zealand. In addition, prison in-reach programmes prioritise medication-based treatment, and only small numbers of people with other presentations or broader treatment needs (such as psychological therapies) are currently able to access these services.

The above data demonstrates the exemplary work that FMHSs are doing in the attempt to meet the needs of people referred to FMHSs. The data also clearly reflects, however, the growing demand, unmet needs and increased inequities faced by the group of FMHS users.

The ensuing chapters describe international and national models of care for forensic services, making a series of recommendations for best practice. Each recommendation strives to keep the needs of the services users and their whānau and their journey toward wellness front of mind.

Achieving equity

Fair and just societies aspire to equality of status, rights and opportunities for all people regardless of their gender, age, ethnicity or sexual orientation. Historic access to power has privileged certain social groups to the devastating detriment of others. This privilege is perpetuated in contemporary society and is starkly reflected in health status (Ministry of Health 2018a).

[11] District health boards collect HONOS data. The data set is incomplete in that approximately one-third of the data has been collected without a recorded diagnosis (ie, a rating of 'diagnosis deferred').

[12] These disorders include schizophrenia, bipolar mood disorder with psychosis, schizoaffective disorder, psychotic disorder not otherwise specified and delusional disorder.

An aim to achieve equity strives to correct such imbalances ethically. It recognises that in Aotearoa New Zealand, 'people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage may require different approaches and resources to get [equal] outcomes' (Ministry of Health 2018a, p. 5).

Inequality manifests in FMHSs both regionally and nationally in the gross overrepresentation of Māori and Pacific peoples, and in the needs of a burgeoning number of female service users. Therefore, achieving equity is a recurring theme in the projected models of care for these services.

Inpatient services

Inpatient FMHSs generally follow what Kennedy et al (forthcoming) refer to as the 'standard model', in which units are organised by 'the step-wise stratification of levels of physical, relational and procedural security from admission and intensive care high security, through medium security to slow stream medium or low security or onwards to low and minimal secure pre-discharge units' (p. 6; see also Skipworth and Lindqvist 2007). These levels of unit are typically termed acute, subacute/pre-rehabilitative, and rehabilitative or hostel. However, as Gournay et al (2013) note, definitions of high, medium and low security vary between institutions, and service definitions lack the clarity required to assist clinicians to provide the best service delivery.

Generally, the clinical mandate is to provide care in the least restrictive environment possible, in keeping with broader international best practices on the reduction of restrictive interventions in mental health services. Over the past decade, emphasis has also been placed within FMHSs on shortening the duration of inpatient treatment (where clinically appropriate), so service users can be reintegrated to the community faster and more effectively and, thus, avoid the detrimental impacts of long-term institutionalisation. As Skipworth and Lindqvist (2007) explain:

> the rules of an institution are vastly different from those that will face the patient out in the community. An institution is liable to foster dependency and passivity, and patients commonly lose social skills soon after admission unless the staff are vigilant in counteracting this. (p. 479)

As such, ensuring service users are equipped with the requisite skills to succeed in the 'real world' after their discharge is an increasing component of care (Skipworth and Lindqvist 2007).

Forensic mental health services in Aotearoa New Zealand use varying models of care. These have not been well articulated in the literature, and organisational documentation is inconsistent between regions. One noted exception is the Māori model of care used within Te Papakāinga o Tāne Whakapiripiri, the first kaupapa Māori unit at the Mason Clinic (Auckland Regional Forensic Psychiatry Services), which has been described by Tapsell (2007) and Sweetman (2017).[13]

[13] See Section 2: Inpatient review for a description of this model.

Community services

Community FMHSs have two main roles:

> (a) to ensure appropriate hand over of individuals to general psychiatry community assertive teams, to support general psychiatric services in the ongoing management of these people, and to provide consultation and liaison services as appropriate; (b) to provide direct clinical management for a small group of individuals, mainly those designated as special and restricted patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. (Ministry of Health 2001, as cited in Skipworth and Lindqvist 2007, p. 479)

Skipworth and Lindqvist (2007) describe three models used for community FMHS provision in Aotearoa New Zealand: (a) outpatient services run by forensic mental health teams, (b) general mental health assertive community teams receiving discharges from FMHSs and (c) collaborative models, with FMHS staff working within general mental health community teams. While services vary between regions, the dominant model is to provide follow-up for most service users after their release from FMH inpatient units or prison via referrals triaged through general mental health assertive community teams, which are closely connected to forensic psychiatrists, who engage in joint discharge planning and follow-up meetings (Skipworth and Humberstone 2002). However, 'some patients, by virtue of legal status or other risk factors, remain under the FMHS, which adopts a similar community treatment philosophy of ACT [assertive community treatment]' (Skipworth and Humberstone 2002, p. 49). Brinded (2000) further explains:

> Most forensic psychiatric services operate a 'parallel' outpatient and community service for patients who have been deemed still too unwell to pass back to general mental health services or whose history of illness and potential for violence is such that it is felt best that forensic psychiatric services continue to follow them up in the community long-term. (p. 459)

Notably, the majority of forensic mental health service users ultimately return to general mental health services (GMHSs) for long-term follow-up once this is deemed clinically appropriate (Brinded 2000; Skipworth and Humberstone 2002). Blackburn (2004) notes, however, 'while the ideal is a "seamless" service of rehabilitation from high security to autonomous community functioning, significant gaps in these services remain' (p. 299). Services may be further hindered by 'the legislative landscape and clinical policy' that 'at times creates unnecessary obstacles' (Skipworth and Humberstone 2002, p. 47).

Prison in-reach services

Prison FMHSs follow a 'culturally informed assertive prison in-reach mental health model' (Cavney and Hatters Friedman 2018, p. 227) that connects prisons and FMHSs. At present, screening is conducted within the prison by 'prison healthcare staff who then refer on to a forensic prison in-reach mental health team' as required (Cavney and Hatters Friedman 2018, p. 226).[14] Following recent recommendations, referrals to forensic prison teams may come from a number of sources, including family, friends, and prison or court liaison staff, and thus do not rely on prison screening mechanisms alone (Cavney and Hatters Friedman 2018; Pillai et al 2016).

In keeping with the other arms of FMHS, service provision within prisons varies between regions in terms of scope, size and capacity. In most cases, the forensic mental health prison in-reach team is a multidisciplinary team consisting of 'psychiatrists, psychologists, nurses, social workers, and importantly, cultural advisers who then undertake a staged process of assessment following an initial referral' (Cavney and Hatters Friedman 2018, p. 226). The implementation of Māori-focused services in particular sets apart the model of care currently employed in the Aotearoa New Zealand context from other international models of in-reach services and is a notable point of difference.

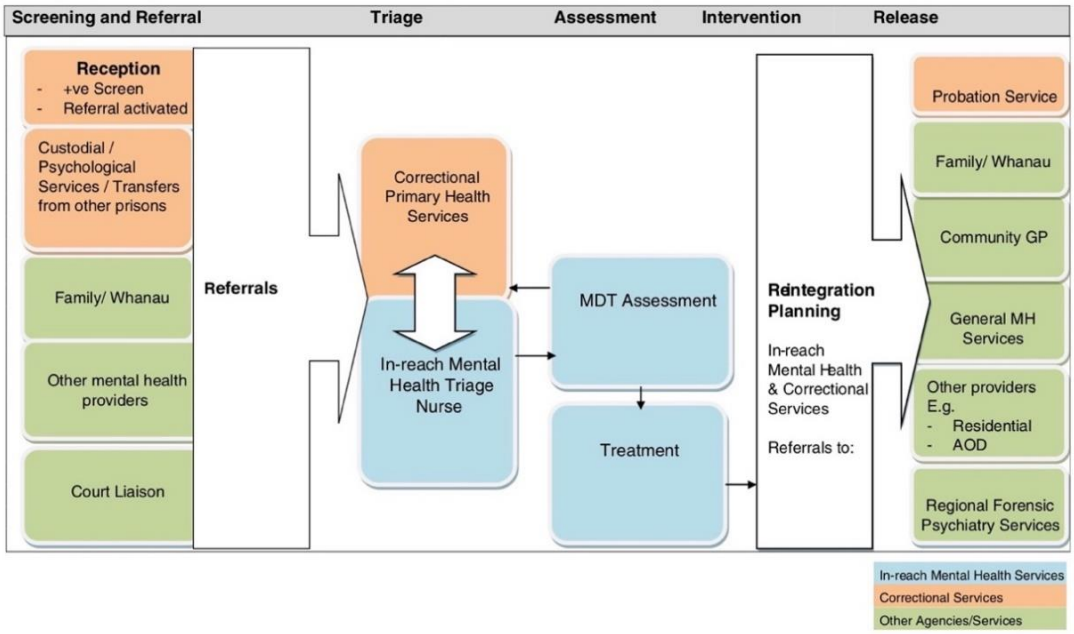
Upon completion of the initial stages, where clinically indicated, prisoners are further assessed and treated as required. This may occur within the prison or, in acute and/or severe cases, involve the transfer to a forensic mental health hospital, where the person may stay until he/she is well enough to return to prison or, should circumstances permit, the community. However, prisoners often experience wait times to transfer to a forensic bed due to availability, during which time they may remain untreated. Prior to release/discharge, planning occurs to support the transition/reintegration phase and, if ongoing care is needed, community GMHSs are engaged, along with other social agencies and services, which may provide various avenues of support (Cavney and Hatters Friedman 2018). As in inpatient FMHSs, a small population of service users may stay with FMHSs (as opposed to GMHSs) for ongoing monitoring after their release from prison, if this is warranted.

Recently, two regional forensic psychiatric services in Aotearoa New Zealand have developed a prison model of care based upon 'a multi-disciplinary "modified" assertive community treatment model with after-hours on-call emergency support', which follows the principles of 'assertive engagement, continuity of care, multi-disciplinary service delivery and a small case load' (McKenna et al 2015, p. 286; see also McKenna et al 2018; Pillai et al 2016). Within this model and in keeping with the broader literature, five key elements are highlighted as the essential requirements of in-reach

[14] See also Brinded and Evans (2007) for a more detailed description of the structure of prison mental health service delivery in the regions. Brinded and Evans describe this slightly differently. They say five regional forensic services have multidisciplinary teams based within community forensic mental health services providing mental health care in prisons. For the four regional services outside of Auckland, prisoners are seen in both nurse and psychiatrist-led prison clinics. Only Auckland has a separate "prison team" that provides assessment/treatment services in regional prisons, with attached forensic psychiatrists working solely in this capacity as opposed to having additional or primary inpatient or outpatient treatment roles (p. 435).

service provision: (a) screening, (b) triage, (c) assessment, (d) intervention and (e) reintegration (STAIR) (Forrester et al 2018; McKenna et al 2015; Nicholls et al 2018; Ogloff 2002). Figure 1 presents an illustration of the Aotearoa New Zealand prison model of care.[15]

Figure 1: The prison model of care referral and treatment pathway



Source: Pillai et al 2016, p. 3

Court liaison services

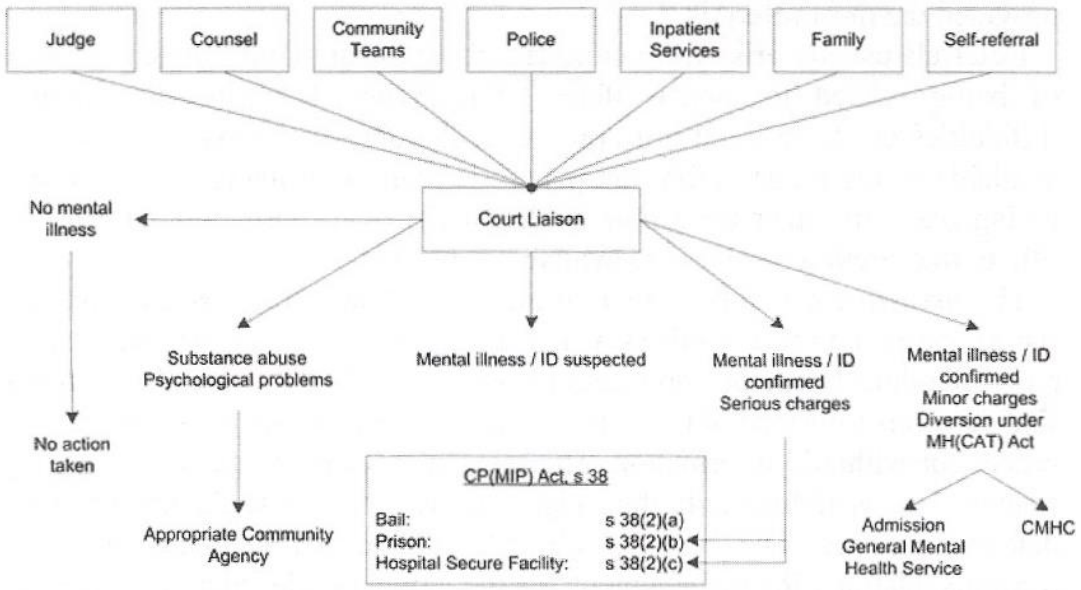
In Aotearoa New Zealand, the first court liaison scheme began in the Otahuhu Court in South Auckland in 1987, following which court liaison services developed alongside broader FMHSs, according to the recommendations of the Mason Report (1988; Brinded et al 1996; McKenna and Seaton 2007). Each of the five regional FMHSs provides liaison services to all courts in each region. These services occupy three distinct yet overlapping roles: (a) consultation, where the court seeks expert advice for individual cases from psychiatrists, psychologists and/or nurses; (b) diversion, where FMHSs coordinate transfer of care, most likely into inpatient services, but not necessarily out of the judicial system; and (c) liaison, where FMHSs provide complementary services (eg, screening, assessment, evaluation and coordination of care) to individuals moving through the court system, which may or may not include diversion.

[15] See Section 4: Prison review for further description of this model.

In terms of service delivery, as in the other arms of FMHSs, regional variation occurs. Typically, mental health nurses are deployed in court during sittings and act in an advisory role to help legal stakeholders to discern individuals' mental health status and needs (McKenna and Seaton 2007). There are multiple referral pathways to engage court liaison services (eg, police, lawyers, judges, the probation service, GMHSs, family and self-referral), following which a mental health nurse may conduct initial interviews (ie, screenings) (Brinded 2000; McKenna and Seaton 2007). Of those interviewed, a portion may require full psychiatric assessment by a forensic psychiatrist, the results of which are reported to the courts with accompanying recommendations to aid in judicial decision-making; the clinical team does not hold decision-making power.

Depending on the severity of the charges, the mental health status of the person concerned and other legal considerations, subsequent service coordination then ensues as required with GMHSs, prison mental health services or inpatient FMHSs (Barnes 1997; Brinded 2000; Brinded et al 1996; McKenna and Seaton 2007).[16] (See Figure 2 for an illustration of this model.) In a process similar to that in community FMHSs, 'the majority of patients who come into contact with forensic psychiatric services through the courts … are ultimately passed back to general mental health service care when it is felt clinically appropriate' (Brinded 2000, p. 459). Ongoing assessment and reporting by forensic psychiatrists and psychologists to the courts may occur throughout the service user's involvement with the criminal justice system, from initial engagement through to diversion/sentencing and release/probation.

Figure 2: Aotearoa New Zealand court liaison service model



Key

CP(MIP) Act	Criminal Procedure (Mentally Impaired Persons) Act 2003
MH(CAT) Act	Mental Health (Compulsory Assessment and Treatment) Act 1992
ID	Intellectual Disability
CMHC	Community Mental Health Centre

Source: McKenna and Seaton 2007, p. 458

[16] See McKenna and Seaton (2007) for a more detailed description of the court liaison process.

Defining 'model of care'

A model of care is an overarching framework used in service planning to guide service provision. In other words:

> a Model of Care broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place. (Agency for Clinical Innovation for New South Wales 2013, as cited in Kennedy et al forthcoming, p. 2)

However, there is no widely accepted definition for 'model of care', and consensus is lacking on what constitutes a model of care in FMHSs (Kennedy et al forthcoming). Moreover, 'models of care are seldom defined with sufficient clarity so that the goals can be specified and measured over time' (Kennedy et al forthcoming, p. 2). As such, models of care vary widely between organisations, regions and jurisdictions in terms of: (a) scope, content and level of detail; (b) how they are articulated; and (c) how they are implemented.

Kennedy et al (forthcoming) provide the only in-depth discussion of the concept of a forensic mental health 'model of care'. Generally, Kennedy et al recommend that such a model should consider therapeutic safety and security and integrate pathways through forensic mental health care and treatment wherever possible to achieve continuity of care. As Kennedy et al explain:

> the key elements of a model of care for a forensic mental health service can be summarised as a means of identifying those in the criminal justice system who have unmet needs for care and treatment for severe mental disorders, allocating patients to an appropriate and proportionate level of therapeutic security and ensuring that patients can progress along a stratified pathway to the least restrictive level of support needed for stability and dignity, and the delivery of a system of treatment that will reduce violence proneness and enhance the four forms of recovery – personal recovery, symptomatic recovery, functional recovery and forensic recovery. (p. 17)

This includes identifying the key points of intersection between services. The model of care should further be 'formulated in such a way that it can be rigorously compared with alternatives, including the current model' (p. 2). It should set clear, specific and measurable objectives (ie, key performance indicators) and detail how its goals will be achieved within a defined timeframe. This explanation 'should be sufficient to enable operational policies and design briefs to be largely determined by it, without having to introduce substantial new aspects of practice and process' (p. 3). Finally, measurement and reporting of outcomes should be conducted to facilitate 'continuous improvement in the effectiveness of the service' (p. 3).

Project brief

The aim of this project was to conduct a review of national and international scholarly literature on models of care pertaining to the four main areas of FMHSs (inpatient, community, prisons and courts), as well as the regional, national and international grey literature. The Ministry of Health tasked the researchers with identifying evidence-based best practices in the literature to generate high-level guidance that the Ministry may use to inform the development of a national implementation guidance document for FMHSs. This process involved a focus on priority populations among FMHS users, particularly Māori, Pacific peoples and women.

The researchers first conducted four scoping systematic literature reviews on models of care for adult inpatient, community, prison and court FMHSs, respectively, between April and August 2019. As 'model of care' has broad definitions and is often not discussed directly, the researchers examined the broader literature on approaches, models, frameworks, service provision and service delivery within adult FMHSs to locate discussion on models of care. The documents reviewed thus represent a large sampling of the forensic mental health literature. It is important to note here that a large proportion of the publications reviewed were produced by larger FMHSs, and therefore may not have reflected regional variations and imperatives or, in the case of international publications, the unique context of service provision in Aotearoa New Zealand.

The researchers conducted searches using a set of predetermined keywords via several databases, namely Scopus, ScienceDirect and Google Scholar.[17] They also obtained literature via recommendations from the Ministry of Health advisors overseeing this project. The researchers screened results first by title, then by abstract, then by full text to determine relevance to the project brief. Literature was limited to English-language works from 1990 to the present. Literature was not required to be peer-reviewed, to allow for a broader scope, though the majority of works located were peer-reviewed articles.

Within the search results, according to the project aims, the researchers restricted the literature to works concerning the adult population of FMHS users. As such, they excluded literature pertaining to non-forensic service users (ie, users of GMHSs, including AOD services) or children/adolescents (ie, users of forensic or non-forensic youth services). Further, the researchers excluded literature focusing on specific interventions, instruments or programmes used in the assessment and treatment of adult FMHS users, including those relating to comorbidities, which may be relevant to the treatment contexts of FMHS users (eg, AOD).

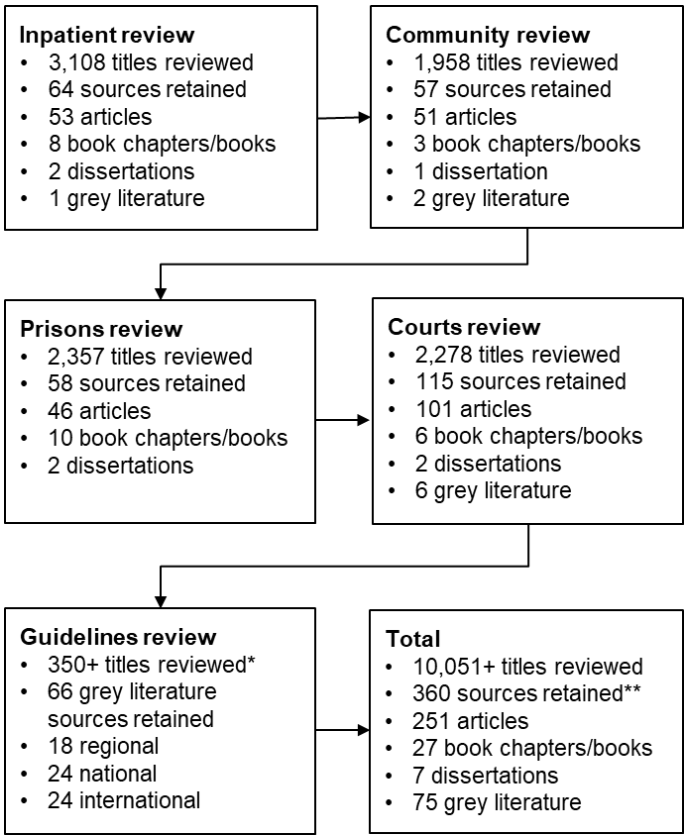
In terms of research methodologies, the literature represented a broad cross-section of qualitative and quantitative approaches; case studies were the dominant method used. Methodology was not a criterion in determining relevance to the project brief. Rather, the researchers focused on content pertaining to models of care. In total, the researchers reviewed 9,701 titles; they retained 294 sources for in-depth analysis (see Figure 3).

[17] Specific search terms and results are presented in the Methodology section of each review.

The researchers then conducted a fifth review of the grey (organisational) literature at the regional, national and international levels to investigate (a) what guidelines exist concerning models of care in FMHSs and (b) how existing guidelines/models of care align with the evidence base. To obtain regional documentation, a Ministry of Health liaison contacted the five regional FMHSs to request service documentation pertaining to models of care. Grey literature was obtained at the national and international levels via searches of relevant organisational websites and through contact with Ministry of Health advisors and international colleagues. In total, 61 additional documents were included in the grey literature review.

The remainder of this report provides the detailed findings of each of the five literature reviews (inpatient, community, prisons, courts and guidelines), followed by a set of evidence-based summaries which may be used to inform the creation of a national framework for FMHS in Aotearoa New Zealand.

Figure 3: Summary of literature review results



* Due to the nature of the websites reviewed, an exact figure cannot be provided.

** Total sources retained may be marginally less than reported, as repetition between the first four reviews was not removed from these figures.

Section 2:
Inpatient review

Introduction

Both internationally and within Aotearoa New Zealand, following the widespread deinstitutionalisation of mental health services between the 1960s and the 1990s), the function of contemporary inpatient FMHSs has increasingly shifted from a custodial (control) function to a rehabilitative (care/treatment) function, evolving alongside psychiatric practices more generally toward a recovery-oriented approach (Barnao and Ward 2015; McKenna et al 2014c; Nicholls and Goossens 2017; Skipworth and Lindqvist 2007). A key facet of this shift is an increase in emphasis on person-centred care, which 'acknowledges the unique needs, concerns, and preferences of the individual and is inclusive of the family and other carers' (McKenna et al 2014c, p. 226). Indeed, the majority of the available literature on approaches to care in inpatient services internationally highlights models that follow the tenets of person-centred care or recovery-oriented approaches to rehabilitation, such as the good lives and Safewards models (see below).

While substantial research has been conducted on assessment and treatment, interventions, and outcomes among the forensic inpatient population in Aotearoa New Zealand,[18] little research has been conducted that explicitly describes or assesses models of care within inpatient services specifically, with the exception of Tapsell (2007) and Sweetman (2017), who detail the Māori model of care used in Te Papakāinga o Tāne Whakapiripiri, the first kaupapa Māori unit at the Mason Clinic (Auckland Regional Forensic Psychiatry Services). The same trend holds true in Australia and internationally: a 'significant research gap' has been identified concerning hospital-based forensic mental health models of care (Khan et al 2018, p. 330). Moreover, as Gournay et al (2013) avow, 'there is a scarcity of evidence regarding the effectiveness of mental health service models when compared to other fields of health research, [and] this lack of evidence is alarming' (pp. 546–547). In this way, as Nicholls and Goossens (2017) argue, FMHSs have often 'been left behind when it comes to developing, implementing, and evaluating evidence-based practice' (p. 496).

[18] See Barnao and Ward (2015) and Nicholls and Goossens (2017) for a more comprehensive discussion of evidence-based interventions, and the latter for an overview of the forensic inpatient population as well.

In addition to the lack of an evidence base, complicating such inquiry is the lack of unified definitions or language within the existing literature to describe a service model or model of care. With little consistency and clarity in terms of the various interpretations FMHSs use to describe their services, 'fidelity to … [a] particular 'model' is difficult to a determine', and it is further difficult to assess the efficacy of such a model (Gournay et al 2013, p. 547). Consequently, researchers or organisations tend to only describe a portion of the service model without describing the complete pathway, or focus more on approaches or principles of treatment/interventions than models of care. This has led to the proliferation of policy-based (as opposed to evidence-based) decision-making in the creation and implementation of FMHS models (Gournay et al 2013).

In this systematic review, the researchers sought to identify literature describing the various models of care used within inpatient FMHSs. Due to the dearth of explicit research on models of care per se noted above, the researchers widened the scope to include literature on approaches, frameworks and principles of treatment in inpatient FMHSs. Overall, the literature falls into four broad categories: therapeutic security, rehabilitation, recovery-oriented approaches and specific (priority) populations. In most cases, models of care are not directly addressed, but rather implied through either the description of approaches/services or best practice recommendations. Throughout, there is an emphasis on both risk (assessment, management, mitigation and reduction) and bettering therapeutic outcomes for service users, highlighting the dual function of forensic inpatient services, along with a wide-ranging set of best practices that can be used to inform a model of care within FMHSs.

Methodology

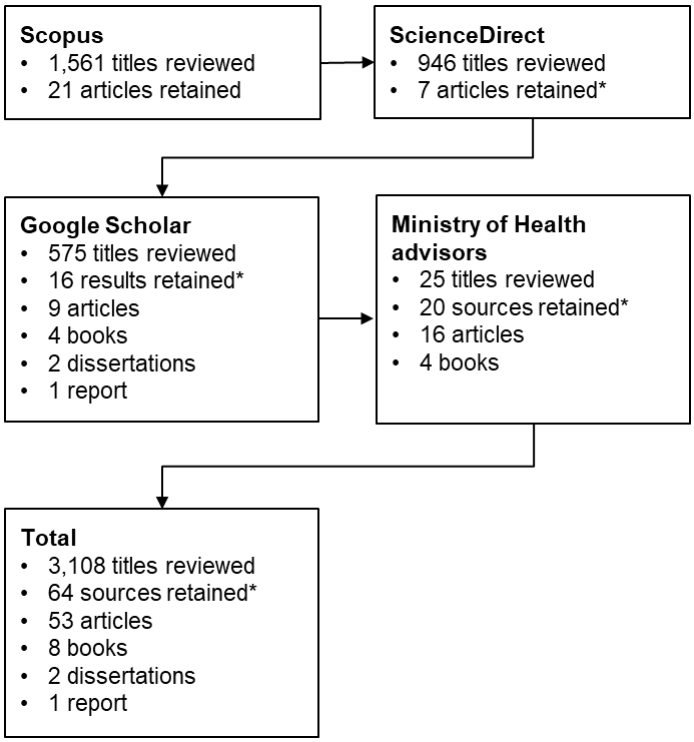
The researchers undertook a scoping systematic review to identify literature on models of care within inpatient FMHSs. Searches used the following search string, along with various combinations of these keywords: (forensic OR criminal) AND ('mental health' OR 'mental illness' OR psychiatry* OR 'serious and enduring mental illness' OR 'mentally-disordered offender') AND (framework OR 'model of care' OR model OR service* or guideline*) AND (inpatient OR in-patient OR residential). Results were limited to English-language documents from 1990–2019. Where possible, the researchers further limited the results to peer-reviewed articles, excluding reviews/notes.

In analysing the results, the researchers first reviewed titles, to determine relevance based on the keywords and aims of the review, followed by the abstracts. Retained results were restricted to inpatient FMHSs only, and did not include results pertaining to broader GMHSs, forensic mental health in other contexts, or literature outside the scope of the review (ie, pertaining to specific interventions, assessment/treatment, outcome measures, population surveys, etc).

The researchers conducted multiple searches in each of six databases via the AUT library website: CINAHL Complete/MEDLINE via EBSCOhost, PsycInfo, PsychiatryOnline, Scopus, ScienceDirect and Google Scholar. Results from three databases (CINAHL Complete/MEDLINE via ESBCOhost, PsycInfo and PsychiatryOnline) were not useful, as the search results were often too large and did not contain relevant articles within the first 100 titles. (The researchers reviewed a minimum of 100 titles per search.) These searches were discontinued.

The three remaining databases (Scopus, ScienceDirect and Google Scholar), after removing repetition, yielded a total of 49 articles, 4 books, 2 dissertations and 1 report for inclusion. As the search of Google Scholar yielded a high volume of results as well as a substantial amount of repetition of results in prior searches, the researchers reviewed only the first 575 results. The researchers combined their database results with recommendations of literature from the Ministry of Health advisors, as well as the researchers and their professional networks (22 articles and 4 books), again removing repetition, to yield a total of 71 articles, 8 books, 2 dissertations and 1 report. Figure 4 illustrates the systematic review results from those searches that yielded retained sources. (Note: these figures do not include additional secondary sources located through reference lists, and thus do not reflect all works cited in this report.)

Figure 4: Inpatient systematic review results



* After removing repetition of results in prior step(s).

Review findings

Therapeutic security

The 'standard model' of FMHSs – including those in Aotearoa New Zealand, Australia, the United Kingdom and Ireland (Craissati and Taylor, 2014; Khan et al 2018; Mental Health Commission 2011; Skipworth and Lindquist 2007) – comprises a stratified system organised through the definition and categorisation of therapeutic safety and security, the basic prerequisite of FMHSs (Kennedy 2002; Kennedy et al forthcoming; Skipworth and Lindquist 2007). As such, it is important to understand first how security is conceptualised, for 'rehabilitation offered within different inpatient settings … reflects both the level of security and the acuity of the patients' (Khan et al 2018, p. 329).

Broadly speaking, there are three types of therapeutic security: environmental, relational and procedural (Kinsley 1998; see also Craissati and Taylor 2014; Kennedy 2002; Khan et al 2018). Environmental or physical security pertains to the brick-and-mortar aspects of the environment that make a ward physically 'secure' (eg, locked doors, building design and maintenance and staff). Relational security includes those aspects related to quality of care as well as resources or recurring cost, and can be divided into quantitative (eg, staff-to-patient ratios) and qualitative (eg, staff-patient relationship) aspects (Kennedy 2002; Kennedy et al forthcoming). Procedural security includes legislation and guidelines governing treatment and management of incidents, including 'policy and practices relating to patients which control access, communication, personal finances and possessions' as well as those relating 'to quality and governance, including information management, legal obligations, audit, research and human resources' (Kennedy 2002, pp. 434–435). Kennedy (2006) argues that due to the tensions occurring between the 'unique needs of each patient and the need to provide services for groups … relational and procedural security, which are easier to individualise, are the most important elements of patient care in any mental health service' (p. 46).

Levels of security are typically described as high (admission/intensive care/acute), medium or moderate (subacute/pre-rehabilitative), or low or minimal (rehabilitative/hostel/pre-discharge) in relation to criteria set by the service and/or broader health legislation.[19] In practice, however, understandings of what the levels of security mean and how they are applied vary. In a recent study, for example, Khan et al (2018) found a combination of service user, clinical, ward and systemic factors contributed to clinicians' understandings of security.

[19] For specific environmental, relational and procedural security guidelines for high, medium and low secure units, as well as open wards and forensic community services, see Kennedy (2002).

Typically, adult forensic mental health pathways are not integrated into GMHSs, and comprise their own parallel pathway. The goal remains for service users to reintegrate with the community and/or GMHSs. Consequently, there is a 'need for multi-disciplinary teams to transfer care as the patient moves between levels of therapeutic security and into the community' (Kennedy et al forthcoming, p. 5). Indeed, 'defining these points of intersection and the criteria for transfers is a key element of a model of care' (Kennedy et al forthcoming, p. 7).[20]

Notably, the standard model may be expanded by adding 'parallel pathways' for specific purposes, such as for women or special diagnostic groups (eg, those with intellectual disability) or culture-specific pathways (Kennedy et al forthcoming); for example, the kaupapa Māori pathway at the Mason Clinic (Sweetman 2017; Tapsell 2007). Such specialised pathways must 'maintain critical mass to provide the necessary breadth and depth of treatments and critical levels of activity so that professionals can maintain their experience and expertise' (Kennedy et al forthcoming, p. 7), and provide for service users' needs at the various levels of security. Kennedy et al (forthcoming) further describe alternative models to the standard model, including clustering ('organising services according to clusters at a common level of therapeutic security or risk-dependency need': p. 8) and matrix models (involving a combination of pathway and clusters). Where possible, evidence supports the integration of services throughout the pathway and across social institutions and agencies (Gourlay et al 2013; Kennedy 2002) in what may be best described as a 'whole-system approach' (Edwards et al 2016). Such an approach aims to combat the fragmentation of services among mixed providers. It is used, for example, in the United Kingdom (Edwards et al 2016; McFadyen 1999).

Within inpatient services (ie, forensic mental health hospitals), Kennedy et al (forthcoming) broadly describe two models of care at the unit level: (a) ward-based multidisciplinary teams, which are led by consultant psychiatrists and include the range of professionals involved in service users' assessment and treatment; and (b) therapeutic communities, which are 'associated with psychotherapeutic environments for hospitals' and involve 'patient-led or co-produced therapeutic regimes' (p. 9; see also Shuker 2013). In Aotearoa New Zealand, FMHSs typically use the multidisciplinary team model, with a senior nurse serving as unit manager and teams for each service user led by a responsible clinician who coordinates care, develops individual treatment plans and reviews patient progress. The use of multidisciplinary teams reflects what can be viewed as a best practice recommendation among the international literature (Haines et al 2018; Orovwuje 2008; Skipworth and Lindquist 2007).

[20] For further discussion on the interface between GMHSs and FMHSs, see, for example, Mullen and Ogloff (2009), discussing services in Victoria, Australia.

One issue affecting the stratified therapeutic model is what Kennedy et al (forthcoming) identify as long-stay quality of life issues (see also Sampson et al 2016). This affects the portion of the forensic service user population who require more than five years of care in secure services. Kennedy et al note the need for services to 'provide structured secure slow-stream habilitation places at low, medium and high levels of security for placements of up to 20 years' (p. 15). Here, the emphasis should be on 'quality of life, personal recovery within the limits of symptomatic and functional recovery' and creative therapies that instil 'hope and a sense of community' (p. 15). Also required are step-down facilities equipped to manage and address the needs of those who have endured long custodial sentences and, thus, may have severe and enduring mental illness as well as significant and lasting impacts from the experience of institutionalisation.

Rehabilitation

The function of inpatient FMHSs has shifted increasingly from a custodial function to a rehabilitative one in recent decades (McKenna et al 2014c), the primary outcome criterion being the service user's discharge or return to the community (Tarasenko et al 2013). As such, a large portion of the literature discusses the rehabilitation (ie, assessment and treatment) of the FMHS inpatient population. However, while there is a growing evidence base on a range of rehabilitative models and interventions that address particular aspects of FMHSs, such as risk (see Barnao and Ward 2015) or various aspects of the forensic inpatient population (eg, psychopathy, personality disorders, sex offending, AOD, arson, intellectual disability, etc: see Craig et al 2013; Gunn and Taylor 2014; Soothill et al 2013), literature on comprehensive models of care that follow rehabilitative approaches within inpatient FMHSs is still lacking.

'Psychiatric rehabilitation' is typically defined in comparison to the traditional institutional 'medical model' (Tarasenko et al 2013), which Kennedy et al (forthcoming) note is not a model of care but an 'overarching conceptual model of scientific and heuristic approaches to diagnosis and treatment' that 'emphasises patient centred ethics, scientific rigor and excellence' (p. 2). However, understandings of what constitutes 'rehabilitation' vary among clinicians internationally, along with understandings of the role of staff and services, and which patients are most suitable for psychiatric rehabilitation (Khan et al 2018). There is also a dearth of literature on '*whether or not*, *to what extent*, and *when* forensic psychiatric rehabilitation alters the individual's level of risk' (Lindqvist and Skipworth 2000, p. 320; original emphasis).

Lindqvist and Skipworth (2000) define rehabilitation as 'a process where the outcome is the result not only of the sum of individual contributions within the treatment system, but also of the interacting effects of these various efforts' (p. 321). This process thus must take into account the various relationships that affect treatment, including those between and among service users, staff, family/whānau and peers (Lindqvist and Skipworth 2000). Robertson et al (2011) identify six elements they believe constitute a good model of forensic rehabilitation:

1. presence of a 'comprehensive rehabilitation theory underpinning interventions with forensic mental health clients'
2. the fact that 'The general origins of offending behaviour that occurs within the context of mental illness will be spelled out'
3. specification of 'the broad aims of rehabilitation'
4. outlining of 'the proposed mechanisms at work in the rehabilitation process'
5. specification of 'the attitudinal, motivational and relational aspects of treatment' and 'guidance on how to manage the therapeutic alliance and issues relating to the process of therapy'
6. identification of 'the ethical and philosophical values embedded in the rehabilitation theory'. (p. 474)

Childs and Brinded (2002) highlight debate as to whether rehabilitation should work to alleviate mental illness or reduce offending behaviour – two aims, it is important to note, that are not mutually exclusive. Debate persists regarding the balance between these two aims, and permeates more recent approaches dominating the field, as discussed below.

Generally, despite the ambiguity in the definition, mental health rehabilitation approaches have been found effective in 'reducing violence and aggression, fostering adaptive behaviour and promoting recovery, and with higher discharge rates and lower costs' (Tarasenko et al 2013, p. 449), and improving quality of life (Linhorst 1995) and staff experiences (Brown and Lewis 2015), while offering a means to enhance community protection by taking into account both community and offender rights (Birgden 2008). Indeed, evidence has shown 'rehabilitation is more effective in reducing reoffending than punishment and prevention' (Birgden 2008, p. 451).

The risk-need-responsivity model

The risk-need-responsivity (RNR) model (Andrews and Bonta 2010; Andrewsand et al 1990) is a model of 'correctional assessment and treatment' (Skeemand et al 2015, p. 917). It is extensively used by clinicians internationally to assess and manage the risk of violence among corrections and FMHS users and in relation to service users' criminogenic needs. While not a model of care, the RNR model has highly influenced the creation and implementation of models of care within forensic mental health due to the centrality of the risk concern. In this way, it serves as an "umbrella framework" that specifies basic conditions that should be met across diverse types of intervention for effective treatment' (Barnao and Ward 2015, p. 80), to reduce the risk of recidivism. For example, Mitchell et al (2016) argue the utility of the RNR approach in delivering forensic cognitive behavioural therapy interventions, while others have used the model to inform the development of needs assessment instruments (Gordon and Wong 2015; Keulen-de Vos and Schepers 2016) and violence reduction programmes (Wong and Gordon 2013; Wongand et al 2007).

As Barnao and Ward (2015) explain, the RNR model follows several key assumptions:

> that certain empirically-based social and psychological risk factors are associated with offending, that an offender's level of risk increases with the presence of each additional risk factor, and that targeting dynamic (ie, potentially changeable factors that give rise to offending) risk factors in treatment will reduce reoffending rates. (p. 80)

To manage risk and thus achieve a reduction in recidivism, the model has three central components:

1. risk principle (match level of programme intensity to offender risk level; intensive levels of treatment for higher-risk offenders and minimal intervention for low-risk offenders)
2. need principle (target criminogenic needs or those offender needs that are functionally related to criminal behaviour)
3. responsivity principle (match the style and mode of intervention to the offender's learning style and abilities) (Andrews et al 2011, p. 735).

There is a strong evidence base supporting use of the RNR model in interventions addressing the criminogenic needs of different groups of offenders primarily in corrections contexts; for example sex offenders (eg, Cortoni and Gannon 2013; Hanson et al 2009; Looman and Abracen 2013), arson (eg, Fritzon et al 2013), and AOD-related offending (eg, Weekes et al 2013). Generally, 'interventions that adhere to the RNR principles are associated with significant reductions in recidivism, whereas treatments that fail to follow the principles yield minimal reductions in recidivism and, in some cases, even increase recidivism' (Andrews et al 2011, p. 736). However, the RNR model has faced increasing criticism from proponents of recovery-oriented approaches, primarily due to its emphasis on deficits versus strengths, lack of attention to human agency as well as contextual/ecological factors, and a 'one size fits all' approach (Andrews et al 2011; Looman and Abracen 2013). There has also been some concern about its predictive validity among minority offenders, particularly in terms of whether it over-predicts risk among women and ethnic minorities (Bonta and Wormith 2013).

Further issues have been identified concerning the applicability of the RNR model for women. There is a concern as to 'whether or not dynamic risk factors for offending in men are equally applicable to women' (Polaschek 2018, np). Polaschek (2018) notes that the RNR model is based on an understanding of male criminogenic need; women's needs are often more complex or diverse due to women's higher rates of mental health and addictions comorbidities and trauma, greater community responsibilities, lesser control over contextual factors and 'more comfort with expressing emotions and opinions, and greater interest in communality' (np).

Hannah-Moffat (2009) further highlights that the RNR model's focus on individual needs 'diminishes the role that social and structural contexts play in women's criminalization' (p. 215) and fails to take into account how social inequality itself constitutes a risk to be managed. Thus, while the evidence suggests the RNR model does apply to women, it is important to consider the wider context that contributes to women's complex needs (Polaschek 2018).

Finally, there is less research examining the generalisation of correctional treatment principles to FMHS users, and thus while some authors:

> believe that with appropriate attention to the question of specific responsivity, the RNR model will improve programs' ability to reach both public safety and public health goals for justice-involved persons with mental illness, … there is a remarkable absence of empirical support for this belief. (Skeem et al 2015, p. 920)

Therefore, more research is needed to understand fully the application of the RNR model within FMHSs generally, as well as among priority populations.

Recovery-oriented approaches

Following the shift toward rehabilitation-focused service delivery within FMHSs and mental health care more generally, recovery-oriented models of care have emerged in a new paradigm of what are broadly termed 'strength-based approaches' (Barnao and Ward 2015; Nicholls et al forthcoming; Vandevelde et al 2017). Strength-based approaches deviate from 'a focus on problems and deficits (ie, mental disorder and risk) and take a more holistic view of the person that includes consideration of their strengths, capacities, personal priorities, competencies, possibilities, and hopes' (Barnao and Ward 2015, p. 82). As such, a significant portion of the research focuses on: (a) the principles and efficacy of recovery-oriented approaches in inpatient FMHSs (eg, Clarke et al 2016; McKenna et al 2014b, 2014c; Mellie 2012; Roychowdhury 2011); (b) describing the development of recovery-oriented services within specific jurisdictions, such as Australia (O'Donahoo and Simmonds 2016), Ireland (Gill et al 2010) and the United Kingdom (Davies et al 2010); and (c) specific models that follow a recovery-oriented approach (see below).

Recovery principles

Overall, recovery-oriented approaches are founded on 'the principles of hope, empowerment, healing, and connection' and promote 'patient choice, responsibility, and self-determination' (Barnao and Ward 2015, p. 82), all of which, as Clarke et al (2016) note, are affected by the restrictive environment of secure FMHSs. Within the forensic mental health context, the recovery movement is a distinct departure from earlier therapeutic models that emphasised control, focused on people's deficits and placed decision-making power solely in the hands of the clinician. While the dual role of inpatient services persists and risk management remains a key concern, legislation demands services users and their whānau hold the right to participate in their treatment decisions to the maximum extent possible. Indeed, some of the key principles of the recovery orientation include the emphasis on patient-centred and collaborative care (Livingston et al 2010; McKenna et al 2014b and 2014c; Nicholls and Goossens 2017), and taking into account historical, dynamic and protective factors in risk assessment and management (Vandevelde et al 2017).

There are several models and definitions of what constitutes recovery in mental health. For example, according to Andresen et al (2003, as cited in Roychowdhury 2011), the process of recovery is comprised of:

- finding and maintaining hope, which includes having a sense of personal agency and optimism
- re-establishment of a positive identity, which includes identity with a positive sense of self that incorporates illness
- building a meaningful life, which includes making sense of the illness and finding a meaning in life despite the presence of illness
- taking responsibility and control, which includes feeling in control of illness and in control of life. (p. 68)

Resnick et al (2005, as cited in Clarke et al 2016) conceptualised the recovery orientation as comprised of 'empowerment, knowledge about mental illness and available treatments, satisfaction with quality of life, and hope and optimism' (pp. 39–40), a definition supported in the conceptual framework of Leamy et al (2011, as cited in Clarke et al 2016), who added connectedness and culturally specific features to the list. Farkas et al (2005, as cited in Roychowdhury 2011) similarly highlighted person orientation, person involvement, person strengths, self-determination/choice and growth potential as key values intrinsic to the concept of recovery. More recently, in a study of Australian acute inpatient mental health services, McKenna et al (2014a) identified six components of recovery-oriented care: creating/supporting hope, promoting autonomy and self-determination, collaborative partnerships and meaningful engagement, a focus on strengths, holistic and personalised care, and community partnership and citizenship.

Many organisations are moving to adopt recovery-oriented practices within FMHSs following the creation of new regional, national and international policy and practice guidelines (McKenna et al 2014c). Indeed, 'even services that have traditionally been institutional, custodial, and involved in compulsory treatment under mental health legislation have been challenged to embrace the systematic transformation to recovery' (McKenna et al 2014c, p. 227). Clarke et al (2016) conducted a systematic review of qualitative literature on recovery in FMHSs. The findings suggested that developing service users' sense of self and connectedness may improve recovery among the forensic mental health population. As such, best practice recommendations to develop recovery-oriented FMHSs include increasing peer mentorships and incorporating service user engagement in service development (Clarke et al 2016), as well as the use of 'champions' to assist organisational change processes within service delivery (Kipping et al 2019; McKenna et al 2014a). McKenna et al (2014c), in a study of the systematic transformation of a custodial mental health service toward a recovery-oriented service delivery model, further identified the development of a manualised guide, adaptation of the guide to the secure care context, and developing the culture of the organisation (including staff, education, reflective learning and leadership) as key to successful organisational change.

Recovery models

The tidal model

The tidal model (Barker 2000) was developed to better address service users' needs within mental health nursing. The model is described as a 'radical, catholic model', meaning it describes 'caring-processes fundamental to mental health nursing' and that it can be used in 'all healthcare settings and with all types of people with mental health problems', respectively (Jacob et al 2008, p. 227). According to Barnao and Ward (2015), the tidal model understands issues in mental health as 'problems of living', and thus focuses on 'patients' experiences and life narratives, and the meanings and values that they give to their experiences' (p. 82). It also emphasises collaborative care and aims to empower people through its narrative approach (Jacob et al 2008). Within the forensic inpatient context in Aotearoa New Zealand, Cook et al (2005) investigated the efficacy of the tidal model in a phenomenological study, concluding it resulted in a '"synergistic interpersonal process" that supported both patient recovery and nursing practice through enhanced professional satisfaction' (Barnao and Ward 2015, p. 82; see also Jacob et al 2008).

The good lives model

Of the recovery-oriented models described in the literature, the good lives model (GLM) has a reasonably strong evidence base (eg, Andrews et al 2011; Barnao 2013; Barnao and Ward 2015; Barnao et al 2010; Barnao et al 2016a; Barnao et al 2016b; Fortune et al 2014; Willis and Ward 2013). While preliminary evidence of the application of the GLM suggests positive outcomes among non-FMHS users and within corrections services (indicating increased treatment engagement and adherence), 'conclusive statements about the utility of the GLM in a forensic mental health context are still premature' (Barnao et al 2016a, p. 767).

The GLM is a comprehensive practice framework that aims to promote service users' goals while reducing the risk of recidivism (Barnao 2010). It is a holistic, person-centred approach that follows the tenets of the recovery paradigm more broadly. In sum, it 'aims to equip individuals with the resources to live a "good life" – one that is meaningful and fulfilling and that does not involve harming others' (Barnao et al 2016, p. 289) by (a) taking into account and using service users' individual preferences and values, and (b) building service users' capacity to gain 'primary goods'[21] in ways that are socially acceptable (Barnao and Ward 2015; Barnao et al 2016).

[21] Barnao et al (2016b) define "primary goods" as "activities, experiences, and/or situations that are sought for their own sake and that benefit individuals and increase their sense of fulfilment and happiness" (p. 290). The authors suggest the existence of at least 11 primary goods: life, knowledge, excellence in play, excellence in work, agency, inner peace, friendship, community, spirituality, happiness and creativity.

The basic premise behind the GLM model, then, is that wellbeing is associated with the attainment of primary human goods, with the inverse also holding true; that is, the absence of primary goods results in various psychological problems (Barnao and Ward 2015; Barnao et al 2016b). It also takes into account the role of offending as a means by which primary goods are sometimes sought.[22] Notably, the GLM provides an alternative conceptualisation of risk that directly contrasts the RNR model by focusing on a strength-based, restorative approach to rehabilitation, though the merits of the two approaches continue to be debated (Andrews et al 2011; Birgden 2008; Gudjonsson and Young 2007; Looman and Abracen 2013; Robertson et al 2011).

Most recently, Barnao et al (2016b) have discussed the applicability of the GLM specifically in FMHSs, considering (a) 'the impact of mental illness on individuals' good lives conceptions', (b) 'the role of psychiatric symptomology as a means by which valued primary goods are sometimes sought' and (c) 'mental health service provision as a facilitator or obstacle to primary goods attainment' (p. 291).

The authors then detail a case study within the Aotearoa New Zealand context, which illustrates the implementation and efficacy of the model in the case of a 26-year-old Māori male forensic mental health inpatient with a diagnosis of schizophrenia. The authors show how the GLM provided the service user with a means to integrate his personal goals and risk management plan into one comprehensive plan with actionable steps to achieving the plan and helped the service user engage with and adhere to the plan. Thus, the authors suggest the GLM 'can enhance treatment engagement and bolster a sense of agency' among inpatient FMH service users, while facilitating 'a comprehensive and cohesive understanding of forensic mental health service users and their core rehabilitation needs' by integrating '*all* components of forensic rehabilitation' holistically (p. 297; original emphasis). It may also support improved communication and relationships between service users and clinicians and increase efficacy over standard rehabilitation programmes.

Safewards

Recently implemented in acute and forensic mental health settings, Safewards (Bowers 2014) is an evidence-based model that aims to reduce incidents within inpatient settings by preventing conflict and containment events that trigger aggression and violence (Kipping et al 2019; Maguire et al 2018). Following recovery principles, 'the model is comprised of six key domains: the patient community, patient characteristics, regulatory framework, the staff team, the physical environment, and factors from outside the hospital' (Kipping et al 2019, p. 2). The model further suggests 10 interventions that should be adopted to prevent events: clear mutual expectations, soft words, talk down, positive words, bad news mitigation, knowing each other, mutual help meetings, calm down methods, reassurance and discharge messages (Bowers 2014; Kipping et al 2019). To date, the evidence shows mixed results; some studies demonstrate reductions incidents (eg, Bowers 2014; Bowers et al 2015) and others show little to no change, perhaps due to already low rates of the use of restrictive interventions (eg, Maguire et al 2018).

[22] For a more comprehensive description of the GLM model and its underlying theory as well as its applicability in FMHSs, see: Barnao 2010; Barnao et al 2010; Barnao et al 2016b.

Other frameworks

While many conceptual models of recovery have circulated within FMHSs, few frameworks exist to evaluate their efficacy in concrete terms. As such, it often 'remains unclear how patients actually progress within in-patient services from admission to discharge' (Doyle et al 2012, p. 54). To address this gap, Doyle et al (2012) developed the miles to recovery (MTR) framework to promote recovery and measure progress through the medium secure inpatient pathway in the United Kingdom. The MTR framework identifies four key targets for intervention: symptoms, behaviour and functioning, interpersonal engagement, and therapeutic engagement; 12 indicators support the targets (p. 55). The authors developed and tested the MTR scale with a sample of 80 inpatient service users, establishing the validity of the framework in clinical practice.

Birgden (2008) proposed a normative framework for offender rehabilitation combining elements of RNR and GLM with a human rights approach to rehabilitation. The framework suggests seven values-based principles that should guide clinicians in practice: recognise normative values, respect human rights, assess risk, treat need, manage readiness, ensure autonomy and create multi-agency approaches. These principles govern a set of practice strategies that form the rehabilitation and recovery plan. These principles also align with some of the tenets of the Māori-focused models, as discussed below.

Balancing risk and recovery

Within the recovery paradigm, the need persists to address risk among FMHS users. As such, a multi-modal approach is often required to address service users' complex needs within 'standard' models of care that combines recovery principles within the more traditional structures of FMHSs (Barnao and Ward 2015). Indeed, integrated or holistic service delivery models have been recommended in recent literature to address the lack of comprehensive models of care within forensic inpatient settings (Gournay et al 2013). However, Barnao and Ward (2015) highlight a set of problems that arises when using multiple approaches. First, the various paradigms have differing ethical values, assumptions and aims that, when synthesised, often create 'conceptual confusion' and fail 'to assist practitioners [to] navigate their way through the stormy waters of the dual relationship problem'. Second, 'they do not provide clinicians with enough guidance about the importance that should be placed on addressing criminogenic needs versus treating mental disorder'. Third, 'they do not … provide a cohesive theoretical basis for selecting the issues to be addressed in treatment programs' (p. 83).

To address such issues, Roychowdhury (2011) proposed a 'human needs-oriented forensic service' that considers service users' basic needs to bridge risk and recovery. More specifically, these basic needs include:

- security/safety/control over events
- variety/creativity/challenge and diversity
- growth and development

- relatedness, love/connection and belonging
- importance: to be needed and valued by others, and do something of meaning
- contribution: to help others. (p. 71)

By focusing on these needs, Roychowdhury argues, a holistic paradigm of recovery is supported in a whole-person approach that inherently manages risk, while removing the tension between other approaches that unequally address risk/recovery.

Priority populations

A subset of the literature focuses on identifying the utility of standard models of care and interventions among priority populations, namely Māori, Pacific peoples and women. Due to the overrepresentation of Māori and Pacific peoples in FMHSs in Aotearoa New Zealand, as well as the rapidly growing population of female forensic service users, these priority populations are of importance when considering models of care for inpatient FMHSs. The following section reviews the literature for each of these subsets, along with literature pertaining to other indigenous groups (eg, those in Canada and Australia) that provides insights of relevance to the Aotearoa New Zealand context.

Māori

While the need for Māori-specific FMHSs was identified early on in the Mason Report (1988) and has been advocated for in more recent scholarship (eg, Tapsell 2007, 2018), little research has been conducted on Māori forensic models of care for inpatient services, perhaps due to the relatively recent advent of kaupapa Māori FMHSs. The limited literature to date focuses primarily on the subacute inpatient unit Te Papakāinga o Tāne Whakapiripiri, the first dedicated kaupapa Māori ('by Māori for Māori') forensic mental health unit in Aotearoa New Zealand (and the first indigenous forensic psychiatric unit in the world), which opened in 2004 at the Mason Clinic (Auckland Regional Forensic Psychiatry Services) (Sweetman 2017; Tapsell 2007).

Tāne Whakapiripiri's 'multi-model' of care 'blends together the clinical and cultural paradigms of Te Ao Tauiwi (the Western worldview) and Te Ao Māori (the Māori worldview), a partnership mandated by the Treaty [of Waitangi]' (Sweetman 2017, p. 162). More specifically, the model of care combines a rehabilitative approach (the Boston rehabilitation model) (Rogers et al 2006) with Te Whare Tapa Whā (Durie 1998) to formulate the 'blueprint' of the unit's model of care, which includes the seven tenets of wairuatanga (spiritual health), tikanga/kawa (boundaries/rules), whanaungatanga (family health), tinana (physical health), hinengaro (mental health), tūmanako (hope for the future) and whakapaitia (service delivery) (Sweetman 2017).

This approach is in keeping with other Māori approaches to mental health service delivery, as well as the broader field of indigenous psychology/psychiatry, which has produced frameworks such as the Meihana model (Pitama et al 2007), a broader clinical assessment framework for use in mental health. The Meihana model is similarly based on a Māori worldview, consisting of the four components of Te Whare Tapā Whā, with the addition of two dimensions – taiao, the physical environment, and iwi katoa, the societal impact.

Tapsell (2018) further identifies five key factors in a Māori approach to FMHSs.

1. The service is underpinned by 'Māori principles and a model of care that is based on Māori kaupapa and tikanga'.
2. The service offers 'a healing environment that facilitates a culturally-informed model of care' and focuses on cultural activities.
3. The service demonstrates 'Commitment to a model that integrates best practices cultural (Māori) and clinical (forensic mental health) interventions'.
4. Unit leaders have 'dual cultural and clinical competencies'.
5. 'Units are well staffed by committed people who, where possible, are Māori.' (p. 120)

These factors reflect the services offered in Māori-dedicated FMHS units like Tāne Whakapiripiri, as well as broader cultural pathways, interventions and support offered alongside mainstream FMHSs and in corrections contexts (Thakker 2013).

Pacific peoples

Regarding Pacific peoples, while models of care have been developed specifically for Pasifika forensic populations in prison (King and Bourke 2017) and general mental health/AOD services (Fotu and Tafa 2009; Suaalii-Sauni et al 2009; Te Pou o te Whakaaro Nui 2010; Vaka 2016; Vaka et al 2016), the researchers found no literature on models of care for Pasifika in inpatient forensic services.

Other indigenous groups

While limited research exists on aboriginal Australian and First Nations Canadian cultural programming within corrections contexts (Thakker 2013), no literature was found on inpatient models of care for aboriginal Australian or other indigenous populations (eg, First Nations/Native American). However, the need to take into consideration the unique needs of these populations, understanding the lasting impacts of the history of colonisation, has been acknowledged (Thakker 2013). Within the systematic review, only one article discussed indigenous populations outside of Aotearoa New Zealand within an inpatient context. Durey et al (2013) advocate for the creation of an 'intercultural space' as an approach to caring for indigenous service users within forensic mental health settings in Australia.

Women

Women comprise a minority of the forensic mental health population – generally 6–10 percent in Western countries (de Vogel and Nicholls 2016, p. 2) – though the population has increased steadily within Aotearoa New Zealand and internationally over the past 20 years, a trend that is continuing (de Vogel and Nicholls 2016). Little research has evaluated how men and women's treatment and management needs differ in FMHSs, and most discussion of gender-informed care has focused on corrections contexts, rather than FMHSs (Nicholls et al 2015). Substantial gaps thus persist 'in knowledge and debate regarding the importance of gender differences, for instance, in developmental pathways to offending and in violence risk factors and assessment' (de Vogel and Nicholls 2016, p. 1).

Within the limited body of literature, researchers have examined women's patterns of offending and mental illness, the validity of dominant forensic and risk assessment measures for women (eg, the RNR model, as discussed above), the particular needs of the female inpatient population, and appropriate interventions/approaches to address those needs (Craig et al 2013; de Vogel and Nicholls 2016; Gournay et al 2013; Nicholls et al 2015; Putkonen and Taylor 2014). In terms of models of care, literature on best practices underscores the importance of services that are recovery focused, address women's criminogenic needs as well as their wider health and environmental contexts, provide gender-responsive programming and incorporate trauma- and violence-informed practice into all aspects of care (Bartlett and Somers 2017; de Vogel and Nicholls 2016; Jeffcote and Watson 2004; Department of Health and Social Care 2018).

As the Women's Mental Health Taskforce (Department of Health and Social Care 2018) explains:

> Trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women. They ensure that staff have the right competencies to work with women, that the environment makes women feel safe and welcome, and that appropriate structures are in place to be able to deliver this kind of service. These types of approaches also take account of the ways in which different parts of a woman's identity can overlap and result in different experiences of disadvantage. (p. 33)

One stream of the literature supports further the application of attachment theory as a model of care for women in secure services (Bartlett and Somers 2017).

Recently, in the United Kingdom, the Women's Mental Health Taskforce (Department of Health and Social Care 2018) developed a set of principles for the provision of gender- and trauma-informed women's mental health services, which may be used as a foundation for a model of care. These principles hold relevance both for the inpatient context and the broader forensic mental health system. The 10 principles are:

- There is a whole-organisation approach and commitment to promoting women's mental health, and effective governance and leadership in place to ensure this.
- Services promote equality of access to good-quality treatment and opportunity for all women.

- Services recognise and respond to the impact of violence, neglect, abuse and trauma.
- Relationships with health and care professionals are built on respect, compassion and trust.
- Services provide and build safety for women.
- Services engage with a diverse group of women who use mental health services to co-design and co-produce services.
- Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.
- Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, with a focus on future prevention.
- Services support women in their role as mothers and carers.
- Services are effective in responding to the gendered nature of mental distress. (pp. 35–42)

These principles align with the recommendations of the National Working Party for Standards of Care for Women in Secure Mental Health Services (McCarten & Leddy, 2019) developed within the Aotearoa New Zealand context, which similarly call for the adoption of gender-sensitive and specific treatment approaches and emphasise relational security (see also Bartlett and Somers 2017; Edge et al 2017; Parry-Crooke and Stafford 2009).

One central issue pertaining to service models for women is the need for gender-specific wards. Gournay et al (2013) described an earlier systematic review (Lart et al 1999) undertaken to investigate the needs of women in prison and secure services, and the efficacy of psychiatric models for this population of women in the United Kingdom and abroad. The review found that women comprised less than 20 percent of service users internationally, and had wide-ranging personal, psychiatric and forensic histories. In light of this and other research recognising the vulnerability of women to harassment and abuse by male patients within mixed-gender inpatient FMHSs in the late 1990s/early 2000s, some health systems, such as that in the United Kingdom, have adopted government policy mandating gender-specific and gender-exclusive services, which have now become the norm (Gournay et al 2013; Putkonen and Taylor 2014). Such services follow the premise that if women are segregated from men, they will be safer and at lower risk of harm and have more privacy and increased dignity (Parry-Crooke and Stafford 2009).

It is important to note in this discussion the unique context of Aotearoa New Zealand and how culturally responsive services may offer an alternative understanding of gender needs. In Sweetman's (2017) study of the Kaupapa Māori forensic mental health unit Te Papakāinga o Tāne Whakapiripiri, participants articulated a different approach to relational security. In accordance with the broader Māori worldview, balance between tāne (men) and wāhine (women) comprised a central aspect of the unit, in terms of architecture, the model of care, programming and staff–service user relationships.

Boundaries between genders were respected both in interactions and physical spaces within the unit; the unit provided designated male- and female-only areas as well as mixed areas. Indeed, mixed inpatient care and programming was seen as an important component in promoting the (re)socialisation of both female and male service users toward more equitable and safer cross-gender interactions, and also in achieving spiritual and cultural balance. More evidence is needed to understand fully the nuances of gender within different cultural contexts and their implications for service provision.

Summary

The inpatient context provided the most robust examination of FMHS service provision out of the four scholarly literature reviews, though literature directly addressing 'models of care' per se was limited. Three broad discussions emerged from the literature. The first concerned the concept of therapeutic safety and security, which includes environmental, relational and procedural security. Here, emphasis was placed on developing a 'whole-systems approach', which integrates services throughout the pathway and across social institutions and agencies. The second discussion focused on the concept of rehabilitation, which has been described in relation to the alleviation of mental illness as well as the reduction of offending behaviour (ie, risk). Here, the RNR model, which takes into account individuals' criminogenic needs, is of relevance. The third discussion examined the emergence of recovery-oriented approaches, including the tidal model, good lives model, and Safewards. Recovery approaches emphasise hope and empowerment and work toward the development of self-determination and self-sufficiency, though the need persists to address risk among FMHS users. In terms of priority populations, the literature is limited. Preliminary evidence suggests the need for and utility of gender-responsive and culturally responsive practices within FMHS delivery.

Section 3:
Community review

Introduction

Accompanying the move toward widespread deinstitutionalisation, there has been an increasing emphasis on using community-based services in place of inpatient services to provide care in the least restrictive environment possible for mental health service users who interface with the criminal justice system (Mental Health Commission 2011).[23] This has been aided by mental health legislation enabling involuntary/compulsory treatment in the community as an alternative to incarceration/institutionalisation.[24]

With the proliferation of community-based options, there has been a subsequent blurring as to who a user of community-based FMHSs actually is, and to which service configuration their needs should be aligned. Internationally, such users comprise both: (a) individuals who are mandated by the courts to community-based mental health services (forensic or general) instead of prison/inpatient services by community treatment orders (CTOs) or similar means (including those who may not have received a conviction) and (b) those who transition back to the community after being institutionalised in prison or FMHS inpatient services.

Blackburn (2004) identifies three types of FMHS community responses: (a) supervision and aftercare following conditional release from secure conditions, (b) continuation of treatment under enforced supervision following release from involuntary hospitalisation, and (c) intensive casework (ie, assertive case management). In all types, service users may be managed by a combination of FMHSs and GMHSs, probation and other specialist services provided by the government or contracted to the private/non-governmental organisation sector.

However, this evolution has occurred largely absent reliable evidence supporting the efficacy of community-based FMHS models of service delivery (Puri and Kenney-Herbert 2018). Indeed, 'outcome data from well-designed research is lacking in the area of community FMH care' (Skipworth and Humberstone 2002, p. 48). Moreover, as Mohan et al (2004b) argue:

[23] The most striking example of this trend is the case of Italy, which no longer has inpatient units and has a solely community-based FMHS. For further discussion, see Barbui et al 2018; Carabellese and Felthous 2016; Castelletti et al 2018; De Vito 2014; Ferracuti et al 2019.

[24] See Buchanan and Wootton 2017 and Shuker and Ashmore 2014 for in-depth resources on the context and provision of community FMHSs.

> these services have, in most cases, evolved in an ad hoc manner, mainly through clinical pressures to manage mentally ill offenders, and they have not relied on an evidence base or well-defined theoretical models as the basis for service development (p. 1,294).

Little research has been conducted on community FMHSs in Aotearoa New Zealand. Internationally, models of care, structures and definitions of community FMHSs vary widely, and consensus is lacking on which structures are most effective in producing positive long-term outcomes – or even how 'positive' outcomes are defined (eg, reducing recidivism versus achieving adequate quality of life). Indeed, the literature presents a range of evidence on a variety of models of service provision that can be used to provide FMHSs in the community in combination with GMHSs and criminal justice/probation services. There is a need, therefore, to identify effective community models to provide support for community-based FMHS delivery and to improve continuity of care between inpatient and community settings, as well as between FMHSs and GMHSs.

As such, in this systematic review, the researchers sought to identify literature describing the various models of care used within community FMHSs internationally. As they did for the inpatient review, the researchers included literature on approaches, frameworks and programme models to identify models of care, as the literature addressing 'models of care' directly is limited. Moreover, the literature often conflates models of care with the structuring of service delivery, indicating the lack of consensus on which elements, specifically, constitute a model of care.

In this review, the findings begin with an overview of the function and structures of community FMHSs. The researchers found that, broadly, aspects of the model of care in community FMHSs align with those in inpatient FMHSs. Thus, the second main section similarly discusses the overarching approaches of therapeutic security, rehabilitation (including the risk concern) and the recovery-oriented approach. Notably, there was a significant dearth of literature examining community-based FMHS models of care among priority populations (ie, Māori, Pacific peoples, other indigenous groups and women). As such, this review did not warrant a separate section on priority populations as in the other reviews, though given the overrepresentation of Māori and Pacific peoples in all arms of FMHSs – including community FMHSs – the integration of a cultural model of care into the overall approach is especially required.

Throughout the literature, the breadth of community-based services is highlighted, along with the need for models of care to account for and engage with multiple stakeholders and sectors in service provision. In this way, community-based services, more so than the other types of services, serve as an interface between the various stages/services in the forensic pathway (eg, court, prison, inpatient services, probation, GMHSs and non-governmental/other specialist sectors), requiring enhanced coordination, communication and collaboration with these sectors.

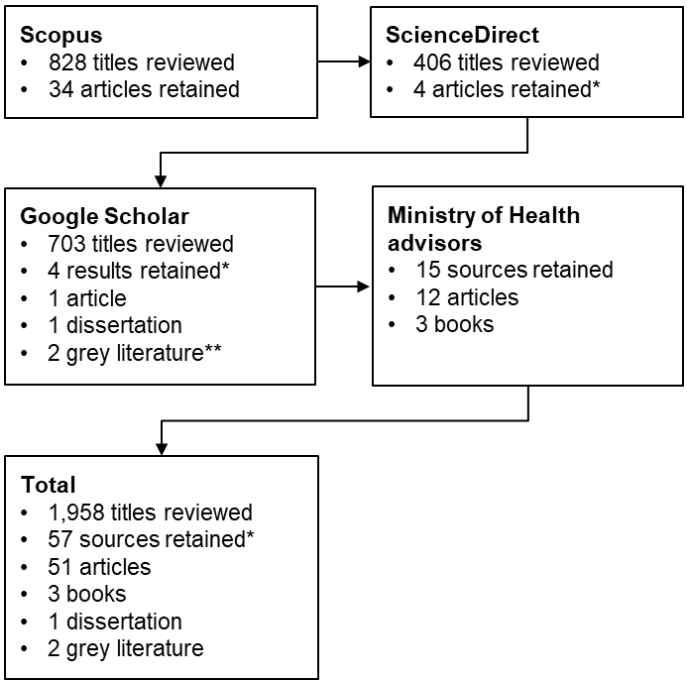
Methodology

Searches used the following search string, along with various combinations of these keywords: (forensic OR criminal) AND ('mental health' OR 'mental illness' OR psychiatr* OR 'serious and enduring mental illness') AND (framework OR 'model of care' OR model OR service* or guideline*) AND (community OR outpatient OR out-patient). Based on the results of the inpatient literature review, the term 'mentally-disordered offenders' was also added to the search string.

The researchers limited the results in the same fashion as in the inpatient review to English-language documents from 1990 to 2019. Where possible, they further limited results to peer-reviewed articles, excluding reviews/notes. The researchers reviewed results first by title and then by abstract to determine relevance. They then screened retained articles in full text to formulate the final list of retained articles. They limited results to literature describing forensic community models of care and/or services. They excluded results pertaining to (a) transitioning from prisons into the community, (b) the role of probation services in community/outpatient treatment and (c) forensic assertive community teams specifically as a component of mental health courts, though those results do relate to community contexts, considering them more appropriately dealt with as part of the prison and court literature reviews. Notably, a large segment of the literature focused on efficacy and/or ethics pertaining to CTOs (also known as involuntary outpatient commitment, supervised community treatment or assisted outpatient treatment). Those topics, while of importance, were beyond the scope of this review.

Based on the results of the inpatient literature review, the researchers refined the search strategy and limited it to three databases: Scopus, ScienceDirect and Google Scholar. Finally, they expanded the search to include literature sent directly to the research team via Ministry of Health advisors as well as the researchers and their professional network; Figure 5 summarises the results.

Figure 5: Community systematic review results



* After removing repetition of results in prior step(s).
** Grey literature was comprised of one position paper and one set of practice guidelines.

Review findings

Functions and structures of community forensic mental health services

Functions

Community FMHSs have a variety of functions, including (but not limited to): (a) providing specialist consultations and advice in the assessment and management of service users, (b) conducting risk assessments and advising/monitoring risk management efforts, (c) acting as case managers for FMHS users, (d) 'co-working' with GMHSs to provide care, (e) acting as liaisons for courts and other criminal justice agencies, and (f) providing specialist interventions such as anger management or cognitive behavioural therapy (Malik et al 2007; Mohan et al 2004a; Puri and Kenney-Herbert 2018). This description is supported by Kenney-Herbert et al (2013), who, in the creation of a set of standards for community FMHSs in the United Kingdom, outline the core functions of community FMHSs within the proposed approach to care.[25]

[25] Kenney-Herbert et al (2013) provide a useful breakdown of specific functions, giving a greater level of detail of what a FMHS should include than most other sources. This includes standards for FMHS case management; referrals, consultative advice and specialist interventions; and care pathway management from secure settings.

As noted above, community FMHS teams engage with multiple stakeholders and services, serving as consultant liaison to GMHSs, mental health intensive care units, other specialist mental health services, probation services and prisons, and secure mental health (inpatient) services (Brett et al 2012; Malik et al 2007; Mohan et al 2004a; Mullen and Ogloff 2009). Therefore, community FMHS teams are, in essence, multidisciplinary teams (Orovwuje 2008), and evidence supports the use of specialist services and interventions in community FMHSs, including occupational therapy (see, for example, Connell 2016; Roberts et al 2015; Talbot et al 2018), social work (see, for example, Sheehan 2012), and psychology (see, for example, Gredecki and Turner 2009) in the reduction of recidivism. Services may be provided to service users in supportive accommodation or step-down facilities, most commonly employed during transition from inpatient to community services,[26] on an outpatient basis, or in the home. As such, in keeping with broader best practices concerning the integration of services, community FMHSs should aim to provide a 'seamless service', offering continuity of care from the courts, inpatient services and prisons (Mullen et al 2000).

Integrated versus parallel approaches to care

There are two main community FMHS structures: Gunn (1977) originally coined the terms 'integrated' and 'parallel' to describe these (Snowden et al 1999; see also Malik et al 2007; Mohan et al 2004a; Mohan et al 2004b; Puri and Kenney-Herbert 2018). In the integrated approach, specialist FMHS professionals work within GMHS teams and the broader mental health service. Forensic service users are therefore discharged to GMHSs upon exiting secure (inpatient/prison) services. According to Mohan et al (2004a), 'the presence of specialist workers in a mixed team of forensic and generic staff facilitates the dissemination of specialist skills to all staff' (p. 11; see also Malik et al 2007). Integrated structures may also reduce stigma, provide support and education for staff, and increase access to forensic services (Whittle and Scally 1998). However, drawbacks include larger caseloads and attenuation of specialist skills due to working with GMHS as well as FMHS users (Malik et al 2007; Mohan et al 2004a).

In contrast, in the parallel approach, specialist FMHS teams work alongside GMHS teams but are not a part of the same team. Specialist FMHS teams provide guidance and accept referrals for case management from GMHSs. Here, community FMHS teams retain responsibility for forensic mental health service users, providing 'outpatient follow-up and community care' (Puri and Kenney-Herbert 2018, p. 709). Benefits of this approach include smaller caseloads, though access may be hindered by the 'separate gate-keeping system' for each service, and there may be a lack of continuity of care between the services (Mohan et al 2004a, p. 11; see also Malik et al 2007). In many international contexts, the parallel approach is the dominant structure of community FMHSs. In England and Wales, for example, 80 percent of services follow the parallel approach (Judge et al 2004). Figure 6 summarises the differences between integrated and parallel structures.

[26] While outside the scope of this review, it is worth mentioning here that the only article in the search results to address women specifically within a community FMHS context examined the efficacy of high-support community-based step-down housing for women in the United Kingdom (Barr et al 2013).

Figure 6: Comparison of integrated and parallel models of community forensic mental health teams

	Integrated	Parallel
Description	CFWs work in the community mental health team	CFWs work in a separate team Separate referrals meeting
Advantages	Continuity of care and good communication More access to community resources Readmission easier if required Level of care can be reviewed	Specialist interventions available Specialist trained staff Links with CJS and secure hospitals Smaller caseload sizes
Disadvantages	Lack of specialist skills Lack of resources to manage difficult patients Larger caseload sizes	Isolated from other services Stigmatization of patients Focus on high-risk patients

CFW, community forensic worker; CJS, criminal justice system

Note: The abbreviations 'CFW' and 'CJS' reflect the United Kingdom context of the source. In the Aotearoa New Zealand context, 'CFWs' equate to FMHS staff.

Source: Mohan et al 2004a, p. 12

In practice, however, as Mohan et al (2004a) note, 'it is likely that the two models [approaches] are on a continuum and many existing services are a combination of the two (Tighe et al 2002)' (p. 11; see also Malik et al 2007). Indeed, in a study of community FMHS structures in the United Kingdom, Mohan et al (2004b) noted the overlap of characteristics between the structures, suggesting that, while most services may view themselves as parallel, they are likely to be 'hybrid' in practice. In a hybrid approach, some service users stay with forensic services while others are discharged to GMHSs; this is determined on a case-by-case basis, depending on the service user's history of offending, risk factors, legal status and individual needs (Puri and Kenney-Herbert 2018). Natarajan et al (2012) further define the hybrid approach, particularly in the United Kingdom context:

> This model [approach] runs integrated services but uses 'shared care' in the critical period following discharge, with forensic services retaining long-term responsibility for the 'critical few' who are considered to be high-risk offenders, such as those on restriction orders. If readmission is necessary, it will usually be to a local general psychiatric hospital; in certain circumstances the patient will return to the medium secure unit (particularly in the case of the 'critical few'). (p. 409)

According to this definition, in Aotearoa New Zealand, the approach within community FMHSs is most similar to this 'hybrid' approach, as previously indicated, as they combine integrated consultation and liaison services with parallel case management of a small group of individuals; mainly those designated as special and restricted patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Skipworth and Lindqvist 2007).

It is important to note in this discussion that the terminology of 'integrated' versus 'parallel' may not be useful in clinical practice. As Snowden et al (1999) argue:

> the integrated/parallel debate has become confused because of terminology. Is it the patient, the service, or the organizational structure that is parallel? … The debate about the merits of parallel care is in many ways meaningless as it does not describe what is being provided. Those responsible for commissioning services misunderstand what the label means, especially as integration of mental health services can also be used to refer to integration of health and social services, not specialist and local services. (p. 592)

Snowden et al (1999) thus offer an alternative way to describe the various combinations of community FMHSs according to level of risk, as discussed below in relation to the rehabilitation approach.

Forensic mental health case management

Literature on FMHS case management structures, particularly forensic assertive community treatment (FACT), comprised a substantial segment of the review results. Forensic case management structures are similar to GMHS case management structures in that they typically encompass 'assessment, individual service planning, implementation, and review' (Kelly et al 2002, p. 208). Case managers play a critical role in community mental health by acting as liaisons who coordinate 'mental health services with healthcare, housing, transportation, employment, social relationships, and community participation', which are 'essential components for successful community re-entry and integral in managing mental health symptoms' for FMHS users in the community (Leutwyler et al 2017, p. 168). Effective case management has been shown to reduce rates of rehospitalisation and recidivism, and increase engagement with community FMHSs (Kelly et al 2002; Leutwyler et al 2017; Pearsall et al 2014).

The FMHS context differs from the GMHS context in that it requires a focus on risk/harm minimisation and recidivism reduction. There are a number of general structures of forensic case management, including FACT, forensic intensive case management (FICM) and integrated dual diagnosis treatment (IDDT) (Jennings 2009), as well as specific localised approaches, for example the Forensicare approach in Victoria, Australia (Kelly et al 2002) and the forensic continuum structure of the Arkansas Partnership Program in the United States, which has also been adapted for the United Kingdom context (Jennings 2009; Smith et al 2010). However, 'no international, national, or state-wide guidelines exist to ensure that formerly incarcerated individuals with SMI [serious mental illness] receive case management upon community re-entry despite evidence that such services can prevent further criminal justice involvement' (Leutwyler et al 2017, p. 168).

Forensic assertive community treatment

Forensic assertive community treatment (FACT) is an approach to case management that has been found effective – albeit with limited evidence – in improving mental health stabilisation and community tenure, and reducing rehospitalisation (Jennings 2009; Kelly et al 2017; Lamberti and Weisman 2010; Lamberti et al 2004; Lamberti et al 2017). It has also shown promise in reducing recidivism among service users, though to varying degrees and with somewhat conflicting results (Jennings 2009; Leutwyler et al 2017; Marquant et al 2016). It adapts the broader evidence-based structure of assertive community treatment (ACT), which:

> calls for a 'total team approach' by an interdisciplinary team (typically consisting of a psychiatrist, mental health nurse, social worker and/or other mental health professionals), who are dedicated to closely monitoring and supporting a specific, small caseload of persons with severe mental illness in real life community settings. Since ACT provides intensive around-the-clock assistance, it is a labor intensive methodology and is therefore usually reserved for individuals with the most severe and persistent psychiatric disorders, who are at greatest risk for homelessness and re-hospitalization. (p. 13)

Marquant et al (2016) further identify the following six elements as the key components of ACT: (a) home-based treatment, (b) involvement of a psychiatrist, (c) small caseload, (d) IDDT specialists, (e) integrated vocational therapy, and (f) 24/7 service delivery (p. 873). These elements may have significant cost and resourcing implications.

Akin to the broader ACT approach, in the FACT context, a multidisciplinary team provides individualised, comprehensive, ongoing support to FMHS users that is 'time unlimited' to monitor service users' mental health symptoms as they fluctuate over time (Leutwyler et al 2017). The proliferation of FACT since the 1990s has led to a fair amount of diversity in approaches (Jennings 2009; Kelly et al 2017; Lamberti et al 2017) and a consequent lack of standardisation or guidelines governing practice. Lamberti et al (2004) thus restricted the definition of FACT to:

> those programs that (1) specifically serve persons with severe mental illness and histories of arrest and incarceration; (2) whose primary source of referrals is the criminal justice system; and (3) are closely coordinated with the criminal justice system. (as cited in Jennings 2009, p. 14)

Despite this more concrete definition of FACT, there remains significant variability in the delivery of FACT services, and a lack of practice guidelines (Cuddeback et al 2008), and there is little consensus concerning a programme structure for FACT (Cuddeback et al 2009). However, in a study of the characteristics of 28 FACT programmes, Cuddeback et al (2009) found practitioners generally agreed upon the following five aspects of service delivery.

1. 'Staffing of FACT teams is of critical importance' – clinical expertise and special skills are required to work with and advocate for FMHS users and to liaise with various services (eg, police, courts, probation and corrections) (p. 232).
2. 'FACT consumers are not necessarily different from traditional ACT service users, but their current needs are' – while demographics or clinical issues between the two service user groups may be similar, the legal involvement of FACT service users as well as the prevalence of substance abuse issues in this group represent significant differences. For FACT service users, IDDT is particularly important. Forensic consumers also experience greater hardship obtaining housing and may be more 'challenging' to serve (pp. 232–233).
3. 'FACT teams must be able to successfully interface with the criminal justice system' – FACT teams interface between the mental health system and the criminal justice system and must be able to negotiate the two, despite their seemingly contradictory goals (therapeutic concerns versus law enforcement). FACT teams must have strong relationships with both sectors to function successfully.
4. 'FACT programs need front doors as well as back doors' – FACT teams must have a means of both acquiring referrals and discharging service users from a team as clinically indicated. This is notably different from the traditional ACT approach, which provides time-unlimited services.
5. 'Sustainable funding is a significant challenge' – Particularly in the United States context, the FACT programmes surveyed in this study were started by seed money from various government and private foundation grants. After these funds were exhausted, programmes experienced challenges obtaining additional funding. Long-term funding is required to ensure sustainability of services. This may be less of an issue in contexts where funding for such services is included in regional or national government-provided health service budgets.

Further research is needed to confirm the efficacy of ACT approaches among the forensic mental health population, particularly in relation to the reduction of reoffending, and to establish best-practice guidelines (Cuddeback et al 2009; Jennings 2009; Kelly et al 2017; Leutwyler et al 2017; Marquant et al 2016).

Forensic mental health liaison approach

In a discussion of the United Kingdom context, Natarajan et al (2012) describe an increase in what is referred to as a liaison approach to service delivery or the 'way of working', which differs from standard community FMHS provision. While acting as consultants for other services/sectors is a part of the work of most community FMHSs, liaison services specifically 'aspire to provide advice, education, support, training and expertise' (Natarajan et al 2012, p. 410). However, 'the responsible clinician role remains with the general adult service, engendering continuity of care' (Natarajan et al 2012, p. 411). As illustrated in a case study of the Wolverhampton Mental Health Services Forensic Liaison Scheme, Natarajan et al identify five principles of the liaison structure: 'shared care, low threshold for referral, early intervention, good collaborative risk management, and good communication between services' (p. 410). Natarajan et al further highlight several advantages to working in a liaison approach; particularly:

- continuity of care for mentally disordered offenders between mental health services (both tertiary and secondary) and the criminal justice system, facilitating good multi-agency working
- rapid access to expert advice regarding risk assessment and management
- oversight of secure admissions to allow for appropriate admissions and timely discharge
- good productive working relationships between FMHSs and local services through partnership and improved communication
- ensuring local accountability and involvement by empowering local clinicians in complex case management, bringing significant increases in the confidence and competence of local service staff in risk assessment and management
- an overall achievement of health and economic benefits through service integration/alignment. (p. 411)

Overall, Natarajan et al (2012) argue that the liaison structure is appropriate for the FMHS user population particularly in terms of its capability to address risk to the community while being cost-effective, reducing inappropriate referrals to FMHSs, empowering non-forensic mental health clinicians and facilitating continuity of care.

Non-custodial sentences and conditional release

A subset of the literature pertaining to community FMHSs provides examples of service structures or programmes specifically for FMHS users who receive non-custodial sentences via CTO or similar means, or who enter FMHSs after conditional release. As noted above, in the Aotearoa New Zealand context, service users who receive CTOs generally fall under the auspices of GMHSs, unless their clinical history indicates a need for ongoing FMHS involvement. As such, the majority of FMHS users in Aotearoa New Zealand are either imprisoned or institutionalised in a forensic mental health hospital (Skipworth and Lindqvist 2007). However, in other international contexts, such as the United Kingdom, CTOs are more frequently employed for the FMHS population, due to the legislation, and are often supervised either by the probation service and/or GMHSs or jointly with community FMHSs where clinically indicated (Clarke 2013; Lamberti et al 2011; Roskes et al 1999).

Various evidence-based approaches used with the prisoner/probationer population may be applied to FMHS users after conditional release; for example, mental health courts, FACT, the RNR model, informed supervision practices, HOPE probation and the Passageway residential approach (Gowensmith et al 2016; Lamberti and Weisman 2010; Lamberti et al 2011; Landess and Holoyda 2017; Melnick 2016). A more detailed discussion of these models and the broader role of probation services is provided in the prison literature review.

Therapeutic security, rehabilitation and recovery

Therapeutic security

As previously indicated, FMHSs in Aotearoa New Zealand have a responsibility for the direct clinical management of a small group of individuals; mainly those designated as special and restricted patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Skipworth and Lindqvist 2007). Case management support for this group is staggered and gradual, in accordance with the transition from very structured inpatient FMHS environments toward eventual transfer of care to GMHSs at the point of discharge. This approach – as is the case with FMHSs more broadly – developed in the early 1990s, largely following the recommendations of the Mason Report (1988), and has remained relatively unchanged since that time.

Kennedy et al (forthcoming) explain how case management support may be conceptualised in relation to stratified levels of therapeutic security in community FMHS provision, similarly to the inpatient context:

> In much the same way that forensic hospital pathways are designed as stratified levels of therapeutic security, community support is often organised into a stratified series of levels of support. Sustainable step-down places in the community typically include community houses with 24-hour nurse care, 24-hour social care, daytime social care and supported independent living. Many of these are provided in partnerships between the public and independent sectors. Some highly dependent patients may be successfully accommodated in bespoke community packages in which high levels of relational therapeutic security are provided, with procedural security measures mandated by conditional discharge, in the absence of any unusual physical security measures. (p. 16)

Forensic mental health services thus support GMHSs in the ongoing management of people who interact with the criminal justice system or present with a high level of perceived risk. In this regard, the FMHS role is not case management but the provision of advice, in a consultation and liaison role. Pivotal to this role is advice on the assessment, monitoring, and management of risk, if it comprises a central focus of the broader rehabilitation approach (Malik et al 2007; Mohan et al 2004a; Puri and Kenney-Herbert 2018). If the team receiving the advice works to a model of care that emphasises therapeutic security, the advice is more likely to be successfully integrated.

Rehabilitation

Although, in the community FMHS literature, risk attracts proportionately less attention than it does in the literature on inpatient services, risk remains a central concern in community FMHSs. It is most commonly discussed through the lens of recidivism (Blackburn 2004; Puri and Kenney-Herbert 2018). Many of the models of risk assessment and management thus apply to the community context (eg, the RNR model) (Gowensmith et al 2016; Mitchell 2015), and/or have been designed to integrate with community FMHS approaches to care. For example, Kelly et al (2002) detail the Forensicare Risk Management Model, a holistic, three-pronged practice approach (involving risk profile, risk assessment and risk management plans) designed for use in the Australian context to conduct risk assessment and management in community FMHSs, which follows the Forensicare case management model of care.

Risk may be further used to reconceptualise the structure of service delivery. For example, in a review of forensic mental health community caseloads in a United Kingdom mental health service, Snowden et al (1999) identified four approaches of service provision (ie, levels of care) in the management of FMHS users, based on the level of specialist care required as well as the level of risk (see Figure 7). In this framework, FMHSs are indicated for service users requiring Level 2–4 care (moderate to high risk), but as the risk increases the responsibility moves from being jointly managed by FMHSs and general mental health services, to FMHSs taking full responsibility. This framework provides an alternative, more comprehensive way to conceptualise the approaches to care community FMHSs use.

Figure 7: The four levels of community management of mentally disordered offenders

		Forensic mental health services	CMHT, probation and social services
High risk	Level 4	Forensic community mental health care: forensic psychiatrist, forensic social worker, forensic CPN	
	Level 3	Forensic lead shared care: forensic psychiatrist, forensic CPN, local authority social worker or probation officer	
	Level 2		Local service lead shared care: forensic CPN, general psychiatrist, local authority social worker or probation officer
Low risk	Level 1		CMHT care: full local team care, social supervisor, local authority social worker or probation officer

(Adapted with permission from Snowden *et al.*, 1999)

Note: The abbreviations 'CPN' (community psychiatric nurse) and 'CMHT' (community mental health team) reflect the United Kingdom context of the source. In the Aotearoa New Zealand context, 'CHMT' equates to 'GMHS'.

Source: Mohan et al 2004a, p. 12

Other trends in community FMHSs also reflect a connection to the broader rehabilitation approach. For example, FACT teams implement the key components of ACT alongside principles of forensic rehabilitation models (eg, the RNR model) that target recidivism (Marquant et al 2016). Notably, Lamberti et al (2004), in a survey of 16 FACT programmes, revealed a high number of residential programmes, which is significant 'because residential rehabilitation is *not* a component in the classic ACT model' (Jennings 2009, p. 14; original emphasis). Other specific structures may target criminogenic need in their rehabilitative approach. Programmes using IDDT, for instance, which aim to address comorbidity of substance abuse disorders among mental health service users, have been applied to FMHS user populations generally and specifically among persons recovering from co-occurring disabilities (Jennings 2009; Smith et al 2010).

Recovery-oriented approach

An emphasis in the literature on structures of clinical engagement that are intensive, proactive and 'assertive' tends to minimalise the role of recovery in such structures. There is, though more recent, focus on recovery in FMHS community structures. Alternative models to and variations of FACT have been developed to address its limitations: for example, a lower-cost variation to FICM with flexible ACT, which was developed and has been widely implemented in the Netherlands (Bond and Drake, 2007; van Veldhuizen 2007) and, more recently, adapted for use in the United Kingdom (Firn et al 2013; Sood et al 2017). As Firn et al (2013) explain:

> in this model, care is delivered by one team for the sector with approximately 90% receiving recovery-oriented individual case management in a multi-disciplinary team with a flexible 10% receiving an AO [assertive outreach] level of service according to need from the same team using AO principles of shared caseload, daily planning and frequent visits. Service users move between the two levels according to need with a simple team-based decision. (pp. 997–998)

Preliminary evidence suggests flexible ACT is as effective as traditional FACT in clinical outcomes (Firn et al 2013; Sood et al 2017).

In keeping with broader trends in FMHSs in recent decades, community approaches to care are drawing upon principles of the recovery-oriented approach with increasing consistency. Particularly, the good lives approach has been used in the community context, and there is evidence of its effectiveness in enhancing psychological wellbeing and general quality of life, increasing service user engagement, and managing risk of recidivism (Barnett et al 2014; Harkins et al 2012; Mitchell 2015; Ward and Attwell 2014). In contrast to the inpatient context, however, such approaches are typically used in targeted outpatient programming or interventions (eg, for sex offenders) (Harkins et al 2012) – that is, one aspect of community FMHSs, rather than to inform the structure or principles of service delivery more generally.

Another structure supporting a recovery-orientated model of care in community FMHSs is recovery learning colleges, which originated in the United States and have recently been adopted in the United Kingdom (Frayn et al 2016). While limited evidence exists of their use in forensic mental health contexts, recovery colleges are well documented in non-forensic community mental health settings (Frayn et al 2016). Recovery colleges embody 'the core principles of recovery-focused services, with an emphasis on self-efficacy and self-management, inspiration and hope provided by learning from others with similar experiences' (Frayn et al 2016, p. 29). Recovery colleges may be designed for the various levels of security spanning inpatient and community FMHSs. Frayn et al (2016) state that a recovery college has the following defining features.

1. There is co-production between people with personal and professional experience of mental health problems.
2. There is a physical base (building) with classrooms and a library where people can do their own research.
3. It operates on college principles. People attend as students rather than patients and select their own courses. Risk assessments are not conducted by the college to see if people are 'suitable' to attend.
4. It must reflect recovery principles in all aspects of its culture and operation.
5. There is a personal tutor who offers information, advice and guidance.
6. It is for everyone in the community.
7. The college is not a substitute for traditional assessment and treatment, or for mainstream colleges.

It is important to note here that recovery colleges do not provide a holistic model of care for community FMHSs, as they do not provide clinical care. As such, recovery colleges should be seen as complementary education-based services that may be incorporated into broader FMHSs to build patient self-sufficiency and support long-term outcomes.

Of particular relevance to the Aotearoa New Zealand context, Skipworth and Humberstone (2002) developed a recovery-focused community FMHS model of care based on 10 person- and family-oriented principles governing the structuring of care. These are:

1. The service must be located in the community, for both philosophical and practical reasons (eg, visibility, accountability, access, community integration).
2. All members of the service must be mobile, to ensure accessibility and facilitate comprehensive assessment.
3. The service must be accessible during weekends and after hours, to meet patients' needs and provide continuity of care.
4. The service must provide culturally informed care (eg for Māori).
5. An effective therapeutic alliance must be formed between the service user and the FMHS team, who must work collaboratively to shared goals.

6. The service must be able to provide a high frequency of contacts with service users, to support rehabilitation and risk management.
7. Service users must have unobstructed access to services, including access to rehospitalisation.
8. The service should work with the service user's family and significant social network.
9. The service must understand and incorporate recovery as a philosophy of care.
10. The service must deliver care based on individual risk management and rehabilitation plans. (Skipworth and Humberstone, 2002, pp. 49–52)

Summary

While the majority of FMHS users will eventually be discharged to GMHSs, a small group of individuals in the community will require ongoing FMHSs. Consequently, community FMHSs provide a range of services, including consultation and liaison as well as various specialist interventions. These services may be integrated with or parallel to GMHSs. Within the various models of community FMHSs, case management and particularly FACT have the most robust evidence base and are most relevant to the Aotearoa New Zealand context. In terms of overarching themes, discussions of therapeutic security, rehabilitation and recovery prevail in the community literature, albeit less directly so. Key here is the need to continue attending to service users' criminogenic and therapeutic needs to reduce their risk of reoffending. Notably, evidence concerning models of care among priority populations within community FMHSs was largely absent from the literature, highlighting the need for further research in this area.

Section 4:
Prison review

Introduction

In keeping with the broader trends in FMHSs, prison mental health services (PMHSs) have received increasing attention over the past three decades, both within Aotearoa New Zealand and internationally. From the 1980s onward, due to the findings of pivotal inquiries such as the Butler Report (Home Office and Department of Health and Social Security 1975) in the United Kingdom and the Mason Report (1988) in Aotearoa New Zealand, it has become increasingly clear that 'the responsibility for the mental health of prisoners in New Zealand and also allied countries is with healthcare services' (Brinded and Evans 2007, p. 424). Subsequent legislation, particularly from the mid-1990s onward, has thus underscored the need for prisoners with mental illness to be 'seen as patients' and receive the same level and quality of mental health care as provided in the community (Forrester et al 2013b, p. 327).

More recent legislation, such as the revised United Nations minimum standards for the treatment of prisoners in 2015, which have subsequently been adapted for mental health populations by the World Psychiatric Association, as well as other international conventions, has confirmed 'the central role of the concept of *equivalence* in enabling improvements within prison healthcare' (Forrester et al 2018, p. 102; see also Nicholls et al 2018; Romilly and Bartlett 2010; Senior and Shaw 2013; Shaw and Humber 2004; Völlm et al 2018). Indeed, this concept has driven significant service changes in PMHSs, such as, in the United Kingdom, the transfer of prison health care from the Home Office to the National Health Service, completed in 2006 (Forrester et al 2018; Senior and Shaw 2013). However, current evidence suggests equity has yet to be fully realised, and the need for service improvement is ongoing (Forrester et al 2013b).

At the same time, these shifts in service delivery have led to the establishment of an in-reach model, where services are provided by multidisciplinary, specialist mental health teams that interface between FMHSs and PMHSs, as is also the case in Aotearoa New Zealand. In other jurisdictions, however, PMHSs are provided solely by corrections services and, in many cases, are still being developed (Forrester et al 2018). Here, it is important to note that this review focuses on prison models of care, which are provided by specialist mental health services for prisoners who present with severe, acute and/or enduring mental illness. That is, this review examines models of care for PMHSs that interface with FMHSs, are used by service users who fall under the purview of FMHSs, and/or are typically administered by secondary or tertiary mental health service providers (ie, FMHSs). This review does not discuss primary PMHS provision or programmes for prisoners in general (eg, AOD services), or those whose mental health

needs do not require FMHS intervention.[27] In Aotearoa New Zealand, primary mental health services and specialist programmes for the general prison population, including those provided in special treatment units, are the responsibility of Ara Poutama. Due to the high relevance of the Māori- and Pacific-focused services delivered by Ara Poutama, the decision was made to include these services within this review, even though they lay outside of FMHS provision. Finally, although it is important to acknowledge the body of research on the role of probation services in the provision of mental health services following prisoners' release, it was beyond the scope of this review to delve into probation service models in detail.

Overall, as Kennedy et al (forthcoming) avow, 'sentenced prisoners with mental health needs require a reliable system for continuity and monitoring of care and treatment under the challenging conditions that prevail in most prisons' (p. 10). Current evidence suggests the prison population requires 'wrap around, holistic services', which provide continuity of care from initial screening through to discharge planning and transition/reintegration to community (Nicholls et al 2018, p. 3). As this report will further discuss, a number of models exist that provide for this process, either in part or whole.

In this systematic review, the researchers sought to identify literature describing the various models of care used to deliver mental health services for prisoners, both within prisons and after release. In keeping with the prior reviews, the researchers included literature on approaches, frameworks and programme models to identify models of care, as the literature addressing 'models of care' directly is limited. However, as noted above, the researchers excluded the literature on primary mental health services in prisons. Literature on mental health services that engage individuals prior to their entry to prison (ie, during the judicial process – though there may be overlap in both the population and the service delivery involved) is not discussed here, but rather in the courts section.

This review is organised into three main sections. The first discusses the structure and key components of the most dominant model of PMHS provision – the in-reach model. The next, in keeping with the other reviews, examines the overarching themes of therapeutic security, rehabilitation and recovery, identifying additional models as they pertain to these themes (eg, high support units and therapeutic communities). Notably, these themes present somewhat differently within the prison context, largely due to the rigidity with which the prison environment shapes the delivery and conceptualisation of care, and the tensions inherent in the opposing goals of incarceration and health care. The final section addresses approaches for priority populations (ie, Māori, Pacific peoples, other indigenous groups and women).

[27] However, it is important to note the substantial issues prevalent in primary mental health service provision within prisons, which 'have historically been underfunded and underdeveloped, and … have faced significant difficulties balancing clinical need with the need to maintain discipline and control' (Forrester et al 2018, p. 105). See Forrester et al (2018) for further discussion of this issue.

Methodology

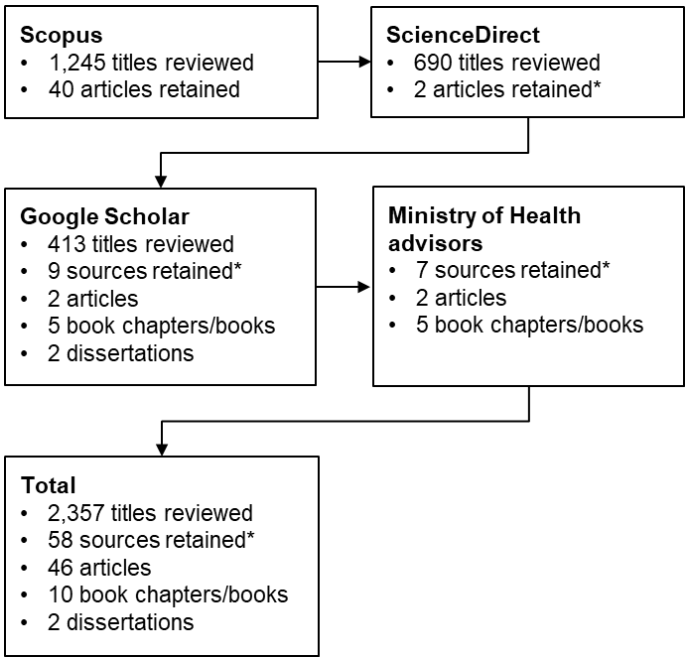
Searches used the following search string, along with various combinations of these keywords: (forensic OR criminal) AND ('mental health' OR 'mental illness' OR psychiatr* OR 'serious and enduring mental illness' OR 'mentally-disordered offender') AND (framework OR 'model of care' OR model OR service* or guideline*) AND (prison* OR probation OR jail OR gaol). After the initial searches, the researchers added 'in-reach' as a keyword, to capture literature that might more directly relate to the Aotearoa New Zealand context.

The researchers limited results (as they did in the prior reviews) to English-language documents from 1990 to 2019. Where possible, they further limited results to peer-reviewed articles, excluding reviews/notes. The researchers reviewed results first by title and then by abstract to determine relevance. After preliminary exclusions, they then screened full-text articles to confirm their relevance, to arrive at the results retained. The researchers limited results to literature describing mental health models of care and/or services provided for the prisoner population in prisons or while transitioning to / reintegrating into the community. They excluded literature relating to processes prior to incarceration, including court diversion, conditional release, findings of not guilty by reason of insanity, and community treatment orders.

A large portion of the search results pertained to determining prisoners' mental health needs, characteristics and outcomes in various contexts. Such data was beyond the scope of this review. Additionally, as they had done in the community review, researchers found limited (though slightly more robust) literature on models of care addressing priority populations (ie, Māori, Pacific peoples, other indigenous groups and women). Most notably, in comparison to the other reviews, literature on therapeutic security, recovery and rehabilitation (including risk assessment and management) comprised a much smaller portion of the discussion and arose mainly in relation to post-release planning and interventions.

In keeping with the prior reviews, the researchers refined the search strategy and limited it to three databases: Scopus, ScienceDirect and Google Scholar. Finally, they expanded the search to include literature sent directly to the research team via Ministry of Health advisors as well as the researchers and their professional network; Figure 8 summarises the results.

Figure 8: Prison systematic review results



* After removing repetition of results in prior step(s).

Review findings

In-reach services

Prison mental health service provision comes in varying forms, dependent upon who is providing care (ie, corrections or mental health services). The majority of the literature reviewed focused on in-reach services as described above, and particularly those developed in the United Kingdom (Armitage et al 2003; Brooker and Webster 2017; Cumming 2018; Forrester et al 2013b; Forrester et al 2014; Forrester et al 2018; Harty et al 2012; Senior and Shaw 2013; Senior et al 2013) and, to a lesser extent, Aotearoa New Zealand (McKenna et al 2015; McKenna et al 2018; Pillai et al 2016). In-reach models have generally been adapted from an integrated, community-based approach and similarly aim to achieve the level and quality of care provided in community mental health services (Senior 2005).

As indicated in Section 1 of this document, the prison in-reach model of care within Aotearoa New Zealand emphasises five key elements within service provision: (a) screening, (b) triage, (c) assessment, (d) intervention and (e) reintegration (STAIR) (Forrester et al 2018; McKenna et al 2015; Nicholls et al 2018; Ogloff 2002). Each of these elements is described below in more detail.

Screening

Screening prisoners upon entry or reception to prison, to address immediate safety issues and identify their mental health needs, is considered best practice internationally. This facilitates early intervention and/or transfer to FMHSs as required (Dressing and Salize 2009). Nicholls et al (2018) state:

> screening entails an investigation by trained mental health workers using validated tools to identify subpopulations or individuals who have some targeted problem, in this case mental illness, substance disorders, and/or are considered to be at risk of adverse events (eg, suicide, violence, victimization, non-suicidal self-injury). (p. 14)

Several screening tools have been developed for this purpose (Adams et al 2009; Forrester et al 2018; Nicholls et al 2018; Ogloff 2002; Pillai et al 2016; Slade et al 2016). In-depth review of screening tools was beyond the scope of this review.

Triage

Triage is defined 'as a strategy for deciding how to prioritize mental health resources (ie, for assessment, treatments) to those with greatest need/urgency' (Nicholls et al 2018, p. 17). Triage is typically the second stage of assessment for all prisoners. However, fewer tools exist for this purpose, and the majority focus mainly on physical health, rather than mental health (Forrester et al 2018). Forrester et al (2018) thus recommend 'assessment and mental health triaging within a number of days (between 3 and 7 days) following prison reception', after which mental health teams should triage referrals and 'allocate them to the appropriate service or individual in accordance with their presenting need (eg, common mental disorder, severe enduring mental illness, acute mental health problem)' (p. 105). At this stage, a common challenge is delays in hospital transfer following referral due to capacity shortages, which affect prisoners' access to FMHS inpatient units. In response to this trend, in the United Kingdom, a limit of 14 days to hospital transfer was proposed in 2009, and programmes have been developed to reduce transfer times for acutely mentally ill prisoners (Forrester et al 2013a).

Assessment

Mental health assessment involves 'detailed evaluation by a specialized mental health professional (eg, psychiatrist), a referral to necessary mental health services, and establishing of a detailed treatment plan' (Nicholls et al 2018). Assessment at this stage provides a more in-depth clinical view of a prisoner's mental health needs than that achieved in the prior steps. Assessment tools in the prison setting are typically similar to those in hospital and community settings, though the correctional population may provide 'unique diagnostic challenges' that must be taken into account, related to the complexity of how mental disorders present in the correctional setting (Nicholls et al 2018).

Intervention

Once the appropriate course of treatment has been determined, in-reach services may continue to provide care within the prison, often in 'wing-based' mental health units (Forrester et al 2018). Such units provide 24-hour care within the prison, 'often managing a mixture of physical and mental health problems, including people with acute mental illness whose behaviour or risk of self-harm cannot be supported in the wider prison' (p. 105). Alternatively, prisoners may be transferred to a forensic mental health hospital outside the prison to receive treatment. Speaking of the United Kingdom context, Forrester et al (2018) further explain that whether a prisoner is treated in a prison inpatient unit or FMHS depends largely on the jurisdiction's legislative framework. Where some jurisdictions enable treatment in prison settings, others (eg, England and Wales) 'specifically exclude compulsory treatment in prisons, and instead require people who need treatment under compulsion to be transferred to secure hospital settings where they can be further managed using mental health legislation' (p. 105).

Within the Aotearoa New Zealand context, specific in-reach interventions may include:

> medication management, psycho-education, psycho-social therapies, motivational interviewing, facilitation of family involvement, alcohol and substance misuse treatment, physical health support, referral to specialist agencies, addressing housing/financial needs, addressing educational needs and cultural support for Māori (50 percent of the prison population) and Pacific Island peoples 11 percent) (McKenna et al 2015, p. 286).

These services thus require access to care from a range of professionals, in keeping with the broader multidisciplinary team model (Nicholls et al 2018). Interventions should follow evidence-based best practices, guidelines and standards to provide services equivalent to those provided to community care, in keeping with international health policy.

Reintegration

Discussing the impact high-quality PMHSs can have on prisoners' successful reintegration, Forrester et al (2018) state:

> There is good evidence that the period of transition from institutional to community living is a vulnerable period, with problematic onward health engagement and increased mortality currently. Intervention, however, can improve subsequent health engagement. Good quality mental health care in prison, offering continuity of care beyond the gates, is therefore important from an individual, social and economic perspective. (Forrester et al 2018, p. 106)

McKenna et al (2017) similarly state, 'release planning constitutes an opportunity for 'critical time intervention,' focusing on ensuring continuity of care across a range of providers as the prisoner transitions through the gate' (p. 3; see also Angell et al 2014; Smith et al 2018). Indeed, the literature highlights that providing care during transition to facilitate community reintegration and coordinate support after prisoners' release is a key component of PMHSs (Hancock et al 2018; Hopkin et al 2018; Pearsall 2016; Sheehan and Ogloff 2014; Smith-Merry et al 2018; McKenna et al 2017). At the same time, 'reintegration is widely acknowledged to be the least well-developed component of correctional service planning despite being recognised as an essential aspect of services, particularly for mentally-disordered offenders' (Nicholls et al 2018, p. 30), a deficit that has significant implications in prisoners' risks of recidivism and long-term health outcomes.

In terms of reintegration services, the first step in this process is to conduct pre-release planning in the months before release that sets in place an individualised re-entry plan, including provisions for supervision, medication and programmes and mobilises resources for community reintegration. Best practices indicate this should occur three months prior to release, though in some services referrals to community mental health teams currently do not occur until closer to release (ie, six weeks prior).

Pre-release planning includes engaging with community mental health services and social care agencies (eg, housing and employment support) (McKenna et al 2015). This step should also include face-to-face contact and relationship building between the prisoner and the service liaison(s), to provide continuity of care and promote service engagement (McKenna et al 2015). Indeed, evidence suggests the importance of integrated services for prisoners after their release and in community mental health more broadly that link together criminal justice, mental health, probation[28] and social/support services to facilitate community re-entry.[29] Dlugacz (2014) further specifies six areas that should be assessed in re-entry planning to determine prisoners' needs: (a) clinical factors (medical/psychiatric diagnoses and substance abuse), (b) social support and connectedness, (c) housing, (d) financial factors (eg, employment/ benefits programmes), (e) motivation and (g) risk factors.

[28] Within the literature the researchers reviewed, there was a notable subset focusing on the role of probation services in supporting and/or delivering mental health services for prisoners after their release (eg, Bourne et al 2015; Geelan et al 2000; Sirdifield and Owen 2016; Skeem et al 2003; Skeem and Louden 2006; Welsh et al 2016; Wolff et al 2014). Although included in the retained results for reference (and thus presented here), probation services are typically provided outside the mental health service in most cases and thus have not been further explicated here.

[29] For examples of specific programmes, see, for example: Angell et al 2014; Draine et al 2005; Hartwell and Orr 1999; Lamberti et al 2001; Lee et al 2019; Weisman et al 2004.

Therapeutic security, rehabilitation and recovery

In contrast to the other reviews, the discussion of therapeutic security, rehabilitation and recovery was largely absent in the literature. Giblin et al (2012) discuss the application of stratified therapeutic security to an in-reach prison service through the creation of a 'high support unit' aimed at 'accommodating prisoners with increased mental health need in a purposeful environment and segregated from the main prison population [which] improves therapeutic assessment and treatment where necessary, in a safer environment' (p. 3). Notably, these units differ from wing-based units, as they are 'functional and dynamic' and feature 'increased relational security (staff to prisoner ratios) in addition to improved environmental security' (Giblin et al 2012, p. 7). Giblin et al recommend the additional development of a 'low support unit', which would further stratify the service, bringing it more in line with the goal to provide care in the least restrictive environment.

Regarding the latter two concepts, rehabilitation and recovery-oriented approaches have not been developed fully in the prison context, and are discussed primarily in relation to risk management/criminogenic need and holistic services/programming. Here, limited research suggests the utility of programming models to reduce recidivism among prisoners after their release (eg, Skeem et al 2011), such as the RNR model (Barnett et al 2014; Dlugacz 2014; Skeem et al 2015).

In terms of recovery, Dlugacz (2014) suggests re-entry planning 'should be congruent with cognitive, motivational and recovery approaches – appropriately individualized and based on positive reinforcement' (p. 15). Powitzky (2011) proposes a correctional mental health recovery model which adapts best practices from community settings, such as 'illness management and recovery, supported employment, family psychoeducation, assertive community treatment, integrated treatment for co-occurring disorders, and medication management' (p. 44). Powitzky further recommends that individualised plans called 'treatment tracks' 'be developed with specified treatment objectives to be accompanied through evidence-based treatment protocols' (p. 45). However, specific details on the application of this proposed model are lacking.

One reason for the dearth in the literature on rehabilitation and recovery within prison FMHSs is likely due to the limitations of the prison environment, which, by its very nature, is somewhat contrary to the goals of rehabilitation and recovery articulated in other mental health service contexts. As Völlm et al (2018) avow:

> prisons are arguably places not conducive to mental well-being. Imprisonment is by its very nature and design associated with the deprivation of liberty, restrictions to one's lifestyle and autonomy, a loss of employment and accommodation, and, importantly, of relationships, including with partners, parents and children. The environment itself may be perceived as harsh and unsupportive and some prisoners, in particular those with sexual offences, may experience bullying and victimization. (p. 65)

The demands of the prison environment (such as lockdowns and scheduling) may inhibit or interfere with mental health service delivery in various ways; for example, by hampering access to assessment/interventions and restricting medication administration time (Brinded and Evans 2007). Such challenges may preclude the adoption of a recovery-oriented approach within the system. Further investigation is needed to understand better the utility and application of the concepts of therapeutic security, rehabilitation and recovery-oriented approaches within PMHS models of care.

Priority populations

Of the areas reviewed, prisons offer the most comprehensive culturally based services for Māori and Pacific peoples within Aotearoa New Zealand, though these are provided by Ara Poutama as opposed to FMHSs. That being said, the majority of documented services/programming have targeted the male prisoner population, and the literature indicates that few culture-focused programmes have historically been available for women, though recent initiatives seek to remedy this gap (Thakker 2013).

Māori

In Aotearoa New Zealand, similarly with both forensic and general mental health services, cultural services are offered to all Māori prisoners; these are employed with varying levels of engagement. Prisons may employ cultural advisors to perform cultural screens and assessments, assist in building relationships, engage whānau, provide cultural programming and offer one-on-one support (Cavney and Hatters Friedman 2018; Sweetman 2017).[30] Within the multidisciplinary in-reach team, a cultural advisor may perform cultural assessments to support the screening and triaging process and to determine a prisoner's specific cultural needs and whether he/she may benefit from further engagement with cultural services and/or kaupapa Māori units or programmes (eg, Māori focus units or inpatient units).

In terms of the broader Māori-focused services offered, Ara Poutama runs five Te Tirohanga units (formerly Māori focus units), two Whare Oranga Ake units (transition units) and Māori therapeutic programmes. These services are delivered by Māori for Māori, using 'Māori philosophy, values, knowledge and practices to foster the regeneration of Māori identity and values to encourage offender motivation to address their offending needs' (Department of Corrections 2019b, np; see also Campbell 2016, 2018; Department of Corrections 2009, 2014; Hape 2017).

[30] Cultural services are also offered for Pacific peoples, though research is currently lacking on this topic.

These programmes have emerged over the past three decades in keeping with the broader creation and implementation of kaupapa Māori ('by Māori for Māori') services within public institutions, and largely following the recommendations of the Mason Report (1988), which published the first documented cultural assessment in a prison.[31] Te Tirohanga units have their own culturally informed model of care, which incorporates tikanga Māori and cultural programming (Brinded and Evans 2007; Cavney and Hatters Friedman 2018; Department of Corrections 2009; Thakker 2013). Preliminary evidence has shown positive outcomes from both Te Tirohanga and Māori therapeutic programmes, including the fostering of a positive and prosocial environment, the development of prisoners' sense of cultural identity and knowledge, and a marginal reduction in reconvictions and reimprisonments (Department of Corrections 2009; see also Hughes 2018; Johnston 2018).

Further evidence suggests that complementary mental health services, such as psychologist services, are also yielding positive outcomes for Māori (Castell et al 2018). It is important to acknowledge that while commonalities exist in terms of 'what works for Māori' – for example, the centrality of whānau – 'tailoring programmes for Māori also [must keep] in focus the vital role of the individual case,' to meet individuals' complex needs (Williams and Cram 2012 p. 5).

Pacific peoples

Another important culture-based approach is the Saili Matagi therapeutic programme for Pacific prisoners, created in 2003. A review of the programme in 2004 recommended the creation of what would become the Pacific Focus Unit at Spring Hill Corrections Facility, which uses elements of Pacific culture to inform its design and model of care, and continues to run the programme (King and Bourke 2017; see also Thakker 2013). This model has a significant criminogenic focus and, while it may have indirect health benefits, does not explicitly focus on mental health. At this time, more research is needed to document the innovations and efficacy of the Saili Matagi programme and the Pacific Focus Unit more broadly.

Other indigenous groups

Outside of Aotearoa New Zealand, limited documentation is available on programmes for indigenous or aboriginal prisoner populations that similarly use cultural concepts and values to inform service delivery. Generally, these programmes are administered within the larger prison environment, as indigenous-focused units and/or cultural services within prisons, and are not, proportionately, as readily accessible as they are in Aotearoa New Zealand; nor offered on the same scale.

[31] See Sweetman 2017 for further discussion of the development of kaupapa Māori services in the mental health sector.

One exception to this trend is the Canadian model of the healing lodge, a kind of therapeutic community[32] in which prisoners 'reside in a culture-focused community which is structured around Aboriginal values and practices' outside the mainstream prison environment (Thakker 2013, p. 398). In one of the few examples the researchers found of women-focused cultural programming, the Okimaw Ohci Healing Lodge:

> was developed in recognition of the heightened levels of past victimization encountered by indigenous female prisoners and the distinct needs of these women. The structured programme adopts culturally derived individual and interpersonal (ie parenting and community) healing practices. Application of indigenous spirituality, role definition, ritual and symbolism is designed to engender empowerment and positive life change. (Moloney and Moller 2009, p. 432)

Such a model may prove useful in considering the needs of female Māori and Pacific prisoners in Aotearoa New Zealand.

Women

International evidence from multiple jurisdictions suggests a 'disproportionate burden' of mental health problems among female prisoners, underscoring the need for gender-responsive programming in prisons (Nicholls et al 2018, p. 10). Yet there is a dearth of literature describing models of care for female prisoners. Where the literature has focused on women, the trend has been to describe the prisoner population and to note specific trends within it, including types of offending, prevalence of mental health diagnoses, incidence of trauma backgrounds, the need for trauma-informed approaches and interventions, and recidivism. There is also a body of literature on gender-sensitive risk assessment tools and interventions.[33] However:

> many questions remain largely unanswered: … are there differences for prison or treatment staff in working with males compared to females; do treatment models work the same for female offenders as male offenders; and are existing gender-responsive programs effective? (de Vogel and Nicholls 2016, p. 2)

de Vogel and Nicholls (2016) underscore that the 'extant research findings have been slow to be integrated into service delivery', highlighting the urgent need for 'gender-informed approaches in daily practice and in policymaking' (p. 2).

Writing in the United Kingdom context in 2014, Bartlett et al (2014) similarly underscored the need for gender-responsive models of care in prisons in relation to the gender-specific policy development occurring in England and Wales at that time. The authors specify:

[32] See Melnick et al (2001) for further discussion of the use of therapeutic communities for prisoners.

[33] See de Vogel and Nicholls (2016) for a brief review of the literature.

> In prison, an invigorated, gender-sensitive service model implies a number of key components: First, all women offenders need registration with a GP to ensure access to routine health care on release. Second, systematic recording of sexual and physical trauma histories would alert services to unmet need. Third, fully integrated, gender-specific, substance misuse services across health care should recognise links with offending and sex-working, sexual exploitation and sexual abuse … Fourth, the unexpected release of prisoners (eg following discontinuation of cases or community sentencing), combined with a reluctance of some community teams to manage women with complex needs, continues to undermine the work of prison mental health teams. Discussion of what happens inside prison … should shift to the adequacy of external community services to assist women offenders on release and to stay out of prison. (p. 630)

Bartlett et al (2014) further recommended that continuity of care be achieved through the creation of community-based psychological and physical 'holding networks', which liaise between the various teams and agencies of the criminal justice system and coordinate potentially co-located health interventions, accommodation and employment and training opportunities (pp. 631–2).

Moloney and Moller (2009) provide several examples of good gender-responsive practice in Canadian, Australian and United Kingdom programmes and policies, all of which attend to female prisoners' trauma and mental health needs through various mechanisms including counselling and education and awareness, intervention-oriented, cultural and research programmes. Three of these examples provide what can be described as an overarching holistic, gender-oriented model of care in tailored environments: the Okimaw Ohci Healing lodge in Canada (mentioned above), the Boronia Pre-Release Centre for Women in Western Australia and the Together Women Programme in the United Kingdom. Common to these models is a focus on the interconnection between trauma, mental illness, substance abuse and offending; developing women's skills and self-sufficiency; and addressing the needs of women alongside the needs of their children/families.

Within Aotearoa New Zealand, Ara Poutama has recently allocated funding to increasing social work and counselling services for women to support them 'to manage their trauma related needs' and provide 'practical assistance relating to family and parenting issues' (Frame-Reid and Thurston 2016, p. 39). Such services aim to provide female prisoners with opportunities 'to develop resilience, establish practical tools and strategies for managing their complex situation, and improve their own responses to external barriers' through engaging in rehabilitative programmes and reintegrative opportunities (Frame-Reid and Thurston 2016, p. 39). This suggests a shift toward a more rehabilitative focus, in keeping with best practices.

Indeed, this focus has been highlighted in Ara Poutama's recent (2017) strategy for women, and its resulting programming. For example, it has introduced Te Mana Wahine, a new cultural programme, in each of Aotearoa New Zealand's three women's prisons (Auckland Regional Women's Corrections Facility, Arohata Prison and Christchurch Women's Prison). The aim of this programme is to work with the women 'to develop their identity and cultural belonging, and build their connections to whānau and tamariki' (Arts Access Aotearoa 2018, np.).

Summary

In the prison context, FMHSs are typically comprised of in-reach services that complement the primary mental health services provided by corrections to the population of prisoners with serious and enduring mental illness. There are five key elements within FMHS provision to this population: screening, triage, assessment, intervention and reintegration. Screening involves using set tools to screen prisoners upon reception to prison, to identify their mental health needs and an appropriate service pathway. In the triage stage, referrals are made to allocate prisoners to the appropriate service. If referred, assessment involves more detailed evaluation by mental health professionals (eg, psychiatrists) to determine appropriate action. Once a plan is set, intervention then occurs within prison or inpatient FMHSs, as clinically indicated. Finally, reintegration focuses on the planning and provision of support services during the period of transition immediately before and after release.

One issue highlighted in the literature is the challenge incurred in providing mental health services within the prison environment due to the counter-therapeutic nature of that environment. Further consideration is needed to determine how prison FMHSs may adopt a more recovery-oriented approach, akin to that in other arms of the service. In terms of priority populations, prison services are particularly well developed for Māori and Pacific populations in Aotearoa New Zealand, though the evidence is still in its infancy. Further attention is needed on the adoption of gender-responsive practice that attends to female prisoners' trauma and mental health needs.

Section 5:
Courts review

Introduction

As Kennedy et al (forthcoming) explain, 'any population-based forensic mental health service should be grounded in a systematic in-reach service to the criminal justice system' (p. 9). This includes mechanisms that provide means for assessment and treatment of individuals with severe mental illness during engagement with police and the courts, as well as during remand and incarceration and after a prisoner's release (ie, probation). This review focuses on FMHSs provided within the courts, which are typically described as either court diversion or court liaison schemes, or a combination of the two.

There is a large amount of variation in court services between jurisdictions. Even when services follow the same overarching model, such as in Aotearoa New Zealand, there may still be variation between regions. However, in keeping with broader FMHS provision, 'all services are aimed at meeting both mental health and criminal justice outcomes' (McKenna and Seaton 2007, p. 450).

In this systematic review, the researchers sought to identify literature describing the various models of care used to deliver mental health services for justice-involved service users moving through the criminal justice system (ie, the courts). Notably, the literature did not adhere to the language of the 'model of care' in the court context, but rather outlined (most often indirectly) various models, schemes or aspects of service provision, particularly in relation to the determination of legal statuses, processes and/or services engaged. This review does not cover the period of mental health service engagement prior to a person's entry into the court system (ie, while in police custody)[34] or during incarceration/institutionalisation (including remand); nor does it cover the post-release period (ie, when a person is on probation). Further, it was beyond the scope of this review to examine specific mental health legislation, including legal statuses and definitions (eg, fitness to stand trial, not guilty by reason of insanity, etc).[35]

[34] Some jurisdictions provide early intervention or 'precontact' police liaison services to divert individuals to mental health services prior to court involvement. See McKenna and Seaton (2007) and Tarrant (2014) for further description of this in the New Zealand context.

[35] For discussion on the various legislation governing mentally disordered offenders in New Zealand, see, for example, Brinded (2000) and Brookbanks and Simpson (2007).

This review is organised in three sections. The first discusses the consultation role of mental health professionals in court proceedings. This is followed by an examination of the various models of mental health service provision in the courts, broadly categorised into diversion, liaison or combined (diversion and liaison) schemes. Finally, in keeping with the prior reviews, the third section examines services for priority populations. Notably, in terms of its relationship to models of care, discussion on therapeutic security, rehabilitation and recovery was largely absent in the literature (and thus is not included in this review).

Methodology

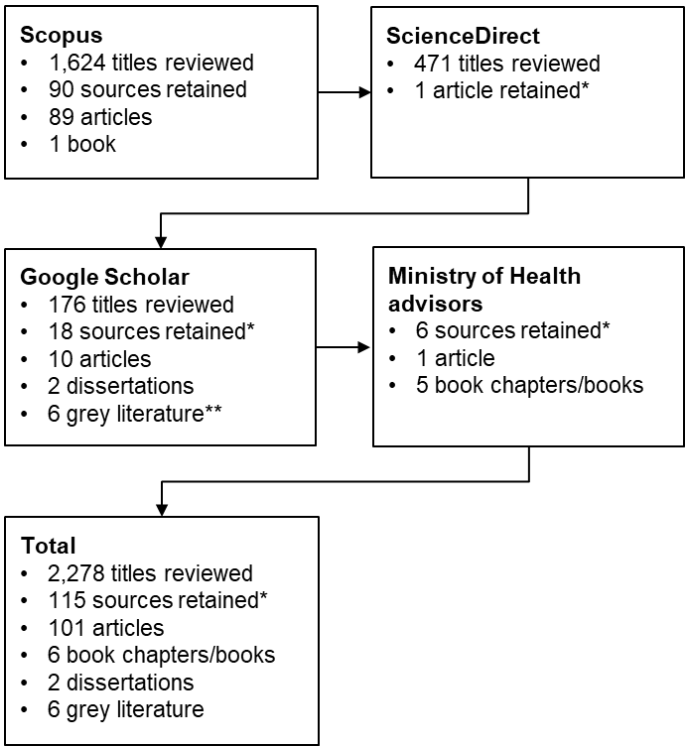
Searches used the following search string, along with various combinations of these keywords: (forensic OR criminal) AND ('mental health' OR 'mental illness' OR psychiatr* OR 'serious and enduring mental illness' OR 'mentally-disordered offender') AND ('framework' OR 'model of care' OR model OR service* or guideline*) AND (court* OR justice).

The researchers limited the results in the same fashion as they had done in the prior reviews to English-language documents from 1990 to 2019. Where possible, they further limited results to peer-reviewed articles, excluding reviews/notes. The researchers reviewed results first by title and then by abstract to determine relevance. After preliminary exclusions, they then screened full-text articles to confirm their relevance, to arrive at the results retained. The researchers limited results to literature describing forensic models of care and/or services within the justice system (ie, courts). They excluded from the review literature relating to processes prior to people's arrival in court, such as engagement with police or other social services.

Of the four reviews, this review yielded the largest and most diverse body of literature. A large portion of the search results pertained to legal pathways through the justice system, including court diversion, conditional release, findings of not guilty by reason of insanity, competency to stand trial and community treatment orders. Within this subset, researchers excluded literature that examined legal processes and/or outcomes of various schemes but did not describe the particular role or approach of mental health services. The absence of literature describing models of care specifically designed for priority populations (ie, Māori, Pacific peoples, other indigenous groups and women) was most marked in this review, of the four the researchers undertook. Similarly, literature on therapeutic security, recovery and rehabilitation (including risk assessment and management) was the least developed in this review.

In keeping with the prior reviews, researchers refined the search strategy and limited it to three databases: Scopus, ScienceDirect and Google Scholar. Finally, the researchers expanded the search to include literature sent directly to the research team via Ministry of Health advisors as well as the researchers and their professional network; Figure 9 summarises the results.

Figure 9: Court systematic review results



* After removing repetition of results in prior step(s).

** Grey literature was comprised of reports.

Review findings

Consultation

A subset of the literature focuses on describing the specific roles of mental health professionals in the courts; namely forensic psychiatrists (Dolin 2002–2003; Freckelton 2007; Galpin 2007; Mendelson 1992a, 1992b; Simon and Wettstein 1997; Tuddenham

and Baird 2007), nurses (Cyr and Paradis 2012; McKenna and Seaton 2007; Tarrant 2014)[36] and social workers (Sheehan 2012).[37]

In sum, mental health professionals – primarily nurses, psychologists and psychiatrists – provide expert advice to the courts as required. This may include conducting mental health screening, assessment and evaluation; and reporting on individuals' mental health status, needs and service engagement at various stages of the legal process. These services may be provided as part of a diversion/liaison scheme and/or on a consultation basis. Pretrial evaluations may take place in either inpatient or outpatient contexts, and a range of models exist for this service (Poythress et al 1991). As such, some services have developed protocols for seeking expert advice, which outline the pathway of psychiatric support provided to the courts (eg, Vaughan et al 2003). Vaughan et al (2003) emphasise the importance of information sharing between the police, diversion schemes, defence solicitors and forensic psychiatric assessors, as well as community and prison FMHSs. Ultimately, the goal is to assist the court in its decision-making process regarding individuals' mental health status, needs and pathways, though the decision-making power ultimately rests with the judicial system and not with mental health services.

Professionals may provide evidence to the court in the form of testimony and/or written medico-legal reports (Bank 1996; Dolin 2002–2003; Freckelton 2007; Galpin 2007; Gray and Williams 2013; Gunn et al 2014; Hean et al 2009; Mendelson 1992b; Puri and Treasaden 2018). In Aotearoa New Zealand, psychiatrists and psychologists within the regional forensic services write court-ordered reports. However, reports for prosecution or defence may also be sought privately (Simpson and Chaplow 2001).

In some jurisdictions, this role may be extended. In Scotland, for example, forensic psychiatrists and psychologists may serve as accredited risk assessors, who provide a risk assessment report for offenders 'solely for judicial purposes, to determine "what risk his being at liberty presents to the safety of the public at large"' under the governing legislation (ie, in Scotland, the Criminal Justice (Scotland) Act 2003) (Tuddenham and Baird 2007, p. 164). This differs from a typical forensic mental health role, which interfaces between justice and mental health, for the focus here is solely on public safety, and not the safety (ie, mental health needs) of the individual.

Court diversion and liaison schemes

As previously stated, the majority of FMHSs in the courts can be categorised into two broad roles: diversion and liaison. Both court diversion and liaison services 'can be seen as an attempt to humanely meet the needs of mentally ill offenders in the criminal justice system in a manner which is directed towards therapeutic gain', following the broader principles of therapeutic jurisprudence (McKenna and Seaton 2006 p. 449).[38] In

[36] Both McKenna and Seaton (2007) and Tarrant (2014) specifically examine the role of court liaison nurses in Aotearoa New Zealand. As such, these two sources are of particular relevance in this discussion.

[37] Ethical issues surrounding the participation of mental health professionals in the criminal justice system, while present in the literature, are not discussed here. See, for example, Evans 2007 and Golding 1990.

[38] McKenna and Seaton (2007) define therapeutic jurisprudence as 'an approach to legal scholarship and law reform that sees the law as a therapeutic agent. Legislation, legal processes and the role of legal actors such as judges and lawyers inadvertently impose consequences on the mental health and

practice, service provision may be one, the other or both. As McKenna and Seaton (2007) note, the two roles are not synonymous, though elements of each overlap.

It is common for varying models to be employed from region to region within jurisdictions, and substantial research has been conducted describing, auditing and comparing various liaison and diversion schemes and their contexts, particularly in the United Kingdom,[39] Australia[40] and Ireland.[41]

In the case of the United Kingdom, for example, 'local and national surveys … have again confirmed huge variations in coverage, size, composition, governance, funding arrangements and quality of services provided' within diversion and liaison schemes, between and within jurisdictions (Dyer 2013, p. 33). More specifically, such variations may include:

> single practitioners versus multi-agency schemes; part-time or on-call services compared with full-time dedicated teams; panel assessment schemes compared with front-line proactive teams; reactive compared with proactive screening; and variations in the services offered by a CJLDS [criminal justice liaison and diversion service] which might include some or all of the following: mental health assessment in police stations, reports to court, providing recommendations on sentence and management, managing and sharing information with probation and prisons, short-term treatment and access to inpatient beds. (Dyer 2013, p. 33)

Similarly, in Australia, discrepancies persist in the options available for alleged offenders with mental illness. Indeed, 'under the federal system, each of the six states and two territories have separate mental health and criminal justice systems which gives rise to significantly different approaches in each jurisdiction' (Richardson and McSherry 2010, p. 249).

This variability has affected the research conducted on court liaison and diversion schemes. The majority of the literature focuses on describing structures and/or metrics pertaining to service delivery. As such, there is a lack of literature discussing overarching models of care that inform service delivery, though evidence suggests the effectiveness of diversion and, to a lesser extent, liaison services, as indicated below. Clear recommendations on best practices have yet to be fully articulated.

emotional well-being of those before the criminal justice system. These consequences can be either therapeutic or counter-therapeutic. Therapeutic jurisprudence suggests that law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values serviced by the law, should attempt to bring about the psychological well-being of those in contact with it' (pp. 448–9). For further discussion on therapeutic jurisprudence, see Ferrazzi and Krupa 2016a, Lim and Day 2016, McKenna and Seaton 2007.

39 See, for example: Birmingham 2001; Birmingham et al 2017; Blumenthal and Wessely 1992; Chung et al 1998; Exworthy and Parrot 1993; Holloway and Shaw 1992, 1993; James 2010; James and Hamilton 1992; James and Harlow 2000; Kingham and Corfe 2005; Orr et al 2007; Pakes and Winstone 2010; Purchase et al 1996; Rowlands et al 1996; Sharples et al 2003; White et al 2002.

40 See, for example: Bradford and Smith 2009; Brett 2010; Davidson 2015, 2016; Davidson et al 2016, 2017a; Davidson et al 2017b; Davidson et al 2019; Dean et al 2013; Greenberg and Nielsen 2002, 2003; Richardson and McSherry 2010; Soon et al 2018; Walsh 2003.

41 See, for example: Gulati and Kelly 2018; McInerney and O'Neill 2008; McInerney et al 2013; Scott et al 2016.

Diversion schemes

Broadly defined:

> court diversion involves the transfer of people suffering mental illness from criminal justice settings (court, remand prison) to hospital or community mental health settings. The objective is to secure mental health service placement without the impediment of the usual processes of court and incarceration associated with the criminal justice system. This does not necessarily mean that there is an avoidance of existing charges, but it does allow the Court to take mental health issues into consideration in its deliberations. (McKenna and Seaton 2007, p. 449)

Alternatively, 'diversion' may also describe more broadly programmes which, after an initial period of increased contact (ie, treatment and supervision), aim to reduce contact with the criminal justice system over time (Richardson and McSherry 2010). Diversion programmes are further 'distinguished in terms of "diversion from" and "diversion to" and the stage at which diversion occurs, that is, pre-charge, pre-conviction, pre-sentence, and post-sentence (suspended) diversion' (Richardson and McSherry 2010, p. 250).

There are various models of diversion programmes, dependent upon the stage at which diversion occurs. Court diversion generally occurs 'post-charge' and employs a court-based mental health professional to conduct assessments and evaluations (Richardson and McSherry 2010), where clinically indicated, to divert people in custody to hospital, typically via available legislative or civil provisions (James 2010). As Fisher et al (2000) explain:

> forensic mental health evaluation services may also play a diversionary role vis-à-vis the mentally ill arrestee. Established to provide criminal courts with information regarding defendants' fitness to stand trial and criminal responsibility, forensic evaluation services are situated in the pathway between arraignment and jail detention. Thus, like formal jail diversion services, forensic evaluation represents an important, albeit less well scrutinized stage in the criminal justice process for examining the involvement of individuals with severe mental illness in that process. (p. 42)

There are also special jurisdiction or 'problem-solving' court models which offer a diversion pathway outside of criminal courts (Petrila 2003), such as mental health courts (MHCs), which have been adopted, for example, in the United States and, more recently, Australia and Canada (Ferrazzi and Krupa 2016b; Richardson and McSherry 2010). As Gowensmith et al (2016) explain, MHCs generally include:

> a dedicated judge, an exclusive docket for the defendants, devoted prosecutors and defense attorneys, a collaborative team effort among the judge and the relevant professionals, voluntary participation, intensive judicial monitoring, and the promise of a reduced or dismissed sentence upon graduation. Mental health courts typically have an identified set of phases for successful participants, as well as sanctions for program violations (including potential jail time). Mental health courts prioritize mental health care for participants, but most programs also require substance abuse treatment and address criminogenic needs. (pp. 411–12)

A robust evidence base supports the use of MHCs, particularly in reducing rates of recidivism (Steadman et al 2011). However, several authors have noted criticisms of the MHC model in terms of mixed reports of efficacy; emphasis on mental health over criminogenic needs; and selection of participants who are likely to succeed, which inflates success rates (Gowensmith et al 2016; McKenna and Seaton, 2007; Skeem et al 2011). Additionally, in keeping with the broader lack of service cohesion, MHC models vary greatly, and there is no one set of criteria by which to define or evaluate an MHC.[42]

In terms of court diversion in criminal courts, a growing body of literature has emerged examining the efficacy of diversion programmes. Generally, court diversion has been found to be effective in identifying mental illness and transferring mentally ill alleged offenders to hospitals with successful clinical outcomes (Green et al 2005). Further evidence has suggested that long-term outcomes include:

- high levels of satisfaction and feelings of fairness by participants with the procedure and treatment they received in an MHC, and low levels of perceived coercion
- reduced recidivism after participation in an MHC
- less days spent in jail by those in the MHC system than those processed in the traditional court system
- improvements in outcomes such as homelessness, psychiatric hospitalisations, and frequency and levels of substance and alcohol abuse, and improvements in psychosocial functioning (Richardson and McSherry 2010).[43]

However, as noted above, high variability in service delivery and scope of diversion schemes makes it hard to compare outcomes between jurisdictions.

Liaison schemes

As discussed above, court liaison services, most commonly as an arm of FMHSs, provide screening, evaluation and assessment, and guidance to the courts – in person or via technology[44] – to aid in decision-making and to determine the most appropriate pathway for the service user, which may or may not include diversion. In contrast to some diversion programmes, such as the MHC model, liaison services do not typically provide an ongoing supervisory role once a service user is referred on to the appropriate agency (ie, an inpatient, prison or community FMHS or GMHS) (Richardson and McSherry 2010). As such:

> court liaison is a broader concept. It includes court diversion but also involves linking, brokering and advocating with a variety of agencies and services to have

[42] For further discussion on MHCs, including models and outcomes, see Acquaviva 2006; Boothroyd et al 2003; Campbell et al 2015; Canada and Ray 2016; Cosden et al 2003; Edgely 2014; Ferrazzi and Krupa 2016b; Han 2019; Han and Redlich 2016; Hiday et al 2016; Kubiaket al 2018; Landess and Holoyda 2017; Lawrence 2004; McNiel and Binder 2007, 2010; Moore and Hiday 2006; Palermo 2010; Ray 2014; Ryan and Whelan 2012; Slinger and Roesch 2010; Sly et al 2009; Thomas 2002; Wren 2010.

[43] For further research on outcomes, see also: Albalawi et al 2019; Chung et al 1999; Earl et al 2017; James 1999, 2010; Sirotich 2009; Trupin and Richards 2003.

[44] Technology is increasingly playing a role in court liaison services and forensic psychiatry more broadly, from the use of video- and teleconferencing (Brett and Blumberg 2006; Khalifa et al 2007; Miller et al 2008) to electronic patient records (Gough et al 2012). As such, future models of care may need to take these new methods of communication and/or reporting into account.

the mental health and psychological needs of offenders met. (McKenna and Seaton 2007, p. 449)

Although there is not as robust an evidence base, research suggests the effectiveness of court liaison services in improving outcomes such as rates of recidivism (O'Neill et al 2016), and some research has been conducted auditing specific court liaison services, mostly in Australia and the United Kingdom (eg, Coombs et al 2011; Sharples et al 2003). Due to the large amount of overlap between liaison and diversion services, best practices are typically articulated in relation to what can be viewed as combined schemes.

Combined schemes

Combined schemes can be broadly understood as the integration of liaison and diversion services. Though combined schemes have been around for several decades (and have been in place since the introduction of court liaison services in Aotearoa New Zealand within the past 10 years), increasing attention has been paid to the integration of services. This has largely been the result of the recommendations of the influential Bradley Report (2009), which advocated for a new model of 'criminal justice mental health teams' to be 'responsible for managing continuity of care across the whole offender pathway (including community, police custody, courts, prison/ community sentence and resettlement)' (Dyer 2013, p. 38).

A key part of an integrated liaison and diversion programmes in the United Kingdom is the inclusion of coordinated police and court liaison services. For example, Earl et al (2015) describe a novel 'neighbourhood outreach' model which expands court liaison services to include police-based deployment of mental health professionals. McKenna et al (2019) further examine referrals within a combined service, noting the central importance of the police context of liaison and diversion.

Within Aotearoa New Zealand, as described previously, court liaison services are provided as an arm of regional forensic psychiatric services, and include diversion services. Notably, however, FMHSs typically do not work with the police; nor do they conduct interventions at the pre-custody stage (this is more the role of GMHSs).

According to Brinded et al (1996), there are several advantages to the Aotearoa New Zealand model:

1. An experienced mental health professional is present throughout court sitting time, being available to police, lawyers and the judge should there be questions regarding the mental state of persons appearing in court;
2. The mental health professional (usually a registered mental health nurse) is part of the overall forensic psychiatry service and is therefore able to access all aspects of the service rapidly if required. Psychiatrists are not used in the initial assessment process;
3. The availability of such a person facilitates the request for an initial assessment of a person before the court without necessarily having to arrange for a remand period;

4. The court is able to use a member of the FMHS to assist in its deliberations over whether a person should be remanded for a psychiatric assessment under [relevant legislation] and if so where that assessment is best performed;
5. When remand reports are not requested, the court liaison worker is available to assist mentally ill persons before the court to access other aspects of the mental health system; [and]
6. Where examination by a psychiatrist is considered urgent, this can be arranged rapidly through the court liaison worker. (p. 169)

In terms of best practices, limited recommendations have been offered based on the literature concerning diversion and liaison services within non-specialised criminal courts. Hartford et al (2004) identify key themes in the development and maintenance of successful programmes, including:

- early involvement of mental health, substance abuse and criminal justice agencies
- 'Regular meetings between key personnel from the various agencies'
- having a 'liaison person or "boundary spanner" with a mandate to effect strong leadership in the co-ordination among agencies'
- 'Awareness of the pre-trial diversion option among lawyers and court staff'
- the importance of 'formal case finding procedures … for the early identification of mentally ill offenders in need of services' (p. iii).

In another review of the literature, Dyer (2013) highlights the shortcomings of existing liaison and diversion models, which:

> tend to focus on 'key stages' in the offender pathway (e.g. police station or court), providing actions to meet the needs of the services at these discrete stages rather than adopting a patient-centred approach which recognises the impact of action on the longitudinal institutional careers (criminal justice, health and social care) of their clients. For instance, early intervention and prevention strategies and services are key in stopping the offender pathway developing further but are a much-neglected part of service coordination and development. (p. 36)

As such, Dyer (2013) recommends multi-agency commissioning and governance arrangements that monitor the diversion service, a minimum of three practitioners who provide continuity of care and 'proactive, holistic services' across the entire offender pathway, and use of individualised support packages, which identify and attend to service users' needs (p. 38). Dyer suggests that a potential model that could be implemented in liaison and diversion services is that of the integrated care pathway (ICP) currently in use within United Kingdom health and social care services. Integrated care pathway services are clinician-led and driven, focusing on service users and best practice, which aims to have the right people doing the right thing, in the right order, at the right time, in the right place, to the right standard and with the right outcome. Emphasis is given to the importance of identifying and measuring 'critical indicators' – outcomes from interventions that make the biggest difference to 'recovery'. Far from being linear, ICPs are designed to accommodate complexity in the form of variations and change as people move along the pathway. The causes of variations can be recorded and monitored over time, allowing the ICP to be altered to include or

manage some of the most common reasons for those variations, or risk factors. These events or actions can then be changed or removed. Variations should always lead to some kind of action (Dyer 2013, p. 40).

Models such as this facilitate proactive screening and inter-service collaboration, two elements that are of particular value (Dyer 2013). Kennedy et al (forthcoming) further support this notion, noting:

> there is excellent evidence that screening for severe mental disorders is more effective than a referral based system, on reception in police stations, … courts, … and remand prisons. … There is further evidence that integrated services in which court liaison services are connected to prison in-reach services achieve faster and more effective diversion from the criminal justice system. (pp. 9–10)

Priority populations

In contrast to the results of the other reviews, in this courts review the researchers found a notable gap in the literature on mental health services for priority populations. They located only a few sources addressing court services for women and indigenous populations specifically.

Māori, Pacific peoples and other indigenous groups

The researchers found no literature describing Māori- or Pacific-specific court liaison services or needs within this aspect of the justice system, nor any documentation of the presence of cultural advisors within the court liaison team in Aotearoa New Zealand. This gap in the literature is consistent with the findings of Jones and Day (2011), who reported that 'indigenous men and women in the criminal justice system can be considered to belong to a significant, but neglected, group whose needs are poorly understood' (p. 325). Speaking within the Australian context, Jones and Day identify four points at which mental health initiatives for aboriginal service users can be positioned: 'pre-contact with the criminal justice system, policing and court processing, during the serving of a sentence, and at transition and post-release' (p. 329). Some such services do currently exist in Australia; for example, in Koori Courts, which offer some diversionary options, and Koori Court liaison officer positions in drug courts and domestic violence courts. In Canada, recent arguments have been made toward the adoption of MHCs and other models of therapeutic jurisprudence that resonate with traditional indigenous values specifically for Inuit communities, though such services have yet to be actualised (Ferrazzi and Krupa 2016b).

Jones and Day argue:

> the missing piece in this picture appears to be service coordination between justice and health so that the two systems can join forces to manage Indigenous clients who belong to both, especially in relation to identification, assessment and treatment of mental impairment in the criminal justice system. (p. 329)

Further barriers to developing continuity of care through the criminal justice and mental health system for indigenous peoples include 'tensions and difference in perspective between the health, justice and possibly other sectors of government

about the scope of their responsibilities in relation to the mental health of Indigenous people in the criminal justice system' (p. 329), the lack of quality indigenous mental health data and the lack of strong partnerships between indigenous/community and non-indigenous/government stakeholders. As such, more research is needed to identify the specific needs of indigenous peoples, including Māori, within the criminal justice system and specifically FMHSs within the courts.

Women

The female prison population is increasing at unprecedented rates, both within Aotearoa New Zealand and internationally (**Department of Corrections 2010**). This has led some services to consider how diversion services may provide an avenue to address this concern (eg, Walsh 2003). Hunter et al (2007) evaluated the work of 10 criminal justice liaison and diversion schemes in England and Wales to determine 'the extent and nature of the service these schemes provide for women offenders and their success in enabling women to receive help in the community rather than serving a custodial sentence' (p. ii). More specifically, the authors investigated: (a) contact between the service and women offenders with mental health issues, (b) the schemes' provision of access to support and treatment and (c) factors facilitating or impeding the identification and support of women prisoners with mental health issues. Overall, the authors could not determine the extent of successful referrals of women from the schemes to mental health services, due to a lack of outcome data. Generally, however, they found that women were the 'minority' client as:

> they were less likely than the males to have previous convictions or to have been arrested for violent offences. Women were also less likely to be diagnosed with severe and enduring mental illness and more likely to be 'diagnosed' with substance misuse problems. (p. iii)

In terms of service provision, few gender-specific services were available at the point of a person's contact with the schemes, and most staff had not undergone gender-specific training on working with female clients. Where such services were available, the most common form was same-sex screening and assessment; however, this was not always feasible. The authors thus recommend resources 'should be deployed in a way that permits more gender-specific working practices' (p. v), including the provision of staff training and education on women's specific needs and the profile of women offenders, as well as on current gender equality strategies within the organisation.

Hunter et al (2007) suggest that proactive screening is especially important given that women's mental health problems may be less visible to non-specialists. Finally, the authors recommend improved working relationships and communication between court and prison in-reach teams.

Summary

Court FMHSs predominantly comprise three distinct yet overlapping roles: (a) consultation, whereby the court seeks expert advice for individual cases from psychiatrists, psychologists and/or nurses; (b) diversion, where FMHSs coordinate

transfer of care, most likely into inpatient services, but not necessarily out of the judicial system; and (c) liaison, where FMHSs provide complementary services (eg, screening, assessment, evaluation and coordination of care) to individuals moving through the court system, which may or may not include diversion. A wide-ranging and relatively well-developed body of literature details the various diversion and liaison schemes operating internationally, particularly in Australia and the United Kingdom. Most relevant to the Aotearoa New Zealand context are combined schemes which interface with prison in-reach services and GMHSs.

Generally, the literature does not clearly articulate models of care; nor does it extensively discuss therapeutic security, rehabilitation or recovery. In terms of best practices, the literature highlights the importance of an integrated, holistic service across the entire offender pathway that uses proactive early intervention and prevention strategies, such as police liaison services, and facilitates interservice collaboration. Further, the evidence suggests the need for gender-responsive and culturally responsive services in the courts, which are currently lacking in comparison to other arms of FMHSs, representing an area for further inquiry and development.

Section 6:
Regional, national and international guidelines

Introduction

The four systematic literature reviews highlighted the emergence of evidence-based best practices pertaining to models of care within FMHSs, primarily within the scholarly literature. Although in the course of these reviews the researchers found several relevant grey literature sources (ie, organisational documents), they identified a need to investigate such sources more directly. The Ministry of Health may use such organisational guidelines to inform the development of a national implementation guidance document for FMHSs in Aotearoa New Zealand. More specifically, it became clear that the scholarly literature represents but one avenue through which to disseminate the research and service development that occurs within FMHSs. A significant portion of documentation particularly concerning FMHS guidelines occurs at the organisational level, through such bodies as the Ministry of Health and Ara Poutama. As such, in the final stage of this project, the researchers conducted a further review of the grey literature at the regional, national and international levels to investigate (a) what guidelines exist on models of care in FMHSs and (b) how existing guidelines/models of care align with the evidence base.

Methodology

To obtain regional documents, a Ministry of Health liaison directly contacted key stakeholders at district health boards (DHBs) to request available service documentation concerning models of care. The researchers thus received a total of 18 documents, from the five FMHS regions (Auckland, Midland (Puawai), Central (Te Korowai Whāriki), Canterbury and Southern).

To locate national documentation, the researchers searched the websites of relevant organisations and governmental bodies, including the Ministry of Health, Ara Poutama, the Ministry of Justice, the Office of the Auditor-General and Te Pou o Te Whakaaro Nui (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), yielding 24 documents for review. To search the websites, the researchers manually reviewed all published documents available within 'publications', resources and research sections, and/or used the search function, where available, with the keywords 'forensic mental health' and 'forensic psychiatry' to locate

results. The researchers reviewed the results first by title and then by full text to determine relevance to the project brief.

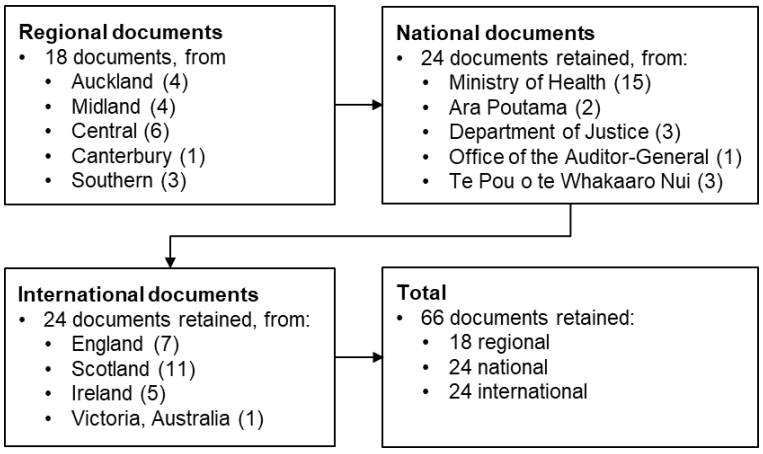
Finally, based on the findings of the systematic reviews, the researchers examined grey literature from four international jurisdictions (England and Wales, Scotland, Ireland and Victoria, Australia) deemed most relevant to the Aotearoa New Zealand context. The search for relevant documents involved a combination of searching organisational websites using the same method as above and contacting international colleagues within the researchers' professional networks. The websites the researchers examined included those of:

- the National Institute for Health and Care Excellence (England)
- the NHS (England)
- the Royal College of Psychiatrists (England)
- the Forensic Network (Scotland)
- Lenus (the Irish Health Research Repository)
- Victoria's Department of Health and Human Services (DHHS)
- Forensicare (the Victorian Institute of Forensic Mental Health).

The researchers retained a total of 24 documents for the four jurisdictions. Notably, in the case of Victoria, they located only one relevant document via the two search methods. They did include this singular document in the review, as it signals a developing model of care that may be of interest in future service development.

In total, the researchers reviewed 66 documents the three levels (regional, national and international).

Figure 10: Summary of grey literature review results



Review findings

Regional level

As Section 1 describes, FMHSs in Aotearoa New Zealand are organised in five regional forensic psychiatry services (RFPSs): Auckland, Midland (Puawai), Central (Te Korowai Whāriki), Canterbury and Southern. The five regions share a similar scope and method of service delivery, but no framework exists unifying services at the national level.

The 18 documents on models of care DHBs provided was uneven and limited (Table 2). Several DHBs stated that they were in the stages of developing a model of care but were not yet ready to disseminate it outside of their service. Many of the regions have documentation of models of care in some but not all arms of the service (ie, inpatient, community, prisons and courts). The Auckland and Central regions had the best-articulated models of care, spanning inpatient, community and prison settings. Models of care for FMHSs in court contexts were generally lacking across the board.

Table 2: Regional documentation reviewed

Region	Author/ organisation	Year	Title
Auckland	Mason Clinic	2011	*The Mason Approach: The Mission, Vision, Values and Approach of the Mason Clinic*
	Mason Clinic	2018	*Te Aranga Hou – Mason Clinic Forensic Community Team/Rimu Model of Care: Improving Service User Flow*
	Mason Clinic	2018	*Te Aranga Hou – Mason Clinic Service User Pathways Future State Map – Milestones Update: April 2018*
	Mason Clinic and Puawai Midland RFPS	2011	*Northern/Midland Region Prison Model of Care*
Midland	Puawai Midland RFPS	2014	*Forensic Client Pathway*
	Puawai Midland RFPS	2014	*Te Puawaitanga Operations Manual*
	Puawai Midland RFPS	nd	*Forensic Inpatient Units Within the Henry Rongomau Bennett Centre*
	Waikato DHB	2010	*Puawai Midland Regional Forensic Psychiatric Service* (pamphlet)
Central	Central Regional Forensic Community Mental Health Service	2017	*Ngā Tapuwae: Walking the Walk – A Co-Design Service Pathway Project at Te Korowai Whāriki – July 2017*
	Central Regional Forensic Community Mental Health Service	2019	*The Redesign and Implementation of the Ngā Tapuwae Forensic Model of Care*
	Stanford House	2018	*Extended Term Secure Regional Forensic Service Operational Policy*
	Stanford House	nd	*Model of Care for Stanford House Extended Secure Regional Forensic Service*
	Stanford House	nd	*Pathway for Recovery Model of Care at Stanford House*
	Te Korowai Whāriki	2018	*Te Korowai Whāriki Prison Model of Care*
Canterbury	E Monasterio and P Mason	2010	*Forensic Service Delivery Review to Christchurch Prisons Project*
Southern	Southern DHB	2016	*Clinical Focus – Southern Regional Forensic Psychiatric Service (District)*
	Southern DHB	2017	*Service Model – Regional Forensic Psychiatric Service Inpatient Services at Ward 9A, Wakari*
	Southern DHB	2019	*Management of Acutely Disturbed or Violent Behaviour in Ward 9A (Flowchart) (Otago)*

Auckland

The four documents provided by the Auckland RFPS pertain to services provided by the Mason Clinic, the region's secure inpatient facility and home base located in Point Chevalier, Auckland (Mason Clinic 2011, 2018a, 2018b; Mason Clinic and Puawai Midland Regional Forensic Psychiatry Service 2011). As articulated in *The Mason Approach* (Mason Clinic 2011), Auckland's model of care is 'recovery- and strengths-focused' and seeks to provide culturally appropriate, evidence-based care (p. 9). Five key principles guide the service: (a) 'recovery as a philosophy and a journey', (b) 'the importance of cultural and personal identity', (c) 'the importance of understanding risk', (d) 'recovery in the forensic setting' and (e) 'excellence' (Mason Clinic 2011, p. 10). Together, service delivery aims to embody a 'whole-of-life concept', 'including understanding the person's life history, respectfully involving them in their care and assisting them in being fully involved as family members, workers and members of society' (Mason Clinic 2011, p. 10).

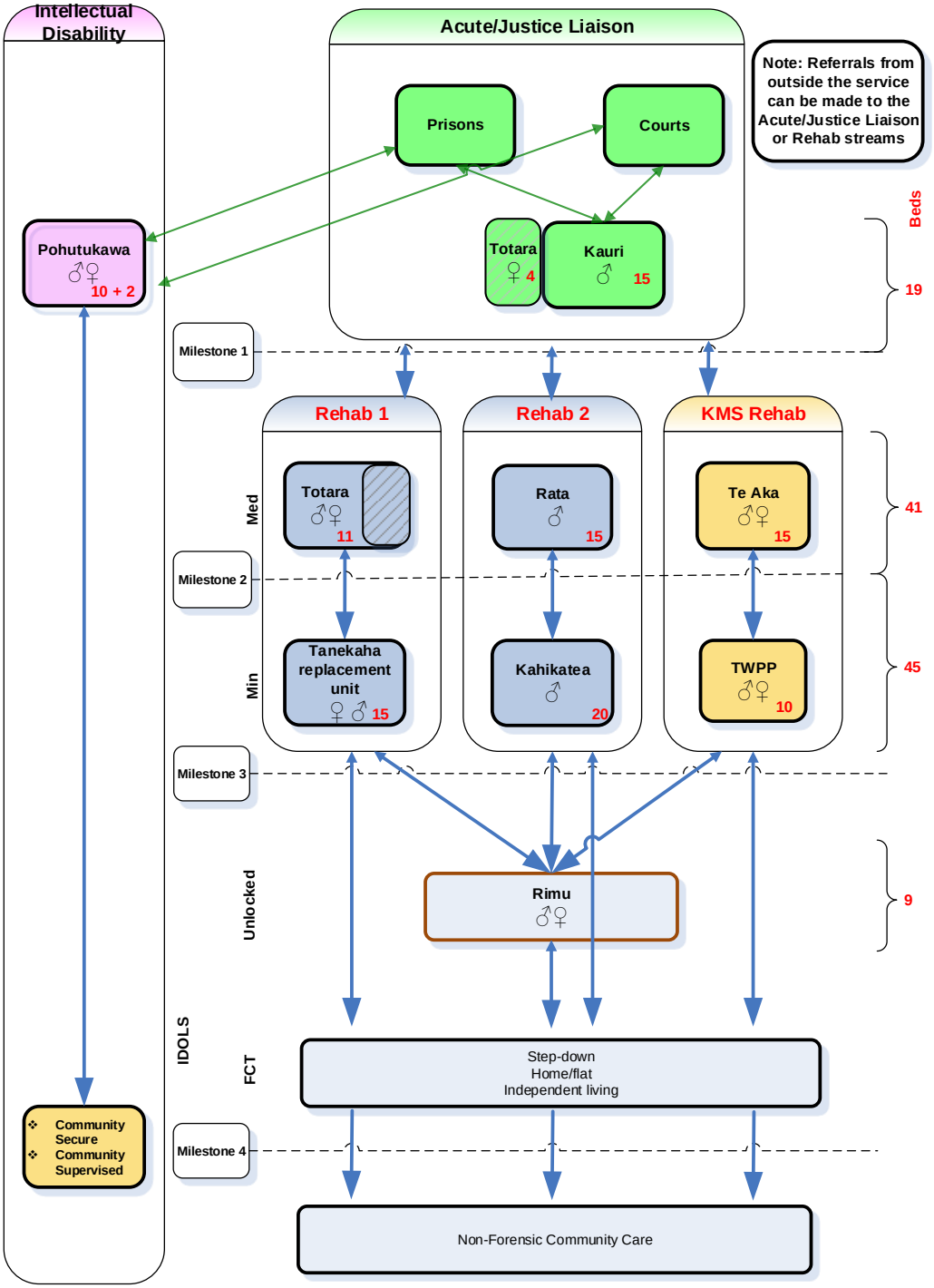
The service is organised as an integrated care pathway (ICP) structured according to levels of therapeutic security. Auckland's current model was implemented in 2014 in conjunction with 'lean thinking' efforts that sought to streamline service user flow through the forensic mental health pathway (Mason Clinic 2018a): see Figure 11. Within this model, four 'milestones' mark completion of one stage within the rehabilitation/recovery process and cue the service user for advancement without the need for clinical referral: they are: (a) entry to the forensic rehabilitation pathway, (b) advancement from medium to minimum security, (c) return to the community under the forensic community team and (d) discharge from the forensic service (Mason Clinic 2018b). To assist in assessing service users' recovery and advancement along the pathway, Auckland employs the evidence-based DUNDRUM Quartet, a structured professional judgement instrument described further below in relation to the Irish case study.

Notably, Auckland is the only service with a kaupapa Māori pathway that operates alongside the mainstream service. Auckland has two Māori inpatient units, Te Papakāinga O Tāne Whakapiripiri (minimum secure), which opened in 2004, and Te Aka (medium secure), which opened in 2017. These units have their own model of care blending mental health rehabilitation and cultural concepts (Sweetman 2017; Tapsell 2007).

The final document provided details of the prison model of care developed in collaboration with Midland RFPS and used throughout the Auckland/Midland regions (Mason Clinic and Puawai Midland Regional Forensic Psychiatry Service 2011). The model of care uses a prison in-reach model, which laid the basis for the STAIR approach (screening, triage, assessment, intervention and reintegration) and is evidence based.[45]

[45] For further details of the STAIR model generally, see, for example, Forrester et al 2018; Nicholls et al 2018; Ogloff 2002. For further details of the in-reach prison model of care used in the Northern/Midland region in the scholarly literature, see McKenna et al 2015; McKenna et al 2018; Pillai et al 2016.

Figure 11: Future state map of clinical care pathways at the Mason Clinic



Source: Mason Clinic 2018b, p. 3

Midland (Puawai)

The four documents provided (in addition to the prison model of care described above) primarily detailed the service's client pathway and operations (Puawai Midland Regional Forensic Psychiatry Service 2014a, 2014b, nd; Waikato District Health Board 2010). Though suggestive of a model of care, no 'model of care' document per se was available. A pamphlet details the service's rebranding as Puawai, a shift incorporating Māori cultural themes to emphasise 'flow, progression and movement from dark into light' (Waikato District Health Board 2010). This orientation is not reflected in the rest of the service documentation, except, within the logo.

The *Forensic Client Pathway* (Puawai Midland Regional Forensic Psychiatry Service 2014a) document details the clinical pathways model used within the service, entailing entry routes; risk mapping and transition between stages of therapeutic security (environmental, relational and procedural); a description of individual wards (covering assessment, interventions, leaves, risk management and progress indicators); and transfer documentation. The *Te Puawaitanga Operations Manual* (Puawai Midland Regional Forensic Psychiatry Service 2014b) provides a list of procedures but does not indicate a model of care.

The forensic inpatients units summary document (Puawai Midland Regional Forensic Psychiatry Service nd) provides a description, entry criteria and the 'philosophy of care' for each unit. Of the Puawai documents the researchers reviewed, this was most suggestive of a model of care, if taken in combination with the client pathway. The level of detail within the 'philosophies of care' varied. Information under this heading included tenets such as providing care in the least restrictive environment, providing a safe environment and assessing and managing risk, enhancing 'mental well-being, wellness and rehabilitation through prevention, promotion and awareness activities' (p. 2), providing 'high quality mental health services through working with people/ tangata whai ora [sic], their families/Whanau [sic] and other providers' (p. 2), supporting the recovery journey, and emphasising 'service user strengths, rather than pathologies' and 'enhancing their rights, responsibilities, self-determination and independence' (p. 3). These philosophies suggest a recovery orientation within the inpatient service, though it is unclear how this connects to other arms of the service within the region.

Central

The six documents provided detail the models of care used within the inpatient and prisons contexts in this region (Central Regional Forensic Community Mental Health Service 2017, 2019; Stanford House 2018, nd-a, nd-b; Te Korowai Whāriki 2018).

Three of those documents concern the model of care for Stanford House, the region's residential, long-term, secure rehabilitation unit (Stanford House 2018, nd-a, nd-b). The model of care is recovery focused and strength based, 'guided by recovery competencies which provide an evidence-based framework within a forensic service' (Stanford House nd-a, p. 1). Key principles of the model of care include person/whānau-centred care, individualised care, planning transitions along the recovery care journey, integration with non-governmental/community/justice organisations, adapting care to individual needs/strengths, evidence-based care and stewardship of resources. The model of care also details further key elements, including trauma-informed care, peer support, accountability to key performance indicator measures and implementation of Te Whare Tapa Whā (Durie 1998).

Central's *Prison Model of Care* (Te Korowai Whāriki 2018) is a detailed document aiming to formalise current forensic mental health practice in the region for review and comparison with practices in other regions. It outlines guidelines on regional provision as well as the various aspects of the STAIR (screening, triage, assessment, intervention and reintegration) model (though it does not explicitly state it is following this model), transfers and other relevant areas. The inclusion of STAIR elements is in alignment with the Northern/Midland Region's prison model of care, as well as evidence-based best practices in the literature. Notably, the model of care mandates comparable or equitable care in keeping with international mandates concerning prisoner health. It also emphasises the importance of the multidisciplinary team and of case managers in release planning and follow-up, further in keeping with best practice.

The remaining two documents concern the development of Ngā Tapuwae, a co-design project aiming to improve service users' pathways through the FMHS (Central Regional Forensic Community Mental Health Service 2017, 2019). Phase I of the project involved engaging with stakeholders (eg, service users, staff and family/whānau) to identify the strengths and weaknesses of service delivery, review the model of care at Te Korowai Whāriki and co-design recommendations for change. Phase II, which began in 2017 and is currently under way, involves implementing the recommendations from Phase I. Notably, one of the three main areas for improvement signalled for service improvement was pathways and the model of care, though the current model of care was not described in depth. Indeed, the first and key recommendation was the need for 'an overarching forensic model of care' that integrates the recommendations and provides 'coherence across the service', as well as a map of clinical pathways and interventions (Central Regional Forensic Community Mental Health Service 2017, p. 37).

Canterbury

Canterbury RFPS provided one document outlining service provision within prisons (Monasterio and Mason, 2010). This document provides an overview of the forensic community team prison service, which provides consultation/liaison psychiatric services within the region. It includes guidelines for referral criteria and processes, acceptance processes, treatment, discharge, meetings, communication processes, clinics, staffing and security, consultation/liaison, identified issues and recommendations. It does not outline a clear model of care, though it does mention recent changes in practice moving toward an in-reach model whereby forensic nursing staff conduct triage assessment.

Southern

The three documents from the Southern RFPS do not clearly articulate a model of care, though they are suggestive of a rehabilitative approach (Southern District Health Board 2016, 2017, 2019). The *Clinical Focus* document (Southern District Health Board 2016) describes the role of the FMHS and assessment, referral and treatment processes, including court liaison, prison liaison, inpatient services and community forensic team services. The other two documents (Southern District Health Board 2017, 2019) concern procedures for the forensic inpatient unit Ward 9A, Wakari Hospital in Dunedin. While the documents do not describe a model of care, they are suggestive of a rehabilitation focus in their emphasis on risk management and functional recovery. They emphasise the provision of evidence-based interventions, as well as the need for family/whānau support and education. While they mention the need for cultural sensitivity and appropriate cultural services for Māori and Pacific peoples, including cultural assessment, they do not describe such services/programming in detail.

Summary

Within the existing documentation, it appears services are moving – albeit at varying speeds – toward the adoption of a recovery-based approach organised according to principles of therapeutic security and recovery-oriented practice, in keeping with the best practices identified in the evidence base. This shift is most pronounced in the Auckland and Central regions. Further, three of the five regions have adopted a prison in-reach model, in keeping with international trends.

Overall, review of the regional documentation highlighted the uneven nature of service development between the regions. Models of care are inconsistently articulated within the various areas of the FMHSs, both within and between regions. Due to limitations in the research methodology, it is unclear whether this inconsistency is due to the lack of documentation or to the researchers' lack of access to available documentation. While some regions (eg, Auckland, Midland and Central) appear to have more clearly detailed models of care for parts of the service, more documentation is needed to understand fully the service models and approaches used across the regions in all four areas of FMHSs (inpatient, community, prisons and courts). Most notably, documentation on models of care pertaining to court liaison services is the least developed, suggesting an opportunity for future service planning and delivery.

National level

The national literature on FMHSs comprised documents from the various government agencies responsible for these services and the organisations tasked with auditing them. More specifically, the researchers obtained documents via the websites of the Ministry of Health, Ara Poutama, the Ministry of Justice, the Office of the Auditor-General and Te Pou o te Whakaaro Nui, as well as from the Ministry of Health advisors overseeing this project (see Table 3). Predictably, the Ministry of Health was the source for the majority of these documents.

Although the Mason Report (1988) suggested an overall framework for FMHSs, and the Ministry of Health did so again in 2001, development of cohesive FMHSs at the national level has yet to come to fruition, and organisational documentation on models of care is wide ranging. Key to recent documentation is an emphasis on Māori needs, responsivity and engagement, as well as a gradual shift toward a more rehabilitative focus within the criminal justice system.

Table 3: National documentation reviewed

Organisation	Author	Year	Title
Ministry of Health	K Mason	1988	*Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (the Mason Report)
	Ministry of Health	2001	*A National Strategic Framework for Alcohol and Drug Services*
	Ministry of Health	2001	*Services for People with Mental Illness in the Justice System: Framework for forensic mental health services*
	Ministry of Health	2002	*Te Puāwaitanga: Māori Mental Health National Strategic Framework*
	Ministry of Health	2007	*Census of Forensic Mental Health Services 2005*
	Ministry of Health	2008	*Te Puāwaiwhero: The second Māori mental health and addiction national strategic framework 2008–2015*
	Ministry of Health	2010	*Review of Forensic Mental Health Services: Future directions*
	Ministry of Health	2010	*Service Delivery for People with Co-Existing Mental Health and Addiction Problems: Integrated Solutions*
	Ministry of Health	2012	*Guidelines for the Safe Transport of Special Patients and Special Care Recipients in the Care of Regional Forensic Mental Health Services*
	Ministry of Health	2012	*Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*
	Ministry of Health	2016	*Commissioning Framework for Mental Health and Addiction: A New Zealand guide*
	Ministry of Health	2017	*Special Patients and Restricted Patients: Guidelines for regional forensic mental health services*
	Ministry of Health	2018	*Night Safety Procedures: Transitional guideline*
	Ministry of Health	2019	*Practice Guidelines for Forensic Mental Health Court Liaison Nurses in New Zealand*
	FC Todd	2010	*Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems 2010*
Ara Poutama (Department of Corrections)	Department of Corrections[46]	2019	*Hōkai Rangi: Ara Poutama Aotearoa strategy 2019–2024*
	Department of Corrections	nd	*Change Lives Shape Futures: Investing in Better Mental Health for Offenders*

[46] Although the Department of Corrections is now called Ara Poutama, 'Department of Corrections' appears as the author within this publication.

Organisation	Author	Year	Title
Ministry of Justice	Ministry of Justice	2017	*Culture-Based Correctional Rehabilitative Interventions for Indigenous Offenders: Evidence brief*
	Safe and Effective Justice Advisory Group/Te Uepū Hāpai i te Ora	2019	*He Waka Roimata: Transforming Our Criminal Justice System*
	Safe and Effective Justice Advisory Group/Te Uepū Hāpai i te Ora	2019	*Hui Māori: Ināia tonu nei*
Office of the Auditor-General	Office of the Auditor-General	2008	*Mental Health Services for Prisoners*
Te Pou o te Whakaaro Nui	Te Pou o te Whakaaro Nui	2014	*Adult Mental Health Forensic Workforce: 2014 Survey of Vote Health Funded Services*
	Te Pou o te Whakaaro Nui	2019	*NGO Adult Mental Health and Addiction Workforce: 2018 survey of secondary care health services*
	Te Pou o te Whakaaro Nui	2019	*DHB Adult Mental Health and Addiction Workforce: 2018 provider arm services*

Ministry of Health

Since the foundational Mason Report (1988), the Ministry of Health has published several planning and implementation documents pertaining to FMHS delivery. These fall into three broad yet overlapping categories: (a) Māori mental health (Ministry of Health 2002, 2008), (b) AOD/co-existing mental health and substance use problems (Ministry of Health 2001a, 2010b, 2016; Todd 2010) and (c) FMHSs (Ministry of Health 2001b, 2007, 2010a, 2012a, 2012b, 2017, 2018, 2019).

Documents in the first category provide a national strategic framework for Māori mental health. While not specific to FMHSs, they highlight Māori-specific needs, which extend to FMHSs. Of particular importance are the three key principles identified in the second of the frameworks (Ministry of Health 2008), which 'apply across the entire framework and are firmly based on current knowledge, including the link between culture and wellbeing, the growing evidence of Māori mental health need and disparities, and learning from and building on the gains of the past', as follows.

- Prioritise Māori – 'Act on evidence of health inequality in Māori mental health and addiction need to ensure that new and existing initiatives are responsive and effective for Māori.'
- Build on the gains – 'Current initiatives to improve Māori mental health and addiction are sustainable and have a development path for the future.'
- Be responsive to Māori – 'Build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori' (pp. 16–17).

These principles align with the more recent strategic planning documents emerging from other national organisations, as discussed below.

The second category, pertaining to AOD/co-existing mental health and substance use problems, was included in the review due to the relevance of such services to the forensic mental health population. These documents may be used to help identify issues in service delivery for those with co-existing problems and to provide a conceptual framework to make services 'co-existing problems capable' (Ministry of Health 2010a, 2010b). Most useful within this subset is the commissioning framework (Ministry of Health 2016), which provides a national four-component framework identifying what is required broadly in a model of care for mental health and addiction services (pp. 9, 33–34), which may be applicable to FMHSs.

Of the documents specifically focused on FMHS, five documents outline guidelines for elements of FMHS delivery, including: (a) safe transport of special patients and special care recipients in the care of regional FMHSs (Ministry of Health 2012a), (b) the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2012b), (c) special patients and restricted patients within regional FMHSs (Ministry of Health 2019), (d) night safety procedures (Ministry of Health 2018b) and (e) forensic MHC liaison nurses (Ministry of Health 2019b).

The remaining three documents are the only documents focused on FMHSs in depth. *Services for People with Mental Illness in the Justice System: Framework for forensic mental health services* (Ministry of Health 2001b) provides the first national framework articulated since the Mason Report (1988). The framework outlines 'a comprehensive, integrated community approach building on enhancing the community care principle at the heart of modern mental health service delivery' (p. iii). It aimed to establish benchmarks for service provision, clarify the responsibilities of the forensic service, identify resource requirements and propose a 'best possible' model for FMHSs (p. xi). This document most closely expresses a model of care, and espouses a recovery-oriented approach based around self-determined, client-focused, respectful, holistic and culturally appropriate care (see pp. 31–32).

The *Census of Forensic Mental Health Services 2005* (Ministry of Health 2007) details service usage in the four main areas of FMHSs (inpatient, community, prisons and courts), and provides background context, which may inform service planning and delivery. Though it does not discuss models of care, it does provide a section on regional FMHS responses to a questionnaire that suggest approaches used within the regions as well as points of emphasis. The need for improved services for Māori, Pacific peoples and women is further underscored.

The final document, *Review of Forensic Mental Health Services: Future directions* (Ministry of Health 2010a) is the most recent document directly examining FMHSs. The review details four strategic objectives to ensure participation and engagement in future FMHS delivery planning: (a) the development of national mechanisms to engage key stakeholders; (b) the improvement of intra-regional collaboration; (c) the delivery of comprehensive, multidisciplinary, responsive FMHSs; and (d) the development of recovery pathways (p. 7). The report outlines priorities for the five-year period following its publication, which mainly focus on improving service delivery to specific populations (ie, Māori, Pacific peoples, women) and improving services and relationships between FMHSs, GMHSs, prisons and youth courts. The report describes in depth the services provided in the four main areas (inpatient, community, prisons and courts), but does not articulate models of care used within the service. In keeping with the priorities outlined, emphasis is placed on identifying service development issues pertaining to priority populations (ie, Māori, Pacific peoples, youth, women, people with AOD problems, people with personality disorders and people with an intellectual disability).

Ara Poutama

Two documents were obtained via Ara Poutama. *Change Lives Shape Futures* (Department of Corrections 2016) is a report on Ara Poutama's focus on improving prisoners' mental health. While it does not pertain to models of care, it suggests a shift toward a rehabilitative approach within Ara Poutama. For example, the report details development projects occurring at Auckland Prison, including the creation of a high-needs unit (Unit 11), which will provide mental health care in a 'therapeutic and humane environment' equipped with a sensory room and other features aiming to promote positive mental health (p. 8). The report highlights the use of professional teams of mental health clinicians and multidisciplinary teams, as well as the need for improved care for women in prison. Additionally, it provides a summary of existing mental health, AOD support currently available to offenders with mental health disorders. A particular project of relevance is Ara Poutama's Intervention and Support project, which offers a model of care to reduce self-harm and suicide and is being piloted in three prison sites.

The other document, *Hōkai Rangi* (Department of Corrections 2019a), details Ara Poutama's future strategic direction for 2019–2024; it is particularly focused on improving outcomes for Māori. From the outset, the plan emphasises the need for partnership, action planning and measurement, and accountability. It identifies and discusses six key strategic areas for change (ie, outcomes):

1. partnership and leadership – shared decision-making at key levels with Māori
2. humanising and healing – reduction of trauma and provision of support
3. whānau – involvement of and support for whānau
4. incorporating a Te Ao Māori worldview – use of kaupapa-Māori based approaches as the foundation of practice, processes and pathways
5. whakapapa – strengthening of cultural identity and connections
6. foundations for participation – provision of support to meet basic needs and interagency collaboration (pp. 16–17).

Again, while not articulating a model of care, the strategic plan thus signals the need for collaboration and engagement, as well as a shift toward a more rehabilitative, person-centred focus in keeping with best practices.

Office of the Auditor-General

The researchers located one document via the Office of the Auditor-General website pertaining to FMHSs. *Mental Health Services for Prisoners* (Office of the Auditor-General 2008) is a performance audit report examining 'the effectiveness of the agencies' systems for delivering mental health services to sentenced and remand prisoners' in three areas: service planning, service delivery and service monitoring and evaluation (p. 5). The findings related to service delivery are the most relevant to discussion on FMHS models of care: the report identifies limitations in several areas, specifically 'timely access to inpatient services, services for those with mild to moderate illness, forensic inpatient services for women, services for those with personality disorders, and services that were responsive to Māori needs' (p. 6). Additionally, the report notes the development of a new mental health screening tool to improve identification of prisoners' mental health needs as well as access to treatment. In keeping with best practices, the report underscores the importance of interagency liaison and collaboration, particularly between Ara Poutama and the Ministry of Health.

Department of Justice

The researchers located three relevant documents published by the Ministry of Justice.

The first (Ministry of Justice 2017) is an evidence brief on culture-based correctional rehabilitative interventions for indigenous offenders, which highlights the need for services to be responsive to Māori, given that Māori comprise more than half of the Aotearoa New Zealand prison population. The brief synthesises international research in this area, which is limited, noting recent programmes administered in Australia, Canada and Aotearoa New Zealand. Overall, the brief suggests that the majority of the culturally responsive programmes cited 'have shown small reductions in reconviction and re-imprisonment when compared with matched control prisoners' (p. 4) and provide other benefits including increased cultural knowledge and identity, improvement of prosocial attitudes and relationship skills, decreased anger and aggression, and reduced rehabilitative needs. The brief especially highlights the Saili Matagi Programme discussed in Section 5 as an example of a particularly successful programme.

The remaining two documents are recent reports on the activities of the Safe and Effective Justice Advisory Group, Te Uepū Hāpai i te Ora (2019a, 2019b) within the government programme Hāpaitia te Oranga Tāngata: Safe and Effective Justice. While not directly pertaining to FMHS models of care, the documents signal the need to acknowledge the limitations of the current criminal justice system – including the fact that prisons are 'good at punishment but poor at rehabilitation' (Safe and Effective Justice Advisory Group 2019a, p. 49) and to make the criminal justice system more responsive to service users through a co-designed approach. Key to this approach is Māori consultation and, in particular, leadership from and engagement with te ao Māori (Safe and Effective Justice Advisory Group 2018b). In terms of FMHSs, the documents highlight Māori needs, as well as the need for accessible, culturally informed mental health services for Māori within the criminal justice system. The documents also acknowledge the impact of trauma, particularly among Māori and women, as well as the traumatic nature of the prison environment, and call for coordinated, trauma-informed high-quality care (Safe and Effective Justice Advisory Group 2019a, p. 62).

Te Pou o Te Whakaaro Nui

The three documents pertaining to FMHSs published by Te Pou o te Whakaaro Nui (2014, 2019a, 2019b) concern workforce development within the adult mental health and addiction workforce. The first details the findings of the 'More Than Numbers' organisation workforce survey administered in 2014, which aimed to identify 'the size and distribution of the workforce across provider and service types' as well as 'provider opinions about areas for future workforce development' within the FMHS sector (p. 4). The remaining two provide more recent figures concerning the workforce across the mental health and addiction sector (both forensic and non-forensic). While not directly related to models of care, the documents highlight challenges experienced within FMHSs concerning workforce development, recruitment and retention, knowledge and skill needs, and cross-sector relationships. This information may be useful in the context of future service development.

Summary

At the national level, documentation on FMHSs is wide ranging and somewhat disparate. A significant portion of the recent documents acknowledge the significant needs of Māori within the criminal justice and FMHS sectors and call for culturally informed and responsive care. Key to this discussion is increased consultation, collaboration and engagement with Te Ao Māori, and the shift toward co-designed approaches in service planning and development. Alongside this shift is a general move toward the adoption of rehabilitative, person-centred approaches, in keeping with the best practice literature. In both cases, these shifts are largely in development and have yet to be fully realised or articulated. Notably, though a national framework for FMHSs was suggested in the Mason Report as far back as 1988 and again by the Ministry of Health in 2001, no models of care for FMHSs within any arm of these services (or organisations which engage with the services) have yet been articulated or implemented at the national level.

International level

International trends in FMHSs are highly relevant to the Aotearoa New Zealand context, and continue to inform current and future service development at the regional and national levels. Given the evidence of best practices highlighted in the scholarly literature reviews, the researchers selected four jurisdictions to review within which to identify relevant guidelines on models of care: England, Scotland, Ireland and Victoria, Australia. It is outside the scope of this review to provide detailed case studies on the structures or processes used in FMHS delivery in these locales.[47] Rather, the following discussion briefly highlights points of difference within these jurisdictions, as well as trends which align with best practices in the evidence base.

Table 4: International documentation reviewed

Jurisdiction	Organisation (Author(s))	Year	Title
England	National Institute for Health and Care Excellence	2017	*Mental Health of Adults in Contact with the Criminal Justice System*
	NHS England	2018	*Developing the 'Forensic Mental Health Community Service Model': Background Information Resources (4 of 5): Core components of the model and the Specialist Community Forensic Team*
	NHS England	2018	*Developing the 'Forensic Mental Health Community Service Model': Background Information Resources (5 of 5): The Specialist Community Forensic Team: Values, Knowledge and Skills*
	NHS England	nd	*Mental Health – Low secure services including access assessment service and forensic outreach and liaison services (adult)*
	NHS England	nd	*Mental Health – Medium secure services including access assessment service and forensic outreach and liaison services (adult)*
	Quality Network for Prison Mental Health Services and Royal College of Psychiatrists (M Georgiou, H Stone and S Davies(eds))	2018	*Standards for Prison Mental Health Services* (4th ed)
	Quality Network for Prison Mental Health Services and Royal College of Psychiatrists (M Georgiou, M Oultram and H Quazi (eds))	2019	*Standards for Forensic Mental Health Services: Low and Medium Secure Care* (3rd ed)

[47] Descriptions of FMHS delivery structures and processes in these locales is available in the scholarly literature cited throughout the four systematic reviews. Please refer to the prior chapters for specific references to this literature.

Jurisdiction	Organisation (Author(s))	Year	Title
Scotland	Forensic Mental Health Services Managed Care Network (W Black and A Robertson)	2004	*Report of the Services for Women Working Group*
	Forensic Mental Health Services Managed Care Network	2008	*Leading Change in Forensic Services: A multi-disciplinary and multi-agency approach to improve care pathways for forensic service users in Scotland*
	Forensic Mental Health Services Managed Care Network (DJ Hall)	2010	*Forensic Long Term Care: Report of working group*
	Forensic Mental Health Services Managed Care Network, Care Standards Working Group	2005	*Care Standards for Forensic Mental Health Inpatient Facilities in Scotland*
	Forensic Mental Health Services Managed Care Network, Care Standards Working Group	2006	*High Secure Care Standards*
	Forensic Mental Health Services Managed Care Network, Care Standards Working Group	2006	*Low Secure Care Standards*
	Forensic Mental Health Services Managed Care Network, Community Services Working Group	2005	*Community Services for Mentally Disordered Offenders in Scotland*
	Forensic Mental Health Services Managed Care Network, Matrix Working Group	2012	*'The Forensic Mental Health Matrix': A guide to delivering evidence based psychological therapies in forensic mental health services in Scotland*
	Forensic Mental Health Services Managed Care Network	2017	*Forensic Mental Health Services Managed Care Network: Annual report 2016–2017*
	National Prisoner Healthcare Network	2014	*National Prisoner Healthcare Network Mental Health Sub Group: Final report*
	National Prisoner Healthcare Network	2016	*National Prisoner Healthcare Network Mental Health Sub Group: Implementation report – post consultation*

Jurisdiction	Organisation (Author(s))	Year	Title
Ireland	HG Kennedy, C O'Neill, G Flynn et al	2016	*The DUNDRUM Toolkit: Dangerousness, understanding, recovery and urgency manual (The DUNDRUM Quartet)*
	Mental Health Commission	2006	*Forensic Mental Health Services for Adults in Ireland: Discussion paper*
	Mental Health Commission	2011	*Forensic Mental Health Services for Adults in Ireland: Position paper*
	Mental Health Commission (O O'Neill)	2012	*National Overview of Forensic Mental Health Services Ireland 2011*
	Health Service Executive, Mental Health Division	2016	*Delivering Specialist Mental Health Services*
Victoria, Australia	Forensicare	2019	*Forensicare Strategic Plan 2018/19–2020/21*

England

Forensic mental health services in England fall under the purview of the National Health Service (NHS), and vary between the regions in terms of service structure and models of care.

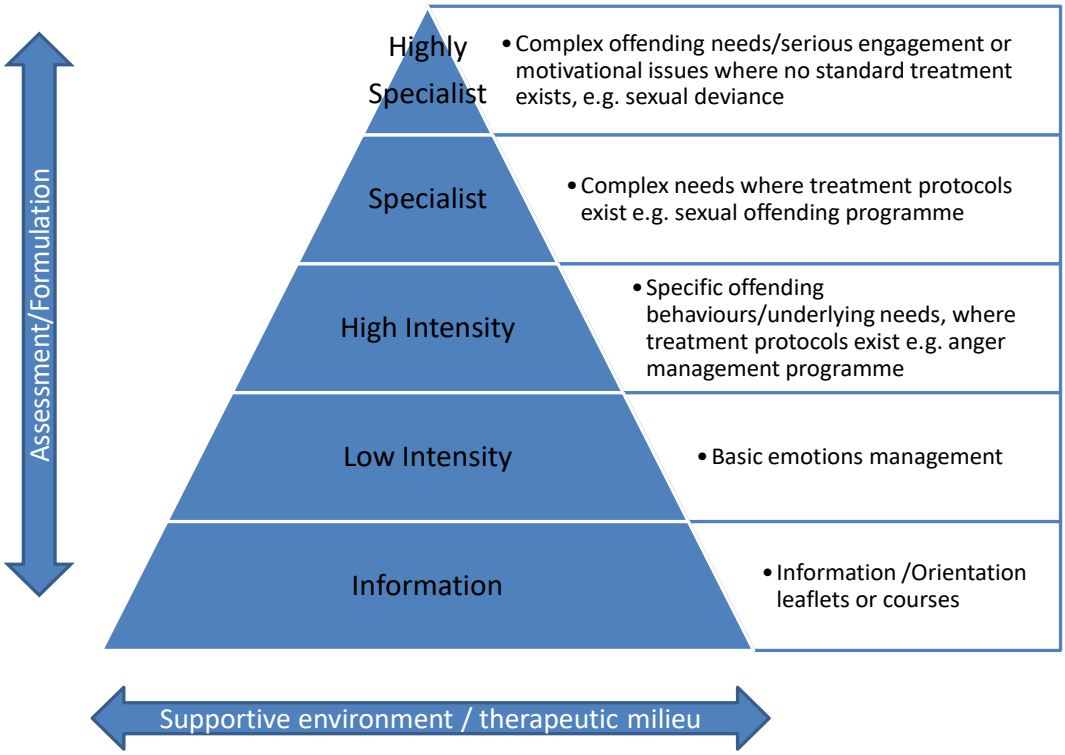
Despite this regional variation, several national bodies have issued guidelines governing different aspects of FMHSs. Indeed, the documents the researchers reviewed regarding FMHSs in England consisted primarily of guidelines or standards for the typical main service areas, including for: (a) low/medium secure inpatient services (NHS England nd-a, nd-b; Quality Network for Prison Mental Health Services and Royal College of Psychiatrists 2019), (b) prisons (Quality Network for Prison Mental Health Services and Royal College of Psychiatrists 2018), and (c) justice-involved adults more generally (National Institute for Health and Care Excellence 2017). Within the inpatient context, emphasis is placed on relational security, in keeping with the other jurisdictions. In both the prison and community contexts, a case management approach is seen as best practice. Notably, while a service model was suggested in the community context in terms of developing forensic community teams (NHS England 2018a 2018b), no models of care were clearly articulated in the grey literature.

Scotland

Scotland's Forensic Network consists of a 'managed care pathway' that provides holistic, integrated services for all FMHS users. This pathway is multi-agency and multi-disciplinary, and thus comprises a 'network' of coordinated joint service providers across the different levels of security (Forensic Mental Health Services Managed Care Network 2008). In this way, the pathway represents a 'pan-Scotland approach to the planning of services and patient pathways', which includes 'the commissioning of research to establish an evidence base for future service development' and teaching to assist in workforce development (Forensic Mental Health Services Managed Care Network 2017, p. 6).

Several documents the researchers reviewed outline the care standards or models for various arms of the service, including high secure care (Forensic Mental Health Services Managed Care Network 2006-a), low secure care (Forensic Mental Health Services Managed Care Network 2006-b), inpatient (Forensic Mental Health Services Managed Care Network, Care Standards Working Group 2005), and community FMHSs (Forensic Mental Health Services Managed Care Network, Community Working Group 2005). In a different context, another document (Forensic Mental Health Services Managed Care Network, Matrix Working Group 2012), while focused on psychological therapies, more explicitly proposes a matched stepped model of care that is person centred and takes into account offending behaviour interventions (see Figure 12).

Figure 12: Stepped care model for forensic mental health services, with examples of offending behaviour interventions



Source: Forensic Mental Health Services Managed Care Network, Matrix Working Group 2012, p. 9

Two documents provide a review of services for specific populations, namely service users in long-term care (Hall 2010), and women (Black and Robertson 2004). Hall recommends the development of recovery-oriented longer-stay units that can manage the risk of longer-term forensic patients. Black and Robertson highlight the need for dedicated multidisciplinary teams focused on women's services. While their report provides evidence of the need to develop gender-responsive practices in keeping with the literature, it is unclear how services have developed since the time of publication in response to the recommendations presented therein.

Finally, two documents by the National Prisoner Healthcare Network (2014, 2016) are planning documents concerning the development of the mental health and learning disability service for prisoners. The documents state an objective to create a detailed model of care for the prison service, though it appears this is still a work in progress.

Ireland

In keeping with the other jurisdictions, FMHSs in Ireland comprise inpatient, community, prison in-reach, and community liaison and diversion services. The National FMHS is a centralised, tertiary mental health service that is part of the Health Service Executive's Mental Health Division. Of the Irish documentation reviewed, three are Mental Health Commission reports (2005, 2011, 2012) reviewing FMHS provision and providing recommendations for service development. These documents may be useful in providing support for recovery-oriented principles in service delivery. A fourth document (Health Service Executive, Mental Health Division 2016) provides an overview of FMHSs, noting especially an emphasis on a recovery focus and the use of ICPs.

Of particular relevance, Ireland's FMHSs are organised according to levels of therapeutic security, in keeping with the best practice literature. Notable in this respect is the recent emergence of the DUNDRUM Toolkit (Kennedy et al 2016), a set of structured professional judgment instruments which provide measures of functioning, recovery, risk and placement pathways. Auckland RFPS has recently adopted the use of the DUNDRUM measures, which highlights the need for further consideration of the role such measures play in FMHSs more broadly.

Victoria, Australia

Forensicare, the Victorian Institute of Forensic Mental Health, is the sole clinical provider of state-wide, specialist FMHSs, and spans the entirety of the mental health and criminal justice sectors in Victoria (Forensicare 2019a). Services (including inpatient, prison, community and court liaison services) clearly follow a recovery focus throughout the forensic pathway. An interesting feature of the Forensicare model is the integration of a comprehensive research institute (the Centre for Forensic Behavioural Science, in partnership with Swinburne University of Technology), which supports the development of clinical services, as well as the provision of specialist training and ongoing professional education for staff.

Although the researchers did not find documentation detailing Forensicare's model of care, given the evidence discovered in the prior reviews, they felt it important to include Victoria as an example of international best practice for consideration in future service development. Upon review of the organisation's website, they found one document signalling Forensicare's innovative model of care. Forensicare's *Strategic Plan 2018/19–2020/21* (2019b) indicates the development of an evidence-based, recovery-focused model of care currently under way as part of a model of care review. The new model of care aims to improve patient flow and address the specific needs of service users, and particularly women. The plan suggests further elements of a recovery-focused approach in keeping with the best practice literature, including the development of a peer-support model, trauma-informed care, culturally responsive care and gender-responsive services.

Summary

The international documentation the researchers reviewed highlights similar trends to those evident within the regional and national documentation, albeit with a more explicit and perhaps more advanced recovery focus and a greater emphasis on ICPs. Some jurisdictions, such as Scotland and Victoria, further emphasise the adoption of gender-responsive practices and are developing services in this respect. As such, these jurisdictions provide useful models of best practices that Aotearoa New Zealand may use to inform the development of a national implementation guidance document for FMHSs.

These four jurisdictions also provide examples of national mechanisms whereby overarching governance structures have been developed to coordinate regional services. The Scottish Forensic Mental Health Services Managed Care Network is a prime example. In Scotland, an emphasis on nationally coordinated workforce development that sits alongside a coordinated FMHS response is noteworthy. This involves university partnerships to drive both research and teaching that align with service improvement.

Summary

The researchers' review of the grey literature revealed wide-ranging and somewhat disparate documentation at the regional, national and international levels concerning FMHS models of care. The majority of the documentation, in keeping with the evidence base, focuses on service delivery more broadly, and has yet to clearly articulate a 'model of care' per se. Within the existing documentation, it appears regional services and the FMHS sector more generally are moving – albeit with varying degrees of implementation – toward the adoption of a recovery-based approach organised according to principles of therapeutic security, rehabilitation and recovery-oriented practice, in keeping with the best practices identified in the evidence base. Examples of overarching national governance structures to coordinate regional service responses in an integrated manner, which include workforce development initiatives, provide potential solutions to the regional disparity signalled above.

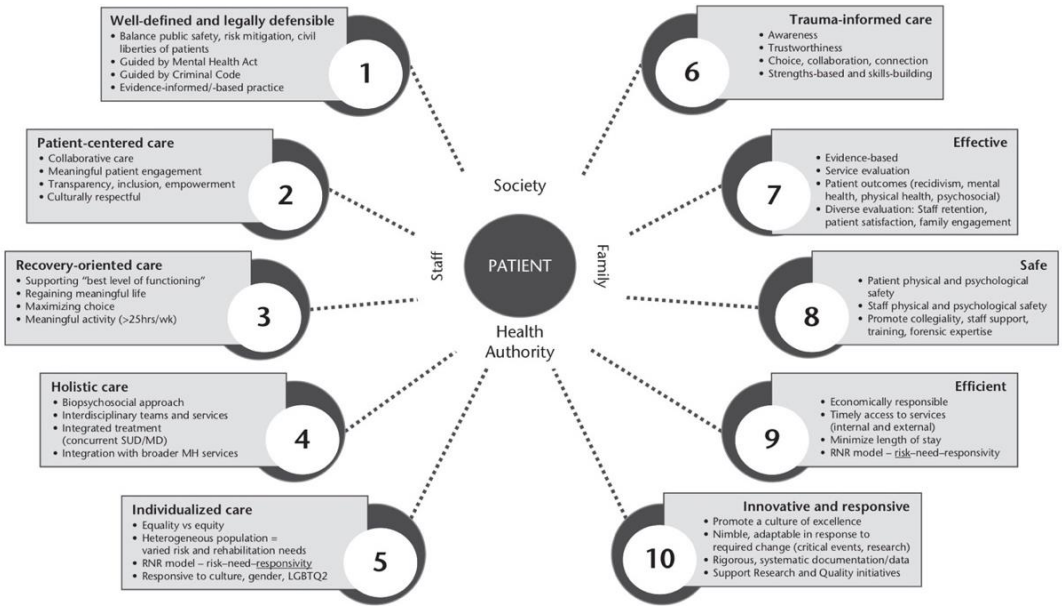
Notably the national documentation highlights the importance of consultation, collaboration and engagement with te ao Māori, and calls for a shift toward co-designed approaches in future service planning and development. Interestingly, the researchers found that, while some jurisdictions (such as England and Victoria) have adopted a focus on gender-responsive services and the special needs of women, discussion on the needs of ethnic minorities or indigenous populations was largely absent. Additionally, it appears these international jurisdictions have yet to adopt a co-designed approach to service development. In this way, based on the regional and national documentation, Aotearoa New Zealand is a leader in this respect, and has a unique opportunity to set precedent internationally in the development of equitable, culturally responsive best practice FMHSs.

Section 7:
Relevance of key findings

While models of care within FMHSs have not been well articulated, evidence exists concerning best practices or principles of treatment that can be used to inform such a model (eg, Barnao et al 2012; Gunn and Taylor 2014; Nicholls and Goossens 2017; Tapp et al 2016; Völlm et al 2018). Of particular relevance to this project as a whole, Nicholls and Goossens (2017) identify 10 core dimensions of high-quality forensic services (see Figure 13), saying FMHSs should be:

> (1) well-defined and legally defensible (ie, attentive to legal mandate, responsible to society, public safety, staff safety, patient safety), (2) person-centered (ie, responsive to patient and family preferences), (3) recovery-oriented (eg, strength-based), (4) holistic (ie, attending to mental health, substance abuse, physical health) (5) individualized (ie, culturally-sensitive, gender-sensitive), (6) trauma-informed, (7) maximizing of positive effects (ie, efficacious, effective positive patient experience), (8) minimizing of negative effects (eg, safe, negative media attention, stigma, least restrictive disposition, adverse outcomes), (9) efficient (eg, fiscally responsible), and (10) innovative and responsive, promoting a culture of excellence (ie, committed to research/evaluation; to change, grow, and develop with research and knowledge). (p. 509)

Figure 13: Core dimensions of high-quality forensic services



Source: Nicholls and Goossens 2017, p. 510

In keeping with these principles of treatment and the literature more broadly, the key findings are presented below.

Recommendations for models of care in Aotearoa New Zealand

The following recommendations are made for models of care in Aotearoa New Zealand based on the literature reviews. If New Zealand were to transform its approach to FMHSs, it should look to implement a model of care with the following characteristics:

- The model of care should achieve equity of service delivery for Māori.
- The model of care should achieve equity of service delivery for ethnic groups specific to each region (eg, Pacific peoples).
- The model of care should achieve gender-specific equity of service delivery.
- The model of care should be proactive in focusing on early intervention and prevention strategies and interagency collaboration.
- The model of care should be collaboratively designed with all major stakeholders (eg, Māori, other relevant cultural expertise, gender-specific expertise, lived experience expertise, whānau/family expertise, inter-facing agencies such as prisons/police/courts).
- The model of care should reflect the reorganisation of FMHSs into an integrated, holistic service across the entire service user pathway (police, courts, prisons, FMHSs, community).

Therapeutic security, rehabilitation and recovery

- A national definition of the levels of therapeutic security should be developed and then consistently applied to models of care in each FMHS.
- A rationale should be provided for the inclusion (or not) of high secure facilities that exist in comparable jurisdictions.
- A holistic rehabilitation focus should be incorporated into all FMHS models of care, which combines an emphasis on mental health, addiction, criminogenic, physical, psychosocial and cultural needs.
- The FMHS model of care should include the integration of primary, secondary and personal health, including mental health and addiction needs.
- A strong recovery component should be central to the model of care in each FMHS.
- Both the rehabilitation focus and the recovery focus should reflect inclusive multidisciplinary, cultural and lived experience input.

- The model of care should incorporate a national response to tāngata whaiora with complex needs.
- All the above should be considered in the distinct models of care for the four components of FMHSs (inpatient, community, prisons and courts).

Recommendations for specific settings

Inpatient

- Although evidence exists for a number of recovery-orientated models of care in inpatient FMHSs, the national implementation of one model is suggested, to enable ongoing refinement.
- The DUNDRUM suite of measures should be introduced nationally, to assist in decision-making regarding service users' pathways through FMHSs.

Community

- Forensic mental health services should articulate either forensic assertive community treatment or forensic mental health case management as central to their models of care in the community, within a recovery-orientated paradigm.
- Forensic mental health services should articulate the nature of the consultation and liaison functions in their models of care in the community. In these community models of care, these services' integration or parallel operation with GMHSs should be clearly articulated.
- A well-resourced diversion model of care should be developed to relieve pressure from FMHSs.
- Forensic mental health services should develop clear relationships with agencies that have a preventative emphasis, to strengthen the diversion component of the model of care.

Prisons

- The STAIR prison in-reach model of care (developed in Aotearoa New Zealand) should be reviewed nationally to consider its culturally specific responsivity, gender-specific responsivity and recovery orientation.
- Once refined, this model of care should be endorsed as the prison model of care for all regional FMHSs.

Courts

- The model of care for courts should clearly articulate the core functions of assessment, consultation, diversion and liaison.
- Consideration should be given to proactive screening for mental health and addictions as a routine process in the models of care for courts.
- To increase responsivity to Māori, further consideration should be given to the use of Māori cultural assessments and provision of cultural support within the court liaison service.

Research

- Research needs to be embedded from the outset in all models of care.
- This research should be both formative (to flesh out progress in the embedding of the models of care) and summative (to consider the outcomes of the models of care).
- This research should be co-designed by all stakeholders, with an emphasis on kaupapa Māori research, given the populations FMHSs serve.

Forensic mental health services in Aotearoa are at an exciting cross-roads. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (Paterson et al 2018) challenges services to develop models of care which are co-produced, recovery-oriented and evidence-based, and which place service users and their whānau at the centre. Furthermore, our health system is being transformed into a single national health service including a new Māori health authority (Ministry of Health 2021). If the findings of this literature review are endorsed alongside these changes, regional FMHSs should be able to achieve consistent service delivery and learn from each other's innovation, to produce the best outcomes for those they serve.

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