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The Problem Behavior Program

Threat Assessment and Management in Community Forensic Mental Health

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Threat assessment has attracted the concerted attention of forensic mental health clinicians and researchers only in the past two decades. Forensic mental health services have traditionally become involved in cases where offending occurs in the context of a mental illness and have primarily focused on treating the symptoms of the illness rather than dealing with issues of threat or risk. There are many reasons for this that are beyond the scope of this chapter, but a succinct overview is provided by forensic psychiatrist Anthony Maden, for those who are interested (Maden, 2007). In practice, the focus on mental illness and past offending means that mentally ill individuals who have not yet offended but may do so, those for whom mental illness is not the primary risk factor for offending, and those who do not suffer from psychopathology at all have been largely excluded from forensic mental health assessment and treatment. This practice disregards the majority of people who engage in difficult and problematic behaviors that may be associated with increased risk and who could potentially benefit from the expertise of forensic mental health clinicians.

This chapter describes the Problem Behavior Program (PBP) in Melbourne, Australia—a service that expands the scope of the traditional community forensic mental health service beyond the focus on psychopathology to other criminogenic needs. The PBP provides a recognizable referral point for clients of criminal justice and mainstream mental health agencies to access specialist forensic mental health services based on the nature of their *behavior* rather than the presence of mental disorder. Unlike the traditional forensic mental health model, expertise in threat assessment, as well as risk assessment more generally, is a central component of the PBP. Clients of this service are often people whose behavior has prompted concern about the potential for targeted or general violence even in the absence of criminal offending. Providing an avenue for comprehensive and evidence-based assessment, recommendations, and treatment of these difficult and sometimes frightening behaviors is the central purpose of the PBP.

WHAT ARE PROBLEM BEHAVIORS AND HOW ARE THEY RELATED TO THREAT ASSESSMENT?

Threat and risk assessments occur in a wide variety of contexts and in response to a range of perceived threats. Threats may be targeted and explicit but are more often inferred from the individual's other behaviors. Uttered threats, the presence of stalking, a history of violence, or a history of harmful sexual behavior or fire setting are all contexts that provoke concerns about the risk of future similar actions; in such cases a targeted threat assessment or a general risk assessment might be desired. Warren, MacKenzie, Mullen, and Ogloff (2005) have described these types of conduct as "problem behaviors"—actions that intentionally or recklessly cause harm to others and to the perpetrator. While in many cases such conduct is also criminal, the term

problem behavior encompasses actions that are prosecuted as well as those that never come before a court (Warren et al., 2005). The problem behavior framework that underpins the PBP described in this chapter operates on two levels. In the individual case this framework presents a way of conceptualizing threatening or otherwise risky behaviors so as to make them more understandable and manageable. At the organizational level it is a model of service provision for clients who would otherwise find it difficult, if not impossible, to access interventions to ameliorate the risks associated with their behavior.

Problem behaviors are inherently complicated and involve a broad range of actions perpetrated by a diverse range of people with various motivations under various circumstances (Warren et al., 2005). All carry with them a perceived threat, or risk, and those tasked with assessing or managing that risk can often feel overwhelmed and confused by the complexity of the presentation. When applied to an individual case, the problem behavior framework is really a set of principles and a process of assessment that can be used to make these tasks more manageable. From the outset, such an approach is based on a health professional's perspective with the aim of being able to help the individual effect change in their behavior and circumstances. There is little interest in ascertaining the "truth" about what happened or acting as ersatz police officers or lawyers; rather, the aim of the assessment is to present the individual as a person within a social, psychological, and personal context so as to better understand their behavior (Warren et al., 2005). In doing so, the clinician using the problem behavior framework moves beyond a narrow focus on psychopathology to a wider perspective encompassing the developmental, social, psychological, and contextual roots of their behavior. Of course, the insights gained from this perspective can be of immense use to others involved in managing individuals who engage in problem behaviors, such as correctional and police services (Russell & Darjee, 2012).

The problem behavior framework takes a reductionist approach, assuming that complex human behaviors can be understood as the product of multiple contributory factors. In the broadest sense, individual factors such as personality attributes (attitudes, beliefs, and values), interpersonal and other skills deficits, and, in many cases, psychopathology, interact with the social milieu and context(s) in which the behavior occurs. Such contributory factors may have developed over time and be present throughout the individual's life or appear only in close proximity to the onset of the problem behavior. In undertaking a detailed assessment with an individual (as outlined later in this chapter), the clinician is attempting to elicit evidence of personal and situational factors that may predispose the individual to the behavior, precipitate its onset, and perpetuate it once it has begun. There is also an interest in identifying factors that may protect against the behavior occurring or lead to desistance from the behavior. Consequently the assessment also emphasizes times that the client has been able to refrain from the problem behavior and how he or she feels about engaging in treatment aimed at reducing the behavior. As might be evident, this framework is broader in scope than just a threat assessment. A structured threat or risk assessment often forms one part of the wider assessment of the problem behavior. A judgment of high or moderate risk informs decisions about whether the client should be offered interventions to reduce the problem behavior and the associated risks, and how immediately intrusive those interventions might need to be.

To identify personal and situational factors that might be relevant to the problem behavior it is necessary to have knowledge of the research literature pertaining to offending generally and to each type of problem behavior specifically. For example, being able to apply a problem behavior framework to a stalking situation means being familiar with the literature on psychopathology among stalkers, types of stalking risk, common motivations for stalking and associated attitudes and beliefs, and the types of behavioral and psychological risk factors for stalking that may be present. Any account of a problem behavior must be based on evidence and make reference to research findings to be of use in the subsequent treatment and management of the individual. It is beyond the scope of this chapter to provide a review of the research literature relevant to each type of problem behavior; suffice it to say that such knowledge is a prerequisite of using a problem behavior approach in conducting an individual assessment. This obviously poses problems when clients come from underresearched populations, such as female sexual offenders or Internet child pornography offenders. In these types of cases the same broad approach is taken, but conclusions are made more cautiously with explicit reference to relevant literature underpinning those conclusions where such exists (e.g., Gannon & Cortoni, 2010, in relation to female sexual offenders).

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DEVELOPMENT OF THE PROBLEM BEHAVIOR PROGRAM

The PBP is one of a number of programs run by Forensicare, the publicly funded forensic mental health service in the State of Victoria, Australia. Forensicare is a statutory body with a statewide jurisdiction, providing forensic mental health services to a population of approximately 5.5 million people. The PBP is part of Forensicare's Community Forensic Mental Health Service (CFMHS), located in metropolitan Melbourne. While most clients of the service are from Melbourne (a city of just over 4 million people), PBP clients from regional and remote areas sometimes travel as far as 400 kilometers to attend an assessment. When Forensicare was established in 1998, the CFMHS consisted of a Mental Health Program (MHP), which worked with forensic patients released from a secure hospital, and a Psychosexual Treatment Program (PTP), which undertook assessment and treatment of high-risk sex offenders, some of whom required antilibidinal or psychiatric medication. With the advent of the community-based Sex Offenders Program within the State Department of Corrections, a review of the PTP purpose and function was conducted in 2002. This review identified an ongoing need for services for those who engaged in sexually problematic behaviors but were not subject to a legal order; and also identified a critical service gap for individuals presenting with other forms of "problem behavior." The CFMHS had been seeing stalkers and stalking victims since the late 1990s; in 2002, under the leadership of Professor Paul Mullen, specific research-oriented clinics were established to collect data on individuals who threatened or stalked (Warren et al., 2005). These clinics attracted considerable attention and requests for secondary consultations and presentence court reports quickly grew. There was also a clear need for an assessment and treatment pathway for adult deliberate fire setters, for whom no services existed despite periodic public attention due to high profile arson convictions.

In the face of this increasing demand, a structured governance mechanism for the non-sex-offender clients was needed. In January 2003, the Problem Behaviour Clinic (PBC) was established, incorporating the existing psychological and psychiatric assessment and treatment services for threateners and stalkers, and expanding them to fire setters, perpetrators of serious or repeated violence, those suffering from morbid jealousy, and querulous complainants. By 2004, demand for the PBC had increased to such an extent that the decision was made to amalgamate it with the sexual violence-focused PTP into a broader PBP. This decision was based on the premise that the target population of both programs shared certain similarities and included offenders or potential offenders characterized by the following factors: (1) they potentially posed a high risk of harm to the community, (2) their needs could not be met elsewhere, (3) their treatment needs were likely to extend beyond any statutory order, and (4) they showed some sign of willingness to engage in treatment and were likely to benefit from it.

Since 2004 the PBP has accepted an average of approximately 230 referrals per year. Of accepted referrals, 40% of clients have been referred by community-based probation services as a condition of a statutory order. The remaining referral sources include publicly funded adult mental health services (30%), self-referrals (7%), referrals from the private mental health sector (6%), youth mental health services (6%), and a range of other community and legal services (11%). Since the PBP began, 40% of clients have been referred for actual or fantasized violent behavior, 35% for problematic and harmful sexual behavior or fantasies of the same (e.g., child molestation, Internet child pornography, rape, exposure), 25% for stalking (including stalking involving violence or threats), 16% for making threats, 6% for fire setting, and 12% for a variety of other problematic behaviors. As is evident from the percentage figures, many clients present with multiple problem behaviors. The client group is diagnostically complex, with personality, psychotic, mood, and substance use disorders featuring prominently among those referred to the program. A small but significant number of clients do not present with any mental disorder.

Advantages and Challenges of the PBP Service Model

The PBP service model offers a number of advantages to clinical practice. The variety of presenting behaviors, legal status, and mental health diagnoses of clients seen within the PBP allows for the development of expertise in the assessment and treatment of a range of problem behaviors and their psychological, psychiatric, and social determinants. This clinical knowledge has been strengthened and underpinned by collaborations between clinicians and local academics to facilitate research into specific

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problem behaviors. The PBP service model provides a unique research opportunity as many individuals with similar problem behaviors accumulate in one location, providing a potential research pool that would otherwise be almost impossible to access. As a result, a significant proportion of international research into stalking and threatening originates in Melbourne. Since 2008, this has been aided by the colocation of the PBP and the Centre for Forensic Behavioural Science (a research center cosponsored by Forensicare and Monash University) in the same building. Problem behavior research to date has focused primarily on stalking and threatening; however, current research projects are under way investigating deliberate fire setting, Internet child pornography, sex offender risk assessment, intimate partner violence risk assessment, and the psychological correlates of violence. Work is also proceeding on an evaluation of the PBP examining both client outcomes and stakeholder experiences.

The PBP model also provides advantages when examined from a service delivery perspective. The program meets a critical service gap, seeing individuals who are at risk of engaging in criminal behavior but have not yet done so. Without the PBP, these clients would not be able to access specialist assessment and intervention unless they committed and were prosecuted for an offense. Even then their access to correctional rehabilitative services may be hampered by the presence of mental disorder or by a lack of services specific to their behavior. Acceptance into the PBP is also often a first step for clients toward establishing links with other key services such as mental health, community health, or other social services. By taking a lead clinical role in the management and treatment of high-risk behaviors, the PBP strengthens referral pathways to those services that may have previously been apprehensive about taking on such clients. The PBP's unique model of service delivery; the complex, high-risk behaviors that staff assess and treat; and the program's strong research links have all contributed to its strong national and international reputation.

While the PBP model clearly has a number of strengths, its implementation is not without challenges. Most notably, there is the delicate balance between managing the need for confidentiality in treating potential offenders and managing public interest and public safety. This is addressed in part by orienting the client from the outset of any assessment or treatment to the limits of confidentiality; that is, that while their interests are paramount, if we believe their actions may place either themselves or others at risk, then action may need to be taken in the form of contacting police or potential victims. An ongoing process of regular threat and risk reassessment informs these types of decisions. Tension may still arise when there is disagreement between the PBP and other services or organizations, such as police or child welfare agencies, as to the nature of the risk posed by an individual; and therefore whether the best interests of the public outweigh the client's right to confidentiality. This can be particularly problematic when a breach of confidentiality has the potential to adversely impact on therapeutic alliance and engagement and so may in itself increase risk further.

Another challenge for the service is being able to undertake assessments of clients in a timely manner while also ensuring they are comprehensive and address both the evaluation and management of risk. The development of program guidelines and an intake and referral policy and procedure are central to managing this issue. Clear policies providing guidance for prioritizing referrals as well as time lines for the provision of verbal and written feedback to referrers are required. Even with these steps, and regardless of the reporting and legislative responsibilities of the referrer, Forensicare is often in the position of taking some responsibility for a potentially high-risk client without yet having assessed him or her. Forensicare must consider its responsibilities in relation to issues such as duty to warn and breach of confidentiality, particularly when an individual is awaiting assessment and has not yet formally become a registered client of the service. To manage these tensions, the PBP has increasingly taken on the role of providing tertiary advice, support, and guidance to services and individual practitioners while the individual is awaiting a PBP assessment. This is an effective way to encourage other services to make use of their skills and expertise in an informed way, minimizes any inclination to wholly defer to the "experts" in community risk management, and promotes the use of evidence-based practice in this area (see Russell & Darjee, 2012, for further discussion of this issue).

The other significant challenge for a PBP service model in a socialized health care environment is to find and maintain a funding source. The service model takes a public health approach to reducing the overall impact of violence and other problem behaviors in the community. This approach is analogous to a public health campaign to prevent deaths from

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heart attack. Encouraging healthy eating and exercise through population wide measures reduces the risk at a population level without having to undertake the virtually impossible task of identifying the specific individuals who are at extremely high risk of actually having a heart attack. In the problem behavior context, a public health approach means treating the risk factors for sexual or other forms of violence in as large a sample as possible, thereby reducing the overall risk in that group. This removes the need to attempt to accurately predict the small number of clients who may actually go on to commit serious violence because their risk is lowered along with that of all other group members. Based on this premise, the PBP employs specialist mental health clinicians who engage in treatments designed to reduce the risks associated with problem behaviors. These clinicians would typically receive funding via a health or mental health funding stream. However, the signature criterion of the PBP service model is that clients need not be diagnosed with a mental illness to access treatment. This creates a funding dilemma because, while the outcomes of treatment have a public and individual health function, clients are not "typical" consumers of health funding. Forensicare initially overcame this dilemma by funding the PBP from within their existing budget. Despite the potential for negative outcomes that is always present when working with a high risk population, the executive made the decision to provide and continue funding in the initial years of the program. What began as a research project in the early 2000s is now viewed as an integral part of the service, and Forensicare has navigated its way through the funding dilemma to secure finance from both the health and justice sectors. Identifying a secure funding source will be a key consideration for any service aiming to develop a similar program model.

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Staff Profile

The staffing profile of the PBP has remained largely unchanged since 2004. Specifically, the staffing complement has remained at four psychology positions since its inception, with the later addition of a full-time PBP manager (a senior psychologist). The program also receives input from psychiatrists and psychiatric registrars and offers a small number of student placements and internships each year. Owing to the specialized nature of the work undertaken within the PBP, all staff providing psychological services in the program are clinical psychologists with specific additional expertise in forensic psychology, forensic assessments (such as court-ordered reports and assessment of risk of violence), and interventions with those at risk of offending. In addition, expert forensic psychiatrists provide monitoring and supervision of high-risk sexual offenders on antilibidinal medication as well as general psychiatric assessment and input to other PBP clients as required. Although some staff members have developed expertise in particular problem behaviors or treatment approaches, all PBP staff provide both primary care and secondary consultations across the range of problem behaviors.

PBP OPERATIONS AND CASE STUDY

This section provides an overview of PBP intake, assessment, and treatment processes, with a case study demonstrating how each works in practice. The case study is an amalgamation of information from a number of clients that presents a "typical" PBP referral for stalking behavior. It provides an example of the types of information clinicians usually receive at intake and what they would try to collect during the assessment. A risk assessment and a threat assessment are outlined, along with basic information about the treatment program that the PBP would aim to deliver in this type of case.

Referral and Intake Process

Referrals to the PBP are managed through a centralized intake system in which an identified intake worker receives the referral and presents it, with supporting documentation, at a weekly intake meeting. It is at this meeting that referrals are discussed to determine whether they are appropriate for the program and their level of priority (low, medium and high). Referrals to the PBP that are considered of high priority are those where evidence-based risk factors are identified in referral documents that place the individual at an increased and imminent risk to the community. Such factors may include recent specific threats, a history of violence (including sexual violence), access to and history of weapon use, lack of social supports in the community, an identified victim/victims and access to these victim/s, unstable mental state, and current substance abuse. A further consideration is whether the individual has assessment, treatment, and support available via other nonspecialist forensic mental health services; or whether his or her problem behavior and the risk associated with that behavior warrants specialist forensic intervention that cannot be provided elsewhere.

Case Study: Intake

The intake worker was contacted by a psychiatrist at a local inpatient mental health unit. He described a current patient, Belinda, a 21-year-old woman who had been admitted three weeks previously after police transported her to hospital. On admission the police reported that Belinda was arrested after scratching "you will die" on the car of Matt, a man who had a restraining order against her. The police told the psychiatrist that Matt had taken out the restraining order because Belinda was stalking Matt's girlfriend, Julia, who had tutored Belinda in the past. The psychiatrist reported that although Belinda had been distressed on admission, she had quickly settled into the ward and was cooperative with all treatment. He described Belinda's open accounts of her "close and wonderful" friendship with Julia and told the intake worker that Belinda would dismiss any challenges to this perception of the relationship. When questioned about Matt, Belinda reportedly became guarded and evasive, saying that she did not wish to discuss him.

The psychiatrist reported that apart from some ritualistic behavior regarding the arrangement of her room and observable distress if anything was out of place, there were no indications of a mood disorder or anxiety during her admission. The rigidity with which she held the beliefs about Julia was considered to be of delusional intensity and a provisional diagnosis of delusional disorder was given. She had been commenced on antipsychotic medication 15 days prior to the referral, but there had been no noticeable attenuation of her beliefs. The psychiatrist requested a second opinion regarding diagnosis and what, if any, risk Belinda posed to Julia and Matt. He also asked if our service would be willing to treat her; or, at a minimum, assist them in putting together a treatment plan. At the intake meeting it was decided that the case should be given a high priority due to the presence of the threat and possible severe mental illness, and a joint assessment with a psychologist and a psychiatrist was scheduled.

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Assessment

Once a referral is accepted at the intake meeting the client is allocated to either a psychologist or psychiatrist for assessment, with the former being more commonplace. In a small number of cases, a joint psychiatric and psychological assessment may be warranted; for example, when a client is presenting with both complex problem behaviors and significant and ongoing psychiatric symptoms that may be linked to the problem behaviors. A typical assessment is likely to take between two and six hours in the form of a semistructured interview, covering areas such as childhood, adolescence and adulthood, educational and employment history, relationship and sexual history, psychiatric and medical history, drug and alcohol use, and offense history. In assessing these domains, it is essential to obtain corroborative information, including criminal history reports, police charge sheets, and previous mental health assessments/reports. Often collateral information is sourced from the family or friends of the client, with their consent. In some cases police informants and/or correctional officers are contacted if insufficient information about the offending behavior is available. This information is viewed in conjunction with results from psychological tests, which are administered in the majority of cases to guide formulation and treatment recommendations. Such testing is tailored to the individual and his or her presenting problem behaviors and will typically comprise some measure of socially desirable responding, personality testing, and other supplementary tests as required. In most cases a structured risk assessment using a set of professional judgment guidelines (e.g., the HCR-20 [Webster, Douglas, Eaves, & Hart, 2002] or RSVP [Hart et al., 2003]) is also completed and informs the results of the wider assessment. This comprehensive assessment process allows the assessor to develop an explanatory formulation of the problem behavior, including a functional analysis, which considers the psychological, psychiatric, and social determinants of the behavior. A written report is provided to the referrer outlining the conclusions of the assessment and providing recommendations for management. In some cases, where risk level and lack of other support services warrants, this may include a recommendation to attend the PBP for ongoing treatment.

Case Study: Assessment

Belinda was brought to the clinic by a nurse a week after the intake was accepted. She presented as a slim, immaculately groomed young woman. She engaged well, and her emotional responses were appropriate to the topics of discussion. The tone, rate, and rhythm of her speech were unremarkable. There was no evidence of perceptual abnormalities and her thought form was normal with no evidence of thought disorder. Although she was somewhat preoccupied with Julia, she was easily enough redirected

and could discuss other matters. Her attention and concentration were largely normal.

Background Information

In this case the assessment included information obtained from Belinda in addition to collateral information from her mother (interviewed on the telephone with Belinda's consent) and from the police informant who had taken Belinda to the local hospital.

Belinda was from a wealthy background and there was no evidence of maltreatment, neglect, or abuse within the family. She had no siblings and stated that she had always been shy and would rather play by herself as a child than join in with others; she added that generally this was still true for many of her current activities. She had excelled academically and on completing high school went straight to university to study history. Her only current social involvement was with her local church; she said that she didn't know many people there very well, but was praised for being a quiet achiever. She explained that she had never worried about making friends as she enjoyed spending time on her own and kept herself quite busy. She reported that she had never had a boyfriend but identified herself as heterosexual.

Belinda strenuously denied ever using or experimenting with any form of drug, expressing her disgust at those who did. She stated that she drank the occasional glass of wine when dining with her family but on special occasions only. She described a pedantic approach to her studies and general chores, and laughingly stated that she had always been "somewhat obsessive" about keeping her bedroom neat and tidy, spending a lot of time ensuring that her clothes and possessions were just as she wanted. She acknowledged being "something of a perfectionist" and "a neat freak." Beyond acknowledging that she "sometimes gets stressed and anxious," she denied experiencing any symptoms indicative of mental illness.

Stress and anxiety became a problem after Belinda commenced a master's degree approximately a year earlier. She found the work challenging and became upset if she did not obtain her usually excellent grades. When she began having difficulty with a compulsory unit, she became convinced she was going to fail despite all evidence to the contrary. She became increasingly anxious, had difficulty sleeping, and began to have panic attacks. Concerned over the level of distress their daughter was experiencing, her parents thought that a tutor might help to alleviate her unrealistic fears. They therefore approached the course coordinator, who recommended Julia, a confident, friendly student who was a year ahead of Belinda. They also suggested that Belinda attend the student counseling service. Although Belinda refused the counseling, the tutoring sessions were scheduled twice weekly in the university library. The impact was dramatic, and with Julia's assistance, Belinda's anxiety about her studies quickly reduced.

Belinda's Account of the Stalking

Although Belinda and Julia never met socially, if Julia had time they would occasionally go for coffee after the tutoring session. Belinda reported that a few weeks after the tutoring commenced she began to regularly text message or email Julia to ask if she would be able to have coffee after the next session. She reported that she would often text Julia just to see how she was doing or what she was up to. Belinda reported that she continued to send "a few" messages after their tutoring arrangement ended at the end of the semester and that Julia had replied, although not every time. Belinda stated that she began to make an effort to see Julia around campus more often because she missed seeing her friend every week with tutoring, but she found this difficult because Julia's other friends didn't like her and seemed eager to make her leave. She denied receiving any messages asking her to stop contacting Julia.

When asked why she had pursued the friendship with Julia, Belinda explained that from the outset she had known that Julia was "special." She spoke with great enthusiasm about how Julia had gone out of her way to help her through a time of crisis and of the strong bond that had formed between them. She was adamant that Julia had done this because they were friends and that they had become so close that they were like sisters. When the questioning turned to why restraining orders had been taken out against her, Belinda became angry, stating that she was convinced that it had been the work of "the others" trying to come between her and Julia because they were jealous of their friendship. When it was pointed out that Julia had contacted the police in regard to the breaches of the order, Belinda stated that she could not believe it was Julia as "a friend just wouldn't do that, it's not the way it works." Although she did not believe that Julia would be frightened by her behavior as "she knows I wouldn't hurt anyone," she acknowledged that the death threat that she had scratched into Matt's car was designed to scare him off. She denied that she would ever act on this threat.

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Collateral Information

The police officer informed us that Belinda's intrusive behavior initially made Julia feel uncomfortable; therefore she tried to avoid Belinda and not reply to her communications so as to discourage her. In response, Belinda began to send up to 40 messages and emails a day. In these messages she stated that Julia was her best friend and that they needed to meet to talk things over. Julia sent Belinda an email asking her not to contact her again. Shortly after, Julia's friends began to experience hang-up phone calls and strange occurrences, such as repeatedly having a flat tire with no puncture, or taxis arriving at their homes in the middle of the night after receiving bookings for that address. After Julia arranged to have Belinda's telephone number and email address blocked, the messages stopped for three days, but then recommenced with the texts sent from public telephones and emails from various newly created accounts.

Approximately three months after the harassment began, Julia and Matt, her boyfriend, arrived home to find Belinda waiting on the footpath opposite their house. Matt lost his temper and began yelling at Belinda that she was a "loony" and needed to get a life rather than hassle Julia. Belinda just continued to stand there silently, watching. The next morning they went to the police and were advised to obtain a restraining order. An interim order was put in place with a court date set for three weeks' time.

Over the next week Belinda continued to send and deliver letters and cards to Julia in which she declared her eternal friendship. When Matt went to his car one morning to find the words "you will die" scratched into the paint work, the police were notified and Belinda was taken to the local police station for questioning. It was during this interview that Belinda began to rock back and forth, gouging her arms with her nails till she bled, prompting them to call the duty doctor and take her to the local hospital.

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Psychometric Testing

Several psychometric instruments were administered, including measures of personality (Personality Assessment Inventory) (Morey, 1991), anger (Anger Disorder Scales) (DiGuiseppe & Tafrate, 2004), and impression management (Paulhus Deception Scales) (Paulhus, 1998). The results supported the clinical impression that Belinda was a perfectionistic young woman with high internalized standards regarding behavior and performance. The items she endorsed suggested the presence of rigid rules and inflexibility in many areas of life, including unrealistically high moral beliefs and ideals in respect to interpersonal relationships. Her responses also indicated a personality style characterized by obsessive and dependent traits. Across the various instruments a pattern emerged suggesting a lack of insight, rigidity in dealing with personal problems, and overcontrolled or suppressed anger. There was no indication of attempts at impression management; however, Belinda showed above average levels of self-deceptive enhancement.

Diagnosis

Although there had been questions as to whether Belinda's thoughts about Julia were psychotically driven, her thoughts and beliefs, taking her history and presentation into account, were considered more consistent with overvalued ideas in the context of an obsessive-compulsive personality rather than evidence of erotomanic or other delusions. There was good evidence of a long and ego-syntonic history of preoccupation and rigidity with orderliness, perfectionism, and very rigid and inflexible views on moral issues. While similarities with the features of Asperger's syndrome were considered, this was discounted due to Belinda demonstrating a capacity for empathy, general social skills, and reciprocity when required; and the absence of other markers of repetitive and stereotyped patterns of behavior, interests, and activities. There was also no evidence of motor clumsiness or atypical use of language. On this basis, a provisional diagnosis was made of obsessive–compulsive personality disorder with a differential diagnosis of monodelusional disorder. Given the changed diagnosis, it was recommended that Belinda be taken off antipsychotic medication and her beliefs and preoccupation with Julia closely monitored for changes.

Structured Risk Assessment

The Stalking Risk Profile (SRP) (MacKenzie et al., 2009) is a structured professional judgment tool used to guide risk assessment in stalking situations. The SRP focuses on the assessment of a specific stalking situation, and assesses for a range of static (fixed) and dynamic (changeable) risk factors related to stalking. Risk judgments are made about the risk of persistence (the likelihood that the current stalking episode will continue over time), the risk of stalking-related violence, and the risk that the stalker will experience significant psychosocial harm as a result of his or her behavior. Typologies of different stalking behaviors are used to tailor the risk

assessment to the particular circumstances of the case (see McEwan, Pathé, & Ogloff, 2011, for further information). Belinda's behavior was consistent with an Intimacy Seeking stalker and she was assessed against the risk factors for that profile.

Using the SRP, the risk of Belinda persisting with her stalking behavior towards Julia and the secondary victims in the short to medium term was assessed as high, indicating a strong need for immediate interventions to help reduce risk. Her risk of continued stalking was increased relative to others because of the nature of some of her behaviors, such as sending unsolicited materials and breaching legal directives, in addition to psychologically relevant risk factors such as the presence of personality disorder, cognitive distortions regarding the victim and her own behavior, and a strong sense of entitlement to the victim's time and attention. In addition, a number of contextual risk factors were present, namely Belinda's social isolation and the possibility of accidental or deliberate encounters due to a shared study environment and Belinda's knowledge of the location of Julia's home.

Even in the context of continued stalking behavior, Belinda was assessed as presenting a low risk of stalking-related violence to Julia and Matt. This indicated little need for specific interventions to reduce the risk of violence. Relatively few risk factors were present (only approach behaviors, property damage, and elevated anger [towards secondary victims], and some evidence of emotional overcontrol). There was no indication of any risk factors suggestive of increased risk of imminent violence (homicidal ideation, suicidal ideation, high-risk psychotic phenomena, or last-resort thinking). In the context of intimacy seeking stalking, threats are not routinely considered a risk factor as they occur relatively rarely and are not often related to violence in this group. A specific threat assessment revealed that Belinda was not engaging in any violent fantasies about harming Julia or Matt and had no plans or means to do so. She stated that the threat was an attempt to scare Matt into withdrawing from the relationship because Belinda felt that he was a negative influence on Julia. There appeared to be no reason to override the original risk judgment based on this information. Given that the stalking was considered likely to continue, regular reassessment of the risk of violence would be warranted to assess for change in this and other risk factors.

Belinda was judged to be at moderate to high risk of experiencing psychosocial harm as a consequence of her behavior, indicating that she was likely to require assistance to cope with the negative social and legal sequelae of her stalking. Most importantly, Belinda demonstrated poor resilience to stress, problems with the expression of anger, preoccupation with Julia and misinterpretation of Julia's actions, and ongoing social isolation. Particularly concerning was the potential for any significant deterioration in Julia's mental state to contribute to increased risk of stalking-related violence. Helping Belinda to improve her problem-solving and stress-management skills, and gradually reduce her reliance on the perceived relationship with Julia, would be central to improving her longer-term psychosocial outcomes and reducing other risks.

Formulation

A formulation is a theory-based explanatory narrative that is commonly used in mental health to hypothesize why a client is presenting in a particular way at a particular time. In this case, the formulation is an attempt to explain why Belinda may have engaged in stalking behavior. Formulation pulls the information from the assessment together and guides the targets and manner of subsequent treatment (See Hart, Sturmey, Logan, & McMurran, 2011, for further discussion of forensic case formulation).

Belinda engaged in intimacy seeking stalking of a former acquaintance and other related secondary victims. A number of factors may have predisposed Belinda to stalking in pursuit of a relationship and then when she perceived that she was being rejected. There is evidence of difficulties forming social relationships from a young age, and while this had not previously presented problems, Belinda has had few experiences of successful reciprocal social relationships on which to model her behavior. There is also long-standing evidence of a tendency toward perfectionism and associated rumination, with difficulties adapting and coping if her high internal standards cannot be met. In this context, there is some evidence that Belinda has difficulty managing strong negative emotions, with catastrophizing and heightened anxiety in response to perceived failure. There is no evidence of maltreatment or the modeling of aggression in Belinda's early life that might predispose her to react with threats or intimidation when experiencing interpersonal conflict, nor does this appear to be a pattern of behavior associated with the presence of antisocial beliefs and attitudes.

Belinda's stalking behavior in this case appears to have been precipitated by a strong belief that she shared a friendship with Julia, when in fact no such

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relationship existed. Her initial intrusive behaviors were inept attempts to maintain contact with someone whom she perceived to be a friend, and she failed to attend to normal social cues indicating that her overtures were unwanted. When her approaches were not accepted, Belinda found it increasingly difficult to moderate her emotional response (in accordance with the aforementioned long-standing difficulties in this area). There is some evidence that Belinda had idealized Julia to the extent that she could not accept that Julia would not want to be her friend, and so externalized blame and her anger about Julia's responses onto Julia's friends and boyfriend. At particular times she was unable to manage her negative emotional state and would engage in behaviors that would make her feel better, such as seeing Julia or warning her friends and boyfriend to stop interfering. Her emotional arousal and consequent stalking behavior seems to have been maintained by obsessive rumination about Julia and others' interference in their "friendship." She appears to have had little ability to moderate her angry responses or reframe her experiences so as to stop the behavior without feeling humiliated or let down. Central to Belinda's ongoing behavior is her continuing belief that Julia is actually interested in a friendship with her and her misinterpretation and distortion of events in a manner consistent with this belief. At present this is not considered to be a delusional belief; rather, it is a consequence of her cognitive rigidity and poor social skills, although ongoing monitoring of her beliefs about Julia in the absence of antipsychotic medication is necessary.

Although these predisposing, precipitating, and perpetuating factors mean that it is considered likely that Belinda's stalking behavior will continue in the short to medium term, Belinda also has a number of considerable strengths that can be built upon to help her cease her behavior. She has support from her immediate family and the church, and, outside of the context of this stalking episode, clearly has prosocial beliefs and values. She does not engage in substance misuse and at present is not suffering from a serious mental illness, both of which could act as disinhibiting factors if they were present. Moreover, Belinda is an intelligent woman who may be able to engage in psychological interventions designed to help her reframe her experiences in a manner that can help her to let go of her attachment to Julia. Given the high risk of persistent stalking behavior and a moderate risk of psychosocial harm, Belinda was judged to be suitable for treatment at the PBP.

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Treatment

Treatment of any problem behavior in the PBP adheres to Andrews and Bonta's (2010) risk, needs, and responsivity principles, using structured risk assessment to identify clients who present at moderate or high risk and so are appropriate for behavior-specific treatment. Relevant risk factors that may be pertinent treatment targets are identified from the risk assessment tools, supplemented with functional analysis of the problem behavior. Treatment is oriented toward the cessation of the problem behavior and the formulation is used to prioritize treatment targets and responsivity factors. This allows treatment plans to focus on the client's criminogenic needs, but also to be individualized and tailored to the specific problem behavior context. Individual treatment may also be an entry point to other group programs that may be operating within Forensicare, such as anger management or social skills groups. Individual psychological treatment may be supplemented by clinical management of any contributory mental disorder; therefore pharmacological treatment may be warranted. Depending on the client and the nature of the medication, this can be managed by PBP psychiatrists or by an external medical provider.

Drawing on current research knowledge and best practice, treatment guidelines have been developed for the various problem behaviors; however, all incorporate a comprehensive functional analysis of the behavior and share similarities in their use of cognitive behavioral techniques. While clients present with a variety of different problem behaviors, the functional analysis often reveals similar targets for psychological treatment, such as offense-supportive cognitive distortions and underlying beliefs and attitudes, emotional dysregulation and impulsivity, and problem solving, social, and interpersonal skills deficits. As outlined previously, treatment is tailored to the individual; thus the length of time in treatment varies depending on the individual's needs and his or her progress in relation to treatment goals. To evaluate a client's progress and ensure that treatment remains beneficial and effective, all PBP clients are subject to a clinical review by the clinical team at the commencement of treatment and then at a minimum of six-month intervals. Clients are also subject to a clinical review prior to discharge from the service. This peer review system also ensures that client's risks are regularly monitored and reviewed and that risk management plans are appropriate. Examples of risk management strategies that may form part of a

client's risk management plan include monitoring of the nature and frequency of deviant sexual thoughts or homicidal fantasies; restricting access to high-risk situations, including to a specific victim or victim group through employment or family/social relationships or access to the Internet; identification of a support network, including crisis services; increased support and monitoring during periods of increased environmental stressors or triggers; and use of pharmacological intervention such as antilibidinal medication for high-risk sex offenders.

Case Example: Treatment

The treatment program implemented with Belinda and described below highlights specific treatment targets that were relevant to her stalking behavior. Wider discussions of treating stalking behavior in a manner consistent with the problem behavior model can be found in MacKenzie and James (2011) and Mullen, Pathé, and Purcell (2009).

Drawing from the above formulation, the identified treatment targets in Belinda's case were prioritized, with the immediate focus on helping Belinda to refrain from stalking Julia on her release from the hospital. Central to this was the fact that Belinda initially did not perceive her behavior as a problem for Julia or herself. The first two-hour session, conducted while Belinda remained in hospital, therefore focused on identifying the pros and cons of her behavior. Belinda was encouraged to think about some of the costs so that she was more inclined to want to desist, at least in the short term. This involved a discussion about what she really wanted to achieve with her intrusions, what she actually had achieved, and education about stalking. The local stalking legislation was shown to Belinda and the risks that she was running by engaging in the intrusive behavior were outlined. This was quite motivating for Belinda and she was willing to work on short-term strategies that might help her not to contact Julia or Matt and so stay out of trouble with the police. These strategies were very practical and involved limiting her time on the university campus, giving her car keys to her parents so she could not drive to Julia's house if tempted, and developing distraction and avoidance techniques that she could use as alternatives if she was so emotionally aroused that she felt that she just "had" to see Julia. She also identified the pastor at her church as someone that she could call and talk to if she needed to vent. He was contacted to discuss the situation and agreed to act as a crisis contact.

Following the assessment, it was recommended to Belinda's treating team that she be taken off antipsychotic medications, as these were not warranted by the new diagnosis. While still in hospital, Belinda was engaged in conversation about other medications that could help her manage her rumination and distress more effectively. Belinda recognized that anxiety could cause her problems (referring to her trouble with her studies) and felt that medication might be helpful for this. She did not feel that medication would assist her with any of her emotional responses to the situation with Julia. An initial prescription for the anxiolytic medication sertraline was provided by the referring psychiatrist, with ongoing management of the medication being the responsibility of Belinda's general practitioner in the community. After the first month of treatment there was a noticeable reduction in Belinda's preoccupation with Julia, and her level of rumination decreased to a more manageable level, allowing for further psychological interventions.

With the stalking behavior under some level of control in the first two weeks, the focus of treatment moved to more medium- and long-term needs. A joint formulation was developed with Belinda to help her develop some sense of why she might have engaged in this behavior in the first place. This involved working with her to undertake a functional analysis of individual examples of stalking behavior (e.g., sending a letter or attending Julia's home), and then building a more comprehensive shared formulation focusing on predisposing and precipitating factors that might be relevant. This process was guided by the above preexisting formulation but also took into account additional factors that Belinda felt were important. Establishing a shared explanation for the behavior not only helped Belinda to understand it in an objective way, but also increased her willingness to work on changing the things that were seen as contributing to the behavior.

In Belinda's case the priority treatment targets were identified as the cognitive distortions she held about her relationship with Julia, her lack of thought as to the consequences of her actions, and her difficulties managing her experience and expression of emotion. Cognitive distortions were framed as "unhelpful thoughts and attitudes" in the sessions, with a shared position that they were unhelpful to Belinda because they made her feel bad and increased the chance that she might do things that could cause her legal trouble. Challenges to "unhelpful thoughts and attitudes" were developed that Belinda could use when she started to ruminate about the situation, which was an identified

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trigger for engaging in an intrusive behavior. Belinda's rigid cognitive style and her ongoing emotional investment in her "friendship" with Julia were significant responsivity factors affecting her ability to challenge misperceptions about her own behavior. Given this, less attention was paid to the impact on the victim in the initial stages and more to the impact of her behavior on Belinda herself. Over time, greater attention was given to Julia's perceptions and the likely effect of Belinda's behavior; however, Belinda never really let go of her belief that Julia had originally wanted "at some level" to be her friend, even if this was no longer the case. She was able to accept that Julia and Matt would have been scared by her approaches and the threat, and regretted causing them fear.

The other primary treatment target in the first two to three months was helping Belinda to develop some emotional regulation skills that she could use when faced with a triggering thought or experience (such as an accidental meeting with Julia at university). This first involved basic psychoeducation about emotions and feedback from the psychometric testing about how Belinda experiences and expresses emotions. Belinda worked on recognizing early signs of emotional arousal and ways of expressing this appropriately at an earlier stage. Some physical anxiety reduction strategies were taught and practiced over a number of weeks, and tied to the cognitive challenges and other behavioral responses as alternatives to engaging in stalking behavior when emotionally aroused.

This skill development work was specifically aimed at reducing the likelihood of continued stalking in the medium term. Clearly there were also underlying factors related to elevated risk of recurrent stalking in the long term, and these became the focus of subsequent sessions. By the fourth month of treatment, sessions were focusing on improving Belinda's communication and social skills, so that she felt more able to express herself to others (while still practicing the cognitive and emotional regulation skills previously outlined). Initially this work was undertaken in individual psychology sessions with role plays and homework tasks, with a subsequent move to identifying opportunities for social activities and developing friendships through church and university clubs. Throughout this "experimental" period, Belinda continued to bring examples of interactions into sessions that could be discussed and examined to gradually improve her ability to read others' meanings and communicate her own effectively.

One of the initial challenges in working with Belinda was her investment in the friendship with Julia. This was partly due to the lack of other social relationships, meaning that relinquishing Julia would lead to almost total isolation. Quite early in the treatment program, after discussion with Belinda's parents, it was agreed that Belinda could purchase a puppy that she would have responsibility for at home, which was hoped would provide her with an alternative emotionally satisfying relationship. The attention that a puppy requires was an effective diversion from thoughts of Julia in the short term and, over time, dog ownership also provided social opportunities through attendance at obedience training classes. Belinda very much enjoyed the routine and structure of dog training and her high-achieving nature led her to pursue this into the competitive arena, where she and her pet began to enter local obedience competitions. Gradually, this hobby not only took up more of Julia's spare time, but also introduced her to people with similar interests with whom she could form friendships.

Belinda saw a PBP psychologist for two hours a week for seven months and then attended three monthly "booster" sessions to help her consolidate her skills. She continued to be prescribed sertraline by her GP and reported being happy with the reduction in her anxiety and rumination. The GP reported her intention to review the need for the prescription at the end of 12 months. While Belinda initially found it very difficult to divert her attention from the stalking situation, she was able to understand that her behavior was problematic for her and carried significant costs. The primary initial motivation for Belinda to attend treatment was fear of the potential legal ramifications, although over time she also acknowledged that her behavior had been inappropriate and she did not want to frighten people in this way in the future. During the course of treatment Belinda pleaded guilty to breaching the intervention order, and the property damage charges were dropped when she paid for repairs to Matt's car. Because she had voluntarily attended treatment and had no previous convictions, she received a fine and a 12-month good behavior bond. At the completion of the treatment program, Belinda's risk of recurrent stalking toward Julia or another victim was assessed as low. The risk factors that remained present were a history of stalking, some social isolation (although significantly improved), personality disorder, and the possibility of future accidental contact with Julia at the university. Belinda had developed viable plans for dealing with this type

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of triggering event as well as some improved ability to manage interpersonal conflict and resultant stress. She was advised that if she felt she needed further help with a specific situation or behavior in the future, she was welcome to self-refer.

INTERNATIONAL IMPLEMENTATION OF THE PROBLEM BEHAVIOR FRAMEWORK

The PBP has attracted considerable attention within Australia and internationally since it was conceived. In some cases this has influenced the development of similar services in other areas. Perhaps the best publicized is the National Stalking Clinic in London. The clinic is a specialist service for the assessment and treatment of stalkers and stalking victims and is an initiative of the North London Forensic Service, part of the Barnet Enfield and Haringey Mental Health NHS Trust. The clinic was established following a visit by senior clinicians to the PBP in May 2011 and opened in November 2011. It is closely modeled on the PBP and offers psychological and psychiatric assessments of stalkers for courts and probation services, mental health agencies, and other social services (incorporating risk assessment as standard). Individual psychological treatment is available to those under legal orders, although it is not always recommended. Like the PBP, the NSC also offers tertiary consultations about handling ongoing stalking cases, although they have a closer relationship with local police services than has been established in Australia. In a departure from the current PBP model, the NSC also offers assessment and treatment services to some victims of stalking.

Another service influenced by the problem behavior framework is the Serious Offender Liaison Service (SOLS), which commenced operations at the end of 2012, superseding the former Sex Offender Liaison Service (Russell & Darjee, 2012). Based at the Orchard Clinic, Royal Edinburgh Hospital (part of the NHS Lothian forensic mental health service), the SOLS receives referrals for sexual offending, stalking, domestic violence, arson and other serious violence. Like the PBP, the SOLS does not require a conviction for referral. Clients who have a diagnosed mental illness or learning disability are excluded from the service, as they can access forensic mental health services elsewhere; however, if these individuals' management is complicated by comorbid personality disorder or paraphilia, referrals are accepted. The SOLS has a slightly different service model than the PBP, developed from the preexisting service for high-risk sexual offenders. Staff at the clinic (specialist psychiatry, psychology, social work, and nursing staff) most often provide tertiary consultation and advice to referrers and less often undertake an assessment themselves. At present the service does not offer treatment, instead focusing on helping the referring agency to intervene and manage cases in a psychologically informed way. A particularly exciting element of the SOLS is their integration with the local policing units, who have a statutory duty to monitor sex offenders on the sex offenders' register. This is consistent with the SOLS' aim to provide clinical consultation, assessment, and advice to help criminal justice agencies with the management of personality-disordered and paraphilic sexual and violent offenders in the community.

At the other end of the United Kingdom, on the south coast of England, the Hampshire Stalking Consultancy Clinic started in May 2012 for a six-month pilot with the support of the local forensic mental health and police services. This clinic—consisting of a consultant clinical psychologist, a consultant forensic psychiatrist, a detective chief inspector from the Hampshire police, and a probation officer—was initiated by practitioners who identified a need for local multiagency work with regard to stalking identification and management. The clinic runs once a month on a case consultation, review, and formulation model. Cases are usually brought by the police or probation service personnel and can involve instances of suspected stalking or postconviction behavior problems. When appropriate, interview and structured risk assessment are used to help guide sentencing, treatment, and management planning. At the time of writing, the pilot program was continuing with an intended evaluation at completion to determine whether it will be continued.

In Australia, community forensic mental health services (CFMHS) outside Victoria have begun to develop their own problem behavior-oriented approaches, although within the bounds of existing mental health funding. In New South Wales, the Sydney CFMHS uses a problem behavior assessment approach, with all clients referred due to combined mental illness and offending behavior. At present they are not able to expand their service provision beyond those with a diagnosed mental illness, although this will hopefully occur in the

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future. In mid-2012 the CFMHS based in Brisbane, Queensland, began an innovative program delivering problem behavior-focused treatment to clients of general mental health services via a Community Forensic Outreach Service (CFOS). Clients engaging in stalking, sexual deviance, arson, querulous complaining and related behaviors are referred for risk or threat assessment. Where a recommendation is made for problem behavior-specific treatment, a CFOS clinician travels to the general mental health service to help the generalist clinician deliver interventions designed to reduce the problem behavior. The CFOS clinician provides written resources to the general mental health clinician, but a core aspect of the program is to build capacity to deal with problem behaviors outside of the forensic mental health service. The program is in a pilot phase and evaluation will be undertaken in the future.

We are less familiar with services in North America that use a problem behavior framework, although one service that we know of has independently developed this general approach. The Intrapsychic Clinic in San Diego, California, is a private psychology clinic that provides assessment and treatment to clients who have engaged in stalking, intimate partner violence, general violence, and problematic sexual behavior. Treatment at this clinic is offered in group format (grouped by type of problem behavior) and guided by repeated risk assessments using structured professional judgment tools. The primary difference between this and the other services using a problem behavior framework is a dual focus on psychodynamic therapy in addition to cognitive-behavioral approaches. Clients' attachment style and disordered attachment are considered key to their problem behaviors and therefore are incorporated into the psychological treatment provided.

CONCLUSION

The problem behavior framework offers a new type of service model that has great potential to bridge gaps in mainstream and forensic mental health services and the criminal justice system. For the individual client, the problem behavior framework can assist in understanding and communicating about complex and sometimes frightening behaviors in ways that can lead to change. At an organizational level, the presence of services such as the PBP means that there is somewhere to go when a threat or risk assessment reveals the need for treatment and management. In the absence of such a service, individuals with problem behaviors would likely not receive help to change their behavior, and instead be subjected to punitive measures that do little to decrease risk over time. While each of the services described above applies the problem behavior framework in a different way, they share the common goal of helping people whose behavior brings them into conflict with the law and other members of the community. Helping these people to access informed assessment and treatment services is consistent with mental health professionals' duty to act in the best interests of their clients and with their wider duty to prevent harm to the community. In this type of work, expertise in structured risk assessment and evidence-based threat assessment is an absolute necessity. Only by providing well-founded and appropriately qualified risk and threat assessments can forensic mental health clinicians identify where treatment and management is most required and where a perceived threat may not actually exist.

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KEY POINTS

- Threat assessments of people who engage in problem behaviors such as violence, stalking, threatening, fire setting, or sexual offending often reveal a range of underlying psychological and social factors that increase risk but cannot be effectively managed by law enforcement alone.
- The skills of forensic mental health clinicians can and should be used to treat people who engage in these types of potentially high-risk behaviors, but current models of service provision (which focus on mental illness) exclude the majority of these individuals from assessment and treatment.
- The problem behavior model provides a recognizable referral pathway for clients of criminal justice and mainstream mental health agencies who are assessed as moderate or high risk to access specialist forensic mental health services based on the nature of their *behavior*, rather than the presence of a mental disorder or criminal conviction.

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- The problem behavior model offers a framework for understanding why an individual might engage in a particular problem behavior so as to facilitate efforts to change the behavior and reduce risk over time.
- Applying the problem behavior model to practice requires an understanding of the research literature relevant to specific types of offending behavior, including threat and risk assessment, offender treatment and rehabilitation, and the role of psychopathology in different types of offending.

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