A Foot in the (Revolving) Door?

A Preliminary Evaluation of Tasmania's Mental Health Diversion List

By Hannah Graham

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Abstract

There is a strong intersection between the health system and the criminal justice system, as exemplified by problems encountered with mentally ill offenders. Therapeutic jurisprudence and the problem solving court model seek to overcome issues associated with the failure of traditional sentencing for this offender population, the 'revolving door' and deficits in treatment support.

Evaluation research was utilised in this study to conduct a preliminary assessment of the effectiveness of the Mental Health Diversion List pilot project. Rich qualitative data contributed to the emergence of various themes and issues indicating the general success of the List. However, different practitioner perspectives and debates revealed opportunities for further development.

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Declaration of Authorship

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis.

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Contents

'Each day, a disturbingly large number of people with mental illness cycle through the criminal justice system across the nation. Before arriving in the criminal justice system, these individuals have frequently fallen through the "safety net" of families, hospitals and community based treatment providers... The results are painfully clear: many defendants with mental illness churn through the criminal justice system again and again, going through a "revolving door" from street to court to cell and back again without ever receiving the support and structure they need. It is fair to say that no one wins when this happens – not defendants, not police, not courts, not victims, and not communities.'

~ *Rethinking the Revolving Door* (Denckla & Berman, 2001: 1, 4)

Introduction

The traditional adversarial criminal justice system works well for the majority of cases appearing in courts such as the Magistrates Court. However, it has failed offenders with a mental illness. The 'revolving door' of sentencing and increasing criminalisation of the mentally ill has resulted in an increased court work load, a sense of futility felt by practitioners, and no reduction of recidivism. As asserted by Denckla and Berman (2001), the results are painfully clear and no one is winning.

However, recent court innovation has been the catalyst for legal and social change, using the study of the healing potential of the law and the framework of therapeutic jurisprudence to overcome perennial challenges. In this non-adversarial court process, no longer is there a sense of 'wasting humanity' (Auty, 2006a), but instead a heightened sense of humanity and social justice in working towards an outcome which is in the best interests of the defendant, the court, the victim and the community. Problem solving courts have moved beyond simply having a hopeful ideology to actually making beneficial solutions a measurable reality. Mental health courts and the use of therapeutic interventions are having a positive impact. Tasmania's Mental Health Diversion List pilot project is an example of this. The preliminary evaluation of the Mental Health Diversion List in this study highlights positive themes and practitioner debates and perspectives which are essential to understanding how it works. Strengths and areas of concern are articulated in the evaluative analysis of the Diversion List, providing a foundation for the recommendations and conclusions made.

Research Question

In this study, the most prominent research question being examined is: 'How effective is the Mental Health Diversion List?' If there is evidence of the List being effective or beneficial, it is important to try to examine which elements are effective and for whom. This question will be

revisited throughout the dissertation. It will be addressed primarily using qualitative methods; also this study will consider what is needed for a fuller evaluation.

Outline of Chapters

Chapter 1 is a literature review on mental health, the criminal justice system, the intersection between the two, and also the innovative philosophy and practice of therapeutic jurisprudence.

Chapter 2 is a description of the research methodology. It describes mental health court evaluation, offers a critique of evaluation research, and briefly reflects on research ethics requirements and the strengths and limitations of the present research.

Chapter 3 describes the practical functioning of the List and contributes to understanding the Mental Health Diversion List; e.g. structure, offenders, offences, and court proceedings.

Chapter 4 explores different perspectives and debates on key themes and issues that have arisen from the research findings.

Chapter 5 is a preliminary evaluation of the Diversion List in light of the research questions, outlining strengths, concerns, matters of significance, and areas for future consideration.

The Conclusion offers direction by advocating recommendations for the future.

Chapter 1:

Mental Health and the Criminal Justice System

This chapter focuses on reviewing the literature and conceptual foundations of several key areas in relation to how the criminal justice system responds to mental illness. It highlights perspectives from the individual level to the level of national policy and practice guiding the service sector and processes of social change. The fields of mental health and the criminal justice system, and the significant intersection between the two, are examined. Therapeutic jurisprudence and mental health courts are advocated as innovative models and methods to overcome the problem of inappropriate handling of offenders with a mental illness.

Mental Health

Mental illness is a common and complex social problem in Australian society. One in five Australians have a mental illness (Australian Bureau of Statistics [ABS], 1998), and the implication of this figure is that it affects the lives of many more.

Definition of Mental Illness

As mental illness is widely distributed across all levels and groups within society, it is clear that people living with a mental illness are far from a homogenous group. Because mental illness is subject to social construction; even defining and clarifying what constitutes mental illness is problematic (Shea, 1999; Busfield, 2001). This is due to a diversity of perspectives on the matter, changing ideology and terminology, and the social context and dynamics of 'the pendulum of public and political opinion' (Shea, 1999: 4). In the Mental Health Diversion List and all other court lists in Tasmania, the definition of mental illness adopted was from the *Mental Health Act 1996* (Sect 4):

> 'A mental illness is a mental condition resulting in: (a) serious distortion of perception or thought; or (b) serious impairment or disturbance of the capacity for rational thought; or (c) serious mood disorder; or (d) involuntary behaviour or serious impairment of the capacity to control behaviour' (State Government of Tasmania, 1996).

There are several stipulations made in the legislation about what a diagnosis of mental illness should not be solely based upon. In addition to this, there is a multitude of diagnostic instruments and criteria used to define and categorise mental illness, for example, the DSM-IV. Yet, whether it be for the purposes of health or law, the point remains that defining mental illness can be a controversial and contested exercise.

Mental Illness in Australia: Statistics

The last Survey of Mental Health and Wellbeing was conducted in 1997, thus forming the most recent national statistics on rates of mental illness. In 1997, '51,102 (just under 10%) adult Tasmanians reported having a mental disorder in the 12 month period prior to the interview' (ABS, 1998 cited in Cameron & Flanagan, 2004: 17).

The statistics surrounding mental illness and quality of life for people living with a serious mental illness (psychotic disorders) are troubling. The following figures were produced from a study of psychotic disorders in Australia (Jablensky, McGrath, Herrman, Castle, Gureje, Morgan, & Korten, 1999) as part of the 1997 National Survey of Mental Health.

- 'The great majority (72%) were unemployed; 85.2% depended on government pensions.
- 47.8% had no school qualification.
- 63.6% of the participants were single and had never been married; 20% were separated, divorced or widowed; 31.3% lived alone in single person households.
- 59.1% of the sample did not socialise outside the home; and in 57.6% of cases, this was rated as social withdrawal, self-isolation and avoidance of people.
- 48.5% of participants reported having used street drugs or non-prescribed medications.

- 51.6% of the participants had been admitted to hospital once or more in the preceding year, with 45.8% having at least one involuntary admission.
- 10.2% had been arrested in the past year and 17.6% had been the victim of violence.
- The participants who were marginalised or homeless and not in contact with mainstream mental health services reported a much higher arrest rate (20.8%) and were much more likely to be a victim of violence (30.8%).
- 47% of all participants reported being unable to access a particular service they needed in the previous 12 months, including 25.6% who needed a mental health service.
- Only 19.1% of the sample reported participation in any rehabilitation activities in the previous year.'

Source: Jablensky *et al.* (1999) cited in Cameron & Flannagan (2004: 19-20).

These statistics provide the evidence base for the assertion by the Human Rights and Equal Opportunity Commission [HREOC] that 'people with a mental illness are among the most vulnerable and disadvantaged in our community' (HREOC, 1993 cited in ABS, 1998: 3).

The rates of mental illness amongst offender and prison populations are significantly higher than rates of mental illness in the community (Ogloff, Davis, Rivers, & Ross, 2006; 2007). Data on rates of mental illness amongst prisoners in Tasmania is either not collected or not released to the public. More than half of female prisoners in Queensland, New South Wales and Western Australia (ranging from 51% to 57%) reported that they had been diagnosed with a mental illness (ABS, 2004). In New South Wales, rates of mental illness are quite high in prison populations:

> 'Detailed results from the New South Wales survey in 2001 also indicated that the self-report prevalence of mental disorders (psychosis, anxiety and affective disorders) during the previous 12 months was very high and significantly higher than among women in the general community, as was the prevalence of substance abuse disorders and personality disorders. The survey results indicated that 90% of women and 78% of men in New South Wales prisons had at least one of these mental disorders in the 12 months prior to the interview' (ABS, 2004: 5).

The high rate of co-morbidity of disorders is an evident feature of the mental health of a significant proportion of inmates in prisons around Australia (James, 2006).

Therefore, rates of mental illness and the accompanying socioeconomic and personal disadvantage experienced by some people living with a mental illness are concerning in regards to both those in correctional facilities and those living in the community.

Deinstitutionalisation, the Community and People with a Mental Illness

The process of deinstitutionalisation is one of the most significant occurrences in the history of mental health policy and practice. The decision and process of closing down asylums for people with a mental illness occurred from the late 1950s onwards; this was a positive breakthrough made possible with the promise of care and support in the community. However, the transition towards community support has not been a smooth one.

Some commentators auspice the view that one institution (the asylum) has been swapped with another (prisons), with the increasing criminalisation and incarceration of the mentally ill in Australia and other countries such as the U.S. and U.K. (Meadows, Singh, & Grigg, 2007). This is supported by Hunter and McRostie (2001) who assert that deinstitutionalisation and lack of community support has been linked to the exacerbation of the 'revolving door' phenomenon.

In Table 1, Meadows, Singh, & Grigg (2007: 576-577) specify the premises and assumptions that were used to push deinstitutionalisation, and compare these with the lived realities in hindsight.

Table 1: The Premises and Realities of Deinstitutionalisation

Premises/Assumptions of Deinstitutionalisation	Post-deinstitutionalisation: The Reality in Hindsight
Premise: Psychotropic drugs will control all of the psychotropic symptoms associated with mental illness, allowing the vast majority of these patients to return to normal life in the community.	**Reality:** Although advances in psychopharmacology have been spectacular in the last 50 years, they continue to offer only partial control of the full range of symptoms, and only if regularly and consistently taken.
Premise: As a result of treatment, patients will gain insight into their illness and adhere to treatment guidelines.	**Reality:** 'Insight' is a complex and multifaceted construct.... Lack of insight into the need for medication is a problem.
Premise: Intensive case management will only be required for limited periods, and the patient will be able to incorporate gains achieved to reduce relapse.	**Reality:** For many patients, case management needs to be continuing and long term, and when it is withdrawn, the benefits may dissipate.
Premise: As a result of insights gained about the effect of substance abuse on their symptoms, consumers will be able to modulate their intake.	**Reality:** People with illnesses such as schizophrenia are at much higher risk than the general population for ongoing substance use, leaving them particularly vulnerable to relapse of illness.
Premise: Over time, the community will demonstrate increasing acceptance and tolerance of the presence of significant numbers of people with a mental illness in their midst, accepting their human rights need to be honoured.	**Reality:** Stigma regarding mental illness remains an omnipresent problem in the general community, with substantial community backlash if a person with a mental illness, for example, acts in an 'abnormal' manner, or perpetrates a crime.
Premise: With increasing numbers of people now living more fulfilling lives in less restrictive environments, the justice system will be more tolerant and supportive when these individuals transgress community or legal norms.	**Reality:** People with mental illness are more likely to fall foul of the law, and the prison system has an overrepresentation of people with a mental illness.
Premise: Adequate safe accommodation options will be provided for those no longer living in long-stay institutions, but who do not require hospitalisation.	**Reality:** There is a chronic shortage of appropriate housing for people with a major mental illness, and many languish in suboptimal conditions, or are homeless.
Premise: Moving the care of people with a mental illness will reduce stigma on them from the general health sector, which will acknowledge and meet their needs.	**Reality:** People with severe mental illness are overrepresented in general hospital emergency departments.... They also carry a burden of physical health problems, often not addressed well.
Premise: Provision of effective community service will reduce the need for acute mental health beds, and virtually eliminate the need for long-term beds.	**Reality:** Given the level of community provision achieved in reality, there is still ongoing intense pressure on acute beds, continuing need for mid-term (step-up or step-down) beds, and greater need for some long-term beds.
Premise: Demand for mental health services will remain stable, or increase only gradually.	**Reality:** Increased awareness in the community has led to much greater specific demand on mental health services.
Premise: The cost of the community care service model will be constrained by limiting service to people with 'severe' mental illnesses, with the majority of other mental health problems left to private psychiatrists and GPs.	**Reality:** Those whose illnesses are too severe/complex for the private system, or who cannot access the private system because of limited or nonexistent private health insurers, are being left to 'fall through the cracks' in terms of service provision.

Source: Meadows, Singh, & Grigg (2007: 576-577)

Table 1 reflects that many facets of this policy have not yet been fully achieved. In an assessment of the transition caused by deinstitutionalisation, Meadows, Singh & Grigg (2007: 577) conclude

that 'we should accept the fundamental thrust of the approach, but refine the system to better deal with those deficits outlined'. The 'realities' in Table 1 illustrate the need for significant strengthening of the system to improve services in the community.

Stigma, Social Exclusion and Discrimination

Whilst positive advances in mental health practice have been made (discussed later), there are still major challenges and barriers to equality and wellbeing. Issues such as the experience of stigma, social exclusion, fear of difference, and discrimination are problematic experiences for many people with a mental illness (Martin, Pescosolido, & Tuch, 2000; Allen, 2005; Lloyd, Tse, & Deane, 2006; McCarron, Gray, & Karras, 2006; Epstein & Olsen, 2007). Not all people with a mental illness may feel these issues are part of their experience, but for those who do, there may also be differing extents or different times in their life when they encounter them.

Historically, the original meaning of the word stigma was the action of literally branding a mark on the skin by burning it with a hot implement as a token of subjection (Oxford English Dictionary cited in Epstein & Olsen, 2007). Today, it is still defined as 'a mark of disgrace of infamy; or sign of severe censure or condemnation' (Oxford English Dictionary cited in Epstein & Olsen, 2007: 13). The authors describe the disempowering and dehumanising effect of stigma and labelling associated with mental illness:

> 'Stigma is a shameful mark of difference, which works as a particularly effective social sanction. In our society, those experiencing 'mental illness' are all too often 'branded' with various (and often contradictory) pejorative and/or disempowering labels. The principal effect of using stereotypical conceptions to label and categorise a person is to dehumanise them...' (Epstein & Olsen, 2007: 13).

There is a surprisingly high amount of stigma, discrimination, dismissiveness, disrespect, and jugmentalism experienced by people with a mental illness from workers in mental health services – i.e. from professionals in the field (Epstein & Olsen, 2007; Bland, 2007 cited in Ash, Brown, Burvill, Davies, Hughson, Meadows, Nagle, Rosen, Singh, & Weir, 2007). In Victorian research, 'negative encounters with the mental health service system were reported by one third of the consumers and one half of the carers' (Ash, Benson, Dunbar, Fielding, Fossey, Gray, Grigg, McKendrick, Meadows, Ozols, Rosen, Singh, & Weir, 2007: 72). Rejection and lack of empathy

and compassion coming from the very people that are entrusted with service provision, treatment and, in some cases, guardianship and control is quite concerning and may compound disadvantage felt by some people with a mental illness.

Philosophy and Practice: Mental Health Policy and Mental Health Services in Tasmania

Another area that shapes the current practice and future direction of mental health services is mental health policy. Before outlining policy initiatives, it is important to specify that a commonly accepted term to describe a person with a mental illness, especially in relation to mental health services, policy and practice, is the word 'consumer'. This term embodies an attempt to try and change the way in which consumers are seen politically and to change the culture of mental health services (Bland, Clarke, Elsom, Epstein, Farhall, Fielding, Fossey, Leggatt, Liaw, Meadows, Minas, Olsen, Roper, Rosen, & Singh, 2007). A consumerist critique of services is underpinned by the human rights agenda and has also 'been seen as a pragmatic strategy in attempting to improve those services and emphasise issues of quality assurance and accountability' (Bland *et al.*, 2007: 193).

In Australia, the National Mental Health Strategy is the governing framework for mental health policy and practice. There are various different documents, standards and policy initiatives involved in this strategy. The first is the *National Mental Health Policy*, which articulates priority areas for reform and key underlying principles for service planning and development in mental health care (Ash, Benson *et al.*, 2007). The second is the National Mental Health Plan (2003-2008) that outlines 'principles and priority themes: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality, and fostering research, innovation and sustainability' (Ash, Benson *et al.*, 2007: 71-72). The third is the Mental Health Statement of Rights and Responsibilities, which specifies the human rights and civil rights framework that is a foundation for the strategy (Ash, Benson *et al.*, 2007). The fourth is *The National Standards for Mental Health Services* which builds on the policy framework to produce outcome-orientated standards and guiding principles, with consumer and carer outcomes as a foremost consideration (Ash, Benson *et al.*, 2007). Overall,

despite some areas for improvement, Australia's National Mental Health Strategy is of good quality and adequately directs mental health policy and practice.

Mental health services in Tasmania are faced by a number of issues that act as potential barriers to good practice (Bland cited in Ash, Brown *et. al.*, 2007). In 2004, the Tasmanian government instigated the 'Bridging the Gap Initiative' and the *Tasmanian Mental Health Services Strategic Plan (2006-2011)* in an effort to engage in widesweeping improvement and service development to 'lift Tasmanian services to at least the national average' (Bland cited in Ash, Brown *et al.*, 2007: 112). This initiative and policy aims to achieve reform in the following areas: quality and safety of services, enacting new service models, extending the nongovernment mental health services sector, strengthening clinical resources in the community, and overcoming issues in workforce development, regionalisation, consumer and carer issues, and creating cross-sectoral partnerships (Bland cited in Ash, Brown *et al.*, 2007). The Tasmanian government reform of services since 2004 has been an encouraging progression. However, there are a number of ongoing issues that continue to challenge Tasmanian mental health services, which are still in the process of change and service reform (Bland cited in Ash, Brown *et al.*, 2007).

Advancements in Mental Health: Consumer Perspectives, Empowerment and Advocacy

A significant development in recent years has been the emergence and growth of the consumer movement. In Australia, consumer participation originated in the early 1970s, and has gained increasing emphasis in the last 15 years (Bland, Laragy, Giles, & Scott, 2006: 36). Consumer perspectives provide fundamentally important contributions to understanding the experience of living with a mental illness, undergoing professional intervention and engaging in mental health services. The value of personal insight being shared with 'outsiders' looking in and support people alongside, and the importance of being heard and understood for the consumer themselves cannot be underestimated. For a large period in the history of mental health services, this voice and perspective was missing. Now, it is being heard in a valid and powerful way. Champ (1998), who is both a consumer living with schizophrenia, and a mental health advocate and public speaker, shares the impact of mental illness on his personhood and sense of self:

> 'I sometimes think that professionals underestimate the psychological dislocation caused by even a single psychotic episode. If your mind has played tricks, making you believe delusional thoughts, hearing or seeing things that are not real, there can be a profound crisis. Prior to developing schizophrenia, the workings of my mind had been unquestioned. Suddenly I was being told by a psychiatrist that I could not trust my thoughts and senses. I felt that my mind had betrayed me. How could I ever trust it again?' (Champ, 1998: 54).

As the above account suggests, consumers living with a mental illness can experience an intense myriad of emotions about what they have been through or are continuing to go through.

Talking about personal experiences and views is a powerful part of the healing and recovery process for some consumers, as well as, when in a place of wellbeing, speaking about it widely to inform and educate professionals working in the area (Champ, 1998). Professionals and accompanying disciplines are increasingly recognising and appreciating the value of consumer perspectives, and this participation and consultation embodies an excellent advancement in mental health (Bland, 2002 cited in Bland *et al.*, 2006). Consumer advocacy, aided by both groups and individuals, is helping to both raise the profile of consumers and amelioratively address issues such as stigma, discrimination, and civil rights (Epstein McDermott, Meadows, & Olsen, 2007). However, despite positive advancements in the field, there are still salient areas for improvement in the future.

The Criminal Justice System

An important principle that underpins the criminal justice system is the system of 'due process of law as a formal means to guarantee the impartiality and neutrality' of the court (White & Perrone, 2005: 109). Perceptions and actuality of fairness contributes to the strength and integrity of the Australian criminal law system. Open justice and natural justice are major standards by which the court measures and conducts the administration of justice and due process. The principle of open justice 'is not merely of some importance but it is of fundamental importance, that justice not only be done, but should manifestly and undoubtedly be seen to be done' (Hewitt, 1924 cited in Popovic, 2006b: 63).

The adversarial system, which is the dominant paradigm in Australian criminal courts, has strengths and weaknesses. The strengths include: 'autonomy of parties; independence of the bench and bar; power of examination and cross-examination to elicit facts; and observance of law is a more realistic aim than attainment of "justice"' (Freiberg, 2007: 1). Freiberg also offers some criticisms of the adversarial system: 'conflict versus cooperation; proof rather than truth; tactics versus best interests of parties; resolving conflict versus problem solving; biased in favour of defendants; lengthy and costly; inadequate remedies; and unsuited to many disputes' (2007: 1). The dichotomies listed exemplify competing or conflicting interests and the inherently competitive nature of the adversarial system.

The Magistrates Court as an Institution

The Magistrates Courts are called 'the people's court' (King, 2006) because they are the busiest courts managing the highest case load, hearing 95% of all criminal cases during 2001-2002 (ABS, 2004 cited in White & Perrone, 2005). Thus, Magistrates Courts are very active, driven by time, case load and schedule (Auty, 2006a; King, 2006).

Sentencing offenders found guilty of a criminal offence is one of the core duties of the court. This involves weighing up and determining the aims of sentencing: 'denunciation and public reprobation; retribution and 'just deserts'; incapacitation and community protection; rehabilitation and reform; individual and general deterrence; and reparation and restitution' (White & Perrone, 2005: 153). However, there is difficulty encountered on the part of magistrates having to balance differing sentencing goals and the often competing interests of the state, victim(s), and offender (White & Perrone, 2005; Roach Anleu & Mack, 2007). In the majority of criminal cases, hearings and sentencing of an individual case is done fairly quickly in court; there are not usually extensive forays into the personal circumstances of the defendant unless, of course, it is highly relevant. The case load and time imperative is particularly salient on a Monday morning with crowded foyers, crowded court rooms, and significant numbers of matters heard and people sentenced before lunch time. In a figurative sense, it may be appropriate to describe the Magistrates' Court as a well-oiled machine that has clear protocols and processes, working quickly to get the job done.

Mental Health in the Criminal Justice System

> 'How have the courts dealt with mental illness in the past? Not particularly well.' (Denckla & Berman, 2001: 6).

There are a few problem areas in the traditional sentencing and criminal justice process that contributed to the emergence of therapeutic jurisprudence and court mandated diversion. These include: 'frustration with traditional approaches to case processing, rising case loads, increasing prison populations, and difficulties in providing adequate and effective interventions' (Freiberg, 2007: 2). Also, Popovic describes the traditional process in relation to mentally ill offenders as a case of 'sentencing the unsentenceable' with 'meaningless sentences' (2006a: 1). Judicial officers, lawyers and other practitioners in the court are aware of these problems. They know that 'if nothing meaningful is done to arrest this tide of ragged, angry, embittered, and isolated humanity the workload will simply multiply – a simple cost benefit analysis would show the abject futility of this. It is also wasting humanity' (Auty, 2006a).

Coming to terms with what they have done

Simply being in the criminal justice system and facing criminal charges is a substantial issue for a person who is still in the process of understanding the manifestations of their illness. The following story, whilst not one facing criminal charges, nonetheless vividly highlights the crisis of a person coming to terms with what they were like and what they did when unwell.

> 'To go into remission after a psychotic episode was to gradually realise what I had thought, believed and done while I was ill. Gradually my memories of events would return and I was faced with seemingly bizarre, embarrassing and sometimes frightening thoughts... It was like recalling a nightmare, except that I had lived it out by manifesting it in the world. My thoughts and actions seemed so out of keeping with my character as I had known it that it was very hard to accept that I had actually experienced them. With much pain, I had to realise that these thoughts and actions were my own, even if they arose out of unknown places inside me' (Champ, 1998: 55).

'Coming back' and facing the reality of what happened can be confronting and overwhelming; the addition of criminal charges, harm done, possible victims, and impending sentencing – the experience of offending caused by mental illness – for some, has a devastating impact. The ability of the mainstream criminal justice system to effectively handle the offender with a mental illness encountering this crisis in some cases is a source of concern.

Therapeutic Jurisprudence

Therapeutic jurisprudence entails both the philosophy and practice that has arisen in answer to the perennial problem of how to manage and understand the complex social problems that regularly arise in law courts. It forms a framework to aid enhanced understanding of the implications of decisions and interventions made by the court, as well as extend the options and methods available for the court to use.

Law as a Healing Agent and Helping Profession

Therapeutic jurisprudence is a theoretical framework that emerged in the 1980s and was first discussed by Wexler and Winick in relation to mental health law (Wexler & Winick, 1992 cited in Freiberg, 2002). Therapeutic jurisprudence, at a basic level, can be described as the study of, and interdisciplinary approach to, the law's healing potential to increase wellbeing (Winick, 2000; Freiberg, 2005). Along with medicine and the Christian clergy, law was one of the three original helping professions. Increasing associations between psychology and social sciences and law and criminal justice has fuelled the impetus to analyse and enhance the therapeutic impact and holistic integrated care potential of law (Curran, 2005). A special area of focus within the theory is an examination of the impact of the law and legal interventions on the lives of those that are subject to it – the defendants that come before the criminal courts. Diversion into treatment for underlying causes to offending is seen as beneficial in helping the offender as well as reducing recidivism and enhancing community safety.

The Language of Therapeutic Jurisprudence

There is a plethora of terminology to describe the theoretical foundations and influences, as well as the practical applications of concepts and models surrounding therapeutic jurisprudence: therapeutic justice, preventive/proactive law, restorative justice, collaborative law, comprehensive law/holistic justice, participatory justice, problem solving courts, problem oriented courts, and court mandated diversion (Freiberg, 2007). Despite this superfluity, the subtle nuances camouflage important similarities and differences, interconnecting links and inimitable distinguishing characteristics. In other words, they are akin to different accents and cultural sub-groups of the same underlying language.

Auty (2006b) examines language used to describe therapeutic jurisprudential and problem-solving court philosophy and practice, and these are compiled in the first (upper) row in the table below. It should be noted that this comparison was designed for an analysis of an Aboriginal sentencing court and, therefore, some words are culturally specific. The second (lower) row of boxes is an addition of language and approach to practice made by the researcher.

Table 2: Therapeutic and Non-Therapeutic Language and Approach to Practice

Therapeutic		Non-Therapeutic	
Ameliorative	Listening	Assumptions	Haste
Dialogue	Respectful	Over-riding	Stereotypes
Engagement	Attentive	Ignoring	Contempt
Inclusive	Gender balance	Linear	Mechanical
Inquisitive	Cautious	Directory	Medicalised
Quiet	Poised	Myths	
Complexity	Recognition		
Thematic	Reconciliation		
Pausing	Knowing		
Organic	Fluid		
Reflexive	Dispelling myths		
Holistic	Integrated	Non-inclusive	Fiercely adversarial
Empathetic	Compassionate	Misunderstanding	Perfunctory
Advocacy	Empowerment	Time-driven	Generalist
Healing	Solution-focused	Insensitive	Sole disciplinary
Accountability	Transparency	Intimidating	Deficit-focused
Recovery	Change	Risk-focused	Extensive jargon
Teamwork	Collaborative	Hierarchical power	Passive non-legal parties
Partnership	Flexible	Overwhelming (for non-legal actors)	
Fair	Capacity building		
Restorative	Reintegrative		
Rehabilitative	Multidisciplinary		

Source: First row: Auty (2006b: 101-102). Second row: the researcher Hannah Graham.

The principles and practice of therapeutic jurisprudence can be applied both in general lists of traditional courts and in specialist diversion lists or specific problem solving courts (Berman, 2004).

Comparing Therapeutic and Traditional Approaches

Problem solving courts that adopt therapeutic approaches are a catalyst for court innovation and social change (Berman & Feinblatt, 2003; Mansky, 2004; Bahkt, 2005; Payne, 2006). Some commentators refer to long-standing court processes and legal practices as 'traditional' and others prefer the term 'mainstream' in recognition of the fact that they are still very much in use, and will continue to be in the future. Warren (1998 cited in Rottman & Casey, 1999) outlines a

comparative summary of differences between the traditional and therapeutic approaches, reproduced below:

Table 3: A Comparison of Traditional and Therapeutic Court Process

Traditional Court Process	Transformed Court Process
Dispute resolution	Problem solving dispute avoidance
Legal outcome	Therapeutic outcome
Adversarial process	Collaborative process
Claim or case oriented	People oriented
Rights based	Interest or needs based
Emphasis based on adjudication	Emphasis placed on non-adjudication and alternative dispute resolution
Judge as arbiter	Judge as coach
Backward looking	Forward looking
Precedent based	Planning based
Few participants and stakeholders	Wide range of participants and stakeholders
Individualistic	Interdependent
Legalistic	Common-sensical
Formal	Informal
Efficient	Effective

Source: Warren (1998) cited in Rottman & Casey (1999) (original use in reference to drug court)

In light of the problem of mental illness, the comparison between the traditional and therapeutic court process is beneficial because it demonstrates how the therapeutic approach has a greater potential to handle the complex cases of mentally ill defendants using court process that is tailor made to ensue problem solving.

Criticisms of the Therapeutic Jurisprudential Model

In order to gain a full understanding of therapeutic jurisprudence, it is significant to examine possible limitations or areas for improvement. Freiberg (2002: 10) outlines five main criticisms:

1. 'They are resource intensive: drug courts, mental health courts and other courts require services, case managers, coordinators and administrative resources to function... A very

common complaint from 'traditional' or mainstream court and correctional authorities is that, given the same level of resources, they could achieve the same results.'

2. 'They are too narrow: They pre-suppose the 'problem' to be solved. If the 'problem' is not the crime (which is only regarded as the symptom of some underlying pathology), then the solution must depend on the accurate diagnosis of the precipitating cause(s) of the problem. Rarely is there a single 'cause' of crime.'
3. 'They place too much power in the hands of judges, who may be idiosyncratic in the way they run their courts, so that the courts become less 'legal' and more 'personal'.'
4. 'Problem-oriented courts are said to compromise the adversarial system and undermine the role of both prosecution and defence by rendering them too ambiguous. It is not clear whether they are there to serve their clients or the court or some greater interest, the public welfare.'
5. 'Where there are no limits on court intervention, sanctions can be onerous and the length of the order may be disproportionate to the original offence. All of the dangers of the 'therapeutic state', of rampant medical positivism, rear their head again. Sociological critiques question whether problematising the individual rather than broader contributing factors returns the criminological debate to the 'disease' model of crime which masked its political and social dimensions of crime.'

Source: Freiberg (2002: 10)

These criticisms are supported more widely as being areas of weakness or concern for problem solving courts (Daly, Hayes, & Marchetti, 2006).

Conclusion

Understanding foundational concepts as well as contemporary issues facing both the mental health sector and the criminal justice system is significant in attaining knowledge of the broader context surrounding specific issues discussed in this study. The experience of people with a mental illness in the criminal justice system was a factor in the emergence of therapeutic

jurisprudence, as well as problem solving courts such as mental health courts. The problem of mental illness in the criminal justice warrants further examination through research so that it can be more thoroughly addressed.

Chapter 2:

Evaluation Research and Mental Health Courts

Evaluation research was the methodology used to evaluate Tasmania's Mental Health Diversion List. The aim of evaluation is to assess the merits and effectiveness of programmes or interventions that are designed to improve the welfare of people, organisations, social processes and society (Shadish *et al.*, 1991 cited in Christie, 2003). This chapter will consider some examples to see how this has been done for other mental health courts. In light of a research culture that is increasingly evidence driven and not untouched by neoliberal and economic rationalist influences, it is important to engage in evaluation of the advantages and limitations of evaluation research itself.

Evaluation Research: Advantages and Limitations

Evaluation research is a common research methodology and has 'almost become a dominant paradigm in researching criminal justice' (Travers, 2005a: 39). It has attracted criticism from different academic groups within sociology and criminology (White, 2001; Travers, 2005a). Critiques of research methodology are beneficial because they contribute to greater understanding and self-awareness of what evaluation is meant to achieve and what happens in practice.

One of the main criticisms of evaluation research, at a basic level, revolves around the old proverb, 'He who pays the piper picks the tune.' An advantage of the current study is that the researcher received no financial payment nor was promised any other incentive, and conducted the study as an independent researcher from the University, rather than as an employee or consultant. There was no interference or pressure applied to the researcher.

A more complex political critique stemming from that criticism is the perception that evaluations always 'present an upbeat picture of organisations struggling with and overcoming problems in a process of "continuous improvement" that must reflect the views of those who commissioned the research' (Travers, 2005a: 40). Thus, hierarchies of power, managerial bias, and vested interests are elements of the political climate and organisational context in which the research takes place, and researchers must be aware of this social and political context (Ezzy, 2002; Travers, 2005b; Neuman, 2006). However, a point to note about the current study is that there are different groups of practitioners and stakeholders in the Mental Health Diversion List, and any assertion that the evaluation findings must reflect their views is erroneous. This is because of differences in perspective on a number of issues. Thus, one perspective may emerge as dominant or widely supported, but it is not the case that a homogenous unified perspective exists in this study between all practitioners.

Evaluation research can produce beneficial effects and make positive contributions to the criminal justice programme or organisation being analysed (Clarke & Dawson, 1999). There are advantages in monitoring progress and effectiveness, and seven of these are outlined below.

> '(1) For accountability purposes: services and programmes are accountable to funders, service users, service providers, the community in general, as well as various professional communities; (2) in order to know what works in a situation, and what does not work; (3) in order to monitor what is being done; (4) in order to generate knowledge, especially in regard to value, merit, worth, and significance; (5) in order to test or verify what is known; (6) in order to keep a programme responsive to changes in needs, attitudes, or the priority given particular issues on the public agenda; and (7) service providers may engage in evaluation because: they want to know the efficiency of their own practice, they want to explore and understand their own experience, or they want to participate in or play a part in effecting systemic or organisational change, or consider changes to existing treatment and intervention practices' (Favilla, Goh, McDermott, Meadows & Wadsworth, 2007: 247).

Undertaking analysis of efficiency and effectiveness contributes to self-awareness and can be the catalyst for improvement or necessary change. In addition to this, the authors argue that the evaluation process and the value of stakeholder and participant input is diminished or ignored if the evaluation recommendations are not put into effect for whatever social, economic, political or historical reasons (Favilla *et al.*, 2007).

Mental Health Court Evaluations

Whilst they are a new initiative in Tasmania, mental health courts/diversion programmes have existed for years in other jurisdictions. There are over 100 mental health courts in the United States (Bureau of Justice Assistance [BJA], 2005). In Australia, there are a few mental health diversion lists or programmes, but it is still a relatively new initiative in the lower courts of jurisdiction. The mental health court in South Australia, known as the 'Magistrates Court Diversion Programme', was the first to be established in the nation, and it commenced in June 1999. It has a significant budget, employs approximately 11 court-based personnel, and sits in nine Magistrates Court locations across South Australia (Courts Administration Authority, 2007). This programme was initially (and continues to be) evaluated by the Office of Crime Statistics and Research in South Australia, and it has achieved positive results. An analysis of post-programme offending found that the diversion programme was successful in reducing recidivism for the majority of cases, even amongst "higher risk" offender participants (Skrzypiec, Wundersitz, & McRostie, 2004).

Mental Health Court Design and Evaluation

Despite the fact that all mental health courts are different, there are various considerations that need to be made in designing and effectively implementing them. In partnership with federal and state governments in the U.S., researchers have drafted 10 Essential Elements of a Mental Health Court (Thompson, Osher & Tomasini-Joshi, 2007):

1. 'Planning and Administration – A broad group of stakeholders representing the criminal justice, mental health, substance abuse treatment, and related systems and the community guides the planning and administration of the court' (Thompson *et al.*, 2007: 1).
2. 'Target Population – Eligibility criteria address public safety and consider a community's treatment capacity... Eligibility criteria also take into account the relationship between mental illness and a defendant's offences, while allowing the individual circumstances of each case to be considered' (Thompson *et al.*, 2007: 2).

3. 'Timely Participant Identification and Linkage to Services – Participants are identified, referred, and accepted into mental health courts, and linked to community-based service providers, as quickly as possible' (Thompson *et al.*, 2007: 3).

4. 'Terms of Participation – Terms of participation are clear, promote public safety, facilitate in the defendant's engagement in treatment, and are individualised to correspond to the level of risk that the defendant presents to the community, and provide for positive legal outcomes for individuals who complete the programme' (Thompson *et al.*, 2007: 4).

5. 'Informed Choice – Defendants fully understand the programme requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about programme involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendants' competency whenever they arise' (Thompson *et al.*, 2007: 5).

6. 'Treatment Supports and Services – Mental health courts connect participants to comprehensive and individualised treatment supports and services in the community. They strive to use – and increase the availability of – treatment and services that are evidence-based' (Thompson *et al.*, 2007: 6).

7. 'Confidentiality – Health and legal information should be shared in a way that protects potential participants' confidentiality rights as mental health consumers and as defendants. Information gathered as part of the participants' court-ordered treatment programme or services should be safeguarded in the event that participants are returned to traditional court processing' (Thompson *et al.*, 2007: 7).

8. 'Court Team – A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process' (Thompson *et al.*, 2007: 8).

9. 'Monitoring Adherence to Court Requirements – Criminal justice and mental health staff collaboratively monitor participants' adherence to court conditions, offer individualised

graduated incentives and sanctions, and modify treatment as necessary to promote public safety and participants' recovery' (Thompson *et al.*, 2007: 9).

10. 'Sustainability – Data are collected and analysed to demonstrate the impact of the mental health court, its performance is assessed periodically (and procedures are modified accordingly), court processes are institutionalised, and support for the court in the community is cultivated and expanded' (Thompson *et al.*, 2007: 10).

These essential elements comprise both a positive ideal and an important foundation upon which to base the workings of a mental health court. It is imperative that these elements be integrated into the design and running of a mental health diversion project as early as possible, and monitored on an ongoing basis – they are not one-off outcomes. The elements listed above will be revisited in the evaluative analysis later in the dissertation.

Research Methodology and Data Collection

For this study, the researcher was requested to conduct a preliminary evaluation of the Mental Health Diversion List by deputy chief Magistrate Hill, on behalf of the Project Team of stakeholders and the Magistrates Court of Tasmania. A separate report will be provided to the Magistrates Court and key Diversion List stakeholders. This is preliminary reflection on the effectiveness of the List, and does not make claims about whether it will be effective in the long-term. The present research methodology is a 'formative evaluation', which is used during the formation or operation of a project or programme – it focuses on *process* (Favilla *et al.*, 2007). This type of evaluation is conducted 'with the intention of providing information that can be responded to reflexively within the programme; information that is used to adjust or inform the conduct of the programme' (Favilla *et al.*, 2007: 245).

The research utilised both qualitative and quantitative methods, using the following data sources:

- Court observation of all sittings during the research period (five months of pilot).

- Analysis of audio recordings of court proceedings and documentation from the Magistrates Court, including court lists, publicly available court files, and the Project Business Plan and Procedural Manual for the List.
- Interviews with key practitioners involved in the Mental Health Diversion List.
- An interview with a defendant participant in the Mental Health Diversion List.
- Observation of a Mental Health Diversion List Project Team meeting of stakeholders.

Quantitative and qualitative data was obtained from court documentation (viewed at the court the day before the hearing) and notes taken by the researcher in court, and was compiled into a spreadsheet for analysis. Also, in all the sittings of the Mental Health Diversion List there was only one defendant who requested, for personal reasons, that no researchers be present for the hearing of his matters; he spoke to the researcher before the hearing and this wish was respected.

The choice to extensively use qualitative methods in the present study was based on their utility in exploring and interpreting meaning (Ezzy, 2002; Neuman, 2006). The main source of qualitative data and observation was the legal and health practitioners involved in the Diversion List. The researcher compiled a list of practitioners that had a professional role relevant to the Mental Health Diversion List. Given the relatively small size of the local legal fraternity and mental health treatment community, potential participants were easy to identify. An invitation to participate (in an interview and/or project team meeting observation) was extended to practitioners from the following agencies or organisations: Magistrates Court of Tasmania and Department of Justice; Forensic Mental Health, Forensic Mental Health court liaison, and Department of Health and Human Services; the Legal Aid Commission of Tasmania; Tasmania Police and Southern Regional Prosecution Services; mental health advocacy groups; and multiple private law firms. For the practitioner interviews, nine practitioners from a variety of organisations voluntarily contacted the researcher and were interviewed using the method of in-depth semi structured qualitative interviews. The interviews were conducted in a private area in the practitioner's workplace and ranged in length from 30-60 minutes; all were audio-recorded. Transcripts were made and analysed using coding and thematic analysis. These techniques were

chosen as most appropriate because they are exploratory and contribute to the development of a systematic and organised account of what has been observed and recorded (Ezzy, 2002).

A Mental Health Diversion List Project Team meeting of key practitioner stakeholders took place on 27th September 2007 with eleven practitioner participants. Information sheets and consent forms were signed prior to the meeting. The meeting was not audio-recorded but written notes were taken, and the main purpose was to observe the interactions and collaborative dynamics of the team. In the meeting, fluid discussion of different issues was observed, with the team leader going around the room and asking practitioners to raise any relevant issues. Direct observation of the Project Team meeting was beneficial for hearing the perspective of the stakeholders present in a trusted environment and adding to knowledge of the context in which the Diversion List occurs. This is one way in which qualitative observation is advantageous and beneficial in evaluation research (Patton, 2002).

Under the supervision of Forensic Mental Health court liaison officers, the researcher invited several defendants appearing in the Diversion List to participate in an interview. The court liaison officers assisted the researcher in the distribution of the information letter and consent form, and had discretion as to which defendants were or were not invited to participate, with the foremost priority given to the individual's current wellbeing. Two defendants said they would like to participate but only one was interviewed, and the other became uncontactable and the researcher decided not to pursue it further. This short interview took place in their Forensic Mental Health case manager's office, and it was audio-recorded and transcribed.

Research Ethics Requirements

The research was conducted with the approval and direction of the Human Research Ethics Committee of Tasmania. Information sheets were provided and consent forms were signed by research participants. The following safeguards were required to protect participants:

- The magistrate presiding over the Mental Health Diversion List was required to announce the presence and nature of involvement of the researcher at the beginning of court proceedings.

- All defendants appearing in the Diversion List were required to read an information sheet and sign a consent form prior to the start of court proceedings to allow the researcher to observe the court.
- Any documentation obtained from the Court not be of a 'private file' nature but instead be publicly accessible.
- Practitioner research participants had to be informed of the possible risk of actual or perceived unfavourable or negative comment in the evaluation, and be assured that individual organisations or practitioners would not be specifically attacked.
- Specific aspects of the research regarding contact with defendants had to be conducted with the assistance and supervision of Forensic Mental Health court liaison officers.

In addition to this, specific safeguards were put in place regarding confidentiality, anonymity, data collection, and security of storage of data. Also, the researcher requested that Advocacy Tasmania (an official advocacy body) write an independent letter on informed consent and research participation, which was given to defendants participating in individual interviews.

The researcher was able to comply with all these requirements of the Ethics Committee. However, objections were raised to the Ethics Committee regarding one specific requirement: that all defendants in the Diversion List were required to read an information sheet and sign a consent form to allow the researcher to observe the court – even though it is an open court. All parties concerned – the researcher, thesis supervisor, and relevant Magistrates Court and Forensic Mental Health practitioners – did not agree this was necessary both because it was an imposition on defendants and difficult to orchestrate graciously in the court foyer 15 minutes beforehand. The Ethics Committee still required this condition, so the researcher complied, even though many defendants found the process problematic and confusing. Other criminologists have found that the 'use of signed consent forms provides protection for researchers and ethics committees... but poses problems for potential research participants, especially offenders' (Roberts & Indermaur, 2003: 2). There is no objection to the development of stringently ethical research procedures and safeguards for all – it is highly important. However, in the case of requirements that are open to

question, the broad umbrella of research ethics may be viewed as comprising elements of fearful bureaucracy rather than wholly being about the altruistic best interests of participants.

Strengths and Limitations of the Research

One strength of this study is that the researcher was made aware of the pilot project and invited to conduct a preliminary evaluation before the Mental Health Diversion List commenced sittings. It was, therefore, beneficial to be on board from the start. A second strength of this study is that it employs mixed methods – it does not solely rely on one form of data – and therefore contributes to a better understanding of the Diversion List in a multidimensional way. A third strength was the relative ease of access and communicative openness with key practitioners and stakeholders. A fourth strength of the research is that it has been one of the first studies of a mental health court diversion programme in Tasmania contributing new knowledge to the public domain. This justifies an exploratory approach employing mainly qualitative methods, with a quantitative study possible once qualitative themes have been identified.

One of the difficulties in this research has been the limited amount of time available for data collection and observation to take place. Due to time constraints, the research period was only five months. Validity and reliability would have been heightened and provided more weight to the themes and findings if the research had been conducted over a longer period of time. It was not within the scope (time frame or resources) of the research to measure important indicators of effectiveness. Only through more comprehensive and longitudinal research can proper evaluation of the Mental Health Diversion List occur. A second weakness is that the researcher was only able to interview one defendant (although this is an important source in providing different perspectives on court proceedings). The time frame available for this to occur was short, and there were added considerations in accessing this group of people as a data source because some of the defendants may be at a complex or difficult stage in life, and it was important to be sensitive to this and not be an imposition or inconvenience. Hearing from more defendants would have contributed to further understanding their perspective and better measurement of procedural justice.

Therefore, evaluation research is beneficial, but it is necessary to be mindful of its limitations. Establishment of the research methodology allows for continuation onto detailed exploration of the problem at hand.

Chapter 3:

Therapeutic Jurisprudence in Action:

The Mental Health Diversion List

> 'There is a quiet revolution occurring in the courts of summary jurisdiction around Australia... As the work horses of the justice system, summary courts have had little time for quiet reflection and considered reform. Yet this unassuming jurisdiction is increasingly leading the way in the implementation of some very innovative therapeutic jurisprudence'
> (King & Auty, 2005: 69)

This chapter includes an introduction to what the Mental Health Diversion List does. In doing so, it provides an overview of descriptive statistics and qualitative observations from court hearings. In order to conduct evaluative analysis, it is important to first attain understanding of each element of the process and project being evaluated. In establishing this, previously un-researched knowledge can be contributed to the public domain about the Diversion List as a pilot project, and how it operates as a specialist List in the broader context of the Magistrates Court.

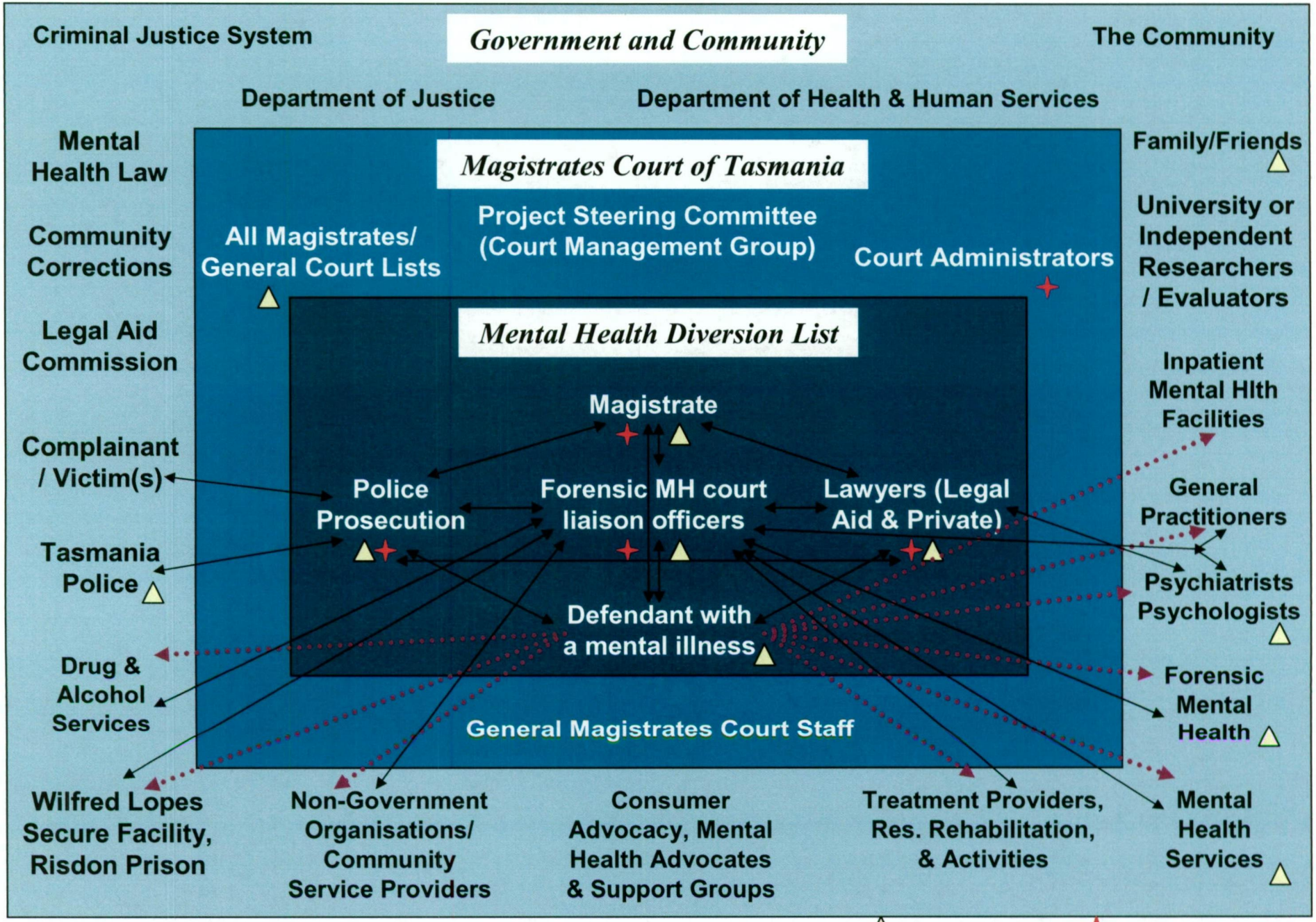
Description

The Mental Health Diversion List is a 12 month pilot project which commenced in the Hobart registry of the Magistrates Court of Tasmania on the 24th May 2007. Rather than being a distinct stand-alone Mental Health Court, it has been set up as a court diversion programme operating as a specialist list in the Magistrates Court. Along with the recently established Drug diversion court and Family violence court, it is one of the first therapeutic jurisprudential problem solving court initiatives in Tasmania. Unlike the first two, this pilot project is operating with a zero dollar budget and no new employment, extra resources, or funding. The manpower and resources have

been volunteered from current practitioners and organisations, whose goodwill and extensive efforts have enabled the Diversion List to proceed.

The current pattern of operation has been for Mental Health Diversion List sittings to occur monthly on a Thursday at 2:15pm in Court 4, but this may change in the future. It is an open court and the public and media may attend. In the courtroom, all parties are seated along the bar table facing the magistrate, with Forensic Mental Health court liaison officers usually seated between prosecution and the defendant and their lawyer. The level of formality exercised in hearings is more relaxed than in general lists, but still retains certain protocols and resembles a normal court. Participation in the Diversion List is entirely voluntary and involves the defendant giving their consent to participate, which can be withdrawn at any stage of the process, resulting in referral back to a general list in the mainstream court. The Diversion List only handles offences of a summary or minor nature. All defendants in the Mental Health Diversion List either enter a plea of guilt or give an indication there is no contestation of the facts in the charges (Magistrates Court of Tasmania, 2007b). The entire court process is clearly illustrated in a flowchart (Police Prosecution, 2007) contained in the Appendix, which outlines the eligibility criteria and demonstrates a person's transition through the court. Figure 1 illustrates the Mental Health Diversion List and its links to stakeholders and other key groups, as well as communication and possible treatment referral pathways (from bail conditions).

Figure 1: The Mental Health Diversion List, Stakeholders, and Relevant Groups By Hannah Graham



In terms of governance, there are two key groups overseeing the Mental Health Diversion List. The Project Team, led by deputy chief Magistrate Hill, is made up of key practitioner stakeholders whose role it is to provide 'expert advice and development of project proposal and procedures' (Magistrates Court of Tasmania, 2007a: 9). The Project Team is directly involved in the running of the List, whereas the Project Steering Committee, which consists of the Court Management Group for the Magistrates Court of Tasmania, is less involved but will be influential in determining the future of the Diversion List at the end of the pilot stage.

Unlike Tasmania's Drug Diversion court and Family Violence court, the Mental Health Diversion List was implemented and orchestrated without any legislative change required – the magistrate utilises power and provisions under existing sentencing law. The following Tasmanian legislation is relevant to the Diversion List: *Criminal Code Act 1924*; *Police Offences Act 1935*; *Justices Act 1959*; *Bail Act 1994*; *Mental Health Act 1996*; *Sentencing Act 1997*; *Corrections Act 1997* (Sect 36A); *Criminal Justice (Mental Impairment) Act 1999*; *Mental Health Amendment Act 2005*; and the *Mental Health Amendment (Secure Mental Health Unit) Act 2005*. The presiding magistrate uses bail conditions to mandate the person into treatment, and adjourns the hearing of their case. There is a pro forma list of nine bail conditions that can be used as is, adapted, or new bail conditions can also be devised. Standard bail conditions include: 'You must attend appointments with Forensic Mental Health or Mental Health Services and comply with all reasonable directions of an officer from those services', 'You must attend rehabilitation programmes or activities as directed by an officer of Forensic Mental Health', and 'You must take medication as directed by an officer of Forensic Mental Health or Mental Health Services or your primary health practitioner'. Case update/review hearings occur throughout the time the person is in the List receiving treatment, and finalisation and disposition of the matters occurs when all members of the court team deem this to be appropriate. Some matters have been finalised very quickly; for others it has been necessary and beneficial for the matters to be dealt with over a period of five or six months. The Diversion List is quite flexible in this way.

There are specific professionals that are 'allocated' or choose to represent their organisation in the Diversion List who have a good awareness of therapeutic jurisprudence and the ability to be

key members of the problem solving team. The main practitioners include one presiding magistrate (who is also still a magistrate in the general lists), two Police prosecutors, two Forensic Mental Health court liaison officers, and two key Legal Aid Lawyers (although other Legal Aid lawyers represent defendants occasionally) because all defendants are allowed to access Legal Aid representation in this List. A variety of private lawyers also represented defendants in the List. The changing role of lawyers and judicial officers has occurred in light of the therapeutic approach and problem solving justice (National Judicial Institute, 2005; Potter, 2006).

Underlying Rationale

The rationale and main function of the Mental Health Diversion List is the use of court process and therapeutic interventions to connect the person to treatment and services, helping them to go beyond the 'revolving door' destructive cycle and achieve sustained wellbeing and quality of life. One interviewee justified the formation of the Diversion List in giving the following account of the problems that had developed in Tasmania.

> *'Ultimately we must see this court diversion system within the broader context. The broader context is that, fifteen or twenty years ago, we had a sea change in how we dealt with mentally ill people... We closed down the institutions, and it was substituted with a policy whereby the people would be subsumed into the community; where they would become part of the community again; they would be looked after by their families, services and non-government organisations. By and large that has not happened. What has happened, in my opinion, is that we have changed one institution for another. We have changed from placing them in the New Norfolk institution [asylum] and we now place them in another institution called the Risdon Prison. What we have is a lot of people that are homeless, and a lot of people that are going into the prison system. What we don't have is the requisite level of government funding to assist our community to keep those people in the community in a respectful and respectable manner. I am hoping that this diversion system will have a small part to play in redressing that problem. I don't want those institutions opened again, but I also don't want people to go to the other institution which is gaol. I don't want people to be homeless. I would like to see people subsumed again into our community. This diversion*

system, I hope, will in a small way assist them back. My hope is that part of the assistance that will be given to these people is that the courts will say 'let's help these people get some accommodation, some care, and some supportive assistance'. So that the court is being used as a means or a conduit to try and get individual people within the community cared for.'

Several other practitioners expressed similar sentiments and motivations for commitment to the Mental Health Diversion List. These views, as illustrated in the above account, link in with previous discussion of deinstitutionalisation and the plight of people living with a mental illness; the Mental Health Diversion List is an attempt to address these underlying problems.

One practitioner revealed that, in their opinion, the Diversion List was a formal recognition and forum for using therapeutic jurisprudential practice that, to a certain extent, had already been happening.

'The stakeholders already knew each other. What needs to be remembered is that there has been a kind of de facto mental health court running in this state for some time. Magistrates will, within the confines of their legislative obligations now, do their very best to try and deal with people before them with mental health issues, to deal with them differently to your normal offender. In doing so, they have used service providers... we're already participating in court procedures where mentally ill people are dealt with. So in a way, this was a streamlining or a formalisation of a process that, to a limited extent, already existed.'

This denotes that a body of knowledge and practice has been developed in the lead up to the start of the Diversion List.

Going beyond what the mainstream court can achieve

The researcher asked a practitioner to comment on setting up the List as a new therapeutic jurisprudential project in the state.

'Surprisingly good! Yes, surprisingly good... And believe me, the courts are well known to be generally conservative, who are loathe to change the status quo. Tasmania is also known as a conservative state when it comes to law. So for this initiative and for therapeutic jurisprudence to even be considered in this state is a big deal.'

One key theme in the practitioner interviews was the strengths and capacity of the Mental Health Diversion List to go beyond what the general lists of the Magistrates Court can achieve:

> *'There are alternatives to sentencing, so you're not just looking at probation, fines, custodial time. You are looking at treatment options, so it is about having those individualised bail conditions in place for up to a six month process. So it really is about maintaining treatment, keeping them well, getting them on track, giving them an incentive to continue their treatment where hopefully at the end of it, there is the option of the prosecution tendering no evidence, and the magistrate dismissing the charges.'*

> *'[The Court] can be better informed, more comfortable with the sentencing decisions, and you can have the defendant leaving the court not bruised by the whole process – that to me is something that the traditional courts can learn from this approach... Whilst we live in an age in relation to court work where disposition rates and time frames are it, in my opinion, they can't be the be-all-and-end-all because the court's obligation is to do justice and of course to do justice is not necessarily to do it quickly. If you are not giving the court and the defendant the opportunity to have the proper issues addressed, in my view, you are not doing justice.'*

Practitioners also noted the time intensiveness (between 12 to 18 months to finalise) and the expense (due to need for two psychiatric reports and hearing of evidence from psychiatrists) of the only other option for defendants with a mental illness – the Section 16 insanity defence used in the mainstream Magistrates Court. It was argued that for minor matters it is quicker and easier to go through the Diversion List. Thus, the therapeutic court process may facilitate more effective and more efficient outcomes using a more appropriate process for defendants with a mental illness charged with minor matters. Further evaluation is needed to substantiate this, but preliminary observations suggest this is the case.

Quantitative Statistics

Although it was not possible to collect statistics that could evaluate the Diversion List in the time available, it is worth giving pure descriptive statistics on offender and offence profiles. These

statistics are collected from hearings and court documentation between the dates of 24th May to 20th September 2007. The researcher voluntarily collected and compiled the Diversion List data, and did so under the direction of the Court Administrator. Whilst data collection involved no breaches of ethics requirements, to protect defendant confidentiality, not all data is reported in this dissertation.

There were a total of 27 participants in the Diversion List, charged with a total of 168 criminal charges. A further seven defendants had their case appear in the court proceedings of the List, but were deemed ineligible at a fairly early stage and referred back to the general lists of the Magistrates Court. Of these, there was only one case of non-compliance resulting in removal from the Diversion List. These seven cases are not contained in the descriptive statistics.

The gender profile of participants (see Figure 2) shows that 44% (12) were female and 56% (15) were male. The age profile shows that 14.8% were aged 18-24 years old; 33.3% were 25-39 years; 40.8% were 40-54 years; and 11.1% were aged 55-69 years.

Figure 2: Profile of Mental Health Diversion List Participants by Age and Gender

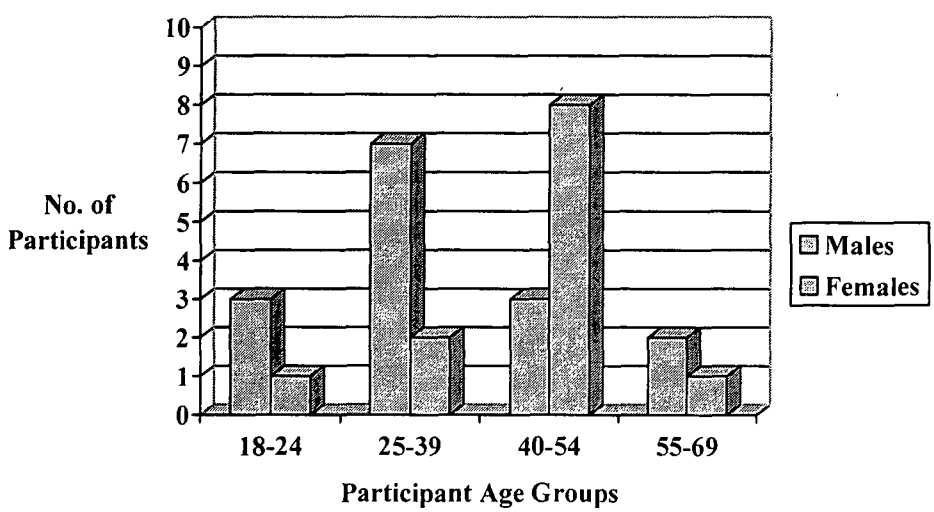
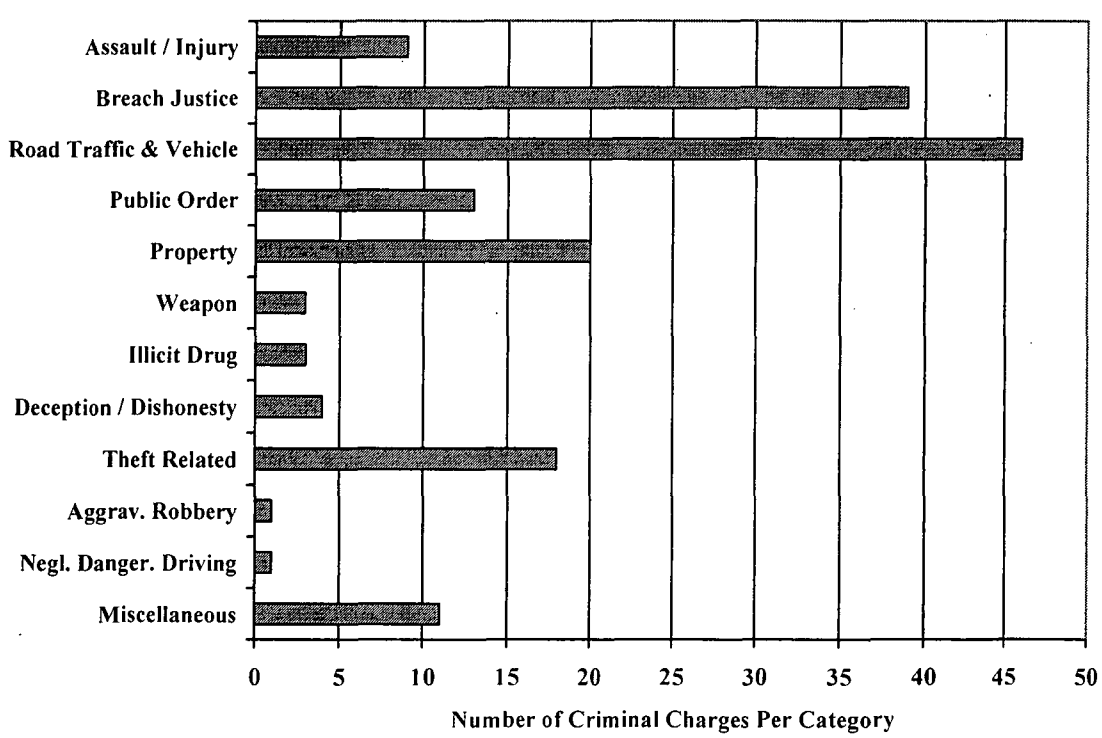


Table 4 shows that the majority of participants in the List were facing only one or two criminal charges. The highest amount of charges for a single person in the List was 27 charges.

Table 4: Profile of Number of Charges by Number of Participants

Total Number of Charges Per Person	Number of Participants	Percentage of Total (%)
1 or 2 Charges	13	48.2%
3 or 4 Charges	4	14.8%
5 or 6 Charges	2	7.4%
7 or 8 Charges	3	11.1%
9 or 10 Charges	0	0.0%
11 to 13 Charges	0	0.0%
14 to 16 Charges	1	3.7%
17 to 19 Charges	1	3.7%
20 to 22 Charges	0	0.0%
23 to 25 Charges	2	7.4%
26 to 28 Charges	1	3.7%
TOTAL	**27 participants**	**100 %**

Figure 3: Profile of Criminal Charges by Offence Category



As illustrated in Figure 3, the profile of criminal charges (total = 168) heard in the Diversion List was classified by the researcher using the Australian Standard Offence Classification [ASOC] Codes (ABS, 1997).

The Breach of Justice category relates to breaches of justice procedures such as bail, probation and parole, restraining orders, or resisting a police officer. The Miscellaneous category includes offences such as stalking, begging, nuisance, and threatening behaviour. Overall, the two largest categories of criminal charges appearing in the Diversion List were road traffic and motor vehicle regulatory offences (27.4%) and offences against justice procedures (23.2%). It should be noted that the majority of road traffic and vehicle offences were committed by two or three defendants with over 20 charges each, whereas the offences against justice procedures were committed by multiple defendants, mainly people with fewer than five charges each.

In terms of legal representation, 55.6% of defendants had a Legal Aid lawyer, 29.6% had a private lawyer, and 14.8% had no legal representation/were unrepresented. A total of seven of the 27 participants reached finalisation/disposition of their case, and these dispositions were supported by all members of the court team. In four of these cases, the prosecution tendered no evidence and the charges were dropped. The other three cases were disposed of under Section 7(f) of the *Sentencing Act 1997*. Two of these were a finding of guilt without conviction, and the other was a finding of guilt with a conviction recorded – all on the condition of good behaviour for a period of 12 months or 2 years (case dependent). Three of the seven finalised cases were disposed of/completed in the one and only appearance of the defendant before the List. Two cases involved a total two hearings, and the two remaining cases involved three hearings before disposition. Five of the seven finalised cases involved one criminal charge, one involved four criminal charges, and one involved seven criminal charges; the charges for each covered a variety of criminal offence types and differing levels of severity or seriousness.

These descriptive statistics are beneficial in establishing the facts of what has happened in the Diversion List, but it is necessary to support this with qualitative data to provide understanding of the social context and why different themes and issues arise in the research findings.

Hearing All the Voices

A key observation by the researcher regarding the therapeutic jurisprudential nature of the Mental Health Diversion List is the openness to contributions from all involved in the court. 'Hearing all the voices' means that the defendants with a mental illness are welcome and encouraged to speak during their proceedings. The literature affirms this: new therapeutic jurisprudence models of the court 'have been designed to give participants a voice where there previously was not one, and to make the proceedings more relevant and comprehensible to the individual' (Popovic, 2006b: 61). The benefit of this for the defendant was affirmed by practitioners.

> *'There is a capacity for there to be dialogue in the court too ... It is a much nicer, friendlier process.'*

> *'We can create an environment in court where we can talk more at length about the offence, and we can talk more at length about the person, and how we can treat people and stop those things happening again. One of the benefits of this is the defendant having a bigger role to play in court, so they are asked what kind of outcome they want, and they can have input on that. We can discuss what some of the likely disposition options will be. They can feel confident that the court is aware of their circumstances and more sympathetic towards their circumstances, rather than being further disadvantaged by having a mental illness, which people definitely are.'*

Hearing the defendant's story helps to contextualise the circumstances in which the offence took place. From observation, the fluid dialogue and opportunity for self-expression, to have a voice and be able to ask questions was a positive element of the proceedings for defendants.

A variety of thoughts and emotions on behalf of the defendants were observed in court. For some, there was the visible experience and direct expression of sadness, tears, anxiety, embarrassment, remorse and regret, tension, frustration, and anger. One defendant felt confident and comfortable enough to directly express to the bench her frustration concerning the time intensive nature of the proceedings, and her comments were acknowledged by the court team and addressed as soon as this was possible. Another defendant was required to remain in custody for an extended period of time, and when he appeared in the List, he spoke frequently with a tone and attitude of frustration

and anger. Despite encountering some disrespect, the magistrate listened extensively to the defendant's questions and even one long tirade, and then addressed the issues at hand in a calm and gracious manner. However, the defendant disagreed and, on both occasions, required more than one security or corrective services officer to escort him from the court.

In contrast, there were many moments during proceedings that were lighthearted, encouraging and, in some instances, rather moving. Many defendants expressed emotions such as joy, relief, deep thankfulness, and pride about personal progress made. On a light hearted note, an elderly defendant commenced her case by declaring her special effort in dressing for the occasion, in reply to which a lawyer noted to the court that he particularly liked her accessorising with a 'lovely' diamante handbag – causing her to beam with pride. After hearing a positive update from the court liaison officer, another defendant was encouraged by the magistrate for her honesty and progress. In reply, she made a poignant personal speech, parts of which are cited below:

> ***M:*** *'It sounds like you are doing well; you're making a real effort.'*
> ***D:*** *'Excuse me your honour, can I please say something?'*
> ***M:*** *'Yes, go ahead.'*
> ***D:*** *'I've come to terms now that I do have a mental illness. But I'm not blaming everything on that. I love my children, I love my grandchildren, and all I want to be able to do is to take them out again and do things together...'*

At end of the hearing of her matters for the day, she asked

> ***D:*** *'So I'm not going to gaol?'*
> ***M:*** *'No.'*
> ***D:*** *'Oh thank you darling! Thank you!'*
> *[A lot of smiling, and she hugged Forensic Mental Health staff as she left the court]*

From observation, hearing all the voices in the court process did achieve open communication, receptive authority, and problem solving that would not usually be possible in a normal court. The expression of heightened emotions by defendants was handled skillfully by the court team who demonstrated a good awareness of the capacity and needs of the individual.

Practitioner Accounts of Defendants' Experiences

Some practitioners, especially those who have ongoing contact with defendants, were asked to give feedback or discuss how the defendants experience and perceive the Diversion List.

> *'I think that so far the feedback has been really good because, for a lot of the defendants, they appreciate the opportunity that the court has to hear about their specific circumstances and how that relates to the offending. They appreciate the opportunity to actively work towards an outcome that will be better for them. They play a part in it so that they are not just at the mercy of the court, so they actually have some power in this whole process. I think that is good, and I think people feel that any kind of process that doesn't sweep issues of mental illness under the carpet is a positive thing.'*

> *'I think they are much more comfortable... I would be hopeful that they would be more comfortable with their issues being discussed in a forum where they are not the only one with those sorts of issues. So that would be more of a comfort for them.'*

All practitioners interviewed had a positive perspective about the potential of the Diversion List to be beneficial for the defendant participants.

Procedural Justice and the Importance of Being Heard and Understood

Perceptions of procedural justice form a significant element of the defendant's perspective and response to (compliance, motivation to engage) interventions made by a problem solving court (King, 2003; Frazer 2007). Research has shown that participants' perceptions of 'whether the court process was "fair" was shaped to a significant degree by the extent to which they were able to tell their story and be listened to by their legal representative and the judicial officer' (Popovic, 2006b: 73).

The sole defendant who was interviewed by the researcher held positive views:

> ***I:*** *Ok, so tell me about what you think about the Mental Health Diversion List?*
> ***D:*** *I found it good because we were fairly dealt with for once. We were understood. People understood us. They gave us a chance to go to a court where people understand us better.*

I: *How did you find going to court? So different people would have spoken to you, and you might have had to come up to the table during proceedings, and the magistrate might have spoken to you?*

D: *Yes.*

I: *How did you find all of that?*

D: *I found it ok, yes.*

I: *Was there anything that could have been made clearer? Anything that could have been explained a little bit better?*

D: *No, not really. No, I think they done a pretty good job of it... It was relatively clear.*

I: *Do you think it needs to be made less formal?*

D: *No, its fine the way it is.*

The defendant stated that he had a relatively good court experience. When asked about this, he agreed that this was related to the fact that the List is specially designed for people living with a mental illness. The defendant was asked his perspective on different members of the court team.

I: *And how did you find the magistrate?*

D: *The magistrate was really good.*

I: *So did he speak to you during the proceedings?*

D: *Yes, he spoke to me during proceedings and told me what was going on, and that it was all ok.*

I: *And how did you find having support staff involved?*

D: *Really good.*

I: *And do you have any thoughts on what the prosecutors did? Did you think they were fair?*

D: *They were good. Yeah, they were good. They just asked everybody, and then asked for everybody's matter to be stood down for a couple of months just to be able to have some time.*

I: *Just to be able to get some support so it's not so full on?*

D: *Yes, mmhmm.*

I: *And overall, the only other thing I have to ask about is: do you think it was a relatively fair process?*

D: *Yes.*

The importance of being heard and understood, as expressed by this defendant, was independently emphasised by multiple practitioners as a very valuable element of the therapeutic court process. The following description aptly confers practitioner feelings generally.

> *'They feel part of the process, and hopefully at the end of it they aren't as damaged by it as they possibly would have been in previous times. So that is an important factor. I also think the defendant gets a lot out of people talking about his or her situation in a non-adversarial way. I think that makes them feel part of the process, that it is not an adversarial process, it is one that is really rehabilitative and that the court really is interested in what their future is. That is really quite positive because you have people leaving the courtroom feeling much better about themselves and feeling much more human than perhaps they were in the old shooting gallery type days when they appeared briefly, there was a brief exchange between the prosecutor and the magistrate, and they were told to come back another day, and they left court in what I would have thought generally was a fairly bewildered fashion – they didn't really know what was happening. But this makes them feel part of the process. Therapeutic jurisprudence is really about getting the process to assist the individual, make them feel part of it, and feel that they have been heard.'*

Therefore, hearing all the voices and perspectives within the court is a source of validation and enhances perception of the court process for those that appear before it.

Conclusion

This chapter has been beneficial in establishing the function and nature of the Mental Health Diversion List. The quantitative data demonstrates that there is no clear homogenous profile or even distinct categories of mentally ill offenders in the List; there is diversity in offender and offence characteristics. The qualitative data presented in this chapter describes how the court operates and the utility and impact it has in the lives of those who participate in it.

Chapter 4:

Practitioner Perspectives and Debates

The qualitative data in this chapter provides analytical differentiation of the roles of the practitioners involved and differences in perspective in answer to the research question on this topic. Understanding these differences is important for both the evaluation and depth of insight about the Diversion List as a whole. Three debates arise from practitioner perspectives that will be influential in consideration of both policy and practice, and thus form key issues in this study.

Understanding Differences

An interesting dichotomy emerges from analysis of the court team. Therapeutic jurisprudence entails collaborative team work in order to solve problems, yet key differences in perspective between members of the court team exist. Topics discussed later bring to light variance and incongruity between practitioners on some specific issues, yet widespread unity and agreement on others. This is not surprising for an initiative that is multi-agency and cross-government using multi-disciplinary practitioners, each of whom have personal goals that have to be balanced with team goals and outcomes in the best interests of all concerned. It is important for studies of criminal justice institutions and practice to acknowledge and understand differences in perspective between practitioners as a normal and healthy occurrence (Travers, 1997). The 'synthesis of competing view points is exactly what therapeutic jurisprudence encourages – informed debate and sound practical work, transparency and encouragement of an increasing climate of innovation in an environment of peer supports' (Auty, 2006b).

Bridging the Gap Between Health and Justice

Despite having good relationships and levels of collaboration, data from this study illustrates the existence of different perspectives in the Mental Health Diversion List – two key players of which are the government departments of Health and Justice and associated agencies.

> ***I:*** *'This is a new therapeutic jurisprudence initiative, so there is a lot more of a formal coming together of Health and Justice. How well do you think the two will work together for the offenders?'*
>
> ***P:*** *'I can only talk from the evidence. Certainly it is saying that that approach is working. To me, I certainly see it as something that is far more just and appropriate. So if a person has a mental illness and their mental illness has had a significant impact on the offence or offending behaviour, then that's the thing that needs to be targeted – their health. So if Health and Justice can come together and work together well on that, I think that's fabulous.'*

The term 'coming together' reflects a bridging of the gap between independent government sectors or agencies in the best interests of their mutual client. Another practitioner agreed.

> *'Instead of just picking those people [with a mental illness] up and dealing with them like everybody else gets dealt with [in the criminal justice system], we are trying to turn them back around, and back into the health system so they don't fall through the gaps.'*

In considering the Diversion List from different perspectives more generally than just Health and Justice, there are different standpoints in discussing reasons for the pilot project being implemented.

> *'When we set it up, we always knew this was a pilot project, this is a trial run if you like to see whether it is of use, to see whether it was a worthwhile exercise. I think it probably will be. But I suppose, we need to have this pilot programme to be able to show the bean counters within government that it is something that is a worthwhile exercise. Now for lawyers, magistrates, and police, a worthwhile exercise would mean that that person, a mentally ill person, whose illness is manifest in what would otherwise be termed criminal behaviour, is being adequately cared for and treated, so that aberrant behaviour is being addressed so they don't have to come back to court.*

That is the stakeholders' interest in this. The government's interest in this, let's face it, is purely, um, mainly fiscal. They would have an interest in what I have said too, but their interest is mainly fiscal. Will this programme mean that fewer people are going through courts so we have to spend fewer bucks on running our courts? So we don't have as many people on our lists, so we don't have as many prosecutors, so we don't have to give legal aid grants for lawyers to appear for this person. And we are hoping that at the end of this pilot programme, that we will be able to say 'yes'. Not only does it assist the mentally ill person, but it is costing the government and us a lot less to deal with this person as well. So we satisfy the bean counters, but we also do the right thing by the subject person, and frankly the community as well.'

Thus, practitioners demonstrated an awareness of differences of perspective (and accompanying different measures of success) relating to both the implementation and the future of the Mental Health Diversion List. Bridging the gap between health and justice will require an integrated partnership to facilitate effective and efficient diversion and results indicative of success.

The Revolving Door: An Imperative for Change

Despite differences in opinion and perspective, there is one specific belief that unifies practitioners and agencies from different disciplines: the traditional approach to offenders with a mental illness is not working very well. Health and treatment professionals must join in partnership with professionals in the criminal justice system because solely dealing with them through sentencing alone is not working – it is creating a 'revolving door'. The common belief behind setting up the List was the recognition of the need for a more appropriate forum utilising a process of diversion which blends the most effective elements of the criminal justice system and the health system to avoid the revolving door and inappropriate handling of these people. A strong commitment to social justice and empathetic treatment of people with a mental illness was observed as a core motivation or agenda for all practitioners in the List.

The 'revolving door' phenomena can involve mentally ill offenders' downward trajectories and being continually caught up in the criminal justice system, experiencing increasingly complex

problems and criminogenic needs, and sentencing outcomes having little effect on high recidivism rates and ongoing court appearances. Various practitioners spoke of concern about the revolving door and the desire to overcome it.

> *'Previously the court was not informed enough about the defendant, and the courts I think reacted somewhat hastily in relation to some cases and imprisoned people because really, there was no other alternative the court thought at the time. Now, that particular disposition didn't address the offending behaviour at all. So that person would come out of prison, become ill or whatever, they'd commence their anti-social behaviour again, the court would put them back in prison, and the revolving door starts. I think in Tasmania we had, as everywhere did, a relatively significant number of people who were caught in that revolving door, and we weren't addressing it. Now, we are not only looking at the individual person's point of view – better health – we are looking at the community's point of view, the prison population reduction, we are looking at a whole host of issues that can be addressed by keeping people out of prison and lowering their re-offending rates. It makes overwhelming sense to me that the court should position itself as an institution that has a role in the reduction of recidivism rates.'*

> *'I think it absolutely is [a move away from the revolving door]. Because a lot of these particular clients are not managed particularly well in the community by services. They do not generally get connected to the support they need. This process is helping to overcome that. I really hope we will be able to move beyond that revolving door to something that is a lot more beneficial for the defendants, for the court, and also for the community.'*

Getting a foot in the revolving door and thus reducing its occurrence is an important step towards achieving better results for each of the parties involved, from an individual to a societal level. If a reduction in the occurrence of the revolving door is successful, it will entail a broader process of social change influenced or instigated by new initiatives and action taken in the courts.

Court Process Within a Therapeutic Jurisprudential Framework – A Balancing Act

Court process is a contentious topic of debate amongst both supporters and detractors of therapeutic jurisprudence, and practitioners had different views in this study. The need to maintain an appropriate balance between traditional legal principles of open justice, natural justice, precedent, judicial objectivity and neutral arbitration, and new innovative ways of interacting and sentencing therapeutically is acute – but is certainly possible. Yet it is fair to describe it as a complex balancing act. Therapeutic jurisprudential and problem solving court initiatives are considered innovative in that they creatively blend together ingredients in the court process, sentencing and criminal justice system that may already have existed but needed development – using these elements in new ways to achieve better results. Nonetheless, it is recognised that these 'transformative' or new therapeutic court processes operate within and can be referred back to the wider traditional court legal framework and environment. Popovic, a magistrate in a problem solving court in Victoria, offers the following caution and counsel:

> 'Judicial practitioners of therapeutic jurisprudence still have some way to go in ascertaining the appropriate parameters of court processes. We must strive to ensure that we are not trampling over the rights of court users while maintaining a flexibility and practicality that have been lacking in traditional court processes... It is timely that we revisit some of the processes we have implemented and taken for granted as being necessary to give effect to the practice of therapeutic jurisprudence' (2006b: 76)

In a similar vein, one practitioner expressed mild concern regarding issues of due process using a new approach to individual cases.

> *'I think it is important that the basic principles be maintained. You must never forget that this court is a court. Its officers are exercising judicial functions, and it is imperative that the principles and ethics associated with that be maintained. There is always a risk when special arrangements are made for those principles or ethics to be compromised, always with the best of goodwill. There is a risk that enthusiasm will say 'this is a special case, therefore we need to perhaps downgrade the safeguards normally associated with defendants... The reality is that courts deal very much in the area of perception and public trust and confidence, and if there is a perception that the*

process has miscarried for some reason, even if it hasn't, then public trust and confidence in the judicial system is likely to be undermined.'

This can be contrasted with the perspective of another practitioner who spoke about the role of the magistrate and the court in protecting due process and their belief that the objectivity of the court is upheld in the Diversion List.

'The court remains objective in this process – the court ultimately has to make the final decision – so I don't see it as a threat to the objectivity of the court at all. In fact, if the court is perceived to be a member of a team – that is fine – because from a therapeutic jurisprudence perspective, the defendant still recognises that the magistrate is the person that needs to make the ultimate decision. The trappings of a formal court are there. The magistrate will hear from the other members of the team, the magistrate will involve his or herself in discussions about it, as you've seen, "how is it going? What should we do?" The magistrate is simply seeking advice on which he or she makes their ultimate final decision... It is the cause of the offending that the court team are talking about – the mental health issues. And to do that, we need to get more information... I would have thought that someone looking in from the outside would say "I think this court is properly informing itself." That is the way I would see it. I don't see it as a threat to judicial independence, objectivity, or anything like that. For both legal practitioners and the judiciary, I don't think we are trying to be social workers or anything like that. I think we are trying to implement a system which is fair to the defendants, fair to the community, and ultimately produces a positive outcome.'

When observing the Mental Health Diversion List proceedings, the researcher did not discern any erosion or relaxation of due process or the principles of justice.

Therapeutic jurisprudence should never 'trump due process; nevertheless, the social order is also enhanced when citizens are healed, when problems are solved, when people are successfully removed from the justice system' (Schma, Kjervik, Petrucci, & Scott, 2005: 61). The title of Popovic's (2006b) article poses an interesting question: 'Court process and therapeutic jurisprudence: have we thrown the baby out with the bathwater?' Asserting that therapeutic jurisprudence should never erode due process or open justice is valid. However, conceptualising the two as opposing elements is a false dichotomy. In answer to the question, figuratively

speaking, it is possible to have a change of bathwater without hurting the baby. Exercising the same due care and caution is the key.

Who is Eligible? Difference of Opinion

The second debate that has emerged is over eligibility criteria. Before examining the debate surrounding who is or is not eligible for the List, it is significant to discuss the debate surrounding the focus of the list – i.e. having a specialist list especially differentiating this population from the general mainstream population of offenders.

The List for Mentally Ill Offenders: Questions of Stigma and Labelling

Stigma and labelling are perennial issues pertaining to mental health, and thus they require consideration in regards to the creation of a specialist and so-titled list for mentally ill people. In the practitioner interviews, there were mixed feelings and different perspectives.

> *'Will the Mental Health Diversion List decrease or increase stigma in regards to mentally ill people? Not from any concrete evidence but just a gut feeling, I think it will do both.'*

> *'I think it will be mixed. I know that there were some that were very relieved to be within the system because they might have had a long history of offending, and it had only been recognised more recently that they have a mental health component to their behaviours. Getting it properly addressed provides a relief for them and also some hope that they can fix their lives up and get a less serious penalty. That is really obviously a real benefit to some people. There are some people that are a bit uncomfortable about it because they might want to move on with their lives. It is a matter of selling them the benefits of going through this process so that it can be ascertained that their lives are settling down or stabilising, and they can expect a more lenient outcome in the future... There is that mixture of people that are very relieved to be in a more supportive environment, a mixture of people who are going to be a bit ambivalent about it, and then those who wouldn't know any better. Yes, as you'd expect, it is a combination of everything really.'*

Another practitioner was asked about this and did not think that stigma and labeling were consequences of the title and function of the Diversion List.

> *'In reality, we are not actually finding that. We thought it would be a huge issue, but I can only really think of one person who has got objections to being in that sort of List. I think the mere fact that people are going to court, it is an open court, open slather, they are there anyway. I actually think even those defendants who don't have much insight, surprisingly enough, have been very amenable to going onto the Diversion List...In reality, it really hasn't been a huge problem, and because it is a specialist list, there is not really an awful lot of interest in it [from the general public].'*

In both interviews and the Project Team meeting, it was emphasised that participation in the List is entirely consensual, and that the defendants appearing in the List are free to withdraw at any time. They can choose to go through the general lists and not raise the issue of their mental illness if they do not want to.

Debates over Eligibility Criteria

Significant debate about who is and is not eligible took place, and there were overt differences in perspective between practitioners. Officially, the eligibility criteria state that the List is for people with impaired intellectual or mental functioning arising from: a mental illness; an intellectual disability; an acquired brain injury; a personality disorder; or a neurological disorder including dementia (Magistrates Court of Tasmania, 2007b). However, on a practical level, the inclusion of mentally ill people was supported by all. Whereas the eligibility and inclusion of people with intellectual disabilities, acquired brain injuries, and personality disorders (a behavioural disorder) was not supported by all.

> *'There is a lot of debate about particular defendants and whether they should be on the List, and a lot of disagreement between parties perhaps. For example, there have been suggestions by particular magistrates for defendants to go on the List that have been refused, in particular people with an intellectual disability, because the List hasn't got the capacity to deal with everybody. We are only dealing with Mental Health Services, people with those kinds of problems, not people with intellectual disabilities. They have to be excluded out of necessity. Whereas there has been a lot of debate that our List*

should be dealing with people whose offending stems out of their intellectual disabilities... We would maintain that those people would probably benefit from being on a List like this, but it simply doesn't have the capacity to take everybody... because we just haven't got the man power to do it.'

Another practitioner was asked directly about this, and offered a similar perspective:

'With something new like this in Tasmania, I think it's important not to take on too much initially, and it is good that they are limiting the eligibility criteria at this point in time; I think that is appropriate. Otherwise it would be huge and very complex.'

However, other practitioners disagreed and believed that people with these disorders or impairments should be included in a specialist therapeutic court process.

'[Referring to people with intellectual disabilities or acquired brain injuries] Often their offending is related to their head injury or intellectual disability, there is a significant connection there... I definitely think that people with an intellectual disability or head injury need to go through the specialist courts.'

'I think it should be inclusive. I have no problem with people with an intellectual disability or a personality disorder being included in this List.'

'[Referring to people with a personality disorder] I think for me, they are often one of the hardest, but they are often the ones that are most at risk of re-offending and potentially the most dangerous. As far as I'm concerned, if they are the ones that are doing the most stuff, don't we want to try and reduce that? Yes, I would lean towards people with serious personality disorders to be included.'

As noted by some practitioners, the inclusion or exclusion of specific groups of people relate to maintaining the parameters of the List and issues of resources and complexity of cases. Nonetheless, this debate indicates that there are significant differences of perspective, and this issue will require further consideration as the court develops.

Resources and Workload

The issues of resources and workload form key theme areas and findings of this study. Extensive debate took place on this topic that is relevant to future policy and practice. First, there was the recognition that the Diversion List was much needed and does not involve an extensive amount of more pressure or strain than already exists. This is because the majority of the defendants in the List were already in the criminal justice and Forensic Mental Health services system.

> *'There are definitely a finite number of resources. But again, these people are not adding to the core business of services, these people are existing clients who are already there. We are not creating work for any agency – we are not creating work for the court and we are not creating work for Mental Health Services. We are simply saying that we are both dealing with these people, or we should be, and so we are simply coordinating it better together to get better outcomes for both of us. I don't think it is a whole lot of new work for the court to deal with because these people are already up on charges and the Court has to deal with them anyway.'*

Cost Neutrality, Resources and Funding

Practitioners were asked the question 'do you have any thoughts or comments on the Diversion List being cost neutral? What impact is it having on resources?'

> *'Well, at the moment it seems to be holding on as cost neutral. If it became bigger, I don't know how we would go with that... I would have thought that we can do pretty well at holding it at cost neutral, I would hope we can. I mean, these defendants would be in the court system anyway. I can't see that what we are doing is adding to the cost of the process really.'*
>
> *'When we set it up, it was set up in full knowledge of the financial constraints we were going to face... But for all intents and purposes, that person coming before the court will be cost neutral.'*
>
> *'Aaah, cost neutral, hmm. I don't know about that. In the short term [pause]... It is a very good way of using our resources, because I feel that this is the work that we really should be doing ... I think in the short term it is going to take more of the courts time. So it might mean that the List blows out a little bit. But I think in the long term is where*

the impact is going to come because we are doing something actively to try and break that cycle of offending being linked to someone's mental state. It will be in the long term that we will see there is quite an advantage, and that it will save the courts time.'

In the Project Team meeting and practitioner interviews, it was noted that there are savings of time and money occurring for those that no longer have to commission expensive psychiatric reports or do as much liaison with different practitioners, as would be necessary in the mainstream lists. Thus, because of the integration of services, a broader body of knowledge is known to the court without having to pay for reports.

However, having no additional funding for the Diversion List pilot project and the pressure put on resources was a topic of concern.

'In the introduction of a List like this, it is pretty well unprecedented that there is no new employment from it with people coming in and doing it. Tasmania, to my knowledge, is the only state in the country where the Justice Department or the Court itself does not pay for anybody to help disabled defendants or mentally ill defendants. So there is that Health arm that comes in and does that... I would certainly like to see that some employment comes from it.'

'Our resources are stretched... I wonder, I hope that if a person is the subject of a court audience that maybe it will put more pressure on these places [referring to mental health services, rehabilitation and treatment providers in the community] so that the government will be required to give more funding to them, so hopefully it will be a snow-ball effect... But it has always been the infrastructure and resource support that has been lacking. This List will be a dud as well; this won't work either – unless we have that support. Nothing is going to work unless the community has the financial ability to make it work.'

Another practitioner expressed similar sentiments towards the government.

'There is no funding, no money. So we have all these wonderful ideas, but until the government actually funds them...Most jurisdictions have these kinds of courts. So why does Tasmania have to do it with zero dollars? They can spend $15 million on football clubs, they can spend it on Elwick racecourse, but for this there is zero dollars! One in four or one in five people have a mental illness... So why is Justice not funding this?'

Impact on Workload

The question of sustainability and increased workloads was touched on directly by another practitioner who mentioned these as possible risks to future of the List.

> *'[There will be] An increase in workload – there is no doubt about that... All these organisations have to be resourced, and this is one of the issues. There is a risk that the success of the Mental Health List – if it is to be successful – there is a risk that it will be so successful that it becomes unaffordable... Sustainability will depend on the reports of people like you as to whether it is worth funding, and if that is answered in the affirmative, then whether it can be funded – obviously a separate question. There are a lot of good things that ought to be funded that are not funded.'*

There were mixed answers relating to the question posed to practitioners 'what impact is the Diversion List having on your workload?'

> *'It is time consuming. It has definitely increased our workload. It is not really going to be sustainable in the long term.'*

Some practitioners noted decreased workloads and demand on resources for themselves, some noting the same or similar level of work, and there was an increased workload for others. Thus, the answer was dependent on who was being asked.

As evident from the section above, a few practitioners spoke their mind. However, the researcher observed hesitance on the part of some practitioners in regards to this topic – a sense of saying a bit but not saying too much – especially when being audio-recorded. The issue of resources and funding was the only area where practitioners seemed to express their views in a more moderate/restrained manner. No practitioners wanted to jeopardise the future of the List. They were aware that high costs and demand on resources would be perceived negatively by decision-makers in the Magistrates Court and relevant government departments of Justice and Health and Human Services. Instead there was an imperative to focus comments on savings to the court, the justice system, the community and potential future victims.

Suggested Solution: New Position of Employment

All practitioners were asked if they had any suggestions for the future for the Mental Health Diversion List. The main answer/suggestion put forward was for a new position of employment to enhance practitioner and defendant support.

> *'I am conscious the workload is intense. I would like to have some more support for the List, and I know that is a dangerous thing to say, but I would like to have it.'*
>
> *'Directly related to the Mental Health Diversion List, I'd like to see a worker based at the court, and have that person take on the role of assessment and liaison with service providers... That would be really useful. I would like to see a full-time position.'*
>
> *'It is probably an area that would really benefit from a dedicated court liaison officer, not those poor people having to do that now as well as all the other stuff. So I'd like to see that sort of thing... Certainly someone who is a coordinator that can check on things... So I think that someone dedicated to that role would be a much more efficient way of doing things, more effective.'*

The creation of a new position of employment to reduce workloads and to increase the coordination and capacity of the Diversion List is an issue for consideration by stakeholders.

Conclusion

Debate and constant grappling with different nuances of an intervention or project is healthy. The three debates contained in this chapter demonstrated differences in perspective. These can be contrasted with the glowing accounts of how well the Diversion List is going. This does not contradict the success of the List, it is merely an indication there are a few contentious issues at hand that warrant further deliberation and action – as will be outlined in subsequent chapters.

Chapter 5:

A Preliminary Evaluation

This chapter contains evaluative and analytical reflection on both positive and problematic elements of the functioning of the Diversion List. It considers strengths and successes thus far, and also weaknesses, then discusses matters of significance in which further research or consideration is needed. It should be noted that issues outlined in both sections are not necessarily ranked in order of importance.

The Successes of the Mental Health Diversion List

A number of successes and strengths have emerged in the first months of the Diversion List.

The Commitment and Work of Key Practitioner Stakeholders

Many practitioners commented on the commitment the team members. The significant majority of criminal defence lawyers representing people in the List did an excellent job. Of special note are the Legal Aid lawyers, who were required at times to step up at the bar table to help with cases for people they had not met (when a person was unrepresented and had not previously asked for help, or whose lawyer did not turn up) – a task they did well. In the Project Team meeting, multiple practitioners noted that they had done a 'marvelous' job in handling the complex and diverse cases and a significant caseload for each sitting. In the practitioner interviews, there was extensive positive commentary on the other members of the court team. By practitioner interviews and researcher observation supports the commendation of the active leadership of Magistrate Hill and the substantial contribution of each of the members of the court team. The amount and calibre of work by the key practitioner stakeholders forms one of the most significant strengths or assets comprised in the Mental Health Diversion List.

Collaboration and Communication

From observation of the court and the Project Team meeting, as well as interview data, it has been established that the collaboration and communication between different groups is one of the strengths of the List.

> *'People have been very collaborative, very cooperative and very positive about what is happening, so that is good.'*

Follow-up or out-of-court monitoring of defendants' cases is generally undertaken by Forensic Mental Health court liaison officers, who may phone case managers, treatment or rehabilitation providers, or health care practitioners for information before the next hearing of a person's case. Encouragingly, court liaison officers have told of multiple occasions when case managers have rung them first, providing all the necessary information, asking questions about court proceedings, providing suggestions in the best interests of the defendant, and generally being very helpful. Referrals to rehabilitation treatment providers outside the court have had positive feedback. Because therapeutic treatment is a key component of the Diversion List, yet it occurs outside the parameters of the court system, the active involvement of case managers and treatment providers in the collaborative process is a significant strength.

Also, most were happy with the level of collaboration and support from the other magistrates referring people into the List.

> *'I haven't experienced any reluctance on the part of magistrates to transfer matters, which is really good. That was one of the things that we might have considered to be a problem, but that has not occurred at all. They've been fantastic.'*

However, a different perspective was expressed by a practitioner saying they were happy to have the support of magistrates and practitioners, but more care and caution with referrals is needed.

> *'I think the magistrates need to be aware as a group of just what the basic criteria are. Sometimes I think, with great respect, they might see this List as an area where if the person is a bit difficult to deal with, well move them into this List... I think the magistrates need to be very alert about the criteria, that we are not a dumping ground for difficult people. I think also practitioners may see us as a bit of a soft option, so they*

need to be told this is not a soft option. Magistrates and practitioners need to be aware that there are boundaries, and we will maintain them for our own integrity, otherwise our system will be threatened. If a defendant is outside the target area, well sorry we can't deal with their matters, and I'm not too troubled by that.'

Collaboration and high levels of referral should not occur because magistrates or practitioners outside the List view it as an easy option, but with careful consideration as to whether each defendant is most appropriate for the Diversion List and vice versa.

Overall, the practitioners involved in the Mental Health Diversion List seem to know each other well, maintain regular contact, and engage in collaboration that is beneficial in the effective administration of the List.

Increased Practitioner Job Satisfaction

A few practitioner accounts have emerged of increased job satisfaction, one of which provides a summary of general sentiments:

'[As a person who has been involved in law and justice for years] It can be fairly relentless depressing work for any number of reasons. I think those of us that are interested in rehabilitation and reduction of recidivism can get quite a buoyed feeling out of somebody saying to you "thank you, this has worked pretty well for me, I have now got a job" or whatever the positive outcome has been. You feel as if at least in some way you have played a part in perhaps assisting that person ... So from a professional point of view, I get great satisfaction out of participating in this List. I think it is excellent.'

The main reasons or themes suggested for increased satisfaction is being able to help people and not simply be an instrument in the administration of sentencing and punishment, or in seeing people get caught in the revolving door.

Problem Solving, Flexibility and Individual Attention

There is evidence from the data to support the assertion that the Mental Health Diversion List involves the process/practice of problem solving. In the court proceedings, different problems were raised by practitioners, and solutions were then enacted. For example, it is common for

defendants with a mental illness to experience problems in areas such as finances and poverty, homelessness, unemployment, substance use, or family related issues. One defendant had major financial difficulties and was not able to pay fines they had previously incurred. Members of the Diversion List team liaised with the public trustee and directly helped the defendant to work towards ameliorating the problem. The court heard that specific goals relating to financial status and housing had been established as part of the person's treatment plan. Observation of the court, the Project Team meeting and practitioner accounts demonstrate that the interdisciplinary collaborative team approach is a strong element enabling problem solving.

> *'We are saying "If we need to hear from Forensic Mental Health, if we need to hear from your GP, if we need to hear from your support worker, if we need to hear from your carer – it doesn't matter who – we will hear all that and we will see where we can go." We can discuss it around the table, and I think the flexibility of the List would enable us to do that... The mental health court approach is to say "Well, if you tell us that's the scenario, then why don't we try this for a month and see how that works"... So I think we might just be pushing the door open, and I hope we are.'*

There is strong evidence to support the flexible nature of the problem solving in court. For example, there have been instances where a defendant stopped attending a rehabilitation programme or when they stopped taking a specific medication because it did not agree with or suit them. This was mentioned to the court and negotiations took place for them to change to another rehabilitation programme or medication regime that was more appropriate. Thus, there is flexibility is handling some non-adherence with bail conditions.

As discussed elsewhere, the importance of giving attention to individual cases so the sentencing will reflect appropriate understanding of the case cannot be underestimated as a positive component of the court for the defendants.

The Consultation of Complainants or Victims as part of the Court Process

In the interests of confidentiality and privacy, little information is publicly available regarding this element of the Diversion List. It has been established that Police prosecutors have provided information and feedback to complainants or victims when the defendant charged with the

offence is a participant of the Diversion List. Throughout any point of the process, the prosecutors are the main point of contact for the complainant/victim. Anecdotally, it is known that most have been fairly understanding of both the role of the defendant's mental illness in committing the offence and the need for treatment to aid recovery and reduce recidivism. In the dispositions attained through the Diversion List thus far (where there has been a complainant or victim), consultation has taken place prior to when the disposition is finalised in the defendant's final court hearing, and victim support for a disposition is relayed to the court. It has been a long held complaint that the perspective of victims has been largely ignored in courts of law; therefore, the consultation of complainants/victims is a positive strength of this List.

Views from the Start Line – Passing Go with Flying Colours

Another strength is the defendant outcomes and progress achieved thus far. All practitioners involved with the Mental Health Diversion List are acutely aware that it is very early days, hence the reference to it feeling like 'views from the start line'. That not withstanding, there are already practitioner stories of surprisingly high levels of treatment engagement and compliance yielding remarkable results.

> *'At the moment, we have got a couple of people on our List that have been coming in and out of this Court for 10 to 15 years, and have never been as good as they are now. We have never been successful at getting them into treatment. We have never been successful at changing their offending patterns. And they are surprising everybody – including us. It is quite exciting to think that we are having an impact on some very difficult people... It is really good. It is clearly what we need to be doing.'*

In addition to the above practitioner interview comments, court observation, Project Team meeting observation, and comments made by several stakeholders outside of recorded interviews (i.e. in informal meetings or other conversations) indicate that real progress is being made. Multiple case managers working reported to the court (via court liaison officers) that the process had been 'very beneficial' and good for their clients. It is the job of subsequent evaluators and future research, using ongoing practitioner and defendant accounts, to measure and attain evidence of positive treatment outcomes.

Areas of Concern

There were also some emerging problems that warrant further consideration and amelioration.

Decentralised and Uncoordinated Data Collection

It is not evident which types of data are being collected by whom using what methods and from what sources. Each organisation or agency collects some data that is relevant to their role and work – data collection is decentralised and fragmented, there is little or no coordination. An example of important information that is not known or being collected at the present is the referral source for each defendant wanting to participate in the Diversion List. This is an issue in light of some inappropriate referrals to the List. Deficits in data collection are a barrier to good practice, but one of the reasons for it is likely to be related to lack of resources available to do additional tasks on top of existing workloads.

Impact on Resources and Workloads

Impact on resources and workloads has emerged as a problematic area of concern because of significant differences in perspective and a more discernible impact on some practitioners and not others. Little needs to be said here because the debate outlined in Chapter 4 is self-explanatory in highlighting this is a contentious topic and may pose challenges in the future. It is evident that pressure needs to be relieved in this area in some way in the future.

Matters of Significance

The following matters of significance delineate themes and issues warranting reflection by all relevant stakeholders and practitioners. They require more thought and demarcate areas of opportunity for future progress and development.

Continuity of Supervision and Sittings

During the period of May to October 2007, it was observed that there were periods of time when the designated magistrate was unavailable to preside, and thus scheduled sittings were organised

around these periods. Holidays, sick leave, or leave for other reasons are certainly acceptable and valid. However, if planned leave or unforeseen circumstances prevent the designated magistrate from presiding over the List, and thus delays sittings of the List, this warrants consideration and planning (see recommendation). It should be emphasised this is not a major area of concern, but a general matter for thought as the List grows and develops.

The Capacity of the Mental Health Diversion List

A second matter of significance, especially in the second half of the 12 month pilot period, is how many defendants will be allowed into the Diversion List. New referrals to the List are being made regularly, and increasing admissions to the List results in more detailed workloads for the practitioners and service providers involved. This is a matter for further deliberation by the Project Team, but researcher observation and practitioner anecdotes suggest that it may be warranted to limit or filter the number of new referrals in the last few months of the pilot stage. The Diversion List team has achieved 'quality' of practice in a skilful manner but, due to pressure on resources, it may not have the capacity to transition into a big List during the pilot stage.

The Title of the Mental Health Diversion List

A third matter of significance is the title or public name of the Mental Health Diversion List, regarding which some debate has occurred amongst practitioners. Some have said that having 'Mental Health' as the title of the List is an important part of the defendant coming to terms with their mental illness and the relationship between their psychiatric diagnosis and offending behaviour. Other practitioners have urged caution about this, and raised issues such as stigma and labelling, which are perpetual issues in mental health generally (Arrigo, 1996). The suggestion was made by one or two practitioners that it be re-named as a 'Specialist Health' List which avoids labelling, and reflects openness to people with a dual diagnosis of a mental illness and an intellectual disability or substance abuse. The debate reflects the heterogeneous perspectives of defendants' in the List, and the official name of the List is a matter for deeper reflection.

The Essential Elements

Earlier, the 10 essential elements of a mental health court were outlined as a form of benchmark or ideal (Thompson *et al.*, 2007: 1-10). The following comprises a brief evaluative critique of progress thus far in the Mental Health Diversion List.

1. Planning and Administration – a broad group of stakeholders exists, and they work well in partnership. It is possible this group could meet more often for discussion and planning. Although, there is little or no direct community or consumer advocacy participation.

2. Target Population – there is some difference in perspective and disagreement surrounding the target population specified in the eligibility criteria. Valid questions were raised about the capacity of the List as a pilot project to have an expanded target population just yet.

3. Timely Participant Identification and Linkage to Services – this is done very well, and has not been difficult because the majority of defendants are already known to services.

4. Terms of Participation – as specified in information given to defendants entering the Diversion List and individualised bail conditions and treatment plans, this is done well.

5. Informed Choice – practitioners are very competent at ensuring participants are aware of what the Diversion List entails, and emphasising it is an entirely voluntary programme.

6. Treatment Supports and Services – there is room for some development to increase the availability and capacity of treatment and services in Tasmania, as noted in literature reviewed earlier. However, the Diversion List is a pilot with no additional resources or workers, so it is understandable this has not occurred yet. It is a broad social process that will require multidisciplinary support and effort over an extended amount of time.

7. Confidentiality – from observation, due care and appropriate protection of participant rights and privacy has been maintained; there does not appear to be any issue in this area.

8. Court team – the court team is one of the most significant assets of the Diversion List. The only thing of mention is that there does not yet appear to have been much specific training in therapeutic jurisprudence or the diversion of mentally ill offenders.

9. Monitoring adherence to court requirements – the practitioners, especially Forensic Mental Health court liaison officers, are well informed about the adherence or non-compliance of defendants. Modification of treatment plans or decisions has occurred.

10. Sustainability – this is perhaps the most significant challenge, but arguably a most worthy undertaking, to ensure the sustainability of the Mental Health Diversion List.

There are both strengths and areas of concern. Flexible development and ongoing monitoring of key areas such as those listed above and elsewhere in other mental health court evaluative literature will contribute to enhancement of the capacity and court process of the Diversion List.

Conclusion

The preliminary nature of the evaluation is indicative of the fact that some topics cannot be discussed and some questions are not answerable in the short term, and require more data and examination over an extended period of time. In a longitudinal evaluation of the List, planning and long term data collection needs to occur in four key areas: participants, treatment services/diversion, criminal justice outcomes, and mental health outcomes (Steadman, 2005). Reflexive consultation with and participation by all relevant individuals (defendants and practitioners) and organisations will ensure more comprehensive data and research findings transpire.

Nonetheless, the evaluation presented in this chapter contains analytical discourse integrating the data and research findings to form a summary of the themes and issues that have emerged.

Conclusion

In light of the preliminary evaluation presented in the last chapter, the following recommendations are advocated by the researcher. They are not listed or ranked in order of importance or urgency; instead each recommendation is stand alone.

Recommendations

1. It is recommended that significant consideration be given to extending the operation of the Mental Health Diversion List beyond the planned conclusion of the pilot project in May 2008. This is only a preliminary evaluation and more research is needed. However, it seems clear that the Mental Health Diversion List demonstrates merit and has successfully engaged in problem solving in court hearings. Allowing the List to continue will enable more data collection and evaluation about its effectiveness, which will bolster informative contribution towards any decisions of a permanent or lasting nature. It is important to make this decision in light of resources available, but practitioners are keen to continue this exercise in therapeutic jurisprudence.

2. It is recommended that the Mental Health Diversion List remain as a specialist list/court diversion programme of the Magistrates Court. There is no current foreseeable need for development into a full Mental Health Court as may be established in other jurisdictions.

3. It is recommended that one relief magistrate who has an affinity for handling complex cases of offenders with a mental illness join the Mental Health Diversion List team. This will enable regular sittings to go ahead if Magistrate Hill is unavailable, allowing the court sit with a frequency that is in the best interests of those appearing before it. However, the current high levels of consistency and continuity will still be upheld if Magistrate Hill and another magistrate maintain strong lines of communication.

4. It is recommended that an individual professional or representative of a relevant organisation adopt a formal role in the capacity of advocate in consultations and planning for the Mental Health Diversion List. This person would serve the capacity of advocacy and representation of the perspective and interests of the mental health consumers that participate in the Mental Health Diversion List. They should have good awareness of all facets of the List without necessarily being a legal/health actor within the regular court hearings. It is up to the discretion of the Mental Health Diversion List Project Team, if this is implemented, to decide the most appropriate/best practitioner or representative organisation to undertake this advocacy role. For example, from the non-expert perspective of the researcher, any of the following would be valid potentials: Advocacy Tasmania, different areas of staff expertise within Department of Health and Human Services, a mental health expert practitioner from the University, a mental health consumer support organisation, or an independent psychological or psychiatric practitioner. It is also up to the discretion of the Project Team to delineate the specific nature of the involvement (e.g. will they join the Project Team or just be consulted on a needs basis?). The contact details and role of this advocate would need to be well disseminated amongst List participants.

5. It is recommended that there be a strengthening of centralised and coordinated data collection. Future evaluation research focusing on effectiveness and efficiency, including concrete outcomes measures of success, cannot be conducted without sufficient data from a number of sources on a number of topics.

6. It is recommended that consideration be given to establishing an information and discussion forum to facilitate informative education and consultation and feedback between key stakeholder practitioners and any practitioners or interested parties of relevance relating to the Mental Health Diversion List. For example, this could involve any of the following: lawyers, magistrates, court staff, Forensic Mental Health or Mental Health Services case managers or support workers, treatment or rehabilitation providers, community social workers, consulting private psychologists or psychiatrists, GP's, Tasmania Police staff, prosecution, consumer advocates, and graduates commencing practice in Law. If implemented, it is the responsibility of the Project Team to determine the regularity of these forums. On a practical note, it is

suggested that the forums are scheduled before, in-between, or after the usual court sitting hours in the morning or afternoon sessions; thus promoting the availability of legal practitioners and judicial officers to be free to attend.

7. It is recommended that the Project Team engage in discussion about the eligibility criteria for the List, specifically whether it will or will not encompass people with an intellectual disability, acquired brain injury, or a personality disorder. The current capacity of the List to do so is an important consideration, as is future capacity should the List be continued and if resources or funding be secured. As discussed in this study, there were discrepancies between the official criteria and different practitioner perspectives. It is certainly not within the scope of this research to make suggestions on this topic, but it is important that the Project Team give it concerted consideration and come to an agreement. The Procedural Manual may then need to be altered to correctly communicate the decisions made on who is eligible.
8. It is recommended that consideration be given to the future creation of a new position of employment for the Mental Health Diversion List. It is not within the scope of this study to give any specific direction regarding this, simply to suggest that consideration be given to the possibility of securing funding and resources for a new position. The desire on the part of practitioners for a dedicated worker was a finding of this study.

Final Reflections

While the position of this study is that the Mental Health Diversion List merits further continuation and growth, hard evidence will be needed to convince policy makers – further evaluation research is needed. Practitioners and stakeholders need to give careful consideration to the debates and perspectives explored in this study to aid self-awareness and development of process and outcomes. The recommendations provide direction in this regard.

Problematic issues arising from social processes such as deinstitutionalisation and the revolving door have triggered the need for the creative use of existing tools by legal and health institutions

to handle complex groups of people in a more appropriate and humane way, resulting in lasting solutions for all concerned.

It looks, however, like problem solving is occurring in the Diversion List as a successful component of therapeutic jurisprudence. The positive perceptions of defendants and practitioners, as well as promising defendant dispositions and treatment outcomes, team work and collaboration all suggest that some important progress has already been made. The use of therapeutic interventions to achieve better justice outcomes for people with a mental illness through the Mental Health Diversion List pilot project is a welcome development in the Tasmanian criminal justice system. It embodies great capacity and promising potential for the future.

Appendix

- Official descriptive flowchart detailing the process through the Mental Health Diversion List (Used with permission from Tasmania Police Prosecution Services, 2007).

Deft flagged as having MH issues

Suitability criteria addressed?

No

Yes

Remain in General List

Application to divert into MHC

Processing staff SRPS:
- Copy facts and priors
- enter file onto MHC database

2 x sets of Facts for Prosecutor and priors on file:
1 x faxed to FMH on 62339427
1 x copy to defence
1 x copy to court

FMH / Prosecution meeting Thursday Prior to MHC at 1pm

1st appearance MHC

Reports Ordered

Bail Conditions Set

- see agreed standard bail conditions list

Next / subsequent appearance date(s) set

MHC database updated

Reports from FMH / defence placed on file

FMH reports are verbal to the court only. Notes need to be placed on the database during the FMH / Prosecution meetings

Deft assessed as not suitable during any stage of proceedings

Return to General List

Facts to Court

Plea

Contact victim re:
- Damages claims / receipts
- Victim Impact issues depending on matter
- Restraint orders / extensions required

Any disputes / variations to Facts for Prosecutor raised are discussed and any variation given to the court

Sentence

7(h)

7(f) WOC + treatment

7(f) C/R + treatment

Another variant

Most matters will have the number of return dates and frequency recommended by FMH based on medical needs / reports required / treatment plans

Eligibility
(as per TMCMHDL Procedural Manual 4/07)

2.3 Participants will have impaired intellectual or mental functioning arising from:
- mental illness as per 2.3.1
- intellectual disability
- a personality disorder
- ABI
- a neurological disorder including dementia

2.3.1 Definition of mental Illness
As per section 4 of the Mental Health Act 1996
Meaning of 'Mental Illness'
(1) A mental illness is a mental condition resulting in-
(a) serious distortion of perception or thought;or
(b) serious imparement ordisturbance of the capacity for rational thought;or
(c) serious mood disorder;or
(d) involuntary behaviouror serious imparement of the capacity to control behaviour
(2) A diagnosis of mental illness may not be based soley on-
(a) antisocial behaviour;or
(b) intellectual or behavioural nonconformity;or
(c) intellectual disability;or
(d) intoxication by reason of alcohol or a drug

2.3.2 Exclusionary Offences
- All indictable matters;
- Sex related offences;
- Offences requiring the mandatory disqualification of a drivers licence; and
- Family Violence Offences

Mental Health Court - Prosecution Process Flow

Version 1	31 July 2007	SGP

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